International Conference

PSYCHIATRY BEYOND SCIENTISM

JANUARY 22 - 24 2015

VU University Amsterdam
ORGANIZERS

Organizing committee
Prof. Dr. Gerrit Glas
Dr. Ing. Leon de Bruin
Dr. Derek Strijbos

Visiting adress
VU University Amsterdam
De Boelelaan 1105
1081 HV Amsterdam

Contactperson
Irma Verlaan
E. g.h.verlaan@vu.nl
T. (+31) 020 59 85283
T. (+31) 06 14605154

This conference is part of the Science Beyond Scientism Project,
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ROUTE DESCRIPTION

Venue Address:
Main building VU University Amsterdam
De Boelelaan 1105
1081 HV Amsterdam

Conference room:
Auditorium
First Floor (Main Building): Take the chairs across from the main entrance.

Parallel Sessions
1A-05
First Floor: From the Auditorium, go to the right, take the stairs on your right hand.
2A-05
Second Floor. Take the stairs to the second floor and go to room 5.
5A-05
Fifth Floor. Take the stairs to the fifth floor, or the elevator to the 6th floor and then the stairs to the fifth (the elevator does not stop at the fifth floor).

Route:
VU University is located close to the railroad station Amsterdam Zuid – WTC. From the city centre you can reach VU with tram line 5 or metro line 51.

Transportation
Travellers arriving at Schiphol can take the train to Station Amsterdam Zuid. There are direct intercity trains from Schiphol that go straight to this station. The journey takes approximately 15 minutes. You can buy a ticket:
- At the yellow self-service ticket machines. Payment can be done by debit card (Maestro) or coins. Unfortunately, not all ticket machines accept credit cards.
- At a service desk at a larger railway station. There is a €0.50 charge for using this service.
- Information on (bus/train) schedules can be found on the NS website or at www.9292ov.nl/en.

From Station Amsterdam Zuid
It is a ten-minute walk to the VU, and there are signs to the VU on the Southern exit of the station. However, if you want to take public transport, it is one stop on either:
- express tram 51 (1 minute), direction Amstelveen Westwijk
- tram 5 (1 minute), direction Amstelveen Binnenhof

From Station Amsterdam Centraal:
- metro 51 to De Boelelaan/VU. Enter in the subway station under the main train station
- tram 5 to De Boelelaan/VU. Enter on the West side of the station square.
- tram 16 or 24 to De Boelelaan/VU. Enter on the East side of the station square.

Travelling by car
The A-10 Amsterdam ring road can be reached from all directions. Follow the A-10 to the Zuid/Amstelveen exit S 108. Turn left at the end of the slip road onto Amstelveenseweg; after about three hundred yards (at the VU University hospital building) turn left again onto De Boelelaan. VU University Amsterdam can be reached via city routes S 108 and S 109.
DAY 1 – THURSDAY JANUARY 22
“Models of explanation in psychiatry”

09.00 REGISTRATION OPENS Auditorium
(Main Building, first floor)

09.30 – 09.45 OPENING Prof. Dr. GERRIT GLAS Auditorium

09.45 – 10.30 LECTURE Prof. JOHN CAMPBELL Auditorium
Imaginative Understanding vs. Causal Explanation

10.30 – 11.15 LECTURE Prof. Dr. DENNY BORSBOOM Auditorium
A network perspective on psychopathology:
implications for the theoretical status of mental disorders

11.15 – 11.45 COFFEE BREAK Reception Area Campus side
(first floor)

11.45 – 12.45 PARALLEL SESSION 1 2A-05 / 5A-05 / Auditorium

12.45 – 14.00 LUNCH BREAK Reception Area Campus side

14.00 – 14.45 LECTURE Prof. ERIK RIETVELD Auditorium
Skilled Intentionality & the System ‘Brain-Body-Landscape of Affordances’

14.45 – 15.30 LECTURE Dr. DEREK STRIJBOOS Auditorium
Explanatory models in psychiatry: a brief overview

15.30 – 16.00 COFFEE BREAK Reception Area Campus side

16.00 – 17.00 PARALLEL SESSION 2 1A-05 / 2A-05 / Auditorium
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<td>LECTURE Prof. Dr. GERRIT GLAS</td>
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<td>Psychiatry as normative practice</td>
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<td>LECTURE Prof. MONA GUPTA</td>
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<td>PARALLEL SESSION 3</td>
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<td>LECTURE Prof. JOHN SADLER</td>
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<td>1A-05 / 2A-05 / Auditorium</td>
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<td>Reception Area Campus side</td>
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<td>16.00</td>
<td>LECTURE Prof. MARC LEWIS</td>
<td>1A-05 / 2A-05 / Auditorium</td>
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<td>When addicts and scientists connect:</td>
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DAY 3 – SATURDAY JANUARY 24
“Psychiatry in the public context”

09.00 REGISTRATION OPENS Auditorium (Main Building, first floor)

09.30 – 10.15 LECTURE Prof. Dr. GERBEN MEYNEN Auditorium
Legal insanity – theoretical debates and practical dilemmas

10.15 – 11.00 LECTURE Dr. Ing. LEON DE BRUIN Auditorium
Mental Disorders as Dysfunctional Patterns

11.00 – 11.30 COFFEE BREAK Reception Area Campus side (first floor)

11.30 – 12.30 PARALLEL SESSION 5 1A-05 / 2A-05 / Auditorium

12.30 – 13.45 LUNCH BREAK Reception Area Campus side

13.45 – 14.45 PARALLEL SESSION 6 1A-05 / 2A-05 / Auditorium

14.45 – 15.15 COFFEE BREAK Reception Area Campus side

15.15 – 15.45 DISCUSSION JAN VERHAEGH, LED BY Prof. Dr. GERRIT GLAS Auditorium

15.45 – 16.30 LECTURE BILL FULLFORD Auditorium
Delusion and Spiritual Experience: Models, Norms and a Challenge for Psychiatry in the Public Context

16.30 – 16.45 CLOSING Prof. Dr. GERRIT GLAS Auditorium

16.45 - 17.00 CLOSING DRINKS Reception Area Campus side
ABSTRACTS KEYNOTES

Thursday January 22nd 09.45 – 10.30h
Auditorium

John Campbell - UC Berkeley

Imaginative Understanding vs. Causal Explanation
I will look at Jasper’s contrast between imaginative understanding and causal explanation, and
suggest that ‘imaginative understanding’ as Jaspers conceives actually does require a certain kind of
causal insight; as Hoerl (2014) suggests, the contrast is properly seen as being between general
causation (claims of the type, ‘Humiliation causes depression’, which link general characteristics),
and singular causation (claims of the type, ‘Sally’s humiliation caused her depression’) which link
particular events. I argue that imaginative understanding is at the moment our only way of finding
out about singular causation in the mind. And I look at whether this kind of singular causation can
be analyzed in the ‘interventionist’ terms that seem readily applicable to causation in science
generally.

Thursday January 22nd 14.00 – 14.45h
Auditorium

Erik Rietveld - University of Amsterdam

Skilled Intentionality & the System ‘Brain-Body-Landscape of Affordances’
Our ‘Skilled Intentionality Framework’ is a conceptual framework for enactive or embodied cognitive
science that is able to relate findings established at several complementary levels of analysis:
phenomenology, ecological psychology, affective science, and neurodynamics. Skilled Intentionality
is skilled coordination with multiple ‘affordances’ simultaneously. Humans share with other animals
such a skilful responsiveness to possibilities for action provided by the environment or ‘affordances’
(Gibson, 1979; Chemero, 2009; Rietveld, 2008, Mind). Skilled Intentionality is the kind of
intentionality that characterizes most of the things individuals do: in everyday human life, in animal
life, and in expert activities (Bruineberg & Rietveld, 2014, Frontiers in Human Neuroscience). We
have recently argued that affordances are best understood as relations between an aspect of the
material environment and abilities available in a ‘form of life’ (Rietveld & Kiverstein, 2014, Frontiers in Human Neuroscience). Crucially, the landscape of affordances in our human form of
life is very rich thanks to the variety of our socio-cultural practices and abilities. Detection of relevant
affordances by a particular individual in a particular place, generate multiple micro-level states of
bodily action readiness (cf. Frijda, 2007) that self-organize into a macro-level pattern of anticipatory
responsiveness to the situation by the individual as a whole. The notion of Skilled Intentionality has
both theoretical and practical significance. From this perspective, the brain is an aspect of the larger
dynamical system ‘brain-body-landscape of affordances’. We have already applied our Skilled
Intentionality Framework successfully in psychiatric practice for understanding the impact of Deep
Brain Stimulation on patients’ subjective experiences (De Haan, Rietveld, Stokhof & Denys, 2013,
Frontiers in Human Neuroscience; Rietveld, De Haan & Denys, 2013, BBS).
A network perspective on psychopathology: implications for the theoretical status of mental disorders

In this presentation, I will argue that mental disorders should be understood as networks of mutually reinforcing factors, many of which are listed in diagnostic manuals as “symptoms”. Thus, instead of being “brain diseases” that produce observable symptomatology, mental disorders emerge out of the causal patterns that connect symptoms, much like the behavior of a flock emerges out of the interactions between individual birds that make up the flock. The network perspective has significant consequences for the theoretical status of mental disorders. First, it undermines the prospects of reductionist accounts of psychopathology, because many of the interactions between symptoms do not take place at a biological level (for instance because they involve factors in the environment). Second, the network perspective allows for cultural variations in the presence and strength of some causal interactions between symptoms, while others are expected to be stable across time and place. Third, the network perspective naturally accommodates the fact that the act of diagnosis will alter the behavior of the individuals diagnosed, which means it offers possibilities to study so-called looping effects in the formation of social kinds that have long been of interest to philosophers. Finally, I will address changes in our understanding of the nature of treatment interventions that are likely to ensue if network theories of mental disorders should prove to be correct.

Psychiatry as normative practice

Abstract: In my presentation I will show that (1) the legitimacy of psychiatric practice can only partly be based on scientific insight; that (2) psychiatry needs a balanced and normative account of itself as a professional practice. The so-called ‘normative practice model’ of psychiatric professionalism is such an account. It describes the relation between qualifying, foundational and conditional principles for psychiatric professionalism and it makes room for overarching regulative notions indicating sources of inspiration and commitment of professionals in their respective practices. Scientific attempts to articulate the legitimacy of professional action, instead of making psychiatry respectable, jeopardize the basis for psychiatry as a clinical discipline.

