CHAPTER 4

Philosophical methods in mental health practice and research

Chapter contents

In Chapter 2 we saw that while the term philosophy covers a broad church, an important strand in Western philosophy has been a concern with concepts, with the framework of ideas—usually of a high level or general kind—by which we organize the world around us. Problems about the concept of mental disorder, correspondingly, turned out to be a particular focus for the new philosophy of psychiatry. In Chapter 3 we filled out the basic 'data' from which philosophical work in this area must start, with an introduction to the wide variety of conditions widely subsumed within the concept of mental disorder.

In this chapter we turn our attention from philosophical problems to philosophical methods. Philosophical methods, like views about what philosophy is, are not only diverse but also themselves the subject of philosophical scrutiny. Hence this chapter, rather than attempting to do justice to the full variety of philosophical methods, will focus on a sample of those that have thus far figured most prominently in the new philosophy of psychiatry.

It happens that these methods have been developed particularly within the two great traditions of twentieth century 'Western' philosophy, called (as we will see, not entirely accurately) Anglo-American analytic philosophy and Continental philosophy. It is important, therefore, before coming directly to these two traditions, to emphasize that there are other great traditions, which in the longer term may prove more fruitful still. Emerging traditions in this regard already include the more meditative and practice-based disciplines of 'Eastern' philosophy–see, for example, the French philosopher, Natalie Depraz', work on schizophrenia (Depraz, 2003); and also the rich resources of classical philosophy, as illustrated by the British philosopher, Christopher Megone's, application of Aristotelian philosophy to concepts of functioning (Megone, 1998, 2000) and the Swedish philosopher, Lennart Nordenfelt's application of Stoic philosophy to cognitive-behavioural psychotherapy (Nordenfelt, 1997). There are also untapped resources in other cultures and language groups. Thus, African philosophy, for example (Gbadegesin, 1991, and Coetzee and Roux, 2002), provides unique insights (inter alia) into the formation and maintenance of personal identity, a deeper understanding of which, as we will see in Part V, is crucial to how we conceptualize (and may come to reconceptualize) a wide variety of mental disorders.

Session 1 Better definitions: philosophy as 'an unusually stubborn effort to think clearly'

You will recall from Chapter 2 William James' characterization of philosophy as a 'an unusually stubborn effort to think clearly'. But how should we go about this? And why does this search have to be 'determined'? Surely we 'know what we are talking about', as we say. And if there are misunderstandings, or if someone uses a word that someone else does not understand, we can just ask them to explain what they mean. 'Define your terms,' as the saying goes. And what are dictionaries for, after all?

In this session we will be digging down a little beneath the surface transparency of language. We will be exploring the scope we have for 'defining our terms' and considering the advantages and disadvantages of definition itself as a way of getting clear about meanings.

As in Chapter 2, we will be starting with an example, though in this case with a non-clinical and (apparently) simple example. Drawing on this example, we will be: (1) looking at the strengths, but also the limitations, of dictionary-type definitions; (2) exploring some of the tensions and trade-offs between different kinds of definition, thinking particularly about the definitions in psychiatric classifications; (3) coming up with a (far from exhaustive) list of seven distinct kinds of definition, reflecting in different ways these tensions and trade-offs; and, finally (4) applying this list to issues in mental health.

How to define 'chair'

So let's start with an everyday, non-clinical, example to look at how we might go about defining our terms.

Starting with an (apparently) simple example, by the way, is itself a feature of (some) philosophical methods. This can be helpful in demonstrating a general point before applying that point to a substantive but more complex case (logic is often taught like this, for example—see Chapter 5). Often, though, what appears to be a simple example turns out to have hidden depths. The meaning of 'bodily disease' in Chapter 2, you will recall, turned out to be considerably more complex than its relatively unproblematic use in practice (compared with the concept of mental disorder) had led everyone to believe. We will find in this chapter that hidden depths are a feature of the meanings of many concepts, non-clinical as well as clinical.

EXERCISE 1 (30 minutes)

How do we search for clear meaning? Think about this with an example in mind (as always, write down your thoughts as you go along). Pick out any everyday object near you: an example would be a chair, but select your own example to work on.

Now, are you clear what 'chair' (or 'door', or 'clock', or 'ceiling', or whatever) means? Write down one or more definitions (if you are working in a group, write your own definitions separately, before comparing notes). Could you define 'chair' for someone who does not speak English? If you did not speak English, or could speak English but had not come across this word before, how would you find out what 'chair' means?

Remember the critical place of *practice* in philosophy. This is especially important in this chapter. If you just read the chapter through in 'passive' mode you will get very little out of it. If you try out the exercises, however, really engaging actively in the argument, you will be starting to develop your own philosophical skills.

How to define 'chair'

For the rest of this session we will be thinking about the concept 'chair'. However, try out the points and follow through the arguments for yourself with whatever object you selected, and preferably with a range of objects, to get a feel for how concepts work and the problems of meaning they raise. From this you will get a better idea of why the search for clear meaning (on this view of philosophy, the philosopher's core activity) has to be in William James' phrase 'particularly determined'.

One common reaction to exercises of this kind is that it all seems a bit dry and, dare one say, trivial. At first sight it seems obvious that everyone (who speaks English) knows what 'chair' means. If you are working in a group, you will probably find that your definitions were along the lines of '. . . thing to sit on', 'an article of furniture for sitting on', and so forth. There will be variations between definitions even here, of course (an important observation to which we will return). However, they all seem to approximate broadly to the same idea.

Dictionary definitions

So, no philosophical (conceptual) problems here? No 'stubborn' search for clear meaning required from the philosophers? With concepts such as 'chair', the meaning seems clear enough, and if there are differences between us over the details, well, we can always refer to a dictionary.

EXERCISE 2 (30 minutes)

Try this for the concepts you are working with. Any reasonable sized dictionary will do. Look up the definition given for your own example. You may find several versions. If so, choose the one nearest to your own definition and write it down. Now look in one or more other dictionaries. Write down the corresponding definitions given in these. Finally, notice any differences between the various definitions you have come up with.

Looking at these definitions, write brief notes on the following questions:

1. In what ways, if any, do the dictionary definitions differ from each other and from the definitions you brainstormed in exercise 1 of the session?
2. Why do you think there are these differences even about an everyday and (apparently conceptually uncomplicated) thing like a chair?
3. Is one or other definition definitely right or wrong?

The *Shorter Oxford English Dictionary* (*SOED*) defines 'chair' as 'A seat for one person; now normally a movable four-legged seat with a rest for the back'. Again, at first glance, this seems reassuringly familiar. Notice, though, that this is a rather more detailed and specific definition than most of our spontaneous definitions will have been: it makes 'chair' a seat for *one person*, for example, thus distinguishing it from, e.g. a settee.

So far so good. But how consistent is this with other 'authorities'? Thus the *Concise Oxford English Dictionary* (*COED*) has it that a chair is a '*separate* seat for one'. So even a dictionary in the same family as the *SOED*, gives a different definition. Hence, turning to a dictionary will not always be enough to resolve differences of view about the meanings even of everyday concepts like 'chair'.

Four kinds of difficulty with defining 'chair'

The difference between the two definitions of 'chair' just noted, one from the *COED* and the other from the *SOED*, illustrates the first of four kinds of difficulty that we run into when we try to define even an apparently simple term such as 'chair', namely that we run straight into a tension between *specifity* and *range* of use.

Difficulty 1: specificity versus range of use

An ideal definition is neither over-inclusive (i.e. it includes too much—thus 'a thing to sit on' includes, e.g. cushion) nor overexclusive (i.e. it excludes too much). However, the attempt to make a definition less inclusive (by making it more specific) always risks it excluding things that in some legitimate understandings of the concept, it should include.

For example, chairs are indeed usually 'separate' (the *COED's* term); however, they need not be (they are not separated in a twin 'baby buggy', for example). There is, certainly, a sense in which any object has to be separable from other objects to be definable at all. But in this sense the *COED*'s 'separate seat for one' could be one of the seats in a two-seat settee. And indeed, if the *COED* is right, why are the seats in a theatre not 'chairs'; or in an aeroplane (especially in 'first class' where they may be fully separated)? The *SOED*, avoiding 'separate', introduces the idea that chairs are 'movable'. This explains the theatre and the aeroplane cases up to a point. But the *SOED* says that chairs are 'usually' movable. So, when can a chair be immovable and still a chair? Why are the (relatively) immovable theatre and airline seats not chairs? When, in a word, is a chair not a chair?

Specificity, range of use, and clinical practice

Difficulties of these kinds are thrown up by all definitions. There is always to some extent a tension between specifity and range of use that generates ambiguities and disagreements about the proper sense of the term in question. But does this matter practically?

EXERCISE 3 (5 minutes)

Take a few minutes at this stage to think about the practical relevance of the tension between specificity and range of use. Where might this be important in mental health?

We will come across problems of this kind particularly in Part III, when we look at the major psychiatric classifications of mental disorders. Recent attempts to make the definitions in these classifications more specific by using explicit inclusion and

exclusion criteria, have resulted in greater reliability (i.e. diagnostic agreement); however, this has been at the expense of certain aspects of validity, notably 'face validity' (i.e. the extent to which a term as defined in the classification corresponds with the way it is understood by patients and practitioners as stakeholders in the classification), and 'construct validity' (i.e. the coherence of the classification with theory—the problem here being that such definitions are disjunctive and classifications based on disjunctive categories are difficult to accommodate in scientific theory and law; see Part III).

A criticism of modern psychiatric classifications has thus been that they fail to capture or correspond with the way mental disorder terms are actually employed. The definition of schizophrenia, for example, in the American classification *The DSM-IV, The Diagnostic and Statistical Manual* (APA, 1994) requires an overall duration for the disorder of more than 6 months (APA, 1994, p. 285, Criterion C). This is to distinguish it from, for example, brief psychotic episodes. However, the WHO's *International Classification of Diseases* (1992) specifies a duration of only 1 month. DSM-IV, to complicate matters further, distinguishes between the duration of individual symptoms (1 month) and of the disorder as a whole (6 months). There are also qualitative as well as quantitative differences. DSM-IV includes a criterion (Criterion B) for schizophrenia that does not appear in ICD-10 at all. (We return to the significance of Criterion B at length in Part IV.)

Authorities vary, therefore, over psychiatric classification. In everyday practice, such very precise definitional points are largely ignored, the diagnostic term being used to cover a relatively wide range of disorders: it is only in research that very specific definitions are required (to allow comparability of results between studies). Note, though, that in the USA, and increasingly in other countries as health-care budgets come under ever-greater pressure, more specific diagnostic categories are demanded clinically.

Difficulty 2: brevity versus depth of understanding

The tension between specifity and range of use leads to a second kind of difficulty with definitions—a tension between on the one hand *brevity*, and, on the other, the *depth of understanding* which can be achieved with a more long-winded treatment.

A brief definition aims to capture the essence of the meaning of a term; however, it has to rely on other terms that may be (and often are—see below) more obscure than the term being defined. A brief definition may therefore actually mask deeper embedded difficulties of meaning. A longer definition, on the other hand, although it can unpack some of these embedded difficulties of meaning, may end up too long-winded to be practically useful.

The idea of *tautology* comes in here. There is a sense in which an accurate definition has to be tautologous (i.e. any definition expresses the same meaning in different terms). In fact some definitions do not rely solely on the meanings of the words they employ and so escape the problem of being tautologous (see below). In most types of definition, however, their tautologous nature creates a tension between brevity (which is, normally, a function of the degree of precision of the definition in question) and the depth of understanding it offers (which is, normally, a function of the degree of informativeness). To be helpful, therefore, the tautology should be neither so narrow as to be un-illuminating nor so long-winded as to be impractical. (The so-called 'paradox of analysis' is attributed to G.E. Moore; see Langford, 1942.) The problem is this. If one takes philosophical analysis to be an attempt to say what something is (e.g. causation is . . . ; free will is . . .) then it offers an analysis of a problematic concept P by saying 'P = Q'. But then either 'P' and 'Q' have the same meaning in which case the claim is trivial or they do not in which the identity is false. Either way, Moore argued, it does not seem that philosophy can offer true but non-trivial analysis.

We can see the tension between brevity and depth of understanding being played out in the development of psychiatric classifications. The last edition of the WHO's Classification, the *ICD-9* (WHO, 1978), gave brief synoptic definitions of particular disorders, mostly of not more than four or five lines. *ICD-10* gives much longer descriptions (often a page or two); however, it seeks to preserve the utility of the classification by including summary checklists of key symptoms (e.g. of schizophrenia; WHO, 1992, p. 87). DSM-IV takes this further. DSM-IV gives so much information it can be used as a really helpful stand-alone textbook of psychiatry (at least on diagnostic categories); however, it preserves utility by summarizing the essential diagnostic features of each category in 'boxes' giving key diagnostic criteria.

Difficulty 3: embedded terms and embedded difficulties of meaning

That the tension between brevity and depth of understanding is not special to the definitions of psychiatric terms is evident if we return to the example of 'chair'. Both the *SOED* and the *COED* define chair as a kind of seat and then seek to specify exactly what kind of seat a chair is (as we have seen, in rather different ways). Both definitions are brief, the *COED*'s especially so. 'Seat' includes 'chair', however, so the definition, given the meaning of the embedded term 'seat', seems clear. But is it? Testing this point a little reveals a third kind of difficulty even with such apparently simple definitions as 'chair', namely that they depend on embedded terms the meanings of which, although taken for granted in the definition in question, are in fact very far from transparent.

