

*From the Editor*

This issue of the AAPP Bulletin is a play in three acts. The first and main act is a challenge put out by Scott Waterman regarding the status of the psychiatric profession, following by commentaries and a final response by Scott. The second act is another challenge, this one by our president, Peter Zachar, encouraging us to work more closely together in the further development of AAPP. Finally, John Sadler offers us a valuable guide in citing literature for articles in PPP.

In lieu of a formal table of contents, let me indicate that my own commentary begins on this page, while Scott's target article begins on page 2. The commentaries continue with Paul Lieberman's contribution on page 3, and Scott's response to commentaries begins on page 9. Finally, John Sadler's guide to references appears on page 12.

### **An Imperfect Psychiatry**

I am writing this response to Scott Waterman following several days in Yosemite National Park. It is spring in the park, with snowmelt gorging the rivers as they roar and plunge downward into the valley in violent currents and massive waterfalls, tearing away anything in their paths. I take from my hikes through the park an impression of nature as both staggeringly beautiful and violently destructive – and indifferent to the concerns of that portion of nature represented by our human selves.

When Scott Waterman summarizes his reasons for no longer being a psychiatrist, he includes his disappointments with the DSM classificatory system, his disillusionment with psychoanalysis, his concerns over the corrupting effects of the psychopharmacological industry on the field, and his more recent awareness of the limited efficacy of pharmacological agents. He could well have included the current

## **President's Column**

### **The AAPP Community – An Open and Bright Future**

Over the past year the AAPP Officers and the Executive Council have been brainstorming ideas for making the AAPP into a more cohesive organization for which the benefits of membership are clear. This has been challenging for a number of reasons. First, we are geographically spread out; not only over the U.S. and Canada, but over the entire world. Second, we are clinicians and academics, M.D.s and Ph.D.s, and ethicists, phenomenologists, social-political philosophers, philosophers of medicine, of science, of mind, and so on, with different scholarly traditions and methodologies.

In some ways all that ties us together is the name philosophy of psychiatry, and that is a flimsy basis for building a community. We are not all interested in the same kinds of journal articles or conference topics. One would think that the philosophy of psychiatry is a narrow specialty area – but it is not. If it were narrower, a community would be easier to build.

Despite these challenges, there are also tremendous resources for us to grow as a community and make the AAPP home to all those committed to advancing both the philosophical understanding of all psychiatry/clinical psychology and advancing the philosophical literature through the study of psychological health and dysfunction.

*Philosophy, Psychiatry, and Psychology* remains the leading journal dedicated to the philosophy of psychiatry. Due to its popularity, there was a backlog of articles and the issues were delayed, but thanks to John Sadler and the editorial team, the journal has worked through the backlog of articles and is now being published on time. We anticipate the publication of a redesigned website sometime in the next year and are planning on distributing an *AAPP Newsletter* twice a year with information about the recent publications and relevant activities of all AAPP members. We are also rethinking the *AAPP Bulletin* and hope to encourage more members to submit materials.

The most important resource is our members – especially those who are interested in becoming committed to the organization itself. Coming to the annual AAPP meeting is an important way to get involved as you start to put faces to names and hopefully begin to make connections. This is easier to do if you attend multiple meetings. It may take some time. When the group you are trying to enter is not populated with extroverts, you typically have to become familiar before you can become known. I was an associate professor before I found AAPP, but I quickly realized that I wanted it (and not one of the APAs) to be my home organization. I would encourage you to consider choosing us as well.

*(Continued on page 2)*

hoopla over “interventional psychiatry,” as its proponents, perhaps excepting ECT, promise more than they produce.

Scott doesn't quite tell us what an acceptable psychiatry would be, but what he writes suggests that it would be a biomedical psychiatry that was truly biomedical. He talks about his early interest in neurology and “biological psychiatry,” and writes: “I seized opportunities to redirect my efforts toward medical student education, eager to exorcise what I had long identified as rampant mind-body dualistic fallacies embedded in medical discourse, training, and practice. Implementation of major curricular reform in the early 2000s allowed me to par-

*(Continued on page 6)*

(Continued from page 1, President)

We invite AAPP members and student members to make suggestions about how to encourage more member involvement. Because the organization is structured with a leadership team (called the Executive Council), opportunities to serve on committees has been limited, but we want to open that up a bit more as well. If you are interested in becoming an ad hoc member of one of our committees, please contact the committee chair.

Scott Waterman (Jaspers award committee): scott.waterman@med.uvm.edu

James Phillips (AAPP Bulletin committee): james.phillips@yale.edu

Christian Perring (Media/website committee): cperring@yahoo.com

We are not an assembly line organization whose workings are automated – all the work is done on a volunteer basis. We cobble it together year after year – but that gives us a feeling of shared ownership that some other organizations lack. It takes effort to get involved, but contributing to a small scholarly organization like AAPP can be a very satisfying part of a career.

\*\*\*

## Why I Am Not a Psychiatrist

G. Scott Waterman, M.D., M.A.  
University of Vermont  
Scott.Waterman@uvm.edu

On March 6, 1927, Bertrand Russell explained to those in attendance at a presentation organized by the South London Branch of the National Secular Society at Battersea Town Hall why he was not a Christian. Although he does not appear to have discussed why his religious (non-) beliefs should be of interest to others, we can logically surmise that, as a well-known thinker, his views were considered noteworthy. In any case, when that 1927 lecture, “Why I Am Not a Christian,” was published thirty years later as part of a collection with several of his other essays on related topics, the editor of that volume, Paul Edwards, made clear in his Introduction why he believed Russell’s thoughts about Christianity were per-

inent then. While many in the West perceived godless Communism to be the paramount threat to freedom in 1950s America and Great Britain, others were concerned that elements of the anti-Communist program were at least as dangerous. In that context, Edwards found in Russell’s free-thinking secularism an antidote to what he saw as the dangers of the ideological – including religious – conformity that was increasingly expected, if not imposed, as part of the Western defense against (ironically) tyranny.

So why should anyone care whether I am or am not a psychiatrist? (I am putting aside the question of whether someone who has decided to leave the profession is still a psychiatrist. As I am also not a Christian, I won’t suggest that the principle of redemption should constitute the basis of an answer to that question!) Perhaps the most straightforward reason why anyone should care about my professional status is the purported shortage of psychiatrists. As reported in a very recent Association of American Medical Colleges press release, 111 million Americans live in “mental health professional shortage areas” and over half of U.S. counties have no psychiatrists. This, in the context of the canonical assertion that about 20% of us are mentally ill (or, in the Orwellian parlance of the day, suffer with “a mental health condition”), is said to constitute a crisis. As Russell would surely recognize, implicit in the syllogism whose conclusion is that we need more psychiatrists is the proposition that their presence in greater numbers would mitigate the problem of human suffering.

My skepticism about the validity of that implicit proposition is doubtless a reflection of my personal journey through psychiatry over the past several decades. I will leave it to the reader to decide whether it was a voyage of discovery or a road to nowhere.

Attraction to neuroscience in medical school contributed to my initial intention to pursue a career in child neurology. Personal experience with chronic worry and periodic gloominess, combined with a conviction that scientific understanding of mental states was on the horizon and curiosity about the widening conceptual schism in the field, led to a

switch to psychiatry. The timing of my change of specialty choice landed me, quite by accident, in one of the nation’s most psychoanalytically oriented residency training programs. My quickly formed suspicion that psychoanalytic doctrine was fundamentally flawed was reinforced by the defensive (and frankly anti-intellectual) responses of my teachers and by the publication of Adolf Grünbaum’s 1984 treatise, *The Foundations of Psychoanalysis: A Philosophical Critique* (and later by the recovered false memory debacle). Those experiences, among others, prompted my decision to pursue training in research in “biological” psychiatry. I was particularly animated by the notion that early-onset psychopathology, not yet contaminated by what we considered the artifactual overlay of the varied consequences of chronic dysfunction and marginalization, would be where causes and mechanisms could ultimately be elucidated. That optimism was eventually dispelled by the reality of an investigatory program that depended on definitions of phenotypes specified in the DSM. My main consolation about that blind alley was that I recognized it for what it was and moved on before many of my colleagues did.