Evidence-based psychiatric practice: the values of science confront the values of psychiatry

EBM is a phrase that first appeared in the medical literature in the 1990s. It promotes a seemingly irrefutable principle: that clinical decision-making should be based, as much as possible, on the most up-to-date research findings. Nowhere has this idea been more welcome than in psychiatry, a field that continues to be dogged by a legacy of controversial, clinical interventions. Many mental health experts believe that following the rules of EBM is the best way of safeguarding patients from unproven fads and dangerous interventions. If something is effective or ineffective, EBM will tell us.
According to this viewpoint, EBM not only offers a solid scientific basis to clinical practice, it also offers an ethically obligatory foundation because it enables psychiatrists to offer the best care to their patients.

I will argue that evidence-based psychiatry is not a value-free tool which merely serves ethical ends. First, ethical values are involved in the entire process of the generation, dissemination, and generation of research data (evidence). Second EBM, as a set of concepts, is itself committed to a certain ethical stance. When EBM is applied to clinical practice it confronts the ethical values that are part of contemporary psychiatry namely, the judgements that certain mental states are abnormal and the privileging of certain therapeutic ends over others. I will discuss the extent to which EBM is compatible with the values of psychiatric practice. The paper will conclude by considering what ethical psychiatric practice looks like and what, if anything, EBM contributes to that vision.

Friday January 22\textsuperscript{rd}  13.45 – 14.30h

\textit{Auditorium}

\textbf{John Sadler - University of Texas Southwestern Medical Center}

\textbf{Scientism, folk metaphysics, and modes of engagement in psychiatry}

As an overview, I consider ‘scientism’ as a folk metaphysics. I situate scientism as an outgrowth of the Enlightenment(s). In the third segment, I explore the extension of scientism into modern technological thinking, and conclude with examples of technological scientism in psychiatric practice. Briefly, folk metaphysics are diffuse, partially shared, philosophically unsystematic and naive, cultural assumptions held by the public about the nature of reality, human nature, and the sources of the good. I argue scientism arose from an Enlightenment ‘split’ where elite Western intellectuals articulated formal ontologies, modern science, and medicine, eroding the Church’s domination. Morality and common law developed within medieval Church folk metaphysics featuring key concepts like free will, desert, and individual responsibility. This split framed today’s ‘culture wars’ and pop-cultural rivalries between science and religion. In the post-Enlightenment Western science and philosophy, contemporary concepts like weak and strong determinism, complex multifactor causality, and rejections of ‘free will’ and individual responsibility ran into conflict with what became Christian folk metaphysics its offspring, Western common law. As science developed powerful technologies, the scientific folk metaphysics of causal determinism, coupled with its great technological successes, clashed with a cultural diversity of folk-metaphysical beliefs clustering around free will, responsibility, and desert. These conflicts, concretized in distinctive modes of engagement in psychiatric practice, span many prevailing difficulties in psychiatry: the science/humanism divide, psychiatry’s ambivalent relationship with religion, the ‘insanity defense’ and ‘criminal responsibility’ in forensic psychiatry, the humanistic void in evidence-based medicine, policies which alternately blame/punish and nurture/care for the mentally ill, and the reduction of the clinician to an anonymous, generic technician rather than a unique, distinctive individual.

Friday January 23\textsuperscript{rd}  16.00 – 16.45h

\textit{Auditorium}

\textbf{Marc Lewis - Radboud University Nijmegen}

\textbf{When addicts and scientists connect: Brain change doesn’t mean brain disease}

The harm done by addicts to themselves and those around them has riveted public attention. To explain addiction, to really understand it, is essential. And to that end, psychiatrists have come to define addiction as a chronic brain disease.
Yet the idea that addiction is a disease doesn't square with how the brain actually works. Nor does it square with the experience addicts have of their own struggles. Lewis, a psychologist and neuroscientist by profession, has marshalled the data on brain change and interviewed dozens of addicts. He shows that the neural changes accompanying addiction also accompany normal learning and development. But these changes are accelerated (and preserved as habits) when learning is driven by intense motivation – an idea that makes a great deal of sense to addicts as well. What is unique about this perspective is that it requires us to look more closely at the biology of desire rather than ignore it. When that happens, the scientific and personal actually come together. Because brain change is continuous, and because it's affected by insight and self-direction, addiction and recovery begin to look like developmental trajectories, both from the viewpoint of neuroscientists and addicts themselves. Until now, neuroscientists have avoided the personal and allied themselves with medical professionals and scientific establishments instead. Now, by combining scientific findings and personal testimony, we are better equipped to find the best solutions for overcoming addiction.

Saturday January 24th 09.30 – 10.15h
Auditorium

Gerben Meynen - Tilburg University

Legal insanity – theoretical debates and practical dilemmas
According to Firestone (2007), “probably no single issue in the annals of criminal law has stirred more controversy, debate, and comparison among laypersons, as well as jurists, than the insanity defense.” Some states in the United States have even abolished the insanity defense. Still, legal insanity is often considered a basic and valuable element of a fair legal system and the defense is available to many defendants worldwide. But those who agree on the availability of the insanity defense, may yet strongly disagree on one or more central aspects of the defense. In fact, across jurisdictions, there is an impressive variety of legal standards defining the criteria for legal insanity. The most influential standard for insanity is the M’Naghten Rule. According to this standard, the defendant is exculpated if, due to a mental disorder, he did “not to know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong.” This rule focuses exclusively on (certain types of) knowledge – and it has been extensively criticized for that reason. It is argued that mental disorders can influence behaviour not merely by affecting a person’s knowledge but also by impairing the capacity to control one’s actions. This is just one of the central issues of debate regarding insanity. In this presentation, we will consider two questions. Firstly, conceptually, why is it that mental disorders may excuse a person? (Meynen 2012) Secondly, which practical issues have to be taken into account when formulating the criteria for legal insanity? Answering these two questions may help society to do justice to the profound impact mental disorders may have on people’s actions.

Saturday January 24th 10.15 – 11.00h
Auditorium

Leon de Bruin - VU University Amsterdam / Radboud University Nijmegen

Mental Disorders as Dysfunctional Patterns
My aim in this talk is twofold. First, I will present a pattern theory of mental disorder. According to this theory, mental disorders should be understood as specific patterns of dysfunctional interaction between aspects of the self and contextual factors. Second, I will introduce the notion of ‘contextualization’ as a practical heuristic and a clinical tool for specifying dysfunctional patterns of interaction between aspects of the self and contextual factors.
Saturday January 24\textsuperscript{nd} 15.15 – 15.45h  
\textbf{Auditorium}  
\textbf{Jan Verhaegh}  

\textbf{Discussion – led by Gerrit Glas}  
"When scientism reduces “psychiatric problems into neurochemical disorders in the brain which are treated only by medicines than there is a high risk that this psychiatry damages more than it heals. Only addition of CBT is not enough”. This is said by the European and World Network of Users and Survivors of Psychiatry for 25 years.  

At this conference philosophers of psychiatry have confirmed this statement on a high scientifically and philosophical level. The conclusion of both users/survivors and philosophers is that we need a broad model on theoretical and practical level in which the whole person, with the whole body and mind, in the whole context, with history and future is involved.  

Neoliberalism (supported by scientism) moves into the opposite direction. That is a threatening for science, psychiatry and the social situation of psychiatric patients (concerning income etcetera). We have to analyze and study neoliberalism, and fight against it.  

We will discuss with psychiatrists, scientistisch and philosophers on the question what we are able to do against it.

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Saturday January 24\textsuperscript{nd} 15.45 – 16.30h  
\textbf{Auditorium}  
\textbf{Bill Fulford - University of Oxford}  

\textbf{Delusion and Spiritual Experience: Models, Norms and a Challenge for Psychiatry in the Public Context}  
The widely held belief that the diagnosis of mental disorder is a matter exclusively for value-free science has been much reinforced within both psychiatry and the wider public by recent dramatic advances in the neurosciences. In this lecture I will draw on the story of a real (though biographically disguised) person, Simon, to show how the distinction between delusion and spiritual experience, as defined by the very criteria adopted in such scientifically–grounded diagnostic classifications as the American Psychiatric Association’s DSM (Diagnostic and Statistical Manual), points directly to the importance of values alongside evidence explicitly within psychiatry and implicitly across medicine as a whole. This has implications, as I will show, respectively, 1) for our models of disorder in psychiatry (that the explicitly evaluative element in their meanings reflects the diversity of individual human values), 2) for the norms of psychiatric practice (that in responding to this diversity of values it is important for psychiatric practice to become equally (and in complementary senses) values-based and evidence-based), and 3) for the role of psychiatry in a public context (that it should own and take responsibility for leading on the development of combined values-and-evidence based approaches to decision making). But the challenge here for psychiatry, as I will illustrate from recent experience in the UK, is the challenge of sustaining values pluralism against what the Oxford philosopher Isaiah Berlin called the ‘retreat to monism’. I will conclude with an indication of some of the potential resources for meeting this challenge from the growing international movement in philosophy and psychiatry.
PARALLEL SESSION 1 (A)

Thursday January 22\textsuperscript{nd} 11.45 – 12.15h

Auditorium

Miriam Kyselo – VU University Amsterdam

The body social: an enactive approach to the self

I examine two recent approaches to schizophrenia and indicate an alternative enactive account. The first approach adopts a phenomenological perspective and suggests considering schizophrenia in terms of disorders of the bodily self. The second is a neurobiological approach that explains symptoms in the social capacities of a person diagnosed with schizophrenia in terms of dysfunctional multi-sensory integration in the brain. I argue that both approaches are limited and risk reifying the disorder instead of explaining it. Furthermore, they downplay the status of symptoms and the relevance of the person’s phenomenological insights. The reason is that both approaches implicitly adopt a mechanistic background assumption on what counts as the human self and also have a dubious preconception concerning the interrelation of normal and pathological. Based on an enactive perspective on cognitive science as well as some considerations by Merleau-Ponty, this paper proposes an alternative look on schizophrenia according to which schizophrenia expresses the struggle in the basic maintenance of human self organization, the oscillation between two existential modes of being: being independent from and being open and connected to others.