Thus, suppose that you do not know what 'seat' means. Can you find this out from a dictionary? The *SOED* gives us 'place or thing to sit upon'. But what does 'sit' mean? It is what you do on seats, but this is too narrowly tautological to help. So we look up 'sit'. This means 'of persons, to be or remain in that posture in which the weight of the body rests upon the posteriors . . .'; and, in turn, 'posteriors' (note the increasingly strained terminology) are 'the hinder parts of the body'.

EXERCISE 4 (5 minutes)

Is this feature of definitions—that as we press them we may unearth hidden difficulties of meaning—hazardous at all? Can you think of any examples, in mental health practice or elsewhere, of a definition giving the *appearance* of clear meaning by relying (explicitly or implicitly) on terms the meanings of which, although taken for granted, are far from transparent?

There is nothing inherently wrong with the embedded nature of definitions. As we have seen, they *have* to be like this. The danger, though, is that the embedded difficulties of meaning are not recognized for what they are. Brief definitions, in particular, useful (indeed essential) as they may be in some contexts, risk masking obscurities of meaning, thus giving the impression of full understanding, where, in reality, understanding is lacking.

Embedded meanings in mental health terms

There are many examples of this in mental health practice, often traceable, ultimately, to difficulties in the meaning of 'mental illness'. We will return to this idea at several points in this book. One example we have already come across (in Chapter 3, on psychopathology) is the standard definitions of 'delusion' as a 'false belief…' (with various further qualifications): in most everyday contexts, we can take the meanings of the terms 'false' and 'belief' to be, if not transparent, at least unproblematic. Hence the apparent transparency of the standard definition of delusion. A moment's reflection, however, shows that neither 'false' nor 'belief' is self-evident in meaning, and, in fact, the standard definition of delusion, as we saw in Chapter 3, turns out to be highly unsatisfactory clinically.

However, it is important to recognize that the definition of 'delusion', and indeed the definitions of other notoriously difficult 'terms of art' in psychiatry, are not alone in depending on the meaning of even trickier embedded terms being taken for granted. This is clearly illustrated by our everyday case of 'chair'. The *SOED* (like the *COED*), you will recall, defined 'chair' as '…. (a kind of) *seat*'; this in turn being defined as 'a place or thing to sit on', and 'sit' being defined as 'of persons, to be or remain, etc. ….' Well, we might jib at 'person', the meaning of which is notoriously obscure, at least among philosophers (we return to this in Part V). However, there is difficulty enough further back in the chain of embedded terms, in the definition of the (wholly neglected by philosophers!) term 'seat'. Notice, for example, that in defining 'seat' both dictionaries imply, not merely that seats (whether chairs or not) are sat on, but that they have the *purpose* or *function* of being sat on. The *SOED* has it as a 'place or thing *to* sit upon'; the *COED* is even more explicit, making it a 'thing *used, especially one made, for* sitting on…'. In order, therefore, to understand the meaning of 'chair', we have to understand the meaning of 'seat'; and in order to understand the meaning of 'seat', we have to understand the meaning of 'purpose' and/or 'function'; and with these terms we are swept up into that whole stable of deep philosophical difficulties, in the philosophy of biology, in ethics, in action theory, and so forth, packed into the one word 'teleology'!

So we seem to be getting into deep waters. But just what kind of waters are we in?

EXERCISE 5 (5 minutes)

At this point, take a moment to think about the concepts of 'purpose' and 'function'. Are these radically different from 'chair' or 'seat'? Are they concepts of a qualitatively different kind?

Difficulty 4: from concrete to abstract terms

With the introduction of 'purpose' and 'function', we have fallen back on concepts that are of a radically different kind from our original 'chair' or even 'seat'. To be specific, we have jumped over a divide, from concrete to abstract.

With this divide we come to a fourth kind of difficulty with definitions, namely that as we trace back the embedded terms on which their apparent transparency of meaning depends, these terms become both more general and more abstract. We will come back to the specific difficulties raised by 'purpose' and 'function' at several points in the book. As just noted, they are core concepts not just for mental health but for the whole of biology and the 'human' sciences. As such, they have been subject to endless philosophical dispute and debate, aspects of which we will be covering later in this book. So, if you think you can get clear about their meanings easily, watch this space! This is quite definitely an area where the search for clear meaning has to be determined indeed. And because the meaning of 'chair' depends on the meanings of the terms in which it is defined being taken for granted, the meaning of 'chair', too, turns out to be, as the meaning of 'bodily illness' in Chapter 2 turned out to be, considerably less transparent than it seems.

Concepts are context dependent

We have now looked at four difficulties complicating attempts to define even an apparently straightforward concept such as 'chair': (1) a tension between specificity and range of use; (2) a tension between brevity and depth of understanding; (3) a tendency for definitions to rely on embedded terms the meanings of which may be far from self-evident; and (4) a particular sense in which these embedded terms become less transparent in meaning, namely that they become more general and abstract.

These difficulties are themselves instances of a further feature of concepts, which complicates the search for clear meaning, namely the extent to which meanings themselves are *context dependent*.

The context-dependent nature of concepts is important in mental health. Contrary to the message of the ongoing debate

about mental illness (noted in Chapter 2), different classifications, indeed different models of mental disorder itself, are not necessarily competitors. Different models (concepts) may be appropriate for different people and in different contexts. Trading different meanings without falling into confusion is not always easy! But it is important to recognize that context dependence is a feature of concept use in general rather than a 'little local difficulty' for mental health.

Thus, the tensions and difficulties we have looked at—just *how* specific the definition of 'chair' should be, just how *far* the embedded terms should be spelt out, etc.—depend on the context in which a definition is required and the reason *for* which it is required. In the *SOED*, a chair is said to be 'usually [a] moveable four-legged seat with a rest for the back'. So far so good. However, if there were a dispute between, say, the stool-makers union and the chair-makers union, both the number of legs and the presence or absence of a back-rest could become crucial criteria for demarcating their respective territories. Similarly for embedded terms. The *COED* allows a chair to be anything that is used for sitting on (albeit that it is usually 'made for the purpose'). Leaving aside the problem of how to define 'purpose' (critical in philosophy, as noted a moment ago), however, even the term 'made for' could be problematic (what about a 'shooting stick', for example, isn't that 'made for' the purpose of sitting on?).

The context dependence of meaning is evident in other ways. We have assumed so far in this session that in defining 'chair' it was 'chair' as an article of furniture that we were talking about. This assumption was legitimate given the context in which the example was set up, i.e. Exercise 1 above involved picking out an object in the room. However, suppose you had been asked simply, 'define chair'. This would have brought in a range of other, related but distinct, meanings of the term: the *COED* includes (1) seat of authority, e.g. professorship, mayorality; (2) seat of office, e.g. person presiding over a meeting; (3) iron or steel socket holding a railway line in position; and (4) various corresponding verbs.

Different definitions for different purposes

Given all these tension and difficulties with definitions, the question arises, where to stop, where to take the meaning of a term as being sufficiently clear?

This is not pre-fixed. The point at which a definition ceases to be too narrowly tautological to be helpful, the point at which 'other words' illuminate the meaning of the term to be defined, and hence the point at which the definition in question becomes useful, depends on such factors as the given understanding of the person seeking the definition and the uses to which the definition is to be put. In this important sense, everyday definitions (including those we find in dictionaries), and the philosophers' 'search for clear meaning', are both normative in character.

Seven different ways of defining your terms

Dictionaries such as the *COED* and *SOED*, being designed for general reference purposes, offer definitions that, in effect, aim to provide the best overall balance between the various tensions and trade-offs outlined above.

Before finishing this session, it will be worth distinguishing some of the many ways in which, for *particular* purposes and in *particular* contexts, different kinds of definition can be generated. In practice, these are not always clearly distinguished, the different kinds of definition being run together, often without any awareness that this is happening. In the pursuit of clear meaning, however, it can be helpful to recognize different kinds of definition for what they are.

Seven kinds of definition

We will first list seven varieties of definition (the list is not exhaustive!) and then go on to Exercise 6, in which we will look at these in action in different areas of mental health.

1. *Ostensive definition*: pointing out instances, illustrating the meaning of a term by shared experience of actual cases. This is how, directly or indirectly, most descriptive terms are learned. 'Chair', obviously, but also more technical descriptive terms, such as 'mitral heart sound': this sound (a particular noise that the heart makes when one of its values, the mitral valve, is damaged and that a doctor hears through a stethoscope) is described in detail in the medical textbooks; however, could you fully understand what it is without having it pointed out to you and hearing it for yourself?
2. *Conventional definition*: agreement on a meaning by convention. The covention may be more or less explicit. Much of statute law rests on explicitly conventional definitions; a group (with authority) establishes the conventional definitions of 'larceny', 'theft', etc. The Oxford philosopher J.O. Urmson gave the example of 'good apple' as defined by the Ministry of Agriculture (Urmson, 1950).
3. *Persuasive definition*: this is the advertiser's definition. A term is used deliberately to persuade you to attach a given meaning to a concept. A famous book on alcoholism was called *The Disease Concept of Alcoholism* (Jellineck, 1960) in order to persuade people that alcoholism should be understood as a disease.
4. *Declarative definition*: a declarative or formal explanation of the significance of a word or phrase (Oxford English Dictionary (OED), CD-Rom version). For example, the meaning of the word 'gold' must contain a reference to the colour of the element gold, as it is this that supplies the meaning of the predicate 'golden'.
5. *Contextual definition*: definition as revealed by use. A definition that does not provide an equivalent for the expression to be defined, but instead replaces the whole context in which the expression occurs by an equivalent not containing that expression (OED). Thus, in mathematics, an 'incomplete' symbol is one that is defined by its role in a formula or equation—its *use* is thus defined, but in itself it is without

meaning. In practice, many technical and scientific definitions are contextual in this sense—remember the proofs in algebra that start with 'let 'x' stand for . . .'?

6. *Essential definition*: a precise statement of the essential nature of a thing, a statement of form by which anything is defined (OED). Thus, we may define velocity as speed plus direction, or a sentiment as a combination of an idea and an emotion.
7. *Semantic definition*: the action of defining what a word means using only the meanings of other words. Thus the seventeenth century English philosopher John Locke, in his *Essay Concerning Human Understanding* (1690) writes: 'Definition being nothing but making another understand by Words, what idea the Term defin'd stands for' (Bk III, CH.III, §10).

Seven kinds of definition in health care

All seven kinds of definition may be important in health care. Think about this for a moment before going on.

EXERCISE 6 (15 minutes)

Where might distinguishing these seven ways of producing definitions be important in mental health? Make a note of any contexts that occur to you.

The most obvious area in mental health where definitions are important is in the classification of mental disorders. We will be returning to classification and diagnosis later, in Parts III and IV. Psychiatric classification, as we will see, has both descriptive (or factual) and evaluative aspects; hence its appearance in both modules. It can be helpful, however, in understanding how classifications of mental disorders work, to distinguish the different kinds of definition that are woven together in them. As we noted a moment ago, these are not always clearly distinct. However, identifying an element of a particular kind of definition in a mental disorder term, can help us to understand the purpose that term serves practically, what its correct use should be, what would be an incorrect use, and so on. Here are a few examples.

1. *Ostensive definition*. If psychiatry is a branch of medicine, learning the meanings of mental state terms ('phobia', 'obsession', 'delusion') should be like learning the meaning of 'mitral heart sound'. We will see later that learning by shared experience is indeed important here. There is a great deal in the use of classifications that has to be learned 'on the job' and which cannot be conveyed simply by definition in words.

   So far as *ostensive definition* goes, however, there is a difference between something that can be pointed out ('chair', 'mitral heart sound') and something that cannot (i.e. an experience in someone else's mind). At any rate, there *seems* to be a difference. We will need to look very carefully at this later on to get a better grasp of how we come to understand (or may fail to understand) other people's experiences (see especially Part V). Psychiatric classification sometimes takes the form of a kind of substitute ostensive definition. Instead of trying to define a mental disorder (or symptom) explicitly, examples (or paradigms) are offered that aim to help us 'recognize it when we see it'.
2. *Conventional definition*. This is the basis of all official classification terms, including those used in psychiatry. Recognizing this is the starting point for a whole series of important observations about these classifications: the extent to which they reflect 'natural kinds' (see Part III); how values become (covertly) incorporated into them (see Part IV); and so on.

   A second, and very different, example of conventional definition is what is sometimes called '*operational definition*'. This concept, developed originally in the 1920s by the physicist, Bridgman, substitutes for an explicit definition of a term a process (or operation) by which the meaning of the term is realized. Thus Einstein, in one of the thought experiments that led to the theory of relativity, substituted for 'time' the behaviour of precise clocks. Another example would be 'circle'—operationally, this could be defined as the shape marked out by moving in a plane and keeping a fixed distance from a given point.