My subsequent focus on clinical child and adult psychopharmacology teaching and practice rewarded the abilities that had made me a very successful medical student – an excellent memory for scientific findings and a capacity to invoke them in appropriate contexts. Initially, I tried to assure myself that the generally modest benefits our clinic patients seemed to derive from our efforts reflected the nature of a university-based tertiary referral service. But as the story of the systematically exaggerated efficacy, along with underplayed (not to mention actively hidden) risks, of various pharmacotherapies unfolded, one conclusion became inescapable: massive conflicts of interest between the profession and the pharmaceutical industry had rendered psychiatry a case study in institutional corruption. I seized opportunities to redirect my efforts toward medical student education, eager to exorcise what I had long identified as rampant mind-body dualistic fallacies embedded in medical discourse, training, and practice. Implementation of major curricular reform in the early 2000s allowed me to participate in the formulation of what was likely the most materialist integrated course in neuroscience

among all American medical schools. At the clinical education level, however, the hegemony of the DSM diagnostic system – whose baleful influence on psychiatric research had become evident to me early in my career – presented an impediment to students' abilities to learn anything potentially useful about psychiatry. Much of my involvement in philosophy of psychiatry has focused on the multiple shortcomings of its diagnostic system – a message that appears finally to have been received, albeit without any clear remedy on the horizon.

To this point, my story might be read simply as one of periodic professional adjustments made in response to gradual acquisition of insight into myself and the world. It might even be spun as a record of personal success – an asymptotic approach to ideal occupational fit within the discipline of psychiatry. But it doesn't end there. Largely in connection with my wife's involvement in the critical psychiatry movement over the past several years, I have come to know many members of the consumer/survivor/ex-patient community and their advocates. Their perspectives – absent from assessments of the psychiatric enterprise until recently – are as compelling as they are discomfiting. We must take seriously the possibility that the staples of contemporary psychiatric thinking and practice – whose social standing is increasingly hegemonic in the arena of human unhappiness and dysfunction in ways reminiscent of the expected ideological conformity of the 1950s – have not only proven to be explanatorily and therapeutically impotent in more ways than most psychiatrists would like to admit, but are in some instances frankly pernicious. By the time I reached my decision to retire from psychiatry, I had developed serious doubts about whether I possessed any scientific knowledge or professional skill that was of any value to people who are suffering.

I hope it is evident that this capsulized account of my professional journey is intended to be descriptive rather than prescriptive. (It is, after all, not titled, "Why You Should Not Be a Psychiatrist.") I leave it to the reader to apportion how much of it is about me and how much of it is about the profession of psychiatry. I mean no insult to my psychiatrist friends and colleagues who have found ways of contributing to general knowledge and individual wellbeing. I have no doubt about the

reality of both and recognize the limitations of my own capacities, imagination, and resilience in this context. I look forward to their (and others') assessments of and prescriptions for the profession we once shared.

\*\*\*

### Fortunate to be a Psychiatrist – A *What?*

Paul Lieberman, M.D.  
Brown University  
paul.lieberman@brown.edu

Daniel Levinson was a psychologist who collaborated with Theodore Adorno studying the authoritarian personality and later helped found the field of adult development, although he's probably best remembered for his discovery, or invention, of the 'midlife crisis.' Dan once reminisced that when he was at the Massachusetts Mental Health Center at Harvard in the 1950s, working with Erik Erikson, Talcott Parsons, Elvin Semrad, Lester Havens, George Vaillant, Eric Kandel and other psychiatric luminaries, he felt extremely fortunate: he was working on the most important problems *there were* and felt that anyone doing anything else was more or less *disadvantaged*. He also said that everyone needed to feel that way about the work they did.

Although Levinson may not have been referring to psychiatry as we know it, for some of us, our field has elicited that kind of response. For me, at least, psychiatry has been an endlessly engaging profession, despite its weakness and corruption (1), and in some ways because of its difficulty and imprecision. Thus, while Dr. Waterman has given us a remarkably eloquent and persuasive recounting of psychiatry's flaws, with which I completely agree, I come to a conclusion different from his.

The difference, I think, lies in what we take psychiatry to *be*, what a psychiatrist *is*. When I chose psychiatry, it seemed to be a field in which one could work at things both medical and something else – hard to specify, but somehow associated with a subject more personal, emotional, comprehensive and meaningful; call

## 2020 AAPP Annual Conference

### Call for Abstracts

#### *Intuitions Meet Experiments: Methods in Philosophy of Psychiatry*

April 25-25, 2020  
Philadelphia, Pennsylvania,  
USA

#### *Keynote Speaker*

Edouard Machery, PhD  
Distinguished Professor  
Department of History and  
Philosophy of Science  
University of Pittsburgh

#### Conference Organizers

Robyn Bluhm, PhD  
Michigan State University

Douglas Heinrichs, MD, Ellicott,  
MD

Christian Perring, PhD  
St John's University, NY

Serife Tekin, PhD, University of  
Texas at San Antonio

#### Instructions

Abstracts, 500-600 words, are due by October 15, 2019 and should be sent to Christian Perring at [cperring@yahoo.com](mailto:cperring@yahoo.com), and to Robyn Bluhm at [rbluhm@msu.edu](mailto:rbluhm@msu.edu).

For full information about the conference, go the conference website at:

[https://  
philosophyandpsychiatry.org/  
meetings-conferences/](https://philosophyandpsychiatry.org/meetings-conferences/)

it, the psychological. Stephen Fleck once said that psychotherapy required using ‘all aspects of your personality’ and being ‘a special kind of friend.’ That was my hope for psychiatry and I think I was not alone in that aspiration. Psychiatry promised us not only a medical career, with all its interests and complexities, but some type of more comprehensive engagement with and understanding of what was at the heart of things in life. Medical students still say things like that when they consider psychiatry, though many, nowadays, go elsewhere, since our field, as Dr. Waterman has shown us, has also gone elsewhere – to a narrow biomedical model with all that that has implied: limited ‘scope of practice,’ brief visits, symptom checklists, over-prescribing, computerized treatments, truncated training in psychotherapy – the ‘baleful’ changes Dr. Waterman describes. All the intellectual excitement is in the biological and the nosological, and, while neither of these has kept the promises of its heady, early years to put psychiatry on a ‘really scientific’ footing and successfully, finally, treat psychiatric problems, (and while those promises are still being made) what already seems clear is that these research programs often ‘pass by’ and ‘don’t touch’ the human, emotional, more ‘comprehensive’ forms of practice which drew people to psychiatry at one time.

Two questions arise. The first is whether this more capacious view of psychiatry is even possible. Is it a realistic vision, or a grandiose one, or perhaps a fantasy, born of ambivalence and an inability to choose between what are, after all, just different realms of professional life (the medical and the psychological) – a compromise which leaves the psychiatrist, at best, more amateur than expert, and, at worst, just another victim of the fear of missing out? And the second question is whether such a psychiatry, if it did exist, would be helpful to anyone – better than no psychiatry at all, as Dr. Waterman wonders.

To the first question, I think the answer depends on what you mean by ‘possible.’ If by ‘possible’ you mean that a psychiatrist could practice in a more comprehensive way and still meet his obligations regardless of patients’ economic circumstances, still learn and develop professionally among like-minded colleagues and learn from a literature which is, both, exciting and

relevant, still enjoy a reasonable standard of living relative to his medical school (not to mention college) classmates, and still be able to earn and enjoy the prestige of a valued profession, then it might not be possible. Certainly, it would be tough, and for a young physician ‘psychiatry’ now means something like that only at the margins (‘keeping a small private practice’).