Thursday January 22\textsuperscript{nd} 11.45 – 12.15h

2A-05

Anthony Vincent Fernandez - University of South Florida

Phenomenology and Operationalism: On the Possibility of Mutuality

Phenomenology and in Psychiatry

Contemporary psychiatric classification, especially as offered in the DSM-5, has recently come under fire. While there are a variety of criticisms being leveled against this system of classification, in this paper I will focus primarily on the issue of operational definitions. Specifically, I will examine critiques of operational definitions from the perspective of philosophical phenomenology. Such critiques have been made explicitly by figures such as Parnas and Zahavi, but much of the recent work in phenomenological psychopathology includes at least implicit criticisms of the use of operationalism in psychiatry—at least insofar as operational definitions tend to be fairly superficial in contrast to phenomenological definitions. I address the criticisms leveled by phenomenologists, and then proceed to develop an alternative account for the relationship between phenomenology and operationalism in this context. I argue that operationalism, in spite of its shortcomings, retains a degree of practicality that phenomenological accounts have failed to offer. For example, operational definitions, by supplying straightforward lists of criteria (or operations) for the diagnosis of disorders, allows for a high degree to reliability among clinicians (at least in comparison to system of classification prior to the DSM-III).

Also, the checklist method that has arisen from these kinds of definitions allows for fairly rapid diagnosis, which in many cases allows for rapid interventions. In light of these benefits of operationalism in psychiatry, it is unlikely that the method for defining mental disorders will simply be replaced wholesale by an alternative method (phenomenological or otherwise). Therefore, I argue that phenomenologists should attempt to enhance operational definitions rather than replace them with phenomenological accounts of disordered subjectivities. By offering rich descriptions of disordered subjectivities, focusing especially on
dimensions of the disorder (such as temporality, embodiment, and intentionality) that are typically ignored in standard operational definitions, phenomenologists can supply psychiatrists with additional resources from which to draw when picking out the relevant symptoms for an operational definition. In addition, phenomenological research is especially well suited to distinguish between essential and non-essential features of disorders, which is particularly relevant when listing diagnostic criteria (as well as exclusion criteria) for particular disorders. In short, I argue that—while phenomenology is unlikely to displace operationalism as the source of definitions of disorders—it can still contribute to the project of psychiatric classification by acting as a foundational resource from which psychiatrists can draw relevant criteria for use in operational definitions.

Thursday January 22nd  11.45 – 12.15h
5A-05
Josephine Lenssen – VU University Amsterdam

Challenges for Thompson’s Life-Mind Continuity Thesis

This paper examines Thompson’s (2007) continuity thesis which claims that there is a deep continuity between life and mind and posits a potential line of objection based on four related aspects on which he draws to support his argument. The continuity thesis can be interpreted as a variant, one line of reasoning, within the movement of naturalizing phenomenology. Important and attractive as this attempt is, this reasoning has important flaws. First, I show that Thompson employs different definitions of continuity pertaining to different levels of explanation within his argument. Second, I show that there are inconsistencies in the relations between core concepts such as “cognition”, “adaptivity”, “auto poiesis”, “autonomy” and “self” which amount to what I term a “deep circularity” of core concepts. Third, I follow De Jaegher and Froese (2009) who show that the Thompson’s deep continuity thesis is based on (over-) stretching the definition of cognition and that this shifts the problem to that of what these authors term “the cognitive gap”, which Thompson’s account does not address. Fourth, I propose that his observation that mind and life both share organisational properties does not necessarily amount to continuity. I argue that these problems, taken together, limit the overall explanatory power of his thesis.

PARALLEL SESSION 1 (B)

Thursday January 22nd  12.15 – 12.45h
Auditorium
Alexander Kremling- Freie Universität Berlin

Causal Argument-Types in Psychiatry

I want to present and discuss reconstructions of different argument types frequently used for justifying causal claims in psychiatry. Though sharing the common feature of starting with manipulative knowledge, the arguments use different argumentative strategies, premise-types, aim at different conclusions (psychotherapeutic, genetic, neurobiological) and have different problematic assumptions. Deriving each type through a concrete example, I will present the argument types in a ‘semi-formal’ scheme and discuss their specific premises regarding their epistemological and metaphysical statuses, showing that argumentative analyses can contribute to a clarification of some important topics of explanatory plurality and conflict in psychiatry: the use of correlational data, the position of mental language, naturalistic premises, the possibilities and limits of animal models. Argument types of expanding practical knowledge to psychiatric causal claims can in addition be used to locate other types of knowledge and give an idea of how to ensure scientificy of fallible explanations without scientism.
**From commonsense to science, and back: The use of cognitive concepts in neuroscience**

Commonsense cognitive concepts (CCCs) are the concepts used in daily life to explain, predict and interpret behaviour. CCCs are also used to convey neuroscientific results, not only to wider audiences but also to the scientific inner circle. This fact makes it imperative that we have a clear view on how we get from CCCs to scientific experiments and from hard scientific data to commonsense concepts. We show, however, that translations from CCCs to brain activity, and from brain data to CCCs are made in implicit, loose and unsystematic ways. For instance, one particular experimental task can be used to measure the underlying neural mechanisms of various different cognitive concepts. The Wisconsin card-sorting task is used to measure both ‘working memory’ and ‘task-switching’. These kinds of problems result in hard to connect data and possibly unwarranted extrapolations. One important way to overcome many of these problems is the use of formal ontologies, which could make the definitions of concepts and tasks more explicit, resulting in facilitated communication and the potential for validation of findings by meta-analyses. For this to be possible, however, we need a clear idea of what underlies the problems in cognitive neuroscience practice. We argue that the root cause is an implicit adherence to what is known in philosophy as ‘mental realism’, the idea that CCCs can be found in the brain. When CCCs are brain processes, then each instantiation of a CCC can be identified with a (set of) brain process(es), at least in theory.

However, in the practice of cognitive neuroscience the idea of such clear-cut mapping is highly problematic. Therefore, we believe the way forward to a clearer and more systematic employment of CCCs in cognitive neuroscience is to explicitly adopt interpretivism as an alternative for mental realism. The crucial distinction between mental realism and interpretivism with respect to the mind–brain relation is that realists think that CCCs refer directly to brain processes; the fact that such ascription is based on behaviour is a mere practical difficulty. Interpretivists, by contrast, acknowledge that the connection between cognitive concepts and brain processes is mediated by behaviour. When researchers use the Wisconsin card-sorting task, it is not an independent, objective fact that the targeted neural process is a correlate of ‘working memory’. Rather, the characterization of the behaviour as an instance of ‘working memory’ is what turns the neural causes of the behaviour in the neural correlates of ‘working memory’. Thus, by shifting from a realist to an interpretivist position, one explicitly acknowledges that there is interpretative wiggle room in the interpretation of neural processes in terms of CCCs. Furthermore, an interpretative stance reminds us that it may well turn out that the concepts we currently employ do not necessarily correspond to any circumscribed neural counterpart. We believe adopting an interpretivist perspective would result in scientific knowledge that is easier to integrate and communicate, which is essential for an interdisciplinary field like cognitive neuroscience and for insights that might affect the commonsense understanding of others and ourselves.

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**Mental disorders – Indifferent and Interactive Kinds?**

According to Ian Hacking (e.g. 1999), many kinds in the social sciences are interactive kinds: These classifications (e.g. ‘schizophrenia’) interact with the objects they classify (people suffering from schizophrenia) by which the classification itself changes. Since mental disorders also have an indifferent part, an underlying pathology that does not respond to the classification, Hacking refers to them as indifferent and interactive kinds. Tsou (2007) criticizes this concept and argues that mental disorders should be conceived of as
indifferent kinds. In this paper I will review his arguments and argue that by understanding mental disorders as indifferent kinds two central aspects of mental disorders are overlooked.

As said, Hacking argues that (many) mental disorders are indifferent and interactive kinds (Hacking, 1999, pp. 115-120): People classified respond to the classification, but the disorders also have an indifferent biological basis. In response to that, Tsou (2007) argues is that Hacking is no longer referring to the classifications in the case of indifferent and interactive kinds, but to the objects of classification. The mental disorder itself has indifferent and interactive causes and parts, but the classification itself cannot be both interactive and not interactive (Tsou, 2007, p. 334). This means that if Hacking is right, we could find out many things about biological and genetic causes, but the classification can and will keep interacting and will not be a fixed target. But, Tsou (2007) contends that ‘the indifferent part of interactive and indifferent kinds [...] can be understood as a stable object of classification that does not change as a result of looping effects’ (Tsou, 2007, p. 339). Then, mental disorders can be diagnosed on the basis of the underlying pathology.

I think that there are several problems with this conclusion. First, mental disorders are difficult to define, but are best understood by the fact that harm is involved (e.g. Bolton, 2008). Without that component, we would and should not classify a person as having a mental disorder on the basis of an underlying pathology. It is understood as a risk factor or possible cause, but not as the mental disorder itself. If we would reduce the mental disorder to this underlying pathology, the essential part of what it is to have a mental disorder is ignored. Second, mental disorders are strongly connected to societal and personal conceptions of normalcy in several ways. They do not take place in isolation, but in relation to norms and expectations of society, significant others, and the person himself. This way, interactions occur between what we find normal or expect from others in particular contexts, what we conceive of as symptoms of a mental disorder, and the way we interpret our own behaviors and that of others. This may even change the underlying pathology (biolooping – Hacking, 1999, p. 109).

On the basis of these arguments I will argue that mental disorders are interactive kinds, even if we discover underlying biological regularities in relation to the disorder.

PARALLEL SESSION 2 (A)

Thursday January 22nd 16.00 – 16.30h
Auditorium
Eric Matthews - University of Aberdeen

Science and the Explanation of Mental Disorder

It is argued that ‘scientism’ usually depends on an oversimplified philosophical account of what it is to be ‘scientific’ in one’s description and explanation of the facts about ourselves and our world. In this account, physics is taken to be the fundamental science, such that the special sciences are properly so called if and only if their statements are, at least in principle, ‘reducible’ to those of physics. Reducibility, in this context, implies the possibility of restating their meaning, without remainder, in the vocabulary of physics, using bridging concepts.

The familiar objection to such reductionism – that it is in principle impossible to carry out this restatement in the case of any of the special sciences – is accepted, especially with regard to the possibility of a scientific psychiatry. The question, what it means to be scientific in one’s description and explanation of mental disorder, cannot be separated from the question, what do we mean by mental disorder?