   The definitions of mental disorders in later editions of both ICD and DSM have sometimes been described as operational, the idea being that they are based on the results of a standardized process of history taking and mental state examination. The use of the term in this context carries overtones of scientific precision and objectivity (an example of persuasive definition!); however, the inclusion and exclusion criteria of these classifications *are* certainly closer to the processes by which diagnoses are made than the synoptic definitions of earlier editions (again, we return to this in Part III).
3. *Persuasive definition*. There is also a good deal of *persuasive definition* in medical classifications. The 'disease concept' of alcoholism (Jellineck, 1960, noted above) was promoted to attract health funds into preventing and treating the condition. Debates during the development of DSM about whether homosexuality or, more recently, 'premenstrual tension', should be included in psychiatric classifications, reflected propaganda (rhetoric!) rather than science—the psychiatric 'advertisers' called the latter 'late luteal phase dysphoric disorder' in order to make it medically and politically acceptable.
4. *Declarative definition*. This is not unlike (indeed it is often a subcategory of) conventional definition. You can think of a declarative definition as a formal enactment of a conventional definition. Thus, the introduction to the DSM includes a definition of 'mental disorder'. The authors of the DSM make clear that they recognize the many difficulties and subtleties involved in defining this term. The ICD, like most textbooks, leaves the meaning of 'mental disorder' implicit (see below, 'contextual definition'). The authors of DSM, however, opted to set out explicitly the definition they chose to adopt and

against which they judged whether a given condition should be included in the classification.

5. *Contextual definition*. This is effectively how the ICD defines 'mental disorder'. Instead of defining the term explicitly, a mental disorder is any condition appearing in the ICD classification. Thus the classification as a whole replaces, and provides an equivalent for, a formal enactment of a conventional definition, without employing the term as such. We will return to the validity of this later. However, it reflects the way many doctors think about diagnosis (i.e. if you don't have a recognized disease then you are not ill!); and it is increasingly how those responsible for health-care budgets operate—insurance companies, for example, may recognize only those conditions that appear on a given list of recognized diseases.
6. *Essential definition*. The DSM includes a summary statement of the precise inclusion and exclusion criteria required for each disorder (i.e. inclusion criteria specify the features that *must* be present for a diagnosis to be made of the disorder; exclusion criteria specify the features that *preclude* that diagnosis). These inclusion and exclusion criteria attempt to capture between them the essential nature of the disorder in question.

Definitions and the illusion of understanding

The slogan 'define your terms', with which we started this session, was traditionally held out as the 'Royal Road' to clear thinking. It is good advice if it is taken as an injunction to be alert to meaning, to think about the meanings of the terms you are using. Meanings are slippery and tricky and often far from transparent: the Oxford moral philosopher R.M. Hare (more on him later) used to say that to be an effective philosopher you have to have good (conceptual) peripheral vision.

You will notice that there is no example in the list above of a semantic definition. In fact, there are elements of semantic definition in all of 1–6, but a *pure* semantic definition (as in a dictionary, for example) tends not to be very helpful in practice precisely because of its tautologous nature. We considered the various features and difficulties raised by this earlier in this session, when we looked at the example of 'chair'.

So, defining your terms *is* important, and it is an activity to which philosophers can contribute. But if this is taken to mean that there is some simple, relatively brief statement waiting for us to capture as the essence of the meaning of a given concept, then this is an illusion.

Ludwig Wittgenstein, the Austrian philosopher whose work (carried out mainly in Cambridge in the inter-war period) did much to expose this illusion, talked of concepts as forming family groups (in his most famous work *Philosophical Investigations*, 1953). This is a helpful image. The concepts we use are evolving, overlapping, variable, and subject to non-rational as well as rational changes; they are not a passive framework within which facts are organized, but engaged in a dynamic interplay with experience. The search for clear meaning, then, is no mere preliminary defining of terms. It is an open-ended search, requiring all of that 'determination' to which, at the start of this session, William James pointed us.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. Are dictionaries fully consistent in the definitions they offer of everyday objects like chairs?
2. What are some of the main difficulties with defining everyday objects like chairs? (We noted four.)
3. Are these difficulties confined to defining everyday objects like chairs or do they apply more widely, including in mental health?
4. In how many different ways could you respond to the maxim 'first define your terms'? (We noted seven different kinds of definition.)
5. How many different kinds of definition are important in health care? Give an example of at least one.
6. Having worked through this chapter, how should we understand the maxim 'first define your terms'?
7. What makes a definition meaningful? What makes it useful?

Session 2 Use and definition: J.L. Austin and the Linguistic Analytic (Oxford) move in philosophy

In the last session we found that even an apparently straightforward concept such as 'chair' can be difficult to define adequately. Brief definitions, as in dictionaries, work well up to a point, but only because they are able to take for granted the hidden complexities upon which the full meaning of the word depends. This is not to say that brief definitions as such are unsatisfactory. On the contrary, within a given 'shared discourse' they have genuine explanatory power and can help to sustain clear and consistent language use.

Brief definitions and clinical utility

Brief definitions are important in many areas of the 'shared discourse' of medicine. Hence, as we noted in Session 1, the traditional medical injunction to 'first define your terms'. We will be looking at the value of defining our (medical) terms in later sessions, in particular in relation to psychopathology and

classification. A good example of the value of definitions (though also of their hazards, see Part III), is the US–UK Diagnostic Project on Schizophrenia. This showed that reported differences between the US and UK in the prevalence of schizophrenia reflected no more than differences between them in the definitions of schizophrenia being employed (unwittingly) in the two countries (Cooper *et al.*, 1972). Agreeing on a common set of criteria for schizophrenia (an example of conventional definition, see Session 1), has thus improved the consistency of language use in clinical practice and increased the extent to which valid cross-comparisons can be made between research projects.

So, brief definitions, although not necessarily plumbing the full depth of meaning behind a concept, may be helpful. However, the very success of 'defining your terms' in medicine has led to a widespread assumption that clear explicit definition is a *precondition of clinical utility*. That is to say, because *some* difficulties in the uses of our diagnostic concepts have turned out to be due to a lack of clear explicit definitions, it has been assumed that concepts can *only* be useful clinically if their meanings can be set out in this way (Fulford, 2001 and 2003).

From definition to use

The main aim of this session, then, is to undermine the 'first define your terms' assumption by driving a wedge between the definition and use of concepts. We will find that far from use being dependent on definition, there is an important sense in which definition (even in the context of 'scientific' work like the US–UK Diagnostic Project) is dependent on use.

Fig. 4.1 J.L. Austin

This will take us a step towards a better understanding of the debate about mental illness: you will remember from Chapter 2 that this debate started out as a debate about 'mental illness' but ended up as a debate about 'bodily illness', this apparently unproblematic (in use) concept turning out to be highly obscure in meaning. It will also introduce us to a method for tackling some kinds of philosophical problem, a method associated especially with the Oxford philosopher J.L. Austin. Working in the 1940s and 1950s, Austin was among those who emphasized the value of looking at the way a concept is actually used in ordinary language as a guide to its meaning. We will find in later sessions that Austin's work, although not widely fashionable in philosophy at present, is helpful at several points in the search for a deeper understanding not only of the concept of mental illness but also of the conceptual structure of medicine generally.

Use and definition of everyday concepts

We will be reading one of Austin's articles later in this session (Exercise 8). True to his method, though, we will start with a practical exercise.

EXERCISE 7 (30 minutes)

Look around you and list 10 things you see (objects, events, actions, persons, or whatever). Now distribute them in a 2 × 2 table like the one shown in Table 4.1, i.e. according to ease or difficulty of *use*, and ease or difficulty of *definition*.

Take a little time over this. It is not always easy to decide into which box things should go. As you do this, make brief notes on:

1. how often ease/difficulty of use goes with ease/difficulty of *definition* (in other words, if a concept is easy to use, it is likely to be easy to define, and vice versa);
2. just *why* a given concept may be difficult to define and/or use; and
3. overall, which boxes you find most trouble in filling.

Finally, repeat this exercise with terms from medicine and psychiatry (as in Table 4.2 below).

This exercise reinforces the point that definition and use are not correlated. As Table 4.1 illustrates, ease of use may sometimes go with ease of definition (as with 'winner of a race'); and difficult to use may sometimes go with difficult to define (as with 'fine wine'). Equally, though, a concept (like 'time' in Table 4.1) may be easy to use but difficult to define or (like 'genuine Ming vase' in Table 4.1) difficult to use and easy to define. Use and definition thus do not have to go together at all. Contrary to the usual medical view (the 'first define your terms' view), the capacity to use a concept effectively is not dependent on the capacity to provide a clear definition.

Table 4.1 Two-way table of use and definition for everyday concepts

		Definition	
		Easy	**Difficult**
Use	**Easy**	Winner (of a race) A 'four' (in cricket)	Time Baroque
	Difficult	Genuine Ming vase Square root of −1	Tort Fine wine

Table 4.2 Two-way table of use and definition for medical concepts

		Definition	
		Easy	**Difficult**
Use	**Easy**	Proptosis Aphonia	Delusion Bodily illness
	Difficult	Depressive affect Anaemia	Schizophrenia Mental illness

Fig. 4.2 St Augustine

Use and definition of medical concepts

A similar point is made for medical rather than everyday concepts by the table in Table 4.2, which reflects our response to the final part of Exercise 8 above.

Thus, 'proptosis' (bulging eyes) is easy to use and easy to define while 'schizophrenia' is difficult to use and difficult to define (as noted above, schizophrenia is an example of where better definition, provided by the US–UK Diagnostic Project and other research initiatives, led to better use). With other examples, however, ease of use may go with difficulty of definition: 'delusion', like 'time', is a concept that is relatively easy to use clinically (it is a reliably identifiable symptom) yet peculiarly difficult to define (see Chapter 3); and conversely, 'depressive affect' (sadness) is easy to define but often difficult to use (it is not always easy to identify, due to, for example, variation in cultural expression; and it is not reliably differentiated from anxiety).

Again, then, notwithstanding the traditional 'first define your terms', effective use of concepts, in medicine as in everyday non-technical contexts, is not dependent on definition.

Difficulties with concepts

There are many reasons why concepts may be, respectively, difficult to use and/or difficult to define. Recognizing this will be important when we come to consider use and definition in relation to the concepts of bodily illness and mental illness.

For the moment, though, here are just a few examples: difficulties of definition include: (1) complexity of criteria ('baroque', 'schizophrenia'); (2) obscurity of meaning ('time', 'delusion'); and (3) uncertain or inconsistent reference norms ('fine wine', 'tort'). Some of these also apply to difficulty of use, e.g. complexity of criteria for schizophrenia. 'Baroque' and 'time', on the other hand, can be used by and large without difficulty *despite* the extreme difficulties of definition they present. Difficulties of use are more often empirical, involving, for example, fine observational distinctions ('mitral heart sound'; 'depression', especially its distinction from anxiety), or technical difficulties ('Genuine Ming vase', in Table 4.1 is a concept that is easy to define but difficult to use because the empirical question of whether a particular vase was made in the Ming dynasty is, in practice, difficult to settle).

Both definition and use may present many different kinds of difficulty, then. This is no less true of non-technical areas (concepts taken from around the room, as in Table 4.1) as of technical concepts (medical and psychiatric concepts, as in Table 4.2). In general, though, and coming now to the third question in Exercise 8, we have less trouble in using concepts than defining them. 'Time', one of the examples in Table 4.1, provides an excellent example of this, which we owe to the work of the theologian and philosopher St Augustine.

I know what 'time' is until I think about it

St Augustine was Bishop of Hippo, not far from Carthage in North Africa, in the early decades of the fifth century AD, during the final collapse of the Roman Empire. In Book XI of his *Confessions*, he struggles with the theological paradoxes generated by the notion of an eternal or timeless Creator and a created universe in time. It is only as he comes to think about time that he realizes he does not know what it is. 'So what is . . time?' he asks. 'If no one asks me, I know; if they ask and I try to explain, I do not know' (St Augustine, Confessions, Bk 11, ch. 14, no. 17).

We thought about 'chair' in Session 1 and found that, despite first appearances, even this turned out to be difficult to define. But with 'time' we do not even have a first order stab at a

definition to offer. (*Try this for yourself.*) The concept, none the less, is entirely straightforward to use, so much so that it requires an effort of conscious reflection to realize with St Augustine, that in an important sense, we do not (really) know what 'time' means.

Philosophers have sometimes argued that to understand the meaning of a concept is to use it correctly. Thus Wittgenstein (1953), for example, says: 'For a large class of cases—though not for all—in which we employ the word "meaning" it can be defined thus: the meaning of a word is its use in the language.' According to this behaviourist account, we all understand the concept of time. But if so, our understanding is wholly *independent* of the ability to give a clear, explicit definition. Yet it is precisely this ability (to give clear, explicit definitions) that medical science seems to expect in the pronouncement 'first define your terms'.

By and large, then, we are better overall at using concepts than at defining them. This is a hard lesson for most of us to learn, especially in medicine. Yet it makes sense developmentally: we come to understand the meanings of concepts by shared use in a social context rather than by looking them up in dictionaries to find explicit definitions. And once the lesson that we are better at using concepts than defining them *is* learned, it has a number of important consequences for mental health.

I know what 'illness' is until I think about it

One rather general consequence of learning the lesson that we are better at using concepts than at defining them is that it gives us a more positive way of approaching the whole question of the conceptual difficulties raised by mental illness.

