Key learning points

Part I Core concepts in philosophy and mental health

Chapter 2 Philosophical problems in mental health practice and research

Session 1 What is philosophy? What is psychiatry?

- Psychiatry is a medical discipline concerned primarily with disorders of the higher mental functions—mood, emotion, volition, belief, etc.—and associated disorders of behaviour.

- A clinical diagnostic formulation in psychiatry covers: differential diagnosis (based primarily on symptoms); aetiology; treatment; and prognosis.

- In so far as it is distinct from science, philosophy is concerned with conceptual problems, science is concerned with empirical problems.

- Among the more specific meanings of 'philosophy', those of particular relevance clinically include: the *Weltanschauung*, specific topic areas (jurisprudence, political philosophy, phenomenology, ethics, etc.), and conceptual analysis.

- The concepts of 'mental disorder', 'mental illness', etc., are at the interface between clinical problems, such as those presented by Mr AB in the session, and the deep problems of general philosophy.

Session 2 Fact, value, and the concept of mental disorder

- Mental disorders can be grouped together in the form of a conceptual 'map' representing what Gilbert Ryle called the 'logical geography' of the subject.

- Any proposed analysis of the meanings of our concepts of disorder must account for (either explaining or explaining away) the features of the 'map' as a whole.

- Among the main groups of mental disorders, we put organic conditions nearest to medical disorders (on the right of the map), non-organic (or functional) psychoses in the middle, and other groups around them.

- The four conceptually significant features of the map we identified were: wide diversity; variable conceptual distance from bodily disorder; variable illness status; variable degree of value-ladenness.

- There has been much debate both about the varieties of values and the overall logical relationship (or relationship of meaning) between fact and value. Putnam has argued that there is a distinction (an often useful distinction) between fact and value but that there is no fact/value dichotomy.

- Moving from right-field to left-field across the map, the three overall shifts towards value-ladenness are: from medicine to morals, from excusing conditions to conditions for which we are held responsible, from (apparently) value-free to (overtly) value-laden diagnostic criteria.

Session 3 Antipsychiatry and the debate about mental illness

- Szasz focused his arguments on the heart of what psychiatry is about, the very *concept* of mental illness: he argued that bodily illness is defined by factual norms (of anatomy and physiology) while mental illness (so called) is defined by ethical, legal, and social norms.

- His arguments, although now very wide ranging, have all been motivated by a concern that the medicalization of mental distress and disorder dehumanizes people.

- The three key structural features of Szasz's core argument can be summarized under problem, method, and conclusion, thus: (1) *problem*—Szasz assumed that mental illness is 'the problem' while bodily illness (by and large) is unproblematic, conceptually speaking; hence (2) his *method* was to argue by comparing and contrasting mental illness with bodily illness, and then, as he finds mental illness to be different from bodily illness (in particular, in being more value-laden), (3) he *concluded* that mental illness is a myth.

- Among the strengths of Szasz' arguments, he has (1) prompted widespread reflection and debate about the conceptual foundations of psychiatry, in particular its more value-laden nature compared with bodily illness, and (2) contributed to the development of a stronger 'user voice' in service development.

- Among the weaknesses of Szasz' arguments are: (1) his characterization of bodily illness as being defined by value-free anatomical and physiological norms is (at the least) widely contested; and (2) his rejection of *any* role for medicine in relation to mental health issues would, if taken literally, cut off an important resource (among many others) for those with mental health problems.

- There are many alternatives to the medical model (we noted psychological, labelling, social, hidden meanings, unconscious mental processes and 'political').

- These different models are all important in reflecting particular parts of the conceptual map of mental disorder but (taken separately) they fail to account for the features of the map as a whole.

- Although some have claimed 'antipsychiatry' to be 'dead', many of its themes in the 1960s and 1970s have now been integrated into policy and practice in different areas of mental health.

Session 4 The medical model (and beyond)

- Kendell developed his arguments about the meaning of mental illness as a direct rejoinder to Szasz's early work on the 'myth of mental illness'.

- He took the core of his ideas from the work of Scadding (a chest physician) and others in bodily medicine.

- Kendell differed from Szasz in concluding that mental illness is essentially similar to bodily illness because (adopting Scadding's arguments from bodily medicine) (many) mental illnesses are,

like bodily illnesses, associated with 'biological disadvantage' as measured by the evolutionary norms of reduced fertility and increased mortality.

◆ Kendell adopted an essentially similar form of argument to Szasz: he assumed that mental illness is *the* problem and bodily illness (relatively speaking) unproblematic; and, hence, argued by comparing (candidate) mental illnesses with (the assumed paradigm of) bodily illness.

◆ The critical difference between Szasz and Kendell is not over the meaning of mental illness but over that of *bodily* illness. Szasz defined bodily illness by reference to norms of anatomy and physiology; Kendell defined bodily illness by reference to evolutionary norms (as above). Hence, the debate turns out (in a sense we will be exploring further in Chapter 4) to be, after all, a debate not about mental illness but about bodily illness!