What we mean by this term depends on what we mean by ‘mental’ and what we mean by ‘disorder’. ‘Mind’, it is argued, is a compendious way of referring to certain non-physical activities and states of living beings (and for present purposes, that means living human beings) – thoughts, emotions, sensations, desires,
wishes, intentions, hopes, etc. (and the behaviour influenced by them). Mental disorders, therefore, are disordered thoughts, emotions, desires, etc. In the context of modern psychiatry, the meaning of ‘disordered’ here takes on a special flavour. Psychiatry aims to be a medical practice, aiming at the relief of the distress of the disordered person. Thoughts, behaviour, etc. are considered to be disordered to the extent that they deviate from some norm of human well-being, causing distress to the person concerned. This deviation is like bodily illness in that (a) it is not part of what we consider to be the inevitable imperfection of human life (like the death of loved ones and the grieving which follows); (b) it is not the direct and straightforward consequence of the sufferer’s own conscious choices; and (c) its relief therefore requires the help of others, preferably with appropriate professional training.

This has implications for the explanation of mental disorder. Because it is ‘mental’, its explanation cannot be solely in terms of biological (especially neurological) dysfunction, but requires also ‘empathetic understanding’ (Verstehen). But because it involves some deviation from normal modes of thinking, feeling, behaving, etc., such understanding cannot be sufficient in the way it can be for normal mental activity. Some sort of causal explanation of how the deviation from the norm became possible is essential: though it cannot be said a priori what kind of causes (genetic, neurological, psychological, sociological) are relevant. This is not a claim about different levels of explanation, but about different components in a complex explanation. Examples derived from psychiatric practice will be given as illustrations of these points.

Thursday January 22nd 16.00 – 16.30h
1A-05
Jos Dirkx - Psychiatrist – psychoanalyst

From psychoanalysis to neuroanalysis. A dead-end journey in a brain-dedicated world of evidence

There is a growing tendency in psychoanalysis to search for scientific credibility by seeking alliance with neuroscience. Neuropsychoanalysis is the new hope for restrenghtening psychoanalysis in an evidence based world of mental health.

Once the reductionistic mission will be completed there is only neuroanalysis left because any behavior can than be explained by a single causative neuron with a specific (representational) task. After the decade of the brain and the search for the final gene everything is neuro-based nowadays, a kind of semantic reductionism: Neurogenetics, neurobiology, neurophilosophy, neuropsychiatry, neuropsychoanalysis. We are our brain and our brain explains us e.g. a puberal brain, a brain in love, a criminal brain, a transsexual brain. This antropomorphism of the brain, the comeback of the homunculus, is also known as the mereological fallacy of neuroscience (Bennett & Hacker, 2003). It’s impossible for merely a brain to fall in love or to behave in a criminal way. Only a human being as a whole, an embodied, and embedded person, can think, perceive, imagine, decide, make plans and experience emotions.

In this presentation I will venture on the epistemological status of psychoanalysis, seen as the most mind focused branch of psychiatry.

In psychoanalysis people are seen as unique individuals with their own idiosyncratic life history, and are approached as such by the methodology of the case history (n=1), opposed to evidence based psychiatry where only the randomized controlled trial (RCT) is taken seriously. Psychoanalysis as a therapeutic endeavour is an intersubjective search for meaning and self-understanding in an idiographical, and hermeneutical context which seems out of date compared to modern psychiatry in its neuroscientific driven attempt to find a generalisable etiology for mental disorders somewhere in the brain.

These different perspectives on mental health and mental disorders through the science of the mind (psychoanalysis) and the science of the brain (originally only neuroscience but nowadays including general psychiatry) are not easy or even impossible to merge into an overall view, taking into account the influence of the brain, the mind, the social environment and developmental history. The biopsychosocial view is only of heuristic value in that sense. There remains an explanatory gap which seems to be unsolvable: how can the mind be explained by the brain, or, in other words, how can consciousness be explained in a neuroscientific
way. Related ‘problems’ are mental causation and subjective psychic reality (qualia). Approaching this mind-brain dilemma, as neuroscientists mostly do, by dual-aspect monism seems to be avoiding the problem because there still is a form of epistemological dualism left. In other words two languages are spoken and never the twain shall meet.

This enhances the possibility for an autonomous scientific position of psychoanalysis as a hermeneutic discipline with epistemological problems of it’s own however. The procedure of investigation and method of treatment that define psychoanalysis coordinate interpretation and the handling of resistances at the same time in psychoanalytic praxis. This calls for a psychoanalytic theory in which the mind or psyche can be seen as a text to be interpreted (hermeneutics strictu sensu) and as a system of forces to be manipulated (Ricoeur, 1977).

Thursday January 22nd 16.00 – 16.30h
2A-05
Jan Swinkels - Academical Medical Center at the university of Amsterdam

Humankind and humanity are they the measures for psychiatry?
The doctrine of the homo mensura was first propounded by Protagoras holding that humankind is the measure of all things, that everything is relative to human apprehension and evaluation, and there is no objective truth. What is the meaning of this doctrine in modern health care and especially in psychiatry? Essential human measures for patients in care are to have an overview on a small scale, recognition and the need for personal contact and the possibility for being in control to take responsibility. This can be addressed even profoundly for psychiatric patients. Humanity is an essential virtue in the ethics for physicians. Aristotle considered ethics to be a practical rather than theoretical study i.e. the Nicomachean Ethics. Soul (now mind) of Aristotle was a function of humans in accordance with reason (logos) which can be seen as functions of the brain. To live a good life, according to Aristotle we need first a good character or moral virtues i.e. humanity. Humanity as a fundamental human experience, which changed during my career as a psychiatrist from patient to client as a patient. Humanity and the homo mensura doctrine are in constant danger in these changes in psychiatry, health care and science, by classification systems and reification of the classes as existing things and human behaviour. Psychiatry and medicine are more than an occupation, intellectual virtues (knowledge and competences) associated with evidence based medicine or mental health are not enough. As a profession confidence in the profession and the person of the physician/psychiatrist are prerequisites for trust which is needed for a good physician patient relationship. Next to intellectual virtues also moral virtues must be lifelong trained, learned and tested to become and stay a good medical professional, researcher and educator.

PARALLEL SESSION 2 (B)

Thursday January 22nd 16.30 – 17.00h
Auditorium
Ula Schmid – University of Basel

The Disanalogy between Psychopathology and Somatic pathology
The terms ‘mental disease’ and ‘mental disorder’ already suggest to treat psychopathological phenomena in analogy to somatic pathologies. It further implies that it is possible to establish ‘psychopathology’ as a science in analogy to (somatic) pathology whose task consists in investigating psychopathological phenomena objectively, in abstraction from individual cases. Psychopathological phenomena thus are regarded as subject
to empirical investigation, causal explanation, medical treatment and as classifiable and recognizable by certain criteria.

This involves two assumptions: First, the seemingly trivial assumption that there are coherent psychopathological phenomena. Second, that it is possible to establish a language for such a theory, the language of psychopathological concepts. In analogy to the somatic case, this view separates the mental disease, i.e. the investigable phenomenon from the patient's mental illness, i.e. his or her suffering whilst experiencing and coping with the disease (Cassell 1976). It further separates the 'scientific' meaning of psychopathological concepts from any 'additional' meanings they might bear or be endowed with in commonsense or in the patient's first-personal use (e.g. Burge 1986) such as the scientific concept of 'influenza' differs from the commonsensical concept of 'the u'. In the following, I will argue that both assumptions are false and that, consequently, it is impossible to develop psychopathology as a science in analogy to somatic pathology.

In the case of most, if not all, somatic diseases it is possible to separate the disease (the investigable phenomenon that concerns an organ) from the patient's illness (the disease as it concerns the person). It is thus possible to investigate the pathological somatic condition in isolation from the person's experiencing the disease and his or her ways of coping with it. In the mental case, however, the distinction disease - illness breaks down. In the somatic case, the disease can be conceived as a disruption, disorder or deficiency of a person's normal bodily constitution and ways of functioning. In the mental case, there is not any entity (such as the patient's 'personality' or 'self') whose loss of specific functions would constitute the mental disease. Rather than an organ or other specifiable part of the person, a mental disease concerns the whole person - it is nothing but the person's illness.

The psychiatric patient's suffering does not present a reaction to a deficiency 'within' his or her mind, but a response to his or her own more or less self-destructive way of tackling with a specific problem or question raised by his or her environmental circumstances. It is impossible, that is, to conceive of psychopathological phenomena in abstraction from the person's ways of experiencing and coping with his or her individual life situation. Understanding the illness means understanding the person - his or her ways of experiencing and acting, his or biography and ways of interacting with his or her social and environmental contexts. It is equally impossible to understand the meaning of psychopathological (and the related psychological) concepts in abstraction from the use in the first-personal form, as means of expressing and making sense of one's current situation.

In other words, the 'science' of psychopathology lacks both an object of investigation and a language to establish a theory. It is, for these reasons, in principle impossible to establish a science of psychopathological phenomena or their non-pathological counterparts, as psychology is supposed to do, as a theoretical basis for investigating 'mental diseases' and developing diagnostic standards and therapeutical methods in psychiatry. Psychiatric treatment thus will rely on focusing on each patient individually, and psychiatry will remain a case-centred practice.

Thursday January 22nd 16.30 – 17.00h
1A-05
Gottfried Vosgerau - Heinrich-Heine-Universität Düsseldorf

On the causal status of mental disorders

This talk aims at bringing together the discussion about the nature of mental disorders and the debate about the causal efficacy of higher-level properties, including mental, cognitive and social properties. Considerable theoretical clarification has been achieved through the discussion of the "causal exclusion problem" (Kim, 2005). The argument is grounded in the largely accepted claim that the physical domain is causally complete: any physical event that has a cause (e.g. a behavioral symptom), has a physical cause that is both sufficient and complete (Papineau, 2002). Accepting this claim raises a dilemma for putative mental causes of such
behavioral symptoms: either these causes systematically over-determinate the behavioral effects or they are purely epiphenomenal.

A way out of the dilemma consists in denying an ontological distinction between the mental causes of symptoms and their physical underpinnings, endorsing a token-identity thesis (Esfeld, 2005). The consequences of this dilemma stand in sharp contrast to the main contemporary accounts of mental disorders. According to the DSM III to 5 approach (APA, 2013), mental disorders are sets of co-occurring symptoms and hence cannot cause symptoms at all. According to the disease analogy of mental disorders, however, disorders are supposed to cause their symptoms, which raises the question of their ontological status. If mental disorders are purely mental entities (psychodynamic accounts) or impaired cognitive processes (e.g. Andreasen 1997), the causal exclusion problem and the above mentioned dilemma obtain. Ruthlessly reductive accounts assuming mental disorders to be purely physical or neurological impairments (e.g. Kandel 1998) fall prey to the multiple realization argument (Fodor, 1974): two individuals with the same mental disorders might differ from a physical point of view. This would result in an entirely new classification based on physical criteria exclusively, completely discarding our current classification and diagnostic criteria. Finally, symptom-network approaches (e.g. Borseboom and Cramer 2013) face the causal exclusion problem when it comes to the non-physical variables they take into account.