But if by ‘possible’ you mean something like conceptually or metaphysically possible, then I think it’s not only possible, but necessary. It’s possible because some psychiatrists actually do seem to practice that way (they don’t usually ‘take insurance’), and because many others seem honestly to miss the fact that they don’t (as if it’s something they’ve *lost*). It’s necessary because people and their psychological problems exist in multiple ‘families’ of causes and non-causal influences which overlap and interact. People are physical things which follow the laws of nature, but they are also sentient beings, talkers and active agents; their disturbances – especially those for which psychiatrists may be consulted – share and disturb these features in ways which ramify throughout our myriad forms of life. Reserpine really does cause ‘depression’ and ketamine, apparently, does seem miraculously to cure it. But ‘feeling depressed’ is not the same as seeing oneself (or being seen) as ‘a depressed person’ (or, ‘prone to depression’), and taking ketamine still leaves open ‘a certain kind of *why* question’ (or, rather, many of them: Why me? Why now? Why this?). There are forms of ‘treatment’ – such as listening, understanding and valuing – which help depression, and (if supervenience is true) change the brain, but which won’t work well if that brain is constrained physically (for example, by reserpine). And, of course, how you think and feel and act will determine whether you even consult a psychiatrist or anyone else at all, and, if you do, what you’ll tell her, and how. (Is this more comprehensive view of psychiatry just grandiosity, or FOMO?)

Yet, one might still wonder: why a psychiatrist, why not *teams* (one person ‘does the medication,’ one ‘does the therapy,’ and so on; it

might salvage the ‘psychiatrist in a box’ model)? I think the answer is that teams are fine, even essential (especially when there are ‘shortages’). But every team needs a manager, and the manager needs to *know the game* well enough to ‘make the calls’ as the game unfolds. There are a lot of managers and coaches who were formerly players because to know the game it helps to have played it. This is true not only because there is a certain amount of information required – to be able to recognize, for example, when the pitcher is getting tired, or when someone should work with the batting coach – but, also, because when you make a choice you have to consult your values. A home run might win the game, but so could a squeeze bunt, and if you don’t know about that, haven’t seen it work and felt its exquisite satisfaction, your options are, necessarily, limited. And it doesn’t work to submit the lineup, start the game up and leave after the first inning.

Finally, the question, which is, of course, the *point*: would this psychiatry, if it existed, be demonstrably helpful to anybody? The answer has not been established to the satisfaction of many, but there is evidence: the innumerable clinical studies comparing placebo or no treatment to many psychotropic medications or psychotherapies or their combinations in thousands of patients; system-wide programmatic innovations which show the benefits of introducing mental health services into other medical sites (‘co-location’); the reassuring studies which show that psychiatric diagnosis is no less reliable, and psychiatric medications no less effective, than their counterparts in other branches of medicine; the testimonials of people we respect (Andrew Solomon, Kay Redfield Jamison, Elyn Saks, our friends and family); the vigorous advocacy of patient and family groups for achieving parity, increasing reimbursement and improving ‘access to care’ by making more care providers, including, explicitly, psychiatrists; and the fundamental fact that people with psychiatric problems are mostly the same as people without them, so that what ‘works’ for one will probably work for all.

Psychiatry, as Dr. Waterman states, is corrupt and its treatments are *weak* (Andrew Solomon calls them, ‘appalling’). But I conclude that psychiatry as it could be is still better than no psychiatry at all.

## Reference

Lessig, Lawrence. *America, Compromised*. Chicago, The University of Chicago Press, 2018.

\*\*\*

### Practicing Psychiatry in the Dark Ages: A Response to Scott Waterman

Douglas Heinrichs, M.D.  
dweinrichs@gmail.com

I fundamentally agree with Scott's characterization of the long-standing deplorable state of psychiatric research and academic psychiatry in general – from the doctrinaire nature of the once dominant psychoanalytic movement (which has led to many clinically useful babies being thrown out with the rigid and arrogant theoretical bathwater) to the striking failure of the research program in biologic psychiatry to generate much solid and relevant knowledge to aid in the treatment of our patients. As Scott notes, much of the problem relates to a conceptually incoherent diagnostic system. In addition, there is the hubris in arguing that the very limited understanding we have of the most proximal mechanism of action of our therapeutic agents tells us much that is useful about the ultimate experiential and behavioral effects that they produce as their impact cascades through the complex and idiosyncratic mechanisms that constitute a specific human organism. Furthermore the matter is made much worse by the distortion of what knowledge we do have by an unholy alliance between academia and the pharmaceutical industry, exaggerating the benefits and minimizing the negatives of our treatment options.

After nearly a decade of full time psychiatric research in an academic setting, my response to a growing appreciation of this state of affairs – and it took that long to shed the indoctrination of my training and my personal desire to do meaningful work in this field (not unlike doubting and then rejecting a religion) – was to leave academia for full time private practice rather than to leave psychiatry all together. Why? In my exposure to psychiatric clinicians during my years of

training and thereafter, I developed the strong sense that a fair portion of practicing psychiatrists are able to help a good portion of the persons they treat to have better quality lives than they would have otherwise. If this is true, and I realize this is difficult to prove, how is this possible given the state of psychiatry as outlined above?

This question has stimulated my interest in understanding the methodology of clinical reasoning in psychiatry. How can the psychiatrist do better in helping her patient than the very flawed information offered by the research and academic establishment would seem to allow? I have come to think it useful to make a distinction between the science of psychiatry itself, where the emphasis is on understanding and treating a unique individual, and the informing disciplines that surround it; e.g. psychopathology, therapeutics, neuroscience, psychology, sociology. I trained in psychiatry just at the transition point when the hegemony of psychoanalysis gave way to the dominance of biological psychiatry and psychopharmacology. The first half of my training was in a strongly psychoanalytic program and the second half in a biological and research oriented one. I was fortunate to have a number of excellent clinical supervisors in both and was struck by the extent to which they shared core approaches to understanding the individual patient and developing an ongoing treatment strategy in response to that understanding, in spite of wrapping their understanding in very different theoretical garb.

The primary focus of my current scholarly work is to articulate with conceptual rigor the actual methodology of this clinical enterprise, and not to trivialize it with the most unhelpful label of the “art” of medicine. It is my contention that practicing psychiatrists who are doing good work, and certainly not all are, do not simply apply generalized bits of psychiatric “knowledge” to a particular patient by some process of deduction. Rather the clinician, by a process not unlike that which many contemporary philosophers of science see as central to the actual methods of all of the sciences as practiced, must select particular trial interventions based of a specific model of the problem that the individual patient poses in light of her

## Karl Jaspers Award 2020

### Call for Papers

**Deadline  
December 15, 2019**

The Association for the Advancement of Philosophy and Psychiatry (AAPP) announces a competition for students and trainees Eligibility includes medical students, graduate students in philosophy, psychology and relate fields, and residents and fellows in psychiatry.

The Karl Jaspers Award is given for the best paper related to the subject of philosophy and psychiatry. Appropriate topics for the essay include, among others, the mind-body problem, psychiatric methodology, psychiatric nosology and diagnostic issues, epistemology, philosophy of science, philosophical aspects of the history of psychiatry, psychodynamic, hermeneutic and phenomenological approaches, and psychiatric ethics. Winning submissions will be offered publication, following appropriate review and editing to meet journal guidelines, in the electronic version of *Philosophy, Psychiatry, & Psychology*. The home universities or training programs of the award winners will be notified of the outcome. In addition, the winning entry will be announced at our AAPP Annual Meeting, held concurrently with the American Psychiatric Association's Annual Meeting. In 2020, the meeting will be on the weekend of April 25 and 26 in Philadelphia. The award carries a cash prize of \$350 and recognition in AAPP publications.

For full details regarding the preparation of a submission, please contact :

[https://  
philosophyandpsychiatry.org/  
jaspers-award/](https://philosophyandpsychiatry.org/jaspers-award/)

goals. Over time the psychiatrist must constantly reassess the interventions, modifying the model when indicated, in light of the patient's evolving condition and goals for treatment, with an eye to possible unexpected effects both positive and negative. This requires listening to the patient with an open mind and not applying a preconceived checklist of symptoms and side effects. It requires willingness to reformulate one's understanding of the patient repeatedly during the course of treatment and striving to develop an understanding that both the psychiatrist and the patient share. Each patient becomes an N of 1 study as the lines between clinical practice and research blur. It is the failure to implement this sort of individualizing strategy that results in psychiatrists failing to see when their treatments in accord with current "standards of care" are actually doing harm to a given patient, even when that harm is obvious and occurring in plain view. I believe there is a great need to make this sort of clinical method explicit, more teachable, and more theoretically justified in scientific terms. Nevertheless I believe that many psychiatrists to varying degrees already practice this sort of approach, if not well articulated even to themselves. In short I believe that what the good psychiatrist actually does with her patient is often much better than the theoretical "knowledge" being taught to psychiatrists at any given time.