Chapter 3 **Experiences good and bad: an introduction to psychopathology, classification and diagnosis for philosophers**

Session 1 **Diagnosis in medicine and psychiatry**

◆ The four key purposes of diagnosis in medicine are: descriptive (of symptoms, signs etc.), aetiological (assigning causes), therapeutic (indicating what treatments and other interventions may be helpful), and prognostic (likely course and outcome).

◆ Diagnostic categories in psychiatry are defined primarily in terms of symptoms and signs rather than in terms of causal disease processes (hence they are like, e.g. 'migraine' rather than, e.g. 'pneumococcal pneumonia').

◆ A positive interpretation of the differences between diagnostic categories in psychiatry and in bodily medicine is that the sciences underpinning psychiatry are more *difficult* (empirically as well as conceptually).

◆ A negative interpretation is that the sciences underpinning psychiatry have been slower to develop and that psychiatry thus remains relatively *deficient*, scientifically speaking, compared with areas of bodily medicine such as cardiology and gastroenterology.

Session 2 **Descriptive psychopathology**

◆ The main groups of psychological symptoms widely recognized in psychiatry are: disorders of mood (anxiety and affect, i.e. happy/sad), thought (stream of thought, connections between thoughts, possession of thoughts, and content, i.e. delusions and related phenomena), perception (hallucinations and related phenomena in all five sense modalities), and cognitive functions (orientation, attention, memory and general IQ).

◆ There is a growing and increasingly rich body of user-narrative literature on experiences of mental distress and disorder. This is the most important of the wide range of resources available from both philosophy and mental health practice for interdisciplinary work on different areas of psychopathology.

◆ The term insight is used in connection with psychopathology in a number of different senses.

◆ Traditionally, loss of insight has marked psychotic from non-psychotic disorders: a psychotic disorder is characterized by symptoms (paradigmatically delusion) in which the person concerned understands 'what is wrong' not as something *psychologically wrong with* themselves but as something (generally negative but in hypomania often partly positive) that they *have done* or that is *being done or is happening to them*.

◆ A recurring worry that one has done 'something wrong' could be (among other symptoms) a delusion (a psychotic symptom) or an obsession (a non-psychotic symptom). The person with the delusion really believes that they have done something wrong (this would be a delusion of guilt), whereas the person with the obsession experiences their worry as irrational and hence as something for which they might seek medical help.

◆ Psychiatry is concerned with a wide range of bodily signs and symptoms. Diagnosis in all areas of medicine should always be 'holistic', i.e. focusing, as appropriate, equally on bodily, psychological, and social contributions to disorder.

Session 3 **Categories of mental disorder**

◆ The main categories of adult mental disorder are: organic (e.g. dementia, etc.); alcohol- and drug-related disorders; psychotic disorders other than affective and organic; affective disorders (depression, hypomania, etc.); anxiety and related disorders (the latter including obsessive-compulsive, associative and somatoform); and disorders of vegetative functions (e.g. anorexia nervosa, disorders of sexual function and of sleep).

◆ Just as personality is relatively stable long term, so a personality *disorder* is a long-term maladaptive pattern of experience and/or behaviour.

◆ A stress-induced disorder differs from the main categories of adult mental disorder much as, in bodily medicine, 'wounds' or 'trauma' differ from illnesses: i.e. a stress-induced disorder is one in which the person's symptoms are clearly a response to major stressful experiences.

◆ Disorders of childhood and adolescence include: learning difficulties and specific developmental delays; pervasive disorders; emotional disorders of childhood; behavioural disorders (e.g. conduct disorder); and disorders of physiological functions (e.g. enuresis).

◆ The main stages in developing a diagnosis in psychiatry are: (1) clarification of symptoms; (2) exclusion of drug/alcohol-related disorders, personality and stress-induced disorders; and (3) differential diagnosis mainly according to symptoms (including those symptoms that point to the possibility of underlying major bodily pathology).

◆ Psychiatric assessment should always include the possibility that a person's experiences and behaviour, even if distressing, may be neither pathological nor, even, wholly negative.

Chapter 4 **Philosophical methods in mental health practice and research**

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

- Dictionary definitions of everyday objects such as 'chairs' are broadly consistent but differ in many details.

- Two particular difficulties with defining everyday objects such as 'chairs' arise from the necessity of trading, (1) specificity *versus* range of use, and (2) breadth *versus* depth of understanding. Two further difficulties arise from, (3) the hierarchy of embedded terms, and (4) the increasingly abstract terms that arise as one moves up the hierarchy.

- Difficulties of these kinds are generic to all definitions including those of mental health terms.

- Among many different ways of 'first defining your terms' we noted seven major categories of definition: ostentive, conventional, persuasive, declarative, contextual, essential and semantic.