We offer a theoretically flexible account, according to which mental disorders should be individuated as dispositions to cause specific sets of symptoms. These dispositions are ontologically token-identical to complex states that include neurological impairments, genetic factors, and environmental factors such as social factors. We thereby secure the causal efficacy of mental disorders without conflicting with the completeness of physics. This token-identity thesis is, however, weaker than ruthlessly reductive accounts focusing on neurological criteria, since it allows for patients to fall into the same diagnostic category while nonetheless differing from a neurological point of view. Psychiatric categories should then be conceived of as theoretical terms, individuated by their relations to specific collections of co-occurring symptoms. These terms refer to theoretical entities that are themselves token-identical to the physical structures bringing the symptoms about, without endorsing any form of type-identity establishing systematic links between types of disorders and types of underlying brain impairments.

PARALLEL SESSION 3 (A)

Friday January 23rd 11.30 – 12.00h
Auditorium

Peter J. Verhagen - Psychiatrist

Values and the professional – the perspective of the profession

Psychiatry needs philosophy. One of the reasons for this premise is the fact that (mental) health care is an inherently moral profession. Another reason is the subject of psychiatry. Since psychiatry focuses on human experience and human behavior questions and visions as to what it means to be human are constantly present. This means an appeal on the way the professional gives shape and content to the completion of his professional role. The need for development and maintenance of a professional attitude and role is met nowadays in training of the seven so-called CanMEDS competencies during residency training and continuous medical training, but it is undeniably also a matter of personal characteristics, worldview, values and virtues of the professional. That deserves more than ‘implied’ attention.

What are leading values in mental health care nowadays? And what are their sources? The last overview of prevailing values in Dutch mental health care dates back to 1996: autonomy, enjoyment of life, authenticity in personal relationships, sexual identity as a personal challenge and composition of life and the capability ‘to consider being true’. These values cannot be seen without twenty centuries of western Christianity. However, a not unimportant detail with regard to these values is their more or less explicit critique of religion, which is quite obvious once one has been notified. However, how valuable is such a general list of values? Far more important is the awareness of values on a personal, on an interdisciplinary team and on an institutional level.
Awareness of values asks for special skills. For psychiatrists therefore, professionalism involves recognizing ethical issues, awareness of one’s own role in the therapeutic process, anticipating ethically risky situations in patient care and approaching and making ethical decisions. A method to develop these skills and to improve the moral competency of professionals would be ‘moral case deliberation’. Moral case deliberation consists of a systematic reflection on actual moral questions related to daily (clinical) work. Qualitative and quantitative results show that participants value the approach positively. And most importantly, their moral sensitivity increases and presuppositions, prejudices and automatic responses decrease.

Friday January 23rd 11.30 – 12.00h
1A-05
Naomi Kloosterboer – VU University Amsterdam

Mental Attitudes and Our Evaluative Perspective
Exploring the role of the first-person and third-person perspective in the context of psychotherapy

At the heart of psychotherapy lies the assumption that understanding who we are, what we feel, and what we think should help us in changing our relations, our lives and ourselves. Put simplistically, acquiring self-knowledge is supposed to free us, for example, of repressive mechanisms or of feelings of powerlessness.

“… [Freud] shares another, more philosophical, assumption, with roots in Plato, Spinoza and others, that self-knowledge is central to the health and freedom of the person…” (Moran 2004: 469)

But what kind of self-knowledge is at issue here? Can any kind of self-knowledge fulfill this liberating role?

Mental attitudes play two roles in our mental life. If I have the belief that it is cold outside, this is a psychological fact about me. I have this psychological state and one might employ it to explain why I put on my winter coat. However, it also says something about how I see the world. Mental attitudes are intentional states, i.e. they say something about the world. This means that they are related to our evaluative perspective. I believe that it is cold outside because – at least in my view – it really is cold outside. This double role that mental attitudes yield is related to different forms of self-knowledge. On the one hand, one might be interested in gaining knowledge of the mental attitudes one has as psychological states. For this, one needs behavioral evidence such that one can infer that one has a certain attitude. The background idea is that we have influential psychological states that are hidden from sight and that should be revealed in order to regain a healthy mental life. We can call this an observational or third-personal account of self-knowledge, since one infers which mental attitudes one has on the basis of observation.

On the other hand, one might be interested in gaining knowledge of one’s mental attitudes as claims about the world, i.e. as part of one’s evaluative perspective. Acquiring such knowledge means that the question about the mental attitude, e.g. ‘Do I believe that it is cold outside?’ is seen as a question about the content of that attitude, e.g. ‘Is it cold outside?’ So, when asked whether I believe that it is cold outside, I need to consider reasons in favor of or against the fact that it is cold outside. Based on my considerations about the weather, I then make up my mind and affirm my belief that it is raining. Let’s call this deliberative or first-personal self-knowledge.

How can we assess whether the third-personal or first-personal form of self-knowledge is more liberating? Importantly, a consequence of the double role of mental attitudes is that although it isn’t unusual to say about someone else that she believes something that is actually false, from a first-person point of view, it doesn’t make sense to say ‘P but I don’t believe P’. This exhibits a paradox or even irrationality, because believing P implies believing it to be true (cf. Moore 1942, cf. Shah & Velleman 2005 for the claim of irrationality). As soon as one neglects the reasons one has pertaining to the intentional content of the attitude, one distances oneself from one’s relation to the world as a rational agent. This is something that prima facie speaks in favor of seeking first-personal self-knowledge and not third-personal self-knowledge. However, our mental lives and cognitive capacities are frail and it might be the case that in situations in which one’s mental health is at stake observational self-knowledge can be as liberating as deliberative self-knowledge.

I want to consider the following examples and see how the different forms of self-knowledge are liberating or, perhaps, restraining:
Observational self-knowledge
Based on evidence about her behavior and the sessions with her psychotherapist, Julie knows that she feels betrayed by her brother. However, when she considers her brother and whether he has indeed betrayed her, she does not take there to be reasons in favor of the conclusion that he has betrayed her (Moran 2001: 85).

Pathology of avowal
Mr. A avows the belief that his girlfriend has betrayed him and cites intelligible reasons for his belief. However, he neglects the reasons that speak against his belief (Lear 2004: 450).

Recalcitrant attitude
B avows that his best friend has not betrayed him. Moreover, he doesn’t think there is any reason to think that his best friend will betray him in the future. However, he often finds himself being anxious that his best friend will not show up or will, all of a sudden, no longer want to be his friend.

PARALLEL SESSION 3 (B)

Friday January 23rd 12.00 – 12.30h
Auditorium
Samuel J.C. Schrevel – VU University Amsterdam

Congruence and Divergence in Day-to-Day Practice of Adult ADHD Care
Adult Attention Deficit/Hyperactivity Disorder (ADHD) has been studied from a biomedical perspective in manifold, resulting in a substantial body of theoretical knowledge on the causes, diagnosis and treatment of the disorder. As the number of adults diagnosed with and pharmacologically treated for ADHD is increasing, insight into the daily practice of diagnosis and treatment of ADHD can prove valuable in understanding how this theoretical knowledge is put into practice – an important topic1 that remains largely ignored in scientific literature. Therefore, this study aims to explore the perspectives of mental health professionals on the day-to-day practice of diagnosing and treating adult ADHD.

The present study is part of a larger Ph.D. project wherein the perspectives and experiences of ADHD patients and professionals working with adult ADHD are explored through interviews and focus groups. The results of this study are based on 22 semi-structured interviews with various mental health professionals: psychiatrists (n=13), psychologists (n=4), mental health nurses (n=3), a coach (n=1) and a physician assistant (n=1).

When asked to reflect on adult ADHD, a high degree of congruence was observed with respect to the theoretical knowledge of (1) the biology of ADHD, (2) the diagnostic criteria of ADHD as defined in the DSM-IV and (3) the validity of the diagnosis and treatment of adult ADHD. On a deeper level, however, this consensus broke down to reveal a variety in perspectives and practices with regard to adequate diagnosis and treatment of adult ADHD. Mental health professionals experienced the seemingly straightforward diagnosis as a challenge where personal expertise, clinical experience and “a sense of things” were needed to verify whether individual patients could “rightfully” be diagnosed with the disorder. The preferred treatment of adult ADHD showed equal variation, with personal expertise and clinical experience playing substantial roles in deciding which patient should receive what treatment. For example, some professionals encouraged the situational use of stimulants, whereas others categorically rejected situational medication use, as that would violate the DSM criteria for ADHD. Again.

The results of this study suggest that the theoretical knowledge concerning adult ADHD is widely and variably interpreted in the day-to-day practice of mental health professionals, which thereby lends to a variety of perspectives and practices towards diagnosis and treatment. In other words, the unequivocal presentation of information, as in consensus statements published in international psychiatric journals2-4, does not necessarily lead to standardization in day-to-day practice. In focus groups with patients, a part of the larger Ph.D. project, the diversity observed in this study was also recognized and resulted in feelings of insecurity as to what information was trustworthy and whether adequate care was received. Possible explanations lie in the context of psychiatric practice, which will be thoroughly discussed. Future directions for research will be
elaborated to understand this diversity, the impact of this diversity and possible strategies to address this diversity.

Friday January 23\textsuperscript{rd} 12.00 – 12.30h
1A-05

Alan Ralston - Psychiatrist

Empirical perspectives on the philosophy of psychiatric practice

Though the recent renaissance of cross-disciplinary interest between philosophy and psychiatry has given rise to an impressive body of knowledge and to challenging new perspectives on psychiatric theory and practice, Fulford et al. (2006) have noted the risk of a ‘communication gap’ between the two parent disciplines, reducing the scope for fruitful cooperation. Though philosophy and psychiatry share a common interest in the human mind, their goals, methods, and professional parlance differ. Despite previous efforts in this area (e.g. Fulford and Colombo 2004) there remain worries about the accessibility of work in the philosophy of psychiatry to the average practitioner. Philips (2011) states: “Most publications in the philosophy of psychiatry are quite technical—whatever the tradition out of which they are written—and expecting them to have an effect on mental health practice is quite unrealistic. If you really want to influence mental health care with Wittgenstein’s account of meaning as use and practice, you will have to get rid of the technical language and translate Wittgenstein’s analysis into the language of practitioners, show them, in their language, what might be the implicit philosophic assumptions they are working with, how those don’t serve them well, and how your suggestions might lead to better practice.”