Thus, we saw in Chapter 2 that because 'mental illness' is problematic clinically (i.e. in use) while 'bodily illness' is not, the debate about the meaning of 'mental illness' has proceeded on the assumption that 'bodily illness' is relatively easy to define. On this assumption, then, 'bodily illness' has been used as a kind of 'probe' for explaining the meaning of 'mental illness'.

In Chapter 2, we found that this assumption was unwarranted, the debate about mental illness in fact turning on the meaning of '*bodily* illness'. This led us to reframe the debate as a debate about the meaning of 'bodily illness'. We can now reframe the debate more precisely as involving two questions:

1. Why is 'mental illness' problematic *in use*?, and
2. Why is 'bodily illness' relatively *un*problematic in use, *despite* being obscure in meaning?

We will return to the debate about mental illness, and to these two questions, in Chapter 6. The point for now is the effect that reframing the debate in this way has on our attitude to 'mental illness'. So long as difficulties in the use of a concept are equated with lack of a clear explicit definition, psychiatry appears to be merely a muddled or confused version of bodily medicine. This is how it is often portrayed (see Session 3). As the argument proceeds, however, we will find that the conceptual problems associated with the use of 'mental illness', far from being marks of muddle, actually point to aspects of the meaning of 'illness' which are masked by the relatively unproblematic nature of 'bodily illness'. So 'mental illness', not 'bodily illness', will turn out to be the more appropriate 'probe' to the meaning of these difficult concepts.

Use of concepts as a guide to their meaning (philosophical fieldwork)

A first consequence, then, of recognizing the pre-eminence of use over definition is to push back against the negative stereotyping of mental disorder arising from the difficulties associated with it in everyday usage. A second consequence is methodological. This brings us back to Austin. We are, in general, better at using concepts than defining them. Hence, Austin suggested, exploring the use of a concept—'fieldwork in philosophy', as he called it (Austin, 1956/7, p. 25)—may be a better way to get clear about the meaning of that concept than by attempting to define it.

EXERCISE 8 (90 minutes)

Read the two short extracts from:

Austin, J.L. (1968). A plea for excuses. In *The Philosophy of Action* (ed. A.R. White), reprinted. Oxford: Oxford University Press, pp. 19–42 [This is reprinted from original Austin, J.L. (1956/57). A plea for excuses. Proceedings of the Aristotelian Society, 57: 1–30.]

Link with Reading 4.1

Make brief notes about:

1. the method of 'doing' philosophy Austin is advocating (and illustrating in the paper as a whole);
2. what objections there might be to Austin's method; and
3. the extent to which he claims this to be a panacea for solving philosophical problems.

In this paper, Austin gives a clear statement of his views about philosophical method. He envisages a huge if largely hidden resource of distinctions built up over the lifetime of our culture and embodied in the everyday use that we make of concepts. Actively exploring concept *use*, therefore, rather than the traditional passive reflection on *definition*, is one way to get a clearer understanding of the meanings of the concepts in question.

As we have seen, this approach reflects the fact that our powers of direct introspection on the meanings of our concepts are really quite limited. The Austrian-born Cambridge philosopher, Ludwig Wittgenstein, who preceded but overlapped with Austin, drew an essentially negative conclusion from this. As with any major philosopher there is a whole literature about the possible interpretations of his view (see, e.g. Baker, 2003). For our purposes, though, we can take the nub of his position to be that when philosophers (or other people) try to think directly about

the meaning of a concept, they inevitably focus on one or other aspect of its meaning and neglect others. This leads to what are in effect illusions (one-sided or otherwise distorted perceptions) of language. Wittgenstein writes of 'grammatical illusions' (Wittgenstein, 1953, §110), of being 'bewitched' by language. The way to solve philosophical problems, then, according to one interpretation of this passage, is to bring the grammatical illusions to light, to reveal the mistaken assumptions that are the origin of much philosophical theorizing. In effect, Wittgenstein suggested that we should reject all philosophical theory.

'Ordinary', technical, and lay usage

Note by the way, that the term 'ordinary usage', as employed by Wittgenstein, means ordinary as distinct from philosophical usage: it thus includes technical as well as lay usage. A psychiatrist's use of the term 'delusion' in everyday clinical contexts is 'ordinary usage' in this sense. A lay person's use of the term 'delusion' is also 'ordinary usage'. A philosopher, or indeed a psychiatrist or lay person, trying to *define* 'delusion' is involved in philosophical usage (in this 'ordinary language' philosophical sense). Austin, as Warnock indicates in the next reading, distinguishes technical (as in law) and non-technical (lay) usage. But both are equally resources for his 'philosophical fieldwork'.

Modest claims for philosophical fieldwork

For Wittgenstein, then, philosophical problems were no more than pseudo-problems, artefacts of the philosophical enterprise. Austin took a more positive view, regarding ordinary usage as a resource on which philosophers may draw in exploring the meanings of concepts.

A modest methodology

Coming, though, to questions 2 and 3 in Exercise 9, Austin is careful not to overstate the case. Linguistic analysis (as this approach came to be known) is not a panacea. Its critics have often pointed out (*contra* Wittgenstein) that if ordinary usage is taken as a guide to meaning, it may well incorporate all the obscurities and deep metaphysical difficulties that philosophical analysis seeks to explicate. But as G.J. Warnock (another Oxford philosopher, and one of Austin's literary executors) has emphasized (G.J. Warnock, 1989), Austin was quite clear that linguistic analysis is at most one way of getting started with some kinds of philosophical problem.

EXERCISE 9 (20 minutes)

Read the two extracts from Warnock's philosophical biography of Austin:

Warnock, G.J. (1989). *J.L. Austin*. London: Routledge

Link with Reading 4.2

Warnock's 'oft-quoted passages' from Austin are those given in the last exercise. In what sense does he think the usual interpretation of these passages is the wrong way up?

Also, how many parallels can you spot between law and psychopathology in what Warnock says about Austin's choice of excuses as an appropriate place for 'philosophical fieldwork'?

Warnock's introductory chapter gives a succinct and well balanced account of Austin's 'method'. His bottom line is that this has often been overblown! There is no 'method', in the sense of a fully worked up, detailed approach, beyond the basic point about philosophical fieldwork.

The 'usual interpretation', moreover, is upside down in the sense that, in these passages at least, Austin is not so much advocating a method (in general) as suggesting that *if* one wants to work on excuses (and by implication agency), then this approach (of doing some fieldwork among legal cases) is a good way of getting started. And in this very limited sense, much of what Warnock/Austin says about law (in the second paragraph of this extract), applies to psychopathology. In both, there is 'useful material to hand', and

- '. . . an immense miscellany of untoward cases' . . . together with
- '. . . a good deal of acute analysis . . .'. Both also . . .
- . . . extend the resources of non-technical language since they face '. . . an immense variety of novel and complicated questions . . .', and
- there is a pressure of necessity, since, unlike philosophy, '. . . we have to *decide*'.

The methodological claim, then, of Austin's paper is modest indeed. But, as a modest claim, it is as apposite to philosophy and mental health as to Austin's topic of excuses.

A modest metaphysics

Philosophical fieldwork, on the other hand, does have *some* contribution to make to the traditional 'problems of philosophy'. As a moral philosopher, Austin was interested in the nature of agency and action. These concepts raise, in traditional philosophy, deep problems of causation, free will, determinism, and so forth. Rather than tilting directly at such deep problems, however, Austin seeks to learn something more modest about some of the components of agency and action by looking at a range of cases where actions fail or go wrong. This is his 'plea for excuses'. We *excuse* something we have done by claiming that in some sense it was not fully *our own* action (in an Austinian example, I knocked over the salt, but intended only to pick up the glass: my excuse—'it was an accident').

Much the same, correspondingly, is true of psychopathology. Here, too, the deep problems of general philosophy lurk just below the surface of the subject. Austin indeed says as much at

the end of his paper, pointing to abnormal psychology as a further resource for philosophers interested in studying action (Austin, 1968, p. 42).

A modest contribution to mental health

As a philosophical method, then, philosophical fieldwork, although not an end in itself, still less the only game in town, does have a role to play. As Austin himself (in Reading 4.1) put it, 'Certainly, then, ordinary language is *not* the last word: in principle it can everywhere be supplemented and improved upon and superseded. Only remember, it *is* the *first* word.' (Austin, 1968, p. 27). As the first word, moreover, whatever its limitations as a philosophical method in general, examining ordinary language turns out to be peculiarly appropriate to the kind of conceptual problems which are practically important in medicine and mental health.

EXERCISE 10 (5 minutes)

Before moving to the next part of this session, think for a moment about the claim made at the end of the last paragraph. Write down as many reasons as you can think of why the linguistic analytical method, Austin's 'ordinary use as a guide to meaning', may be helpful in medicine and mental health.

As we have emphasized, the linguistic analytical method is only one way of 'doing philosophy'; it is only one way of pursuing William James' 'stubborn effort to think clearly' (see last session). We will be looking at other important methods before the end of this chapter.

None the less, linguistic analysis *is* important in medicine and psychiatry for several reasons:

1. *The right level of problem*. It is at the Austinian level of ordinary usage that conceptual problems arise in practice. Difficulties, *conceptual* difficulties, in the use of 'mental illness', are not, as such, 'merely' philosophical. They do reflect deeper philosophical difficulties (see Chapter 6). But as difficulties arising in ordinary (as distinct from philosophical) usage, they are difficulties arising at the clinical (and/or research) coal-face.
2. *Useful results*. We do not have to trace these conceptual problems to their metaphysical roots to get clinically useful results. Austin, as we saw, focuses in his paper on everyday excuses rather than attempting a (direct) assault on 'freedom of the will'! Correspondingly, therefore, just as the conceptual problems with which we are concerned in mental health arise at the level of ordinary clinical usage, so any *clarification* of these problems is necessarily at the same clinically relevant level. (We come to a clinical example of this in Chapter 6.)
3. *Well-defined parcels*. The linguistic analytical approach tackles conceptual problems in manageable parcels. General philosophical theorizing often seems excessively open-ended for practitioners whose essential requirement is to take action, to decide and to do. Linguistic analysis, with its focus on actual use, encourages a closer connection with practical utility. (Again, we come to examples of this in Chapter 6.)
4. *Cases and case studies*. The linguistic analytical method is (partly) empirical and often case based. These features of the method 'gel' naturally with the methods with which practitioners are familiar. They also make linguistic analysis a natural partner of all the techniques of empirical research— statistical, methodological, and so on—used in such areas as sociology and anthropology. Austin's critics complained that he operated at an amateur level as a linguist (Fann, 1969). But he died relatively young and who knows how far, given time, he could have developed the method through partnerships with other disciplines. In 'A plea for excuses', he was working in partnership with law; however, psychology, ethnography, comparative linguistics, history, and so on are all natural partners of philosophical linguistic analysis. The method is thus capable of potentially very rich interdisciplinary connections. (See Reading Guide for examples.)
5. *A connection with deep metaphysics*. Although not primarily metaphysical in focus, the method may contribute to the analysis of the traditional problems of philosophy. Austin worked on excuses as a step towards analysing the concept of action as a contribution to the philosophy of action. Thus, although the conceptual problems of mental health arise at the level of ordinary usage, like most problems of this kind they reflect deeper metaphysical difficulties and thus provide at the very least, a resource of examples for general philosophy.

This means that general philosophy as a whole (not just the linguistic analytical method) is relevant to mental health. It also means, conversely, that the problems of mental health are critically relevant to general philosophy. For example, if various kinds of psychopathology may impair responsibility, and if this in turn reflects issues about freedom of the will, philosophy has in principle something to offer mental health. But mental health, conversely, through the rich variety of forms of psychopathology it covers, may have much to offer philosophy. Austin indeed makes exactly this point at the end of his paper, encouraging philosophers to examine abnormal psychology as a rich resource for the philosophy of action. More recently, the Oxford philosopher, Kathleen Wilkes, argued that philosophy of mind as a whole should give up its current reliance on 'thought experiments' and turn instead to the rich resources offered by psychopathology (Wilkes, 1988).

There is thus considerable potential for *two-way* exchange between philosophy and practice by way of the conceptual problems arising in ordinary usage in mental health. Here, perhaps above all, there is in the resources of ordinary (technical as well as lay) usage, '…gold in them thar hills', as Austin put it (Austin, 1968, p. 24).

Who wears the trousers?

But Austin has yet one further point to make, directly relevant to the importance of psychopathology (and hence to reframing our

view of the 'problem' of mental illness). This is summed up in his memorable, if politically unreconstructed, aphorism to the effect that in linguistic analysis it is often the negative word that may 'wear the trousers' (Austin, 1968, p. 32).

We can see what he meant by this if we think back to the last session for a moment. Recall how even the concept of 'chair' turned out to have hidden depths of difficulty. Austin's point was that much of the difficulty inherent in the meanings of concepts is effectively hidden by the ease with which we normally use them. It is the facility with which we are able to use even deeply obscure concepts, such as time, that hides their complex meanings behind what Austin called 'the blinding veil of ease and obviousness' (Austin, 1968, p. 23).