My deep concern for the future of psychiatry as practiced results from the change in training that has come with the transformations in academic psychiatry. As theoretically rigid and doctrinaire as psychoanalysis was in its heyday, training in that tradition encouraged listening carefully to the individual patient and understanding their uniqueness in the context of an ongoing and evolving treatment relationship. Some attempt was even made to distinguish clinical theory from metapsychological theory. Even if that clinical understanding was often shoved into a rigid and questionable theoretical straitjacket, the emphasis on listening to the individual left room for thoughtful clinicians to develop some of the elements of a meaningful clinical methodology of the sort I am trying to characterize more explicitly. High status was accorded to senior clinicians upon whom trainees could model themselves in how to evaluate and treat individual patients. In the current climate, howev-

er, future practitioners are taught that clinical method is largely a matter of applying the algorithms of Evidenced Based Medicine to the patients they are treating, reducing them essentially to tokens of a type, while some vague lip service is paid to the need for the "art" of medicine with little actual attention to what that entails. Rather than inculcating a healthy skepticism in the future psychiatrist toward the sifting, commonly unreplicated, and frequently biased "knowledge" being churned out by academic research, often funded by and in collaboration with the pharmaceutical industry, trainees are taught a questionable schema for a hierarchy of evidence that suggests that randomized clinical trial results simply trump every other source of knowledge available to the clinician.

There is little reason to expect this to change in the near future, given the massive financial incentives for academic psychiatrists to keep doing what they are doing. As departments of psychiatry rely ever more heavily on research dollars, much of it with ties to the pharmaceutical industry, the status of researchers eclipses that of clinicians in training programs. Consider, for instance, the incoherence of a common policy in departments of psychiatry that forbids residents and clinical staff from meeting with pharmaceutical sales representatives, while allowing research faculty to accept massive research grants to carry out work of potential value to the pharmaceutical industry. Apparently the clinician cannot be trusted to resist the allure of an explicit sales pitch and a free sandwich, while research faculty, whose very livelihood may depend on drug company money, are free to impart information to trainees that is assumed to be objective, scientific and unbiased. (As an aside, it has always seemed to me that residents should meet with drug reps but only in the presence of experienced clinical supervisors who can help them identify the biases and critically assess what they are hearing. If one does not learn this healthy and critical skepticism in training, then when?)

Given this pessimism, how do I think about myself as a psychiatrist? I have chosen to stay as a practicing clinician in spite of how I see the field evolving. I try my best, with considerable humility about what I know, to

help the individuals I treat to have improved lives in terms that they set. I think I succeed often enough to keep at it for now. In my limited time for scholarly pursuits, I continue to try to articulate the clinical method of psychiatry. Will anyone listen or care? I'm not sure. But perhaps a few will and perhaps it will help this rearguard action to keep good clinical care alive. Scott began with a religious comparison, citing Bertrand Russell. Let me end with a different one, perhaps reflecting a detour in my earlier life involving four years in a Benedictine monastery. Trying to practice good clinical care in psychiatry and to understand its methodology feels a bit like what I imagine medieval monks to have felt trying to preserve some of the classical wisdom in dark times. Perhaps something of value can be preserved and nurtured for future use, if at some point the barbarians depart, or decide it is time to become civilized.

\*\*\*

### **An Imperfect Psychiatry**

*(Continued from page 1, Editor)*

ticipate in the formulation of what was likely the most materialist integrated course in neuroscience among all American medical schools." Inasmuch as 'materialism' has become a superannated concept, with material now a matter of waves and quarks, I assume that in speaking of materialism he means naturalism, the major tenets of which are fact and empirical evidence. With naturalism as its philosophical underpinning, scientific research involves what can be seen, measured, and confirmed. The effort to explain as much as we can naturalistically is of course a reasonable, scientific goal, but with one caveat: if one moves from trying to explain naturalistically to declaring that naturalism is the only way to explain, one is shifting from science to ideology. This is where Scott may be getting into trouble. And it may be the reason why he sees psychiatry at a dead end, while others of us don't.

Allow me to review some other opinions on this theme. Naturalism certainly resolves the problem of dualism, but at quite a price. We do, after all, think of ourselves as more

than those plunging rivers in Yosemite. Philosopher Simon Critchley, writing about his early mentor, philosopher Frank Cioffi, and the latter's attitude toward such scientific reductionism, says:

This is the risk of what some call "scientism"—the belief that natural science can explain every thing, right down to the detail of our subjective and social lives. All we need is a better form of science, a more complete theory, a theory of everything. Lord knows, there are even Oscar-winning Hollywood movies made about this topic. Frank's point, This is of course Critchley's way of noting the point made above, that claiming naturalism (or materialism) as a theory of every thing is a declaration of ideology, not science.

Let me add to this chorus another philosopher, Alfred North Whitehead, who writes:

There persists, however, throughout the whole period the fixed scientific cosmology which presupposes the ultimate fact of an irreducible brute matter, or material, spread throughout space in a flux of configurations. In itself such a material is senseless, valueless, purposeless. It just does what it does do, following a fixed routine imposed by external relations which do not spring from the nature of its being. It is this assumption that I call 'scientific materialism'. Also, it is an assumption which I shall challenge as being entirely unsuited to the scientific situation at which we have now arrived. It is not wrong, if properly construed. If we confine ourselves to certain types of facts, abstracted from the complete circumstances in which they occur, the materialistic assumption expresses these facts to perfection. But when we pass beyond the abstraction, either by more subtle employment of our senses, or by the request for meanings and for coherence of thoughts, the scheme breaks down at once."

To which he adds in another place: "There are then two possible theories as to the mind. You can either deny that it can supply for itself any experiences other than those provided for it by the body, or you can admit them."

Whitehead takes me back to Yosemite. Blind nature is certainly indifferent to human concerns, but those concerns are also part of nature; as anyone writing or reading this text must surely know. Rocks don't read or write, nor do sodium ions passing in and out of neurons. But humans do.

As a final gesture in this commentary, let me invoke Karl Jaspers, psychiatrist and philosopher, who wrote his *General Psychopathology* in 1913 and revised the text into the 1940s, when he had long since given up psychiatry and become a world-famous philosopher.

Writing against a background of nineteenth-century biological psychiatry, Jaspers begins with a major distinction between causal explanation and meaningful connections. The former is the world of the positive sciences, the latter the world of relations of meaning. If a man becomes delusionally (and inappropriately) jealous following the development of a brain tumor, that jealousy has a presumed physical cause. If on the other hand a man becomes angry following an insult, there is no physical cause, only a meaningful connection between the two events. Jaspers is quite clear that most human interactions involve a mixture of the causal and the meaningful, writing, "Biological, psychic and cultural factors are an indivisible reality; they have to be pulled apart and interrelated so that we can explore them scientifically; they are radically different in meaning." Jaspers would reject a charge of dualism and would insist that his concern is the difference between two methodologies in studying human psychopathology.

In the *General Psychopathology* Jaspers makes still another general point that is relevant to this discussion. He distinguishes a 'case' of psychopathology from the individual whom I am treating.

There is a radical difference between our perceiving in a case an instance of something general (the scientific approach) and perceiving something which immediately confronts us as unique, an enigma which can never be turned to good account by the use of general statements...The difference is radical because here at the mar-

## INPP 2019

*Experts in Mental Health  
21st Annual Conference  
of the International Network  
for Philosophy and Psychiatry  
Warsaw, 22-24 October 2019*

### Participation

Panel proposals  
Oral presentations  
Posters  
Listeners

### Topics

Expertise in mental health  
Role of diagnostic categories  
Psychiatric patients  
Healing and psychiatric models  
Psychiatry and values  
Critical perspectives  
Psychiatry and philosophical practice  
Representations of madness

For full information, contact:

[www.osfp.org.pl/inpp2019](http://www.osfp.org.pl/inpp2019)

[inpp2019@osfp.org.pl](mailto:inpp2019@osfp.org.pl)

gins of scientific knowledge and arising from the immediacy of experience the essential communication is that 'I recount but I cannot generalize what I know'.