One way of following Philips’ suggestion is to empirically examine the presence and action of philosophical ideas in practice. The author performed a qualitative study of 30 psychiatrists working in three different outpatient settings: academic, private, and institutional, and explored three main areas: diagnosis & classification, science & legitimacy, and the concept of mental disorder. Using a framework analysis methodology, thematic frameworks were developed for these areas. The findings throw new light on the practice of psychiatrists: the diagnostic process, the role of classification in practice, scientific development and professional legitimization, and the nature of mental disorder as it is represented in practice.

In the presentation the methodology will be briefly described and critiqued, subsequently the main findings of the study will be presented. The results carry implications for the scientific and ethical grounding of the profession of psychiatry. A proposal for such a professional characterization will be presented and defended.

PARALLEL SESSION 4 (A)

Friday January 23\textsuperscript{rd} 14.30 – 15.00h

Auditorium

Eva Maassen - VU University Amsterdam

The diagnostic process in bipolar disorder: integrating intuitive and analytic knowledge in decision-making processes

\textit{Aim:} To increase our understanding of forms of reasoning and knowledge involved in decision-making processes of mental health care professionals in diagnosing bipolar disorder.

\textit{Background:} Bipolar disorder is a considerable public health issue, associated with a decrease in quality of life and high societal costs. It is of great importance to diagnose and treat people suffering from bipolar disorder early and correct in order to limit the consequences of this disorder\textsuperscript{1}. However, diagnosing bipolar disorder is a complex process, due to the existing symptomatic overlap between psychiatric illnesses and the high rate of comorbidity stabilization. It is interesting to understand the forms of reasoning processes and knowledge involved in decision making of mental health care professionals.

\textit{Methods:} Decision-making was studied by evaluating the diagnostic pathway of a Dutch outpatient clinic for bipolar disorder. 21 patient files were analyzed quantitatively and retrospectively. In-depth interview
were conducted with clinicians to elaborate on the forms of reasoning processes and knowledge involved in the decision making.

Results: Two reasoning processes are at play during decision-making regarding diagnosis and treatment; intuitive and analytical processes. They are analytically distinguishable but closely intertwined in practice. Clinicians are able to clearly articulate the added value of each type of reasoning and knowledge and the way they contribute to decision-making in different cases. The results indicate that clinicians’ decisions benefit from a combination of building on formalized knowledge, following clinical guidelines, and administrating validated tests on the one hand, and using their intuitive and experiential knowledge and feelings and personal perspectives on the other.

Conclusion: The diagnostic process in mental health entails a complex interaction between intuitive and analytical reasoning. Mental health care professionals need to go beyond their formal and recognized knowledge base, and include contextual, experiential and intuitive knowledge into their decision making processes. This dual decision-making approach is already part of clinical practice but not yet understood well. It is argued that, in order to improve the diagnostic process in mental health, diagnostic tools need to incorporate both formal and experiential knowledge.

Friday January 23rd 14.30 – 15.00h
1A-05
Sanja Dembic - Humboldt University Berlin

What kind of explanation is psychoanalytic explanation?

If psychoanalytic explanation is considered to be a valuable explanation of human behaviour at all, it is often taken to be an explanation of irrational behaviour. In this regard, psychoanalytic explanation is often taken to show that the behaviour in question is only allegedly irrational, i.e. that really—taken into account, for example, the unconscious desires of the agent—it is perfectly rational behaviour. Hence, psychoanalytic explanation seems to be explaining away irrationality rather than accounting for it.

One prominent exception to this view is Donald Davidsons interpretation of the role of psychoanalytic explanation. Davidson claims that in order to be able to explain irrationality, we must adopt some of Sigmund Freud’s most central claims concerning the mind, namely that we must conceive of the mind as containing a number of semi-independent structures. But what kind of explanation of irrationality is given by such a reference to semi-independent structures of the mind? According to Davidson, this explanation is still an explanation in terms of reasons. Even though the mental state which explains an irrational action is not the reason, but just the mental cause of the action in question, it has to be a reason for some other mental state in order to be a mental cause at all (rather than just being a cause that is only describable in physical terms). Hence, according to Davidson, this account might be a good solution to what Davidson calls “the paradox of irrationality”, I will argue that this is not an instance of a specifically psychoanalytic explanation.

I will propose that a psychoanalytic explanation is a kind of functional explanation. In giving a psychoanalytic explanation of a certain behaviour, one is not asking for the „hidden“ reasons of an agent—how can an agent act upon reasons that are not conscious to him?—but for the function that the behaviour has for the agent, or rather, for the overall mental functioning of the agent. But, of course, a certain behaviour can serve all kinds of functions, so the problem arises of how one can determine the function of the behaviour in question. Based loosely on the etiological account of biological functions, I will propose that the function of the behaviour (or psychological mechanism) in question is what it—i.e. this type of behaviour—was selected for in the (ontogenetic) history of the agent. This selection process is nothing like the process of natural selection. It may be thought of as a process of social reward and punishment, where the goal of the agent—and this is one thing that makes the account specifically psychoanalytic—is to sustain a psychological equilibrium, i.e. to avoid or resolve mental conflict.
Psychiatric Classification between Science and Practice

The current classification system in psychiatry (as exemplified by the DSM) exhibits severe problems, and its recent revision, culminating in the DSM-5, has left many disappointed. On the one hand, there are controversial debates on the criteria for individual diagnoses and the question, whether they pathologize normal feelings and behavior, for example in the cases of ADHD or depression. On the other hand, there are also numerous critics who question the overall system. It is often argued that the heterogeneity of groups picked out by the DSM’s polythetic criteria, the excessive rates of comorbidity, and the lack of predictive success of the DSM diagnoses indicate a severe lack of validity. This lack is commonly attributed to the DSM’s phenomenological approach to classification, the current system being based on co-occurring, observable symptoms. The main proposal for improving the situation is to change the classification from a phenomenology-based one to an etiology-based one that groups symptoms according to our best scientific theories about their underlying causes. Proponents of such an etiological revolution often present it as a move forward towards a more scientific, evidence-based nosology. Even more cautious criticisms often seem to assume that the change towards a more valid etiological classification is only a matter of time, awaiting further research results.

What I want to show is, first, that the question of the classificatory basis is not one that can be answered by empirical evidence alone. Instead, it requires judgments on what level of evidence is needed to justify changes as well as judgments on what kind of evidence is most important. Second, in making these judgments we need to weigh the needs of clinical practice and scientific research. Regarding the question of how much evidence is enough to legitimate a more radical revision, it is important to note the DSM’s multiple purposes. While it aims to be a suitable basis for research, it also thoroughly shapes psychiatric practice. Changes can be very consequential in that they affect patient’s diagnoses and possibly treatment, might impact questions of reimbursement, and even change public views of mental disorder and normality. Therefore, before one starts a revolution, there should be solid evidence that this will improve the situation in terms of science as well as health care. What exactly that means is moreover not a purely scientific question but calls for value-judgments on the weighing of inductive risks and consequences of possible errors.

In consequence, the needs of clinical practice and of scientific research do at present stand in conflict with each other. While the former calls for a conservative approach and high standards on evidence before every radical change, the DSM’s problems as a basis of scientific research are indeed severe and call for pluralistic explorations of possible alternatives and causal explanations. The central difficulty in psychiatric classification is, accordingly, not just a lack of validity or a lack of evidence, but lies in trade-offs between the different demands of research and practice.

PARALLEL SESSION 4 (B)

Friday January 23rd 15.00-15.30h
Auditorium

Louis Flores - King's College London

The concept of clinical Judgment in the era of Evidence Based Medicine.

In a recent article published in the British Medical Journal the “evidence based medicine (EBM) renaissance group” emphasised that clinical judgment (CJ) should play a fundamental role in overcoming the crisis currently affecting EBM 1. According to the authors “real EBM” is about “judgment not rules”. But what exactly is CJ? Is there any version of this concept (either everyday or technical) sufficiently precise, uncontroversial, and properly understood to advocate for?

The main purpose of this paper is to characterise the concept of CJ descriptively and to discuss the problems generated by a selection of attributes typically associated with it. The paper begins offering the
results of a review on the current usage of the term in the medical literature, which indicates the presence of various interpretations. It is suggested that CJ evokes radically different reactions, at least in part, because the concept is affected by an important degree of ambiguity and vagueness, and also because of disagreements as to what is the gold standard to measure the correctness of diagnostic, prognostic, and therapeutic assertions.

The paper continues with a theoretical analysis in which I distinguish three main interpretations, namely: CJ as evidential source or testimony, CJ as process, and CJ as product. From the perspective of EBM the first sense in which CJ is used is the most controversial. It is problematic because its usage seems to convey acceptance to the epistemological role of some forms of knowledge (intuitive, implicit) potentially affected by “subjectivity” not only in the context of discovery but also the context of justification. In a second sense, CJ is understood as a certain type of “process”, which conveys the presence of a series of actions or steps taken by the doctor in order to achieve a certain goal. This interpretation is less controversial than CJ as testimony but it remains affected by a degree of ambiguity and lack of consensus as to (i) the kind of processes encompassed by the concept, (ii) the relative priority and desirability of different types of inputs and (iii) what kind of norm should be embraced to assess the quality of various outputs. Finally, CJ can be used to denote a product or resolution. In normal circumstances this latter sense does not generate significant problems. However, its identification remains important, in particular as a reminder that, regardless the framework of practice, it is the clinician the one responsible for advancing diagnostic hypotheses and therapeutic suggestions to individuals.

Then, in the light of the aforementioned interpretations, I delineate areas of overlap between CJ and closely related notions (clinical intuition, reasoning, experience), discuss to what extent certain attributes assumed to be desirable (reliability, consistency, replicability, accuracy, objectivity, truth-wardiness) are in practice attainable, and to what extent properties generally taken as objectionable (tacit, intuitive, subjective, speculative) are truly undesirable. The paper concludes suggesting the necessity of a more balanced account of CJ.