Well, there is nothing easy or obvious about the concept of mental illness. We noted above that a first consequence of recognizing the pre-eminence of use over definition is to push back against the negative stereotyping of mental disorder arising from the difficulties associated with the concept in practice. Austin's final point takes this a step further, showing that these difficulties may actually provide a valuable window on the meanings of the medical concepts. The bottom line, then, as we will see in later sessions, is what one of us has called elsewhere, 'mental health first' (Fulford, 2000). The bottom line, just as Austin anticipated, is that the trickiness of the negative concept of mental illness, far from being a mark of muddle, actually points directly to important if all too easily overlooked aspects of the meaning of the apparently more transparent concept of bodily illness.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. Does ease of 'use' of a term go with transparency of 'definition'? Either way, think of at least one example.
2. What are the implications for the stigmatizing of mental health compared with bodily health, of the fact that the concept of 'mental illness' is not only difficult to define (like the concept of 'bodily illness') but also difficult to use (unlike the concept of 'bodily illness')?
3. What did Austin call the philosophical method that exploits our greater ability to use than to define concepts?
4. What are the strengths and limitations of Austin's method?
5. Which is the more likely to be illuminating about the meaning of 'illness', mental illness or bodily illness?
6. What does 'ordinary usage,' as in Austin's 'philosophical fieldwork' model of how to get started with a philosophical problem, include?

Session 3 Illness and disease: definition and ordinary usage

In the last two sessions we have looked at the work that can be done towards clarifying the meanings of concepts, first by defining them explicitly, then by examining the way they are used.

In this session we return to the debate about mental illness but focusing on the concept of bodily illness. You will recall from Chapter 2, that one outcome of the Szasz/Kendell version of the debate about mental illness was to point the analytical finger at bodily illness. It was the meaning of bodily illness about which Szasz (1960) and Kendell (1975) disagreed, not, as they thought, mental illness. Hence a more careful analysis of bodily illness was called for.

In this session, we consider such an analysis by way of definition. We look at an ingenious attempt by the American philosopher, Christopher Boorse, to define mental illness by way of a more careful definition of the concept of bodily illness. The key to Boorse's approach, as we will see, is to draw a distinction that we have so far ignored, between 'illness' and 'disease'.

Boorse on the distinction between illness and disease

In much of the debate about mental illness, and notably in the papers we examined in Chapter 2 by Thomas Szasz and R.E. Kendell, the terms 'illness' and 'disease' are used interchangeably. In everyday English these terms, although often used as synonyms, can also express the distinction between, broadly speaking, a *patient's experience of illness* and *medical or specialist knowledge of disease*.

The distinction between illness and disease can be analysed in a number of ways (see Fulford, 1989, chapter 2). Christopher Boorse (1975), in an important and widely cited paper, developed a particular technical form of the distinction, specifically targeted at improving our understanding of the concept of mental illness.

EXERCISE 11 (2 hours)

Read the following article:

Boorse, C. (1975). On the distinction between disease and illness. *Philosophy and Public Affairs*, 5: 49–68

Link with Reading 4.3

Make brief notes on:

1. Boorse's view of the problem of mental illness.
2. How he conceives the distinction between illness and disease.
3. The use that he makes of this distinction in attempting to resolve the problem of mental illness.

4. Any strengths and/or weaknesses of Boorse's account, in particular of his central treatment of the concepts of 'illness' and 'disease'.

It is important to think about these points for yourself before going on. The temptation is just to skim Boorse's paper (or not read it at all!), and to jump directly to the account given below. Remember, though, that learning philosophy is not primarily a matter of absorbing facts. It involves learning new skills. Hence, like all skills acquisition, it is critically dependent on practice, with appropriate feedback. You learn philosophy by *doing* it. This is what the exercises in this book aim to achieve: a problem is set up, you do some work on it, and only then get feedback.

Boorse's paper is rich and detailed. It illustrates the power of philosophical work directed towards clearer understanding of the meaning of concepts by direct reflection on their definitions. Here are some notes on the four questions you have been thinking about. Don't take them as 'gospel'. Think about them; compare them with your own notes; see if you agree or disagree with them.

1. *Boorse's view of the problem represented by mental illness*. Like Szasz and Kendell, in Chapter 2, Boorse takes mental illness to be the target problem. He recognizes, though, that the development of a better definition of *bodily* illness is central to making progress in understanding the concept of mental illness.

   Also like Szasz and Kendell, he identifies the value-ladenness of mental illness as being central to its problematic nature. In terms of our map of the logical terrain of mental health (see above, Chapter 2), Boorse argues that the real problem with mental illness is its territorial ambitions. Psychiatry, he says, is laying claim to more and more of life's problems. It is the 'medicalisation of morals' that is the danger, as the territory of 'mental disorder' is allowed to extend further and further to the left of the map. The way to put a stop to this, he says, is to establish a value-free science of health (here he is back with both Szasz and Kendell), a science that can tell us unambiguously which conditions are properly within, and which are not within, the territory of medicine.

2. *Boorse's core distinction, between 'illness' and 'disease'*. Recall that both Szasz and Kendell moved fairly quickly to definitions of bodily illness. We noted at the time that a definition of '*disease*' would not necessarily be, as both authors assumed, an appropriate mould or template for deciding the validity of this or that concept of *illness*, mental or otherwise.

   Boorse avoids this conflation. Indeed his argument shows that in a critical respect, 'disease' is *not* an appropriate template for 'illness'. He draws attention to an important feature of 'illness' by which, in general, it is distinguished from 'disease', namely that it is more overtly value-laden. As you will have gathered from his paper, he identifies 'disease' with scientific medical theory, 'illness' with the application of that theory to practice. He defines 'disease', broadly as Kendell (1975) did, in terms of 'biological disadvantage'. Boorse has a more sophisticated analysis of what it is for a function to be impaired (see Reading Guide for a sample of Boorse's other papers). But, like Kendell, he takes survival and reproduction to provide key *factual* criteria (he identifies these as 'apical goals' towards which the functioning of all an organism's parts are directed). 'Illness', on the other hand, is a value concept. It is defined by adding an evaluative element to the concept of disease. An illness is a disease which is 'serious enough to be incapacitating' (p. 4).

   Boorse's separation of 'illness' and 'disease' has many advantages:

   (a) it is consistent with ordinary use (in as far as they are distinct, we use 'disease' of medical scientific theories, 'illness' of our direct experience of being ill);

   (b) it allows for the self-evidently value-laden nature of the experience of illness, whether mental or bodily (to be ill is to be in a bad condition, other things being equal); and

   (c) it gives Boorse what he is after, a value-free science of health by which, in principle, the proper scope of medicine can be defined, a science 'continuous with biology and the other basic sciences'.

3. *How Boorse applies this to the demarcation of 'mental illness'*. Boorse (1975) has relatively little to say about the concept of mental illness in this paper: he writes about it in detail in a second paper (Boorse, 1976a). He presages his general line of argument in his first paper (Boorse, 1975), though, when he says that the demarcation between medicine and morals in mental health should be made by reference to scientifically defined norms of mental functioning. Mental diseases, then, are defined in precisely the same way as bodily diseases. Of course, the science of psychology is not as well-developed as that of biology. Hence, he says, we lack norms of mental functioning against which to make the relevant comparisons in many cases. But the principle, at least, is clear; and as psychology and the related brain sciences develop, so the demarcation of genuinely *medical* territory among mental disorders will become clearer in practice.

   The relatively value-laden nature of 'mental illness', meanwhile, is legitimate. It reflects the value-laden nature of the concept of illness, which in the case of 'mental illness', lacks, to this point in time, the relevant scientific disease criteria to mark out medicine from morals. 'Mental illness' differs from 'bodily illness' only contingently, then, by the current lack of an adequate science of the mind.

4. *Some strengths of Boorse's argument*. Boorse takes seriously the value-laden nature of the medical concepts while at the same time recognizing the importance of medical science. As an

argument about 'mental illness', therefore, his model represents a significant advance on the polarized pro-psychiatry/antipsychiatry debate. He is able to acknowledge and thus seek an explanation for the value-laden nature of 'mental illness' (rather than simply denying it or seeking to define it away, as Kendell does); at the same time, though, he is able to provide a central place for future scientific advances in understanding mental disorder (which Szasz's position, taken literally, would preclude; though as noted in Chapter 2, Szasz says that when we find a 'lesion' to explain schizophrenia he will accept it as a genuine illness, albeit a bodily illness).

Boorse's value-free definition of disease

Boorse's model is a sophisticated form of what has become widely known as the 'medical' model. In fact, this is a large group of models. (The American philosopher, Ruth Macklin (1973), gives an excellent summary of the varieties of medical models in the literature.) The term, though, serves as a generic for the kind of model of medicine that most doctors more or less explicitly hold. This model assumes that medicine is, at heart, a science; in medicine, facts are accumulated and built into disease theories, which in their fully developed form, are set out in terms of disturbances of well-defined bodily and/or mental functions.

As in Boorse's model, then, the medical model takes the theoretical basis of medicine to be defined by three elements—facts, diseases, and disturbances of function. Many doctors will acknowledge that there is more to medicine that just science. But, as also in Boorse's model, it is science that is at the core: values and the patient's experience of illness are important but peripheral. As specifically *medical* concerns, these are secondary to and dependent on the body of scientific theory by which the proper scope of medicine is defined.

Boorse's model is shown diagrammatically in Figure 4.3. As a model, which is immediately recognizable to the medical mind, it is consistent also with much thinking in psychiatry—in forensic psychiatry, for instance, psychiatrists have sometimes sought to limit their expertise to 'scientific' questions of mental disease, leaving issues of responsibility, with their value-laden overtones, to others.

But is this model correct? You will probably have come up with a number of problems with the model when you were thinking about question 4 of Exercise 11 (above). Many of these are similar to the problems with Kendell's model (both models rely, ultimately, on the same 'biological' criteria). We can also ask, is Boorse's account of 'function' correct? Is his account of the relationship between illness and disease correct (e.g. it explains cases where we can say that someone has a disease but is not ill; however, does it explain cases where we want to say that someone is ill (physically ill) when we do not know whether they have a disease in Boorse's sense? For a discussion of some of these issues, see Fulford, 1989, chapters 2 and 3).

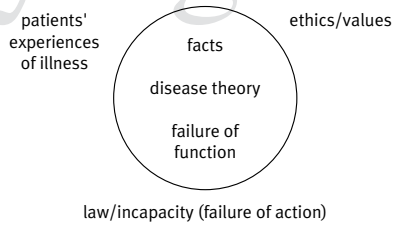

Fig. 4.3 As in Boorse's account, most doctors conceive of medicine as being based on a value-free body of scientific disease theory, which, in its fully developed form, is cast in terms of disturbances of the functioning of bodily and/or mental systems. The patient's experience of illness, their values, and the incapacities (or disturbances of action), which are the key features of the experience of illness, are recognized to be important but they are marginalized.

Boorse's value-laden use of disease

A more critical question, though, is whether Boorse's central claim to have established a value-free definition of disease (and with it a value-free science of health, and with this an unambiguous scientific criterion for demarcating genuine mental illness), is correct.

EXERCISE 12 (10 minutes)

Before going on, go back to Boorse's paper (1975) and re-read from the bottom of p. 56 to, and including, the top half of p. 59. In this passage, he offers two definitions of disease. In each case, think carefully about Boorse's own *use* of words, in particular as they reflect his use of the concept of disease. Is he consistent? If not, what might this tell us about the concept of disease?

This passage is central to Boorse's argument. It summarizes the connection he requires between disease and function and then extends the definition of disease to take account of endemic diseases. He thus offers two definitions of disease both of which are value-free: a disease is (1) a 'deviation from (statistically) normal functioning', and (2) a deviation that is 'mainly due to environmental causes' (see p. 59). Thus far, Boorse is consistent.

The critical shift from definition to use

But now notice this. Immediately after defining disease in these value-free ways, value terms leap back in: four lines after disease has been defined value-free as a 'deviation' from a statistical norm (of functioning), it becomes the value-laden '*deficiency* in functional *efficiency*' (emphasis added); and correspondingly, in the same passage, immediately after the definition of disease has been extended by the value-free 'due to environmental causes', it becomes the value-laden '*hostile* environment' (again, emphasis added).

So, Boorse is inconsistent. 'So what?' you may say. Is this not merely a slip of the pen? Well, hardly, for Boorse is a careful philosopher, and at this point in his paper he is establishing the

very core of his argument. So, how *should* we understand this inconsistency?

One way to think of what is going on here is in terms of the shift introduced in the last session from *definition* to *use*. Of course, there is a sense in which Boorse is still defining disease—his whole paper is about defining disease and the closely related concept of illness. But there is also a sense in which, in these passages, having explicitly *defined* the concept of disease he then goes on to *use* it. And it is a crucial observation about his *use* of the concept of disease that, once his eye is off the definitional ball, value terms slip straight back in. What this suggests, given the thrust of Session 2 (that use is a better guide to meaning than definition), is that 'disease', despite its more 'scientific', and less overtly value-laden, appearance compared with 'illness', is after all a value term. Boorse (1997) firmly resists this conclusion. But if even Boorse cannot *use* 'disease' value-free, and even in the context of a paper the whole aim of which is to establish a value-free definition of the term, this suggests, from a linguistic analytic perspective, that an evaluative element really is essential to its meaning. We follow up some of the implications of this in Chapter 6.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. In so far as they are distinct, how do the terms 'illness' and 'disease' differ in their everyday usage.
2. How does Boorse develop this distinction into a more formal version of the medical-scientific model?
3. In what important ways does Boorse's analysis represent an advance on the Szasz/Kendell debate and earlier work on 'biological dysfunction' analyses of the medical-scientific model?
4. In what respect does Boorse's *definition* of 'disease' differ from his own *use* of the term?
5. What is the significance of the difference between Boorse's use and definition of 'disease' from the perspective of Austin's 'philosophical fieldwork'?