Jaspers is here carrying his argument as far as possible from any simple theory of naturalism. The issue is not just that we're in the world of human meaning, as opposed to that of causal explanation. It's also that we are not working with a case of a general disorder. We're working with a particular individual in all his or her uniqueness.

From Jaspers' perspective we would fault Scott's putative materialism on two counts: first, that it misses the dimension of human meaning, and second, that it ignores the unique quality of the person we're treating. And the latter means that, even at the level of meaning, there is a particularity of every individual that renders him or her more than just another case.

I have written this commentary with the assumption that my understanding of Scott Waterman's materialism is correct. I of course wait for him to confirm that. I have also invoked some major figures to buttress an argument for the limitations of what I take to be his approach. And I have done all this to argue that while his approach may lead to the conclusion of a failed psychiatry, the more expansive approach presented in the commentary could readily allow for a conclusion of a flawed but quite productive psychiatry.

JP

\*\*\*

## Why I Am a Psychiatrist

Jeffrey D. Bedrick, M.A., M.D.  
Drexel University  
Jeffrey.Bedrick@DrexelMed.edu

Following Dr. Waterman, perhaps a capsule biography might help explain why I am a psychiatrist, though I am not a Christian nor a believer in god. While I appreciate the rhetorical flourish of linking psychiatry and Christianity, I do not think the two are analogous nor that psychiatry is a religion.

I started off my undergraduate career as a biochemistry major with a specific interest in understanding the

biology and biochemistry of the brain. I quickly realized that we were so far from being able to understand the functioning of the brain to produce so-called "higher mental processes" that I did not see the sort of understanding I was looking for being found in my lifetime, if ever. I decided if I could not understand the brain in the way that I wished that I would switch to trying to understand the products of brain functioning. I switched my major to philosophy and went on to graduate work in philosophy. It was while doing that graduate work that I came to think that psychiatry could be a way of bringing my interest in the brain and the "mind" together, and doing it in a way that might allow me to help people in a practical way. I did a post-baccalaureate year and went on to medical school to become a psychiatrist.

I have talked of "brain" and "mind" and I imagine I can hear the materialist Dr. Waterman moaning. But in talking this way I am not positing a dualism. The mind is not something different than the brain. "Mind" is a convenient shorthand way of referring to those products of brain functioning that we study in philosophy and psychology - and that let us study the biology of brain processes or other disciplines such as history.

I believe the root of the quandary Dr. Waterman found himself in was an embrace of an overly reductionist materialism. His philosophical view would only seem to allow room for neurology, and he might have been happier with his professional choice if he had stuck to his original plan. But what if we think that there is a reason for the DSM to be the *Diagnostic and Statistical Manual of Mental Disorders*? What if we think there are valid distinctions to be drawn between neurological and psychiatric disorders? I have addressed this issue in several papers and I do not have the space to repeat those arguments here, though I will point to some of the ramifications of such a view.

Dr. Waterman rejects psychoanalysis and embraces Grunbaum's work. Whether or not he is correct in this rejection, rejecting psychoanalysis does not necessarily entail rejecting a notion of mental processes that may not be able to be usefully reduced to the purely biological now, or

ever. There may still be a therapeutic role for psychotherapy. In fact, there are many studies now supporting such a role, most for cognitive-behavioral therapies, but some even for psychodynamic therapies.

If you want to practice a "biological psychiatry" as Dr. Waterman seems to conceive of it there seems little to do but be a psychopharmacologist as Dr. Waterman was (or administer such things as ECT, TMS, or other neuromodulation therapies). When the limitations of such therapies are noticed there is nothing left to do - if you have decided that talking with your patients cannot possibly have therapeutic value.

Dr. Waterman then turns to the discomfort he has felt from his encounter with critical psychiatry and members of the consumer/survivor/ex-patient community that he has met. I have met these people as well, and in my meetings with them have found them to be most unhappy with biological psychiatrists, who treated them as if they were diseased brains and thus not worthy of talking with or recognizing as full fellow human beings. When they have had positive impressions of a psychiatrist it was because they had met one that was willing to talk to them as a fellow human being, one who might be suffering and interested in help with this, rather than with a psychiatrist who just wanted to write out a prescription and hand it to them to treat their supposed diseased biology.

Dr. Waterman suggests that the DSM has played a major role in the hegemony achieved by psychiatry, and in the disaster this has posed. Whether the DSM has been as much of an impediment to biological psychiatric research as Dr. Waterman and the proponents of the RDoC proposal seem to think remains, I believe, a somewhat open question. It is worth remembering that the changes embodied in DSM-III and subsequent versions of the manual were undertaken so as to facilitate research, most especially biological research. If it has not succeeded in this, the fault may not all lie with the DSM.

Further, the hegemony of psychiatry today is largely of a biological psychiatry. Prescribing medication is cheaper and less time-consuming than talking to the people who come to us for help, and is thus supported by the insurance industry as well as the pharmaceutical companies (and the govern-



ment as well, which seems to think that help for people in need is almost always an unnecessary expense, while supporting the military and big corporations is crucial to the nation). Studies have shown, however, that being instructed to think of psychiatric symptoms as symptoms of a “brain disease” rather than a mental disorder decreases empathy rather than increasing it. A psychiatry without empathy is perhaps a psychiatry none of us should be a part of. But I do not think it is the only psychiatry possible.

Habermas, a member of the Frankfurt School, argued in *Knowledge and Human Interests* that psychiatry, which he saw as rooted in psychoanalysis, could be a truly liberatory practice, as long as it was not derailed by positivism. That psychiatry has not followed this course is a testament to the power of the economic interests of insurance and pharmaceutical companies and the government, and the hegemony of biological psychiatry that they have championed. I think we need to fight for such a liberatory psychiatry, not abandon it. And to those who would say that such therapeutic practices do not belong within the biologically based arena of medicine, but to theology or some other field, I would argue that expelling these practices from medicine would be to diminish medicine and to reduce its freedom of thought. They have been within medicine and should stay there. Psychiatry, unlike Santa Claus, does exist and can move people.

\*\*\*

## Responses to Commentaries on “Why I Am Not a Psychiatrist”

G. Scott Waterman

Memoir-writing – even the 1200-word variety – is an act of self-indulgence and I appreciate the seriousness with which four eminent physician-scholars, each of whom I have known and respected for many years, have prepared commentaries on mine. Not unexpectedly, there are areas of agreement and of disagreement among the five of us on the status of psychiatry. Far more surprising is the extent to which at least some of the commentators believe their views to contrast sharply with mine, even on matters for which that is evidently not the case. While formulating my responses I have come to see that last observation as being almost as interesting as the ideas the commentators and I expressed in our individual pieces. My replies to each of the commentaries, avoiding redundancy to the extent possible, are below.

### Response to Paul Lieberman:

I thank Paul Lieberman for a wonderfully engaging, well-reasoned, and generous commentary. It left me feeling that, were I a better person, I too might have appreciated having been a psychiatrist. And, to a significant extent, I did. To amplify Paul’s points about what he refers to as psychiatric practice that reflects “a narrow biomedical model” – what I think of as simply a crude caricature of medicine: During my career I had (or took) the luxury of never needing to practice in that way. I found, and taught my students and residents, that regardless of one’s “theoretical orientation,” the complexities of the problems with which patients present are such that even a barely adequate grasp of them does not come easily or quickly. Thus, I couldn’t possibly have made a living as a clinical practitioner in the contemporary environment and I am grateful that I didn’t need to. Should those observations engender nostalgia for an era that has passed? Paul’s first paragraph brings me back to my days as a chief resident at the Massachusetts Mental Health Center, when the likes of

Semrad and Havens were no longer present but whose still-fresh legacies reverberated within those decrepit walls. Their abilities to “connect” with psychotic people were legendary, but do any of us wear red hats that say, “Make Psychiatry Great Again”? Perhaps if psychiatric practice at that time had been widely reflective of the purported humanity and skill of such clinicians, we would. But it surely was not.