Friday January 23rd 15.00-15.30h
1A-05

Michael Lacewing - Heythrop College London

Meaning and causal explanation: beyond the dichotomy
In this presentation, I argue that the famous opposition between causal explanation and understanding meaning, defended by Jaspers following Dilthey, and adopted by a number of 20th century hermeneutic and phenomenological conceptions of psychiatry, is mistaken. However, this is not because psychological accounts of human behaviour form a natural science (they do not), but because the conception of causal explanation derived from the natural sciences is not the only form available. Drawing on contemporary work in the philosophy of mind and action, I defend the claim that, although the slogan ‘reasons are causes’ is false, at least many explanations in terms of meaning are causal in form. I then spell out the implication of this view that there is no sharp contrast to be drawn, only a continuum, between clinical understanding and theoretical scientific knowledge, noting that much of the distinction relates to the general issue within science of understanding individual v. general phenomena.
Schizophrenia and Moral Responsibility

In this paper I give a Kantian answer to the question why, if at all, people suffering from mental disorders that fall within the schizophrenia spectrum should be exonerated from blame. I answer that question by reconstructing Kant’s account of mental disorder, particularly his explanation of psychotic symptoms. Kant discusses these symptoms under the header “mental derangement.” I assess the plausibility of Kant’s explanation of the different psychotic symptoms in terms of various cognitive impairments and discuss his claim that the unifying feature of mental derangement is the patient’s inability to enter into a mutual exchange of epistemic or moral reasons with others.

In order to prepare the ground for a discussion of some real life cases, I develop Kantian Quality of Will Test for inculpably ignorant actions. According to this test, an inculpably ignorant action does not express a lack of good will if the action would be either morally justified or excused if the agent’s beliefs were true. On the basis of this test combined with Kant’s explanation of the psychotic symptoms I analyze five real life cases. On the basis of the first three cases, I argue that schizophrenic patients who are unable to enter into a mutual exchange of epistemic reasons are exempted from doxastic rather than moral responsibility. They are exonerated from blame only if their actions do not express a lack of good will. On the basis of the two remaining cases, I argue that patients who are either unable to form intentions and make plans or unable to enter into a mutual exchange of moral reasons are exempted from moral responsibility on the grounds that they do not satisfy the requirements for moral agency.

Why paraphilias are not mental disorders: The case of DSM-5

Throughout history, three negative attitudes towards unusual sexual behaviors and desires can be discerned. Thus they have been conceptualized as criminal offenses, vices and/or (symptoms of) disorders. In this paper I zoom in on the legitimacy of the third attitude, i.e. pathologising. More particularly, I scrutinize the evidence and arguments that supposedly substantiate the claim that the sexual deviations (or paraphilias, as they are now known) are mental disorders. In doing so, I will focus mainly on the American Psychiatric Association’s dealings with sexual deviance as laid out in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

The question whether paraphilias are mental disorders inevitably leads us back to an underlying conceptual question: what is mental disorder? What necessary and sufficient conditions, if any, does a set of behaviors and desires have to fulfill in order to be a mental disorder? Since 1980 the DSM is based on an explicit definition of the concept of mental disorder. I will argue, however, that the subsequent editions of the manual, including DSM-5, have failed a) to define a number of terms used in the general definition of disorder; b) to properly implement the definition in the context of the paraphilias; and c) to provide solid evidence or arguments to keep the paraphilias listed in the handbook. Given these shortcomings, advocates of DSM-5 cannot convincingly continue to claim that paraphilias are mental disorders.
Integrative psychiatry; a new professional practice that bridges different medical paradigms

Western medicine (WM) and complementary and alternative medicine (CAM) are based on rather different paradigms. This often leads to heated debates. Integrative medicine is a new concept of health care that fits the spirit of the age and has the potential to bridge these differences (Hoenders et al., 2012).

The differences between WM and CAM can be illustrated by comparing them as regards to five factors: perspective, paradigm, organization, scientific method and procedures (see table 1). Theoretically, WM and CAM are categorically opposed to each other in many respects. In practice, they seem to differ only gradually. However, in one aspect they seem to differ categorically both in theory and practice, namely in the commonly used theoretical models (mechanism / reductionism versus vitalism / holism). This aspect is therefore the main reason for the heated debates that are sometimes observed between opponents and proponents of CAM. We nevertheless think these differences can be bridged using an integrative model (integrative medicine) that accommodates both (Hoenders et al., 2008).

Integrative medicine has been defined as: ‘the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing’ (The Consortium, 2004).

Integrative psychiatry is integrative medicine applied to mental health care (Sarris et al., 2013). It is also based on four pillars. It emphasizes the importance of the therapeutic relationship between clinician and patient using shared decision making and a personalized approach. It focuses on treating the ‘whole person’ from a holistic perspective, considering mind-body and its systems as interrelated, with biological, mental, emotional, cultural, ecological and spiritual / religious aspects. It seeks to provide the ‘best of both worlds’ combining WM and CAM based on evidence for their safety and efficacy. Its focus is on increasing qualities and strengths (salutogenesis) as well as decreasing symptoms (pathogenesis) and it aims for increasing general wellbeing and mental health (Lake et al., 2012).

PARALLEL SESSION 5 (B)

Saturday January 23rd 12.00-12.30h
Auditorium

Dorethee Horstkoetter - Maastricht University

Medicalization, Demedicalization and Beyond: Antisocial Behavior and the Case of the Dutch Youth Law

Youth antisocial behavior (ASB) is frequently considered to be carried out by children and adolescents who suffer from behavioral disorders. Consequently, attempts to reduce ASB increasingly comprise mental health interventions. Moreover, early signaling of children at-risk and early prevention of behavioral problems are considered crucial remedies. Critical investigations of these developments, however, are in particular concerned about the accompanying medicalization of society and the behavior exhibited by infants, children and adolescents. On this note, the new Dutch Youth Law even refers to demedicalization as a central aim.

From an ethical point of view, this article critically investigates the meaning and relevance of the medicalization reproach in the context of ASB. We will show that the term medicalization (M) can reasonably be attached to three different developments: the biomedical turn (M1), an increase in (forensic) youth mental health care (M2) and early signaling and prevention (M3). The ethical implications of these developments, however, are diverse, referring to both risks and benefits. By itself, neither the term medicalization nor demedicalization carries a self-evident normative meaning. Therefore, a careful ethical analysis is needed to reveal which social developments are actually laudable or condemnable.
Janette Dinishak - University of California

The Deficit View and Its Critics

In this talk I examine what it is to understand human differences in terms of deficits and criticisms of this explanatory approach. My focus case is autism. The most well-known and influential instance of a deficit treatment of autism is the “theory of mind” account. On this view autists have a specific cognitive deficit: a lack or delay in the development of the “theory of mind” module. This module is supposed to account for typical individuals’ ability to attribute mental states (e.g., intentions, beliefs, desires) to oneself and to others, an ability thought to be integral to explaining and predicting behavior.

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

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

PARALLEL SESSION 6 (A)

Saturday January 23rd 13.45 – 14.15h
Auditorium

Michael Flexer - University of Leeds

Making us mad; the (re)construction of mental illness as myth

Thomas Szasz (in)famously dismissed mental illness as a myth, and schizophrenia as a hollow sign to justify the pseudo-science of psychiatry; for Szasz mental illness was a ‘metaphor literalized’ and psychiatry behaved as though ‘the symbol were the thing symbolized’.

Whilst fundamentally rejecting Szasz’s argument, this paper provides a semiotic analysis of the mythology of mental illness, drawing materials from a range of cultural products and theoretical approaches from key semiotic theoreticians Ferdinand de Saussure, Charles Peirce, Roland Barthes and Yuri Lotman.

First, this paper considers how the productive machinery of television and cinema has necessitated a visualization of inherently invisible phenomenological symptoms of psychosis, including voice hearing, delusions of reference and bizarre thinking. This paper examines how recent popular cultural products, such
as US TV series Perception, Oscar-winning films Silver Linings Playbook and A Beautiful Mind, have created a mythology of psychosis and its treatment. The paper then compares these visual metaphors with those produced by current neuroscience. The paper argues that the visual outputs of functional magnetic resonance imaging (fMRI), the imaging of blood-oxygen-level-dependent (BOLD) signal changes or positron emission topography (PET) should be understand as sign products of another mythology of mental illness no less susceptible to falsity than that produced by popular culture.

This paper will demonstrate how these two systems of metaphors – comprising often wildly false icons – have been adopted within broad cultural discourses about mental illnesses so that, put simply, public debate’s true object has been the productive machinery of visual culture (be it in a cinematic or clinical context) rather than the internal mental states these signs are supposed to represent.

The paper concludes by triangulating these metaphorical sign systems with an analysis of the ever-mutating diagnostic sign of schizophrenia, as expressed through the iterations of the DSM and ICD. This triangulation will demonstrate that the clinical, theoretical and cultural signs of schizophrenia are all – in their different ways – representations of their own ideologically informed modes of production, rather than representations of the lived experience of psychosis. In creating false mythologies of psychosis, these sign systems create a new, subtler form of internalized stigma, whereby people with lived experience find their own phenomenological reality fails to measure up to the medico-cultural representations of their mental illness. In effect, these medical and cultural discourses have generated metaphorical sign systems that have obscured ‘mental illness as subjective phenomenological reality’ with their own product(s): ‘mental illness as myth’. In final refutation of Szasz’s reductive polemic, this paper asserts that, regardless of all the many different myths of mental illness, mental illness endures as a phenomenological reality idiosyncratic to the subject experiencing it and unknowable to external observers.

Saturday January 23rd 13.45 – 14.15h
1A-05
Dylan Paauwe - University of Amsterdam

Towards a non-reductionist understanding of psychosis: integrating different levels of explanation.

Broadly speaking, there are two main currents of research into the etiology of psychosis. On the one hand, biologists are looking for and hypothesizing on its’ neurobiological underpinnings (e.g. Abi-Dargham 2012), whereas on the other, epidemiologists using large databases look for quantitative correlations between specific social factors and the incidence of psychosis (e.g. March et al 2008; Vassos et al. 2012). My Research (Paauwe 2014) on the role of social experiences in the onset of psychosis points out that one can only truly understand and work towards an explanation of psychosis, when one does not start by reducing lived experience to fragments or aspects thereof, but instead looks at its’ totality.