Session 4 Anglo-American and Continental philosophy

So far in this chapter we have concentrated on two ways of exploring the meanings of concepts, directly by careful definition, indirectly by way of their actual uses. As we have seen, both are relevant to many of the conceptual problems arising in day-to-day practice and research in mental health.

We will be looking at some of the products or outcomes of these ways of analysing concepts in Chapter 6. But before going on, we need to set them in context with the main traditions of philosophy and to consider a selection of the many other philosophical perspectives and methods available. As we will see, many of these are important for research and practice in mental health. Indeed, part of the richness of the new philosophy of psychiatry consists in the range of philosophies relevant in principle to mental health, and, vice versa, the range of problems in mental health available as material for philosophical research of different kinds.

With many schools of philosophical work, it is easier to illustrate their approaches than to define them. Hence in what follows we will often be referring you to examples. We will be returning to many of them in detail in later sessions. The idea of this session is just to give you a first impression of the scope and diversity of philosophical approaches relevant to mental health.

We begin the session with a brief overview of two major intellectual orientations by which philosophy was characterized through much of the twentieth century, Anglo-American and Continental.

The split between Anglo-American and Continental philosophy

For much of the twentieth century, Western philosophy has been broadly separated into two main traditions, generally called Anglo-American and Continental. Both traditions include many subdivisions, and the traditions themselves also overlap. However, they may be distinguished roughly thus:

- *Anglo-American philosophy* has been more analytic in orientation, seeking explicit understanding of the meanings of high-level concepts such as agency, mind, person, and so on. The approach, indeed, has been called, simply, analytic philosophy. The distinction between definition and use, as explored in this chapter, is associated particularly with Anglo-American philosophy (through J.L. Austin).
- *Continental philosophy* has generally sought to explore meaning and ethical value through a more intuitive understanding of human experience and expressiveness. Its three main subdivisions are *phenomenology*, *existentialism*, and *hermeneutics* (see below).

Both kinds of philosophy can be thought of as working at the edge of the meaningful. Yet as they split apart, they became increasingly suspicious of each other, essentially because their basic assumptions and methodologies appeared so radically different. Anglo-American philosophy sought explicit clarification of concepts and the structure of reason; Continental philosophy was more implicit, seeking better understanding of the human predicament. Yet in mental health, in which the most radical *failures* of meaning are to be found, the two approaches are entirely complementary. Here, above all, philosophy, in helping us to explore meanings, can draw to excellent effect on both approaches.

The linguistic turn

The origins of the split in philosophy into these two great traditions are complex. One important factor was a development in late nineteenth century philosophy that culminated in the early twentieth century in what came to be called 'the linguistic turn'. Certain influential philosophers during this period gradually became convinced that the key to improving the understanding of philosophical problems lay in the study of language. No one philosopher can be credited with precipitating the linguistic turn; many were involved in what was a gradual process, and it came to maturity only in the 1920s.

So far as the split in philosophy was concerned, the effect of the linguistic turn was indirect. It did not, directly, cause philosophy to split into two subdisciplines; its effect was rather to emphasize the differences between the two traditions in philosophy, each of which had been gradually taking shape for at least a century. The focus on language was then taken up particularly by that strand of philosophy that later came to be called 'Anglo-American'.

The origins of Anglo-American philosophy

The name 'Anglo-American philosophy' reflects the fact that the analytic tradition, which grew out of the linguistic turn, has been most influential in Britain and America. In its origins, however, it is strongly European—the Oxford philosopher of language, Michael Dummett, has suggested that a more appropriate name for this philosophical tradition should be 'Anglo-Austrian', in recognition of its geographical origins (Dummett, 1993).

Thus, four key figures, who established the tradition in the first half of this century, were all either German-speaking or English: Gottlob Frege (working at the University of Jena between 1890 and 1925, his most influential work being *On Sense and Meaning*, 1892); the Cambridge philosopher G.E. Moore (who worked on ethics and the theory of knowledge from around the turn of the century until the 1950s, his best-known work being *Principia Ethica*, 1903); Bertrand Russell, also at Cambridge (especially important being his work on logic and the foundations of mathematics, which culminated in a book co-written with the Cambridge philosopher, A.N. Whitehead, *Principia Mathematica*, 1910); and Ludwig Wittgenstein (we met Wittgenstein earlier; he was Austrian, but worked mainly at Cambridge).

Moore and Russell were most influential during their lifetimes; Wittgenstein has had a continuing influence; Frege was unfashionable for a while (essentially because Russell exposed certain fundamental flaws in his logic of mathematics), but there is currently renewed interest in his work on the relationship between thought and language (see, e.g. Dummett, 1981).

Logical Positivism and the Vienna Circle

The formative years of Anglo-American philosophy were contemporaneous with the birth of the philosophical and scientific movement known as Logical Positivism. In fact, many influential figures were common to both.

As a detailed philosophy, Logical Positivism was developed by a group of philosophers based mainly in Vienna. This 'Vienna Circle', as the group came to be known, included many of the big names of pre-Second World War philosophy—Maurice Schlick, Rudolph Carnap, Herbert Feigl, Kurt Gödel, and Otto Neurath. It was following a visit to this group that the young Oxford philosopher, A.J. Ayer, wrote *Language, Truth and Logic* (first published in 1936), virtually single-handedly introducing Logical Positivism to the English-speaking world. The influence of Logical Positivism declined sharply after the Second World War, but Anglo-American philosophy has continued to maintain a strong interest in the philosophy of the natural sciences (see, for example, Reichenbach, 1951).

With the rise of Nazism in the 1930s, members of the Vienna Circle were forced to relocate, mostly to America. It was partly through this dispersion that analytic philosophy came to be so influential on both sides of the Atlantic. (We return to logical positivism in Part III.)

Three kinds of Continental philosophy

The three main subdivisions of Continental philosophy, as noted above, are *phenomenology*, *existentialism*, and *hermeneutics*. As with Anglo-American philosophy, these are heterogeneous and overlapping (many philosophers in the Continental tradition have worked in more than one area). None the less, the terms mark distinct philosophical approaches, each of which has been important in different ways to philosophy and mental health. We will look briefly at these by way of introduction and then consider each of them in more detail.

Phenomenology and existentialism put people first. *Phenomenology* (as it has been understood since the work of the German philosopher Edmund Husserl in the early twentieth century) is a philosophical method: it seeks in human awareness, and the structure of consciousness, the ways in which we structure and give meaning to experience. Husserl's greatest pupil, Martin Heidegger, moved away from Husserl's later focus on transcendental methodology (i.e. reasoning beyond the limits of experience) and his idealism, preferring instead to develop Husserl's earlier ideas on the nature of lived experience. Heidegger is probably unique in being highly influential on all three main strands of Continental philosophy. The influence of both Husserl and Heidegger is evident in the work of later phenomenologists, including the French philosophers Jean-Paul Sartre and Maurice Merleau-Ponty.

Existentialism, founded by the nineteenth century Danish philosopher Søren Kierkegaard, is a philosophical attitude or position, which in its twentieth century form, has developed largely out of phenomenology. Its defining claim is that existence precedes essence: in other words, there are no 'essences' independent of our individual existences; we create the world as we know it through our actions. In the second quarter of the twentieth century existentialism was developed into a school of philosophical thought by the writings of Heidegger, the German philosopher–psychiatrist Karl Jaspers, and the French philosophers Gabriel Marcel and Jean-Paul Sartre. There is an emphasis

in existentialism on the understanding of the individual's subjective view of the world and his/her place in it, and it is in this sense that existentialism is like phenomenology in putting people first.

Hermeneutics is often characterized in such terms as 'it takes as primitive the semiology of discourses'. This rather grandiose phrase just means that it seeks to provide a clearer understanding of language through the interpretation of the meanings of instances of discourse and the texts in which they appear. The German philosopher Hans-Georg Gadamer has done most to shape contemporary philosophical hermeneuticism, drawing on the influence of Martin Heidegger (as above). There is also an Italian school of hermeneutics (which stresses the *techniques* of interpretation rather than the intuitive and existential nature of Gadamer's hermeneutics) of which the most influential figure is Emilio Betti. In addition there is a strong French influence through the work of philosophers such as Jacques Derrida, Michel Foucault, Jacques Lacan, and Paul Ricoeur. Despite its rather formidable image, hermeneutics, like phenomenology and existentialism, also puts people first by placing human expressiveness at the centre of its concerns.

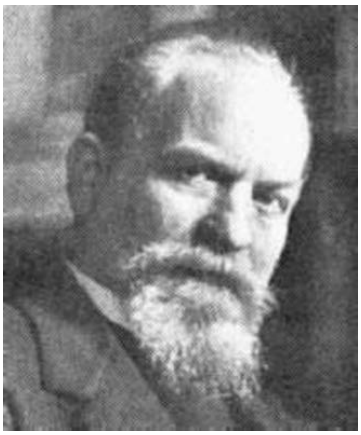

Fig. 4.4 Edmund Husserl

Phenomenology, existentialism, and hermeneutics

We will now look at these philosophies in a little more detail, and especially as they relate to the philosophy and ethics of mental health, starting with phenomenology.

Phenomenology

Although the term 'phenomenology' goes back at least to the eighteenth century German philosopher, Immanual Kant, in its twentieth century form phenomenology is generally attributed to Edmund Husserl with a series of books published in the first half of the twentieth century, in particular *Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy, First Book* (1931; published in English translation in 1982), *Cartesian Meditations* (1950; English translation in 1960), and, his greatest work, *Logical Investigations* (1900–1; English translation in 1970).

Husserl's ideas (to which we return in detail in Part II) became highly influential, and were later adopted by his pupil, Martin Heidegger, and by Jean-Paul Sartre and Maurice Merleau-Ponty. As with many philosophers working in the Continental tradition, each of these philosophers has also attracted the label 'existentialist'. This is one reason why the distinction between phenomenology and existentialism can sometimes be problematic. One way to think of the difference is this: existentialism is primarily a philosophical *attitude* (broadly, of being aware of and insisting on our powers of self-determination—see later), while phenomenology is best understood as a philosophical *method* for exploring the structure of consciousness. It is thus quite consistent to be *both* a phenomenologist *and* an existentialist.

The best known connection between phenomenology and psychiatry is of course through the work of the founder of modern descriptive psychopathology, the German philosopher–psychiatrist, Karl Jaspers. We return to Jaspers in detail later (in Part II). For an introductory reading in phenomenology in this chapter, however, we are going to look at a passage from Merleau-Ponty's major work, *The Phenomenology of Perception* ([1945], transl. 1962) (see Exercise 13). First, though, a brief introduction to Merleau-Ponty himself and to his philosophical project.

Merleau-Ponty (1908–61) had close ties with Sartre (they collaborated on, and edited, the journal *Les Temps Moderns*), and was in debt to a number of Heideggerian themes, although the roots of his thought were primarily in Husserl's brand of phenomenology combined with key concepts from Gestalt psychology. He anticipates recent work in the philosophy of psychiatry by drawing explicitly on disturbances of consciousness associated with neurological problems (such as aphasia) in developing his themes (see below).

Merleau-Ponty's phenomenological project was to develop a theory of perception. The key to this, he believed, was to undermine of any type of dualism, whether it be the Cartesian *res cogitans (mind)* and *res extentia (matter)*, or the Sartrian being-for-itself (mind) and being-in-itself (matter). In place of dualism, Merleau-Ponty sought to develop a description of our 'pre-reflective' or primordial perceptual *interaction* with the world, what he called our 'being-in-the-world'.

Merleau-Ponty: the phenomenology of perception

Merleau-Ponty sketches out his project in the 'Preface' and 'Introduction' to *The Phenomenology of Perception* (translated into English, 1962, original French edition 1945). He adopts a

Fig. 4.5 Merleau-Ponty

two-pronged strategy. First, he rejects 'associationist' empirical theories of perception, launching an attack upon the empiricist employment of distinct units of 'sensation', which, he argues, leave us with the problem of how the units are associated and unified (see Introduction, chapter 2). Second, he criticizes 'intellectualist' theories of perception, attacking both the privileging of the transcendental subject (namely, a subject set apart from and monitoring perception—i.e. a subject, somehow, separate from and standing over and above the world), and the conflation of judgement and perception (see Introduction, chapter 3).

Having rejected both empiricism and intellectualism, Merleau-Ponty then draws on elements from both to build up a picture of the lived-experience of the 'Phenomenal Field' (See Introduction, chapter 4). Critical to his argument is that our access to the phenomenal field is given by our *body*. This is the irreducible link to a particular world. The 'lived-body' is thus always already *in* the world prior to any reflection. It cannot be objectified (set *apart* from the world or the individual), and perception must be taken as *embodied* perception that exists only within a specific context or mode of activity.

One way to understand Merleau-Ponty's antidualism—his rejection of both empiricism and intellectualism—is to reflect on our everyday experiences of perception. Try this for yourself. Look at an object, any object near you—a lamp, say. When you reflect on this you might think of the pattern of colours and shapes that can seem to form the basis of an interpretation: that those colours and shapes comprise a lamp. But ordinarily we do not do this. We do not infer the lamp experience from anything more basic. Ordinarily, we do not separate an intellectual interpretation 'seeing a lamp' from any more basic experience of colours and shapes. We just *see a lamp*.