Paul asks whether a “more capacious view of psychiatry” is possible. I wonder if it is desirable and, relatedly, whether that ambition has been our undoing. Although what Paul labels “a narrow biomedical model” (brief “med checks” guided by symptom checklists, etc.) is a caricature of medicine, is there reason to expect that the discipline of medicine could or should have the capacity to encompass within it the range of perspectives and skills required to understand and address all of the variegated and complex miseries and dysfunctions to which members of our species are prone? Paul’s wonderfully articulate and succinct description of those complexities seems to suggest a negative answer to that question, at least when it comes to populating such a discipline with actual people. I would suggest that it also undermines the notion – conventionally taken as axiomatic – that psychiatrists should be the managers of treatment teams. The assumption that physicians are (or should be) the foremost experts on human problems privileges (by definition) medical conceptualizations of those problems, which begs one of the primary questions at issue in this discussion – thereby returning us to the matter of just how capacious the psychiatric enterprise can or should be.

Lastly, the evidence Paul adduces to demonstrate the efficacy of the idealized psychiatry he cautiously proposes is a bit of a bait-and-switch, as the subjects of the studies (contemporary psychiatric diagnostic and treatment procedures, employing outcome measures that are dubiously reflective of the sort of human flourishing many believe we should be aiming for) and observations (including “vigorous advocacy” for “access” by organizations whose funding derives predominately from the pharmaceutical industry) to which he alludes are mostly reflective of the

current practices we both decry. They nevertheless can be interpreted as indicating that the profession of psychiatry has the capacity to do some good – a low standard, of course, but an important conclusion with which I will not quarrel.

#### Response to Doug Heinrichs:

Having retired from medicine to pursue graduate studies in history, I appreciate Doug Heinrichs' allusion to medieval monasticism. To carry the reference to its conclusion: If any work from our own time is to survive to be "rediscovered" (as Aristotle's was in the Christian West) in some future renaissance, I hope Doug's is included. He has long drawn a useful distinction between the "N-of-1" focus of clinicians and the sought-after generalizability of the disciplines that are meant to inform their work, though of course (as Doug recognizes) these are not fully distinct methodologies and goals but rather gradations along a continuum from fully generalizable "laws of nature" (not to be found in the biological, let alone human, sciences) to thoroughly idiosyncratic and thus unintelligible processes that are presumably inaccessible by scientific methods. I agree wholeheartedly with his assessment of applying the label of "art" to the abilities of skilled clinicians to navigate that continuum productively. It is both inaccurate and (as Doug points out) trivializing of what is likely the most vital of all elements of clinical reasoning.

Although he is hardly naïve to some of the pitfalls of the psychoanalytic theory and practice to which he was exposed earlier in his career, Doug credits his experiences with psychoanalytic teachers with imparting – via the premium placed on careful listening and an emphasis on individual uniqueness – a capacity to engage in the sort of clinical thinking and understanding he has so persuasively described and championed over the years. Although I find his observations on that topic compelling to a degree, my training experiences led me to formulate an admittedly crude typology of psychoanalytically oriented practitioners and teachers. There were those who took as axiomatic the claims of psychoanalytic theory as a complete and valid system for understanding human mental life, including but not limited to its pathologies, and who sought to squeeze all clinical observations into that framework, all

without being explicit with patients about what that framework and the rationale for adopting it is or what the conclusions drawn from employing it are, thereby generating misunderstanding at best and potential harm to patients (and, in related ways, to trainees) at worst. On the other hand, there were those who were clearly drawn to psychoanalysis as the then-dominant way of channeling their deep interests in and intuitive understandings of people, and of taking seriously the reports of individual human experiences, cognitions, emotions, and behaviors. They were skilled at generating a sense of understanding and thereby providing benefit to patients (and trainees). If that typology is accurate, then the goal might be to replace the flawed theoretical edifice of psychoanalysis with something that is, at best, more empirically valid, and, at least, more humble in its claims and more open and democratic in its methods. This might be one way of describing the impetus behind the sort of practice Doug seeks to capture in his clinical and scholarly work.

Finally, although this was explicitly an aside, Doug touched a nerve with his comment on pharmaceutical representatives that I am unable to ignore. It is, unfortunately, naïve to believe that clinical supervisors will be found to perform the role of modelling interactions with pharmaceutical company representatives that Doug envisions. His suggestion elides the fundamental difference between the goals of the medical profession and those of salespeople. Pretending that there is common ground to be found only adds to the confusion that the ethical imperative of eschewing such contacts addresses. Spending valuable time in pseudo-intellectual sparring with people well trained to perform a function antithetical to our own is at best silly. The "healthy and critical skepticism" of which Doug writes is better employed in the service of questioning the notion that anything beneficial to patients or the profession can come from attempting clinical-scientific discourse with marketers. Likewise, research faculty members whose livelihoods depend upon industry relationships ("thought leaders," as the drug companies' description-cum-wish would have it) have no business taking part in medical education or training.

Returning to the main points of his commentary, I am left with these

questions (some of which Doug raises himself): Is there any reason to believe that significant portions of the population of people becoming psychiatrists can be taught to think and practice like Doug? Is he correct that many already do? Are his suggestions for psychiatric practice scalable? From where would support for that come?

#### Response to Jim Phillips:

My first reaction to Jim Phillips' commentary was to make mental note to visit Yosemite one of these days. I have savored my time at Yellowstone, Glacier, and the Grand Canyon; perhaps Yosemite should be next. My second reaction was a combination of admiration and envy of Jim's poetic sensibilities, which I surely lack. My third reaction – presumably the pertinent one in this context – was that his brief essay is worthy of readers' attention in its own right. It might also serve as a rebuttal to someone's views and assertions, albeit not mine. Jim's diagnosis of "scientism" is wide of the mark, but I share some of the blame for that error. Diagnoses are only as good as the information available to those who formulate them, and the "history of the presenting problem" that I provided in my target piece was necessarily truncated. It is the case – and Jim and I have known each other long enough for him to be aware of this – that among the factors that drew me to philosophy of psychiatry was the observation and consequent frustration that medical discourse (including that of psychiatry, and especially that of neurology) is highly dualistic. But it isn't dualistic in the sophisticated sense by which important objections to dogmatic materialism (or naturalism or physicalism or the positivism of which Jim spuriously accuses me) can be cast as dualistic. Rather, it is dualistic in the unreflective and simplistic folk-philosophical sense by which illnesses are either "organic" or "functional," "medical" or "psychiatric" (and, oddly, these well-worn dichotomies are not congruent with each other). It is dualistic in the sense by which "biological" therapies are effective for "brain" problems while "psychological" therapies are indicated for "mind" problems. It is dualistic in the mangled sense by which anxiety is (redundantly) a "mental symptom" while pain is (oxymoronically) a "physical symptom" – rendering their mutually rein-

forcing effects a purported case of “mind-body interaction.” It is a dualism by which “psychiatric” conditions are what remain after “medical” illnesses are “ruled out.” I’m guessing that all clinicians quickly recognize the dualism to which I refer. Moreover, it is a dualism that runs rampant among those who conceive of themselves as thoroughgoing monists (i.e., most physicians). It is true that for a stretch of time I embraced eliminative materialism as a solution to this problem, but its flaws (some of which are explicated in Jim’s commentary) have been evident to me for quite some time now and, in fact, underlie to an extent my current concerns about the ever-expanding medicalization of human misery and dysfunction.