During the course of this research a total of 12 in-depth interviews with six participants were held, as well as a focus group discussion in which preliminary results were discussed with those interviewed. The interviews focused on ascertaining participants’ social context in the period prior to psychosis. Six similarities emerged across the stories participants told. Not only can these be seen to match some epidemiological findings, but links with the neurobiology of psychosis can be presumed as well. An idea already put forward in Selten’s social defeat-hypothesis (Selten & Cantor-Graae 2005; Selten et al. 2013) that can be argued to find support in my study, this suggests that at least to some extent the biological and social factors work in tandem.

In addition, the social experiences of the participants seem to be intimately related to the content of at least some of their psychotic experiences. This suggests that the phenomenology of psychosis, too, can be understood best in their social context taken as a whole. It moreover opens up yet another avenue to connect biological and social levels of explanation, for instance because Kapur (2003) has already suggested a framework in which the psychotic experience can be linked to its’ hypothesized biology.

Above all, what is clear that it is not a question of singular events or experiences that in the case of some trigger a psychosis. Not just one of those similarities, but all of them, at more or less the same time. And not just those similarities, but also what is unique about each life history, together with those similarities. Whole social contexts and how they are experienced seem to be implicated in psychosis, and starting from this it appears to be possible to integrate social and biological levels of explanation.
When psychiatrists get lost

Abstract: Is it possible that quite a lot of psychiatrists wander lost, seduced by the idea that only ‘empirical’ research can save them from the morass of ignorance? Did they forget that the ‘natural processes’ (‘nature’) include both physical (‘matter’) and mental processes (‘mind’)? Epistemologically, humans are dualists. They live in two worlds: an ‘external’ world of which their brain is a part, and an ‘internal’ world of their mental processes. The first has to be explained by non-volitional causes, the second by volitional reasons. Psychiatrists who separate ‘mind’ from ‘soma’ are silly, and psychiatrists who do not distinguish ‘mind’ from ‘soma’ are even more silly. We are our brain but our brain is not us. We are blessed or doomed to be striving beings: we cannot be otherwise, and we call that ‘our will’. Therefore, an exclusively ‘positivistic’ approach in psychiatry is to be regarded as dehumanizing reductionism, said modishly: robotisation. Gravity is responsible for the fall of stones but “gravity cannot be held responsible for people falling in love” (dixit Einstein)

PARALLEL SESSION 6 (B)

An Outline of a Theory of Mental Health

Although the empirical sciences have made great advances in uncovering the causal mechanisms underlying mental disorders and the effectiveness of different forms of treatment, one important question falls by default outside the scope of scientific inquiry, viz. the question about the meaning of mental health and disorder itself—i.e. what mental health and their opposites itself consists in. Scientific investigations into mental pathology must presuppose an account of the nature of mental health and disorder, but cannot prove or verify such an account due to its inherent methodological constraints. What mental healthiness and unhealthiness itself consists in is a conceptual question, and one that philosophy can make important contributions to. The ambition of this presentation is to provide such a contribution.

One immediate concern might be that health and disorder are normative concepts and therefore resist objective definition (e.g. KWM Fulford and Jerome Wakefield share this concern). In evaluations of health one does not merely describes someone state of being, but contrasts this state to a certain norm; i.e. how a human being, or any of its functional parts, should be so as to be in a state of health—or at least in a state of better health. I will argue that the normativity of health does not pose an obstacle to the formulation of an account of mental health; values and norms are not necessarily subjective values and norms, and precisely in the context of health are there good reasons to assume that there relevant norms are objective norms (I will briefly touch on recent meta-ethical papers from Philippa Foot, Peter Railton, and Paul Bloomfield to illustrate this point).

The theory of mental health I will present is derived from ideas on the nature of physical health. The central idea is that the greater the range of capacities for activities one has (on the level of the whole) the healthier one is. When a (somatic) functional part does not function well, or if one suffers from a diseases, this means one’s range of capacities has contracted, i.e. one can do less—pathology incapacitates. When a (somatic) functional part functions well, by contrast, it increases range of capacities for activities on the level of the whole.

I will make a case for the claim that the same account of health applies in the context of mental life and that it captures best what we mean with the concept mental health. When people suffers from mental health issues their range for activities shrinks: depressive disorders will undermine one’s capacities for activities; anxiety disorders reduce the scope of one’s action potential, obsessive compulsive disorder constrain and rigidify what one is capable of; and so on. Mental health then—and this is the central claim—just
like physical health, consist in a form of mental functioning that conditions the widest possible range of capacities for acting.

I will end with some general reflection on the proposed theory of mental health, especially how it enables us to appreciate an intrinsic relation between individual autonomy and mental health, how it shows that there are no limitations to mental health (we could always be healthier), and the implications for diagnostic and therapeutic practice.

Saturday January 23rd 14.15 – 14.45h
1A-05
Bert Loonstra – VU University Amsterdam

Interaction Between Psychology and Anthropology in Psychotherapy

Anticipating the discussions of the second day, I assume that psychotherapy, as an activity familiar with psychiatry, is more than applied science; it is a human encounter that beside scientific theory includes both the patient’s and therapist’s experiences and worldviews.

In order to get an integral overview of potential focal points in therapy, it could be clarifying to connect elementary psychological skills that are pursued in therapy, with relevant anthropological basics in which these skills are rooted, but that often remain implicit. By this connection between psychology and anthropology the entire field of human existence comes into the therapist’s picture, while the latter continues to focus on healthy psychic functioning, of course.

As primary psychological functions could be recommended self-acceptance, self-actualization, and self-transcendence. These terms are derived from humanistic psychology, but also appeal to object-relations psychology. They are even compatible with cognitive behavior therapy: accept who you are, and develop your possibilities within your limits. Self-transcendence implies awareness of, respect for, and openness to the perceived reality beyond the self, ranging from people, phenomena, nature, and art to the divine.

Obvious and relevant anthropological basics are: otherness, nearness, and temporality. ‘Corporeality’ and ‘mind’ or ‘soul’ are not included as separate parameters, but are presupposed in the mentioned aspects.

By viewing psychology and anthropology as two independent dimensions that interact, nine fields of psychological functioning arise, like individuality, autonomy, relatedness, participation, and sense of temporariness, that may be objectives for therapy. The table presents a schematic picture.

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<thead>
<tr>
<th>Psychology:</th>
<th>Self-acceptance</th>
<th>Self-actualization</th>
<th>Self-transcendence</th>
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<tr>
<td>Anthropology:</td>
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<tr>
<td>Otherness</td>
<td>individuality</td>
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<td>Nearness</td>
<td>participation</td>
<td>purposiveness</td>
<td>inspiration</td>
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<tr>
<td>Temporality</td>
<td>sense of temporariness</td>
<td>perceived opportunity</td>
<td>eternity awareness</td>
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Model of Interaction Between the Psychology and Anthropology

When we observe the way different psychotherapeutic approaches relate to the model, we observe that the majority of individual psychotherapies focus on the anthropological notion of ‘otherness’, particularly on individuality and autonomy. Relationality is usually addressed under the perspective of independence from others (self-acceptance) or social skills (self-actualization), and less under the perspective of respecting the otherness of the other (self-transcendence). Increasingly, therapists are confronted with feelings of emptiness, meaninglessness, and dissociation. Often these can be traced back to a lack of participation in a family group or other social units that contribute to identity and meaning of life. Relatedness and participation are employed more as temporary therapeutic tools than as treatment purposes. The second level of distinctness, that is, ‘nearness’, is discounted explicitly by systems therapy and gestalt therapy. And narrative therapy lingers in the lower left corner of the matrix, including participation, purposiveness, temporariness, and perceived opportunities. None of the prevailing therapies, except for existential psychotherapy, is characterized by exploring the significance of the transcendent other, and temporality for self-perception.
The model provides an opportunity to the therapist to reflect on his/her own existence, to widen the scope of treatment, to consult a community’s representative for the sake of the patient’s sense of belonging, and to include worldview issues in the conversations.

Saturday January 23rd 14.15 – 14.45h  
Auditorium

Piyush Pushkar - University of Manchester

Health as a human right: the implications of medicalised subjectivities

In this work I aim to interrogate Paul Farmer’s statement that health has come to be seen as the least contested of the economic, social and cultural (ESC) rights (2005). I hypothesise that health carries more moral weight than the other ESC rights because of a peculiar valence of sickness as a form of suffering. This has led to a medicalising of our subjectivities, thus creating a privileged place for health in our moral economies.

I enter this investigation as a physician, a trainee psychiatrist and a student of anthropology. I am concerned regarding global inequalities of health, but also cognisant of the dangers of totalising discourses of universal human rights that do not give adequate consideration to how human rights are enacted and used in local moral worlds, how transcendental justice is translated into the everyday. As such, I examine human rights not just as a set of state-led legalistic rules, but through the responses and critiques offered by citizens, families and legal and medical professionals. Central to this study will be Foucaultian ideas of power, the state, the subject and the biopolitical relationship between them.

My sources for this investigation are multidisciplinary, but the majority of the empirical weight of my argument comes from ethnography. Only this form of evidence can demonstrate the lived experience of human rights discourses, revealing how purportedly transcendental universals become embroiled in socio-cultural milieus with divergent and overlapping interests, motivations and responsibilities.

Civil and political rights became separated from ESC rights in the context of the Cold War. ESC rights were generally seen as less important by an increasingly dominant USA. However, medical suffering came to be seen as a particular kind of ‘preventable’ and therefore unacceptable suffering, linked with the most basic of rights, the right to life. Farmer calls the causes of inequalities in such suffering “structural violence” (1997, p.261) Neurobiological understandings of suffering have been increasingly leading to a universal conceptualisation, converging with human rights discourse as a just response.

Therefore, biomedicine becomes one form of rationality in which a struggle can take place against structural violence and other forms of oppression. I draw on Bhabha (1984) to depict the ambivalence of the medical gaze, with the potential for oppression or empowerment. Frequently, transcendental ethics are reworked through socioeconomic necessity to form new ethicopolitical relations and responsibilities, transforming understandings of what is human, what is just and what is possible. I compare the different kinds of medicalised subjectivity described by writers such as Rose (2003), Brotherton (2012) and Biehl (2013), demonstrating how it becomes a site of manipulation of local moral economies in which power differentials are concealed behind a rhetoric of justice which paradoxically silences the subaltern.

However, in the possibility of slippage there is also hope, as health as a human right can provide a discourse to which people can attach their immediate struggles, if we listen. Therefore, human rights activists are challenged to socialise and ground their ethics in the everyday through a dynamic and neverending process of democratic reflection.