Merleau-Ponty argues, in effect, that it is the 'seeing a lamp', the pre-reflective experience, which is the basic unit of consciousness. There are no further perceptual 'atoms' from which the perception of the lamp is built up (as the associationists argued); there is no transcendental subject 'judging' that what we see is a lamp (as the intellectualists thought). There is just our lived-experience of meaningful engagement with the world.

Merleau-Ponty on aphasia

So far so good. But how does this help us to understand psychopathology? The following reading is taken from part 1 of *The Phenomenology of Perception*. It comes from chapter 6 ('The body as expression and speech'). Here Merleau-Ponty examines the issue of how speech represents an effort to project one's self towards a world of meaning. He tackles this by looking at the breakdown of speech in aphasia.

EXERCISE 13 (30 minutes)

Read the two short sections from Merleau-Ponty:

Merleau-Ponty, M. (1945/1962). The body as expression and speech. In *The Phenomenology of Perception* (transl. Colin Smith). London: Routledge, pp. 174–177, 184–185

Link with Reading 4.4

Make brief notes on:

1. the approach of 'traditional' theories towards the breakdown of expression, and how they relate to Merleau-Ponty's previous criticisms of empiricism and intellectualism;
2. the relationship between authentic speech, gesture, and the body;
3. the difference between the pre-reflective or existential layers of language and its conceptual layers; and finally
4. how the loss of figure-background horizons and self-transcendence are part of Merleau-Ponty's existential theory of aphasia.

Again, much of what motivates the reading with Exercise 13 is Merleau-Ponty's attack on dualism: he wants to bridge any distinction between language and thought, and to show instead that language is not part of a specific mental realm, rather that words themselves have significance or meaning. Merleau-Ponty rejects the empirical psychologists' approach to the loss of expression in aphasia on the grounds that language is treated as a type of 'verbal image' (p. 176), thereby reducing speech to an inert, third-person phenomenon, that fails to take the function of the word into account. Equally, the intellectualist approach merely attributes the problems of aphasia to a breakdown in thought and the

categorial (i.e. rationally ordered) operation of the intellect—language is seen to be an external counterpart to inner thought.

Merleau-Ponty proposes that the word is not some outer layer of thought, rather the recognition of an object is in fact the act of naming it, and thus speaking accomplishes thought. This immediacy of naming and perceptual recognition in language is a glimpse into the primordial-existential layer of language that lies before the categorial level of reflection and objectification. Our access to this primordial level is through the body, indeed the body of speech—the gesture (pp. 184–186). Meaning is gained immediately, through the gestural aspect of speech, and prior to any subsequent intellectual or reflective clarification. In Merleau-Ponty's account of aphasia, then, the *disruption* of expression occurs because of phenomena losing their meaningfulness for the patient.

This example illustrates the power of the modern phenomenological method to afford a richer conceptualization of the processes at work in pathological forms of experience. The link between meaning and psychopathology was important for Karl Jaspers. But as we will see in Part II, Jaspers also used the phenomenological method to develop a detailed classification of the phenomena of consciousness and then of its specific breakdowns in psychopathology.

Modern authors, too, have used phenomenology in both ways, general and specific. As an example of the former, Pat Bracken, a psychiatrist who has worked with the humanitarian organization, Amnesty International, in post-conflict situations, has explored the breakdown of meaning in PTSD (post-traumatic stress disorder); and, drawing on Heidegger's phenomenology, he has developed approaches to management that depend on re-establishing social relationships rather than individual 'counselling' (Bracken, 1998). As to specific uses of phenomenology, there are many current examples from the work of both philosophers and psychiatrists. This work has been given a new urgency by the demands of the new neurosciences, such as brain imaging and behavioural genetics. (See Reading Guide.)

Existentialism

As a philosophical *attitude* rather than a school of thought, existentialism has bred a number of highly individualistic philosophers. The first exponent is generally acknowledged to have been the nineteenth century Danish philosopher Søren Kierkegaard, but as already noted, in its twentieth century form existentialism has developed largely out of phenomenology. It has been adopted by, among others, the German philosophers Martin Heidegger and Karl Jaspers, and also by the French philosophers Gabriel Marcel and Jean-Paul Sartre.

The existential attitude involves the rejection of the primacy of objective knowledge, putting in its place the primacy of *being* (i.e. existence). An individual's experience of his or her situation is the starting point of inquiry. This is the ground of what Sartre called the 'authentic', any concessions to the expectations of others being 'inauthentic'. Existentialist thinkers differ in their view of what resources we have in facing up to the deceptions and depredations of the demands of society. They also differ over the status of the self and whether this is authentic or inauthentic.

Fig. 4.6 Sartre

Being and nothingness

One of the most influential existentialist thinkers was Jean-Paul Sartre. Like many existentialists, Sartre initially adopted a phenomenological philosophy, his existentialist ideas developing as a response to what he took to be the limitations of his initial position. Sartre's best-known work is *Being and Nothingness*, published originally in 1943. In this he introduces his famous distinction between 'being in-itself' (matter) and 'being for-itself' (mind). In the next exercise, we will be reading the introduction to this work, in which Sartre sets out the issues he will address.

EXERCISE 14 (30 minutes)

Read the opening paragraphs from:

Sartre, J-P. (1956). Introduction, The pursuit of being. I. The phenomenon. In *Being and Nothingness* (trans. Hazel E. Barnes). New York: The Citadel Press, pp. xlv–lxvi

Link with Reading 4.5

Do not write anything down, instead reflect upon the ideas in the text as you read it.

Note how carefully Sartre sets up his project, building both on his dissatisfaction with phenomenology, and also on what he sees as its strengths. Note how the idealism of Berkeley is disposed of, as providing insufficient grounds for the existence of consciousness. Finally, note how Sartre sets up the argument for Being-for-itself and Being-in-itself. How do you feel about this? Are you convinced?

Sartre's basic position is that Being is self-revealing and cannot be denied. Whatever one feels about this, there is no doubt that its influence in France in the middle years of the twentieth century was enormous. By the time of his death Sartre had become almost a cultural icon, his ideas inspiring a generation of intellectuals, influencing moral and political thought, and also the expressive arts (through his novels).

Sartre versus Freud

The existentialist concern with the nature of consciousness and its status as the primary ontological category brought it into conflict with the ideas of psychoanalytic theory. In a later chapter of *Being and Nothingness* Sartre offers a damning critique of Freud's ego theory, especially of the censor mechanism. He argues that Freud's mechanism of repression cannot function as it would involve an untenable division of the psyche, and, in any case, once the censor knows of the material to be repressed, the conscious mind must also know it. Sartre's reading of Freud has attracted much criticism, a recent example being by Sebastian Gardner (1993, chapters 2 and 3). We will be returning to Sartre's critique of Freud later in this book.

Hermeneutics

The term 'hermeneutics' originally referred to the techniques of Biblical exegesis. It was first used in its modern sense by the German philologist Freidrich Schleiermacher in the early nineteenth century. Hermeneutic theory and methodology was further developed by the German philosopher Thomas Dilthey in the late nineteenth century; and later still by the German philosopher Martin Heidegger (until just after the publication of *Being and Time* in 1927, after which he no longer described his project as hermeneutical). In more recent times hermeneutics has been dominated by the work of the German philosopher Hans-Georg Gadamer; by the Italian philosopher Emilio Betti; and by French philosophers such as Michel Foucault, Jaques Lacan, Jacques Derrida, and Paul Ricoeur.

In relation to mental health, hermeneutics is directly concerned with one side of the tension (to which we will be returning several times in this book) between causal and meaningful accounts of human experience and behaviour, and the closely related tension between explanation and understanding. It has also been highly influential in the philosophy of psychoanalysis. Put crudely, science in the twentieth century has focused largely on causes and explanations, hermeneutics on meanings and understanding (although of course it has not been alone in this).

An accessible and at the same time seminal example of the application of hermeneutics to psychoanalysis is provided by the French philosopher Paul Ricoeur. In his influential *Freud and Philosophy* (1970), Ricoeur offered an interpretation of Freud's texts which was both original and thought provoking. In the following exercise, we are going to read a passage from this book, in which Ricoeur sets out his view of the methodology of hermeneutics.

EXERCISE 15 (30 minutes)

Read the two extracts from:

Ricoeur, P. (1970). Hermeneutic method and reflective philosophy. In *Freud and Philosophy* (trans. Terry Savage). London: Yale University Press, pp. 37 and 41–42

Link with Reading 4.6

From the start, you will find this very different from the paper by J.L. Austin, which we studied earlier (see Exercise 8). But exactly how does it differ from Austin's work? The difference is not merely of style—there is something fundamentally different about the philosophical presuppositions and methodology of each philosopher. As you read, make short notes on the main characteristics of Ricoeur's philosophical method.

Finally, what is it about Ricoeur's hermeneutics that makes it eminently suitable as a tool for interpreting psychoanalytic texts? Do you think Freud would have recognized himself in this? Does it matter?

We will be returning to Ricoeur's text later in this book (in Chapter 11). The point now is that hermeneutics is concerned with uncovering the hidden meanings behind the explicit story. Freud conceived his project (rightly or wrongly) as part of science, producing generalizations based upon observation of specific instances; in contrast, hermeneutics is concerned with the individual meaning generated in a specific instance of discourse, and also with the methodology by which the meaning can be extracted. By concentrating on the way in which texts can be interpreted at two levels, as having a superficial and a deeper meaning, it is possible to chart the interplay of ideological influences and symbolic forms. As we will find when we return to Ricoeur's text in Part III, he interprets psychoanalysis as a kind of hermeneutics of the mind.

Continental and Anglo-American philosophy: a new partnership

We have looked at examples of how all three main branches of Continental philosophy have produced ideas that are important for mental health. Ricoeur's hermeneutics contains a thorough analysis of Freud's ideas; Merleau-Ponty's phenomenology offers a rich and detailed account of psychopathology (as noted earlier, we return to Karl Jaspers' phenomenology and the origins of descriptive psychopathology in Part II); and existentialism produced its own critique of Freud. It also had an important influence on the early movement in antipsychiatry through the work of such seminal figures as R.D. Laing. We will be returning to each of these later.

In philosophy and mental health, then, the two great traditions, the Continental and the Anglo-American, should be partners, rather than split apart. In the philosophical world generally, there

is indeed a growing awareness that Anglo-American and Continental philosophy have many concerns in common. For example, both traditions are increasingly focusing on the nature of the self, and even their methods should be seen as complementary (in that each illuminates aspects of an issue which is neglected by the other).

Thought experiments, the case method, and real people

The complementary nature of these two approaches is also well illustrated by work on the concept of mental illness. We noted the importance of Foucault's work, for example, to the debate about mental illness in Chapter 2. Methodologically, however, perhaps the most exciting development, particularly with mental health research and practice in mind, is the increasing focus on substantive human issues and experience. We have seen that this has been explicitly so with all the main schools of Continental philosophy, but it is now also emerging in some contemporary work in Anglo-American philosophy. Traditionally, Anglo-American philosophy has employed abstract general notions, avoiding the concrete and specific. This allowed it to operate with great rigour, but also gave it a reputation for 'armchair philosophy'.

By the 1970s, however, there was a growing realization among some philosophers that much was to be gained from the consideration of real cases. This found expression in a number of areas, but particularly in the philosophy of mind and in ethics, and coincided with the recognition among practitioners of the need to engage with the philosophical issues (ethical and conceptual) generated by difficult cases. In ethics, one result of this has been a shift from general theory to the consideration of actual cases and the development of a modern version of casuistry (we will return to this in Part IV).

In the philosophy of mind, a strong statement of the requirement for philosophy to return to empirical (as well as conceptual) methods, has been made by the Oxford philosopher, the late Kathleen Wilkes, in her book noted above, *Real People: Philosophy without Thought Experiments* (1988). It is from this book that the last reading in this session is taken.

EXERCISE 16 (15 minutes)

Read the two extracts from:

Wilkes, K. (1988). *Real people: personal identity without thought experiments*. Oxford: Oxford University Press

Link with Reading 4.7 (2 extracts: 'Losing touch with reality' and 'A promissory note')

Note what Wilkes says about Kripke's methodology (p. 43)—in what way does J.L. Austin's methodology (examined earlier in this chapter) try to avoid criticism of this kind? What is Wilkes's central message in these last two sections of chapter I of her book?

Wilkes is attacking philosophical methods that rely on thought experiments to the exclusion of the rich variety of material available in the real world of real people. Elsewhere in her book she examines multiple personality disorder in particular. The *general* claim that she and other philosophers (notably another Oxford philosopher, Jonathan Glover, 1988), are making is that psychopathology offers a wide variety of real experiences that are more challenging than anything philosophers can imagine by mere reflection, and yet which, at the same time, are rooted in the real world.

This is the central message in the final two sections of Wilkes's chapter 1. Philosophers are mistaken, she argues, if they believe that by imagining fantastic and impossible thought experiments, they can give greater clarity to the concepts that we use in the real world.