Having (I hope) cleared up that misunderstanding, let me comment on one element of Jim’s erudite recitation of the use to which Jaspers puts the German philosophical distinction between *Erklären* (causal explanation) and *Verstehen* (meaningful or interpretive understanding). Although Jim notes that a grasp of human phenomena generally requires a combination of the two methodologies, his examples contradict that prescription in a way that is instructive. He notes, as examples, that delusional jealousy in the context of a brain tumor has a “presumed physical cause,” while in the case of anger following an insult, “meaningful connection” rather than “physical cause” does the explanatory work. There is, of course, a sense in which this dichotomization is reasonable, but it can provide sophisticated cover for the unreflective, folk-intuitive dualism I outline above. For example, many members of the consumer/survivor/ex-patient community testify that the denial by mainstream psychiatrists that psychotic experiences can validly be viewed as having “meaning” – based on the conviction that we now “know” that the conditions that are associated with hallucinatory or delusional experiences have “physical” causes (never mind that we don’t know what those causes actually are) – is a source of invalidation and consequent suffering. Explanatory pluralism might be the intent of invocation of the twin methods of *Erklären* and *Verstehen*, just as it avowedly is of the biopsychosocial model (about which I have commented many times previously), but the result in practice is often indistinguishable from the naïve, folk-intuitive ontological dualism to which I refer above. And that

might bring us back to the matter of the nature and extent of psychiatry’s flaws, which inhere not in the rarified formulations of the handful of psychiatrists interested in its theoretical underpinnings but, rather, in the effects of its practices on actual people.

#### Response to Jeff Bedrick:

Having appropriated the linguistic form of Bertrand Russell’s essay title for my own, perhaps I should have anticipated that others might think I was assimilating the status of psychiatry to that of religion, though I confess – er, sorry, admit – that I did not. Beyond that, I find myself at a loss to say much in response to Jeff Bedrick’s commentary that I have not already said. As I hope I have made clear, my commitment to a materialist ontology – hardly a rarity among people of our era and educational class and, more to the point, only an aside in my assessment of the state of psychiatry – leaves plenty of room for recognition of the ongoing value, and in fact necessity, of attention to phenomena best described and understood in terms of “mind.” I recognize some problems with nosologies that posit principled distinctions between “mental” and “neurological” conditions (e.g., seeing obsessive-compulsive and Tourette disorders as being more different from each other, reflective of their positions on opposite sides of the “mental/neurological” divide, than the former is from mania or the latter is from multiple sclerosis), but I cringe even more when I hear the patently ridiculous, banal mantra that “mental illnesses are diseases like any other.”

Jeff’s assertion that many studies support the efficacy of a variety of psychotherapies is as uncontroversial as his apparent implication that I “have decided that talking with ... patients cannot possibly have therapeutic value” is baseless. Moreover, if “talking with patients” were an activity specific to the psychiatric enterprise, or if there were reason to believe that psychiatrists possess such skills while other do not,

then at least these points would be more pertinent to the topic at hand.

In discussing my observations regarding the testimonies of members of the consumer/survivor/ex-patient community, Jeff avers that it is “biological psychiatrists” with which such people find fault. And to the extent that the type of practice to which most people are currently exposed falls under that heading, his assertion is surely accurate. But his interpretation of the problem is too narrowly drawn. The problem is, in fact, far more generic to the psychiatric enterprise than Jeff recognizes. It entails a disease model whereby an expert collects evidence, renders a diagnosis (whether framed in “broken brain” or “diseased mind” terms, and whether explicitly shared with the patient or not), and embarks on a course of therapy, whether drugs, talk, behavior modification, or combinations of such modalities. These procedures as conventionally carried out – whether by modern “psychopharmacologists” or psychoanalysts or harried physicians in public mental health clinics – often fail to include acknowledgment of the problematic nature of the database on which psychiatric understandings and interventions are founded, and are experienced by many as usurpations of their epistemic authority and thus assaults on their dignity and humanity. Jeff is correct in locating in the neoliberal order under which we have been living for the past three decades the impetus for the switch in the predominant mode of psychiatric practice to brief encounters dominated by prescription-writing. And it is, indeed, lamentable. But it is the more generalized elements of psychiatric practice across its various incarnations – rooted in paternalism and manifested in large and consequential power and perspective differentials – that are the more fundamental underpinnings of the dissatisfaction such people are experiencing and reporting. The question this analysis raises, then, is whether a liberatory psychiatry – which Jeff and I agree is desirable – is possible.

#### Conclusion:

What began as a highly capsulized recounting of the various turns – and my reasons for making them – of my professional life has culminated in a wide-ranging, if rather unruly, discussion of psychiatric theory, training,

and practice. To whatever extent a “target” piece is supposed to engender such results, mission accomplished. But as I

hinted in my introduction to these responses, I was taken aback by the vehemence of some of the argumentation that purportedly (albeit not actually) refuted my positions. Is that a reflection of the impossibility of providing (or, at least, my failure to provide) a fully coherent explanation of several decades of professional career decisions in 1200 words? That is doubtless a contributing factor. I suspect, though, that much of our discourse has become so schematized that we jump to rehearsed responses to what we recognize (even if not entirely accurately) as indications that our interlocutors are in some “camp” other than our own. I have not thought this through sufficiently and will be intrigued to learn of others’ assessments.

If I was left bewildered by some elements of the commentaries, I certainly wasn’t by others. Most specifically, despite my explicit (and sincere) disclaimer that my essay was intended to be descriptive rather than prescriptive, all commentators to one degree or another evinced a defensiveness of their (our?) profession that was not only expectable but encouraging. My own assessment of the prospects for psychiatry are not rosy, but if there is hope, it lies in the commitments of smart, talented, and caring people like Paul Lieberman, Doug Heinrichs, Jim Phillips, and Jeff Bedrick and (importantly) those they teach and influence. If I or anyone I care about seek psychiatric attention (a near-certainty, of course), I hope we are met by the likes of them. The odds of that, I’m afraid, are not high.

None of this is to deny the serious needs toward which a successful psychiatry would be directed. People who suffer deserve both public policies and individual interventions that help them live less painful and more connected and fulfilling lives. Psychiatrists should have a voice in formulating both – just not the loudest one. Which brings me to my final point: All five of us are older men with M.D. degrees. I would like to know, formally or otherwise, the reactions to this exchange of those readers whose backgrounds differ systemically from those of the five of us. That would likely be instructive for us all.

## On citing literature in Philosophy, Psychiatry, & Psychology (PPP)

John Z Sadler MD  
Editor-In-Chief, PPP

As an editor and as an author, I learned how to cite prior publications informally, through example and the sometimes-painful process of peer and editorial review. I don’t think I’m unique in this regard. So for this short paper for the AAPP Bulletin, I thought it might be useful, albeit not particularly sexy, for PPP readers and authors to know some of my principles for appropriate citation of the literature. Making my tacit principles overt is also a useful exercise for me as an editor, and presents an opportunity for discussion amongst our colleagues.

It turns out that library science and related fields have generated a literature on the use of citations, and scholarly organizations often offer assistance. I refer the reader to the three references below that I found helpful, as well as online scholarly organizational advice like the following from the International Consortium of Medical Journal Editors:

<http://www.icmje.org/recommendations/browse/manuscript-preparation/preparing-for-submission.html>

However, instructions addressing mechanics of citation, like those of the ICMJE, don’t really address the questions I face as an author and editor: When is a citation needed for scholarly rigor? How many? What are inappropriate and inadequate citation practices? So I’ll take these questions one at a time.

When is a citation needed for scholarly rigor?

I see the basic function of citations as relieving the necessity of recounting the entire history of ideas relevant to a paper’s topic. From this standpoint, citations provide reference to an expanded background supporting a new paper. For example, if you are planning to respond to a facet of Jen-

nifer Radden’s interpretation of Burton on melancholia, you should probably cite Burton’s book on melancholia as well as Radden’s book on Burton. However, what ideas require an abbreviated mention in a scholarly paper are not limited to ‘background’.