Wilkes agrees with Wittgenstein in saying that the analysis of concepts that have no application in our lives does not thereby give them meaning, and, therefore, they cannot possibly help us to a better understanding of the concepts we find problematic in the real world. We should, instead, look at real life instances where our ordinary concepts seem to be inadequate, and, as Wilkes makes clear later in her text, it is psychopathology that offers possibly the best opportunities of this kind.

This was, after all, precisely Austin's point. Austin was concerned with agency; Wilkes and Glover were concerned with personal identity. But all three are pointing to psychopathology as a resource for philosophy.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. How does Anglo-American philosophy differ from Continental philosophy (in so far as they are distinct)?
2. What are the three 'schools' of Continental philosophy? Give an exemplar from each whose work is relevant to psychiatry, psychoanalysis and/or psychopathology.
3. Continental and Anglo-American philosophy are beginning to converge—What is the link between them?
4. Are the methods of philosophy and empirical science essentially antagonistic, independent or complementary? (Think about this before reading the Conslusions, below.)

Conclusions: philosophy, science, and mental health

In this chapter, we have reviewed a variety of methods from both Continental and Anglo-American philosophy. We have also

noted that these two great traditions are increasingly working together in a complementary way and that this is especially important in relation to mental health.

We have covered a lot of ground in this chapter, but before finishing it will be worth spending a few minutes reviewing the relationship between philosophical methods generally, whether Anglo-American or Continental, and those of science.

Science versus philosophy versus dogmatic religion?

Much philosophy proceeds imaginatively, through the manipulation of thoughts, symbols, meanings, concepts, and so on, 'in the mind'. In this it is sometimes thought to stand in contrast to science, which is taken to proceed by observation of the world. Indeed, 'natural philosophy' (the late medieval term for natural science) could be said to owe its origins to the stand, sometimes taken in the face of great personal danger, by Bacon, Galileo, and others for the primacy of observation over the received authority of religion (Rossi, 2003).

But philosophy, too, had to liberate itself from theology. Indeed, in 'Western' Europe, it emerged as an independent subject only in the seventeenth century: compare, on the one hand, Hobbes's *Leviathan*, published in 1651, the second half of which is biblical exegesis aimed at legitimating the ideas in the first half of the book in order to appease religious sentiment, and, on the other, Locke's views on the role of philosophy in his *Essay Concerning Human Understanding*, published in 1690. Locke felt able, in his 'Epistle to the Reader' at the beginning of his book, to characterize philosophy as being aimed as removing impediments to knowledge (he meant religious superstition, among other things). Locke visualized philosophy as an 'underlabourer' to those who produce real knowledge (he meant, here, natural scientists). Science and philosophy *can* work productively together, and this is, in part, a function of the fact that they produce different, but complementary, sorts of output.

Science and philosophy versus authority

We will be looking in Chapter 6 at some of the ways in which the outputs of science and philosophy differ. As to their methods, though, they are closer than either side is generally prepared to recognize. Thus, the stand of both disciplines is characteristically anti-authoritarian; Socrates was the 'gadfly of Athens'. We will find in Part III that according to at least one influential view (Kuhn, 1962), science as well as philosophy is subject to fashions, to periods of relative stability during which given authorities shape the development of theory. However, both disciplines aim to advance knowledge and understanding primarily through the overthrow of received views rather than by their exegesis.

Parallel experimental methods

Both disciplines, moreover, are experimental, in the broad sense of following through the implications of an idea and seeing whether it remains tenable. Philosophical experimentation is more conceptual, scientific more empirical. But they are both experimental. Nor is the divide between the two kinds of experiment as sharp as is often supposed. Scientific breakthroughs are often made initially by thought experiments—Einstein's crucial insight, leading to the theory of relativity, was generated by thought experiments, such as imagining how to determine whether two widely separated events were simultaneous, or what it would be like to travel on a beam of light. And, of course, philosophy, like science, often proceeds through inspired guesswork or intuitions rather than cold reason alone.

Complementary disciplines

We argued in Chapter 2 that philosophy is more concerned with conceptual, while science is more concerned with empirical, problems. For our purposes, of clarifying the role of philosophy in mental health, this is perhaps a helpful generalization. But neither discipline can proceed indefinitely in isolation from the other.

Reading guide

Concepts of disorder: (3) Austin and other analytic methods

Austin and the concept of mental disorder

G.J. Warnock's biography, *J.L. Austin* (1989), provides a lively and readable overview of Austin's philosophy. The introductory chapter, in particular, offers a well-balanced appraisal of the strengths and weaknesses of linguistic analysis as a philosophical method. The collection, *Symposium on J.L. Austin*, edited by K.T. Fann (1969), includes articles exploring these issues in detail. Austin's papers have been brought together in a collection edited by J.O. Urmson and Geoffrey Warnock (1961, 1989).

The potential importance of linguistic analysis as a bridge between philosophy and mental health is set out in an article by Fulford (1990) 'Philosophy and medicine: the Oxford connection' and in Fulford (2003). For empirical research combining linguistic analytic and empirical methods, see Colombo *et al.* (2003) 'Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multidisciplinary teams', Fulford (2001), and Fulford and Colombo (2004a and 2004b). Linguistic analytic methods are also the basis of new policy and practice developments in mental health (Fulford, Stanghellini and Broome, 2004) including training programmes in working with complex values developed for mental health practitioners, see Woodbridge and Fulford, 2004. Austin's approach influenced Hare, Warnock, Urmson, and others in the 'Oxford School', whose work has directly influenced these practical developments (see also Reading Guide to Chapter 6). As noted in the chapter, a thorough

discussion of the importance of philosophers working on real cases, and on the real cases represented by the different forms of mental disorder, is Kathleen Wilkes' (1988) *Real People: philosophy without thought experiments.*

Illness, disease, and disorder

In addition to Christopher Boorse's work, as examined in the chapter, the distinction between disease and illness is discussed further by Barondess, J.A. (1979) 'Disease and illness—a crucial distinction'; and in chapter 2 of Fulford (1989). There are a number of philosophical refutations of the value-free status of disease assumed by the traditional medical model. An early argument to this effect was set out by the English sociologist, Peter Sedgwick (1973), in his 'Illness-mental and otherwise'. A number of American philosophers have made important contributions to this literature, in particular George Agich (1983) 'Disease and illness: a rejection of the value-neutrality thesis'; Loretta Kopelman (1994) 'Normal grief: good or bad? Health or disease?; and Tristram Engelhardt (1975) 'The concepts of health and disease'. A useful discussion of key aspects of this debate is to be found in Sadler and Agich's (1995) critique of Wakefield's analysis in their *Diseases, Functions, Values and Psychiatric Classification*, with a response by Wakefield (1995).

Murphy and Woolfolk (2000a) explore Wakefield's analysis in *The Harmful Dysfunction Analysis of Mental Disorder*, with a commentary by Wakefield (2000), and a response to Wakefield by Murphy and Woolfolk (2000b). Boorse's (1976a) follow-up paper on mental illness, 'What a theory of mental health should be', is in *Journal of Theory and Social Behaviour*. Boorse (1976b) in 'Wright on functions' and 'Health as a theoretical concept' (1977), gives more detailed treatments of the concept of 'function'. Boorse (1997) has developed a detailed update of his work in his 'A rebuttal on health'.

Combining philosophical and empirical methods

An early contribution to the field illustrating the value of analytic philosophy in supporting empirical work is Marshall (1994) 'How should we measure need? Concept and practice in the development of a standardized assessment schedule', with commentaries by Crisp (1994) and Morgan (1994). Marshall's article explores the resources from Oxford analytic philosophy on which he drew in developing a new psychometric measure for assessing need.

Van Staden (2002a and 2002b) draws on Frege's logic of relations in an empirial study of recovery (with commentaries by Falzer and Davidson, 2002, Gillett, 2002, and Suppes, 2002). Similarly, philosophical and empirical techniques are combined in Fulford and Colombo's (2004a) 'Six models of mental disorder', with commentaries by Bendelow (2004, from a social science perspective), Heginbotham (2004, from a policy perspective), Williams (2004, from a training perspective), and Williamson (2004, from a voluntary sector perspective), and a response by the authors (Fulford and Colombo, 2004b). (All based on Colombo *et al.*, 2003).

Continental philosophy

A highly accessible introduction in English to some of the main schools of recent Continental philosophy is Eric Matthews' *Twentieth Century French Philosophy* (1996).

Merleau-Ponty's phenomenology

Merleau-Ponty's (1945) *Phenomenology of Perception* (trans. Colin Smith, 1962, original French edition 1945) has been in print in English for many years, and is probably his best known work. Less well-known is *The Structure of Behaviour* (1963/5; original French edition 1942). Also of interest is *Signs* (trans. Richard C. McCleary, 1964, original French edition 1960), *The Visible and the Invisible* (ed. Claude Lefort, trans. Alphonso Lingis, 1968, original French edition 1964), and a collection of Merleau-Ponty's papers, *The Primacy of Perception*, edited by James M. Edie (1964) (trans. various).

Of the secondary literature, two useful texts are M. Hammond *et al.* (1991) *Understanding Phenomenology* (chapters 4–9), and M. Langer (1989) *Merleau-Ponty's Phenomenology of Perception: a guide and commentary*. Eric Matthews' (2002) *The Philosophy of Merleau-Ponty* provides an authoritative and accessible introduction.

For a contemporary firsthand analysis of the experience of illness drawing on Merleau-Ponty's phenomenology, see Kay Toombs (1993) *The Meaning of Illness*. As a sufferer from multiple sclerosis, and also an expert in phenomenological philosophy, Toombs offers a uniquely insightful account of the core feature of illness, incapacity.

Additional readings on Merleau-Ponty and concepts of mental disorder are given in the Reading guide to chapter 8 on 'Phenomenology and psychopathology today'.

Existentialism

The existentialist literature is freely available in English translation. Sartre's *Being and Nothingness* has appeared in two versions. One lacks the passages critical of Freud (which were originally published in English translation as a separate volume). The most widely available translation of *Being and Nothingness* is that by Hazel Barnes (see Sartre, 1956) with an introduction by Mary Warnock. This is available with and without the 'Freud' passages. A paper by Sartre (1967) entitled 'Consciousness of self and knowledge of self' appeared in *Readings in Phenomenological Psychology* (ed. N. Lawrence and D. O'Connor). For an example of a detailed application of Sartre's phenomenology to psychopathology, see Morris (2003).

Peter Caws' (1979) *Sartre* gives a clear overview. Mary Warnock's (1970) 'Existentialism' is a readable and comprehensive introduction. A classic title is John MacQuarrie's (1973) *Existentialism*.

Hermeneutics

A well-chosen selection of readings from the hermeneutic literature from the early nineteenth century to the present is provided by Gayle Ormiston and Alan Schrift (ed.) (1990) *The Hermeneutic Tradition*, and (1989) *Transforming the Hermeneutic Context*.

In *Philosophy, Psychiatry, & Psychology*, Phillips (1996) gives an excellent and clear introduction in his Key Concepts article on 'Hermeneutics'. Widdershoven (1999a) explores the relationship between hermeneutics and psychological methods of treatment in his 'Cognitive psychology and hermeneutics', with commentaries by McMillan (1999), Phillips (1999), and Warner (1999), and a response (Widdershoven, 1999b). An early article in *Philosophy, Psychiatry, & Psychology* exploring the relationship between hermeneutic and scientific explanations is Drury (1994) 'Cognitive science and hermeneutic explanation: symbiotic or incompatible frameworks'.

A highly readable introduction to a debate that took place between Michel Foucault and Jacques Derrida on the nature of reason and madness is Roy Boyne's (1990) *Foucault and Derrida: the other side of reason*.

The French psychoanalyst-philosopher Jacques Lacan wrote a number of highly influential works, his best known being Ecrits (1966), available in English as *Ecrits. A Selection* (trans. Alan Sheridan); and *The Four Fundamental Concepts of Psychoanalysis* (The Seminar, Book XI), (ed. Jacques-Alain Miller, trans. Alan Sheridan, 1997/1991). Carlo Strenger's (1991) *Between Hermeneutics and Science*, offers a thought-provoking account of the interplay between the scientific and hermeneutic conceptions of psychoanalysis.

Continental and analytic philosophy: bridging the divide in the philosophy of psychiatry

The complementary roles of analytic and Continental philosophy are particularly evident in descriptive psychopathology. Stimulated by developments in neuroscience, recent work in this area draws equally on phenomenological as well as analytical philosophy; see, for example, several articles in the 1996 *Current Opinion in Psychiatry*, History and Philosophy Section, Vol. 9, September 1996.

The journal, *Philosophy, Psychiatry, & Psychology*, publishes work from both Continental and Anglo-American perspectives. See, for example, Read (2003a) in 'Literature as Philosophy of Psychopathology', with responses by Coetzee (2003) and Sass (2003), and a response by Read (2003b). Similarly, recent edited volumes on philosophy and mental health include chapters by authors from both traditions. In addition to Fulford, Morris, Sadler, and Stanghellini's (2003) *Nature and Narrative*, and Radden's (2004), *The Philosophy of Psychiatry: A Companion*, see for example, Sadler, Wiggins and Schwartz's (1994) *Philosophical Perspectives on Psychiatric Diagnostic Classification* and Graham's and Stephens' (1994) *An Introduction to Philosophical Psychopathology*.

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