Peritz (1983) describes a functional classification of citations for scholarly works. She provides eight general categories of citations, which I believe are mostly transparent, and often partially overlapping: (1) Setting the stage for the present study, (2) Background information, (3) Methodological, (4) Comparative, (5) Argumental/speculative/hypothetical, (6) Documentary, (7) Historical, (8) Casual. Not all of these categories warrant more discussion in a short, practical, and nonscholarly paper like this one, but a few do. #3, Methodological, for philosophy papers typically refers to the methods of philosophical analysis or supporting claims, but could include methods of reviewing a literature as well. I find that philosophical papers often assume their methods rather than spell them out; hence, the consternation encountered by philosophers of psychiatry from medical journal requests for ‘methods’ in the abstract portion of the manuscript. #4, Comparative, refers to papers which, in philosophy, the author wishes to critique or provide the frame of the research question. #5, Argumental/speculative/hypothetical, Peritz lists as ‘all citations made in supporting the formulation of new hypotheses and conjectures, suggestions for future research, speculations, and other arguments’ (p. 305). #6, Documentary, refers, in philosophy, to prior publications from which the author draws ideas or viewpoints in developing a new analysis or argument. Finally, #8, Casual, refers to cited work of an inessential, amusing, or anecdotal interest.

These functions of citation are of descriptive interest, but as an author and editor I’m interested in prescriptive questions - when should I cite? I have a few rules of thumb for this for philosophical papers. Authors should cite when:

(1) They make an empirical, factual claim that is not transparently true from ordinary life experience or brief reflection. I would not ask an author to cite a reference for the claim “The sun sets in the West.” I would want citations for the claim “Psychiatric diagnosis is in

crisis.” or “The efficacy of antidepressant drugs in bulimia nervosa is 70%.”

(2) The author is building a paper as a step in a research program in which earlier steps have been published earlier. This is an example of Peritz’ “Documentary” and/or “Historical” function.

(3) The author is making sweeping generalizations about a state of affairs which is not transparently true or is controversial. “Psychiatric diagnosis is in crisis.” is relevant again here as an example.

(4) The author is using a technical term or concept which either has multiple meanings in the literature, is an unconventional use of an ordinary-language term, or is a new word or concept used by a few scholars. For example, the word ‘Dasein’ when Heidegger’s *Sein und Zeit* was first published would need citation. A more recent example might be ‘moral enhancement’.

(5) When making a complex argument, authors often need to acknowledge a prior publication (theirs or someone else’s) with the suggestion that “for a detailed discussion of X see Author, 2012”.

(6) We’ve had some discussion within the PPP Senior Editor staff about the issue of self-citation. While this can be abused, self-citation is the foundation for both a science as well as a philosophy research program. The principle is self-citation is appropriate when it is needed to advance an argument or analysis in a new paper with an original thesis.

(7) The following is a more encompassing principle of when one should cite works: When complete, a set of citations should provide the minimum additional information needed to support a credible argument or analysis. I see reference citation as establishing a level of credibility in this age of tweets, where anyone can say anything with no evidence or logic and, unfortunately, be taken seriously.

How many citations are appropriate?

We live in an age of exploding

scholarship and journal publication, with a wide range of article quality. Many of you may have noticed the trend to limit reference citations. For PPP, main articles are limited to 40 references, and review articles 75. The reasons are various, and will be more apparent from the discussion in the next section. The main reasons are to avoid allocating undo editorial space to reference lists, and the proliferation of crap publications. Regarding particular articles and guidelines there:

(1) Revisit principle (6) in the above section. The emphasis is on ‘minimum’. If one reference will do to aid credibility judgments, pick the best one and cite that.

(2) More citations are needed if a topic has diverse opinions, viewpoints, or findings, and you want to illustrate treatments of each.

(3) Citations of books over articles can condense multiple threads of argument and content, especially if the books are good, and have rigorous peer review like, for instance, OUP performs.

(4) Avoid citation abuse - described below. What are inappropriate and inadequate citation practices?

Here I describe some citation practices that I find objectionable or negligent.

(1) Citation assault: listing multiple references that make the same point, for this or that claim, for the purpose of rhetorically bolstering a claim, regardless of its intrinsic merits. This is an abuse of citation.

(2) Minimize in-press, in-preparation, personal communications, and other citations which are short of material actually published.

(3) While shameful that I need to mention this, but incomplete, incorrect, or fake references drive editors crazy.

(4) Finding reasons to cite one’s work, with peripheral relevance to the task at hand, is citation abuse.

(5) Often people new or unschooled in philosophy writing will write non-original opinions without citation, or, without an effort to situate their viewpoint in the literature. Opinions can be situated in the literature as well, and should be. To not do so is citation negligence.

#### Suggested reading:

Bonzi S, Snyder HW. 1991. Motivations for citation: A comparison of self citation and citation to others. *Scientometrics* 21: 245-254.

Frost CO. 1979. The use of citations in literary research: A preliminary classification of citation functions. *The Library Quarterly: Information, Community, Policy*. 49 (4): 399-414.

Peritz BC. 1983. A classification of citation roles for the social sciences and related fields. *Scientometrics* 5: 303-312.

\*\*\*

*The Association for the Advancement of Philosophy and Psychiatry was established in 1989 to promote cross-disciplinary research in the philosophical aspects of psychiatry, and to support educational initiatives and graduate training programs.*

**OFFICERS**

*President*  
Peter Zachar, Ph.D.  
*Vice-president*  
Christian Perring, Ph.D.  
*Secretary*  
James Phillips, M.D.  
*Treasurer*  
John Z. Sadler, M.D.

**EXECUTIVE COUNCIL**

Robyn Bluhm, Ph.D.  
Jeffrey D. Bedrick, M.D.  
Louis C. Charland, Ph.D.  
Edwin L. Hersch, M.A., M.D.,  
F.R.C.P.

Brent M. Kious, M.D., Ph.D.  
Robert S. Kruger, Ph.D.  
Paul Lieberman, M.D.  
Douglas Porter, M.D.  
Nancy Nyquist Potter, Ph.D.  
Claire Pouncey, M.D., Ph.D.  
Kathryn Tabb, Ph.D.  
Serife Teikin, Ph.D.  
G. Scott Waterman, M.D., M.A.  
J Melvin Woody, Ph.D.  
Jon Tsou, Ph.D.  
Duff Waring, LL.B, Ph.D.

**EMERITUS MEMBERS**

Jerome L. Kroll, M.D.  
Jennifer H. Radden, D. Phil.  
Louis Sass, Ph.D.

**INTERNATIONAL ADVISORY BOARD**

K.W.M. Fulford, FRCP, FRCPsych  
Gerrit Glass, M.D., Ph.D.  
Emilio L. Mordini, M.D.  
Giovanni Stanghellini, M.D.

*Bulletin Editor*  
James Phillips, M.D.  
88 Noble Avenue  
Milford, CT 06460  
*Phone* (203) 877-0566  
*Fax* (203) 877-1404  
*E-mail* james.phillips@yale.edu

*Philosophy, Psychiatry, & Psychology*  
K.W.M. Fulford, D.Phil., MRCPsych.  
Founding Editor

John Z. Sadler, M.D.  
Editor-in-Chief

*AAPP Web Site*  
www3.utsouthwestern.edu/aapp

**ASSOCIATION FOR THE ADVANCEMENT OF PHILOSOPHY & PSYCHIATRY (AAPP) MEMBERSHIP APPLICATION**

Membership in AAPP is open to all individuals interested in the subject of philosophy and psychiatry by election through the Membership Committee. The Association welcomes Student Members (enrollees in degree-granting programs in colleges and universities and physicians enrolled in approved psychiatric training programs and post-graduates in post-doctoral programs). In order to join AAPP please detach this form and mail to: Ms. Alta Anthony, Journal Subscriptions/Memberships, The Johns Hopkins University Press, P.O. Box 19966, Baltimore, Maryland 21211.

Annual Dues: \$115 Members; \$42 Student Members (this includes a year's subscription to *Philosophy, Psychiatry, & Psychology (PPP)*). Make checks payable to The Johns Hopkins University Press.

Name \_\_\_\_\_ Qualifications (clinical and/or philosophical)/Speciality/Interests \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
FAX \_\_\_\_\_

Amount Enclosed: \_\_\_\_\_ Check: \_\_\_\_\_ VISA: \_\_\_\_\_  
Exp.Date: \_\_\_\_\_

MasterCard: \_\_\_\_\_ Exp.Date: \_\_\_\_\_