- All these categories of definition are important in different ways in health care: for example, all but formal semantic definitions, are to be found in major psychiatric classifications of mental disorder.

- 'First define your terms' should be understood as 'be alert to difficulties of meaning' rather than as a 'clearing up' of all problems of meaning before starting on the 'serious' business of empirical research.

- Definitions are meaningful only to the extent that we already understand the meanings of the terms (further up the hierarchy) in which they are cast. But definitions are none the less useful within given contexts and for particular purposes.

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

- The facility with which we *use* a term does not run parallel with the extent to which we are able to give a clear explicit *definition* of it. For example, we can use the concept of 'time' without being able to define it; conversely, we can define 'depressive affect' but it remains difficult to use (depression is in practice difficult to distinguish from anxiety).

- The fact that the use of the concept of 'illness' in psychological medicine is more problematic than in bodily medicine, far from being a sign that psychological medicine is relatively primitive scientifically, is a sign that it is more complex conceptually (there are corresponding conceptual difficulties about 'time' in theoretical physics but not in mechanical engineering).

- Austin called focusing on the use of concepts as a guide to their meanings, 'philosophical fieldwork'.

- Focusing on the use of concepts allows us to develop a more complete picture of the 'logical geography' (see Chapter 2); but

it is not a panacea—it is, as Austin emphasized, only one particular way of getting started with some kinds of philosophical problem!

- Much of the literature on concepts of disorder has focused on the relatively unproblematic (in use) 'bodily disorder'. However, we are more likely to gain insight into the meaning of 'illness' through the more problematic (in use) 'mental illness' (recall Austin's comment that it is when there are difficulties in the use of a concept that we break through the 'blinding veil of ease and obviousness').

- Ordinary usage in 'Austin's philosophical fieldwork' means any non-reflective use of a term (in both lay and professional/technical contexts) as distinct from reflective attempts to provide explicit definitions (whether by philosophers or others).

Session 3 **Illness and disease: definition and ordinary usage**

- The terms 'illness' and 'disease' are often used as synonyms in everyday usage. However, they are also used to mark the distinction between people's individual *experiences* of illness and professionals' generalized *knowledge* of disease.

- In Boorse's theory, 'disease' (defined by reduced fertility and/or increased mortality) is a value-free concept covering the scientific theory at the core of medicine, while 'illness' is a value-laden concept covering people's experiences of illness when a disease process becomes serious enough to cause incapacity.

- In developing the distinction between illness and disease, Boorse is able to contain in a single model both value-laden individual experiences and (supposedly) value-free medical-scientific theory. He thus bridges between the polarities of the traditional psychiatry versus antipsychiatry debate in regard to the concept of mental illness.

- Boorse *defines* 'disease' stipulatively in value-free terms; however, he none the less *uses* the concept with evaluative connotations (the value-free term 'deviation' becomes the 'value-laden deficiency'; the value-free 'environmental causes' becomes the value-laden 'hostile environment').

- If use is a better guide to meaning than definition (as Austin's 'philosophical fieldwork' approach suggests), Boorse's value-laden use of 'disease', despite his value-free definition of the term, suggests that the meaning of 'disease' (the linguistic *work* that the term does for us in both professional and lay contexts) depends (in part but essentially) on an evaluative element in the meaning of the term.

Session 4 **Anglo-American and Continental philosophy**

- In so far as they are distinct, Anglo-American philosophy is analytic (including formal logic—see chapter 5) while Continental philosophy is more text-based.

◆ The three major 'schools' of Continental philosophy are:

1. *phenomenology*, concerned with the structure of subjective experience (as illustrated in the work of Merleau-Ponty on disorders of speech, perception, etc.—and phenomenology, through Karl Jaspers, is also the basis of descriptive psychopathology);

2. *existentialism*, concerned with putting 'existence' (including our powers of self-initiation of action) ahead of 'essence' (hence it sustains an empowering ethic of choice, as illustrated in the critique of Freud by Jean-Paul Sartre); and

3. *hermeneutics*, a set of techniques for analysing the meaning of discourse, as illustrated by Paul Ricoeur's hermeneutic reconstruction of psychoanalysis.

◆ An important factor in the convergence of Continental and Anglo-American philosophy towards the end of the twentieth century has been the recognition among analytic philosophers of the importance of focusing, as Continental philosophy has always done, on real people. This is why *both* traditions are so crucial to the new interdisciplinary field of philosophy and mental health.

◆ Philosophical-analytic and empirical-scientific methods are essentially complementary.

Chapter 5 **Arguments good and bad: an introduction to philosophical logic for practitioners**

Session 1 **An introduction to deductive reasoning and formal logic**

◆ The aim of deductive argument is to preserve truth. True premisses should never lead to a false conclusion.

◆ A valid argument is one where if the premisses are true then the conclusion must also be true. A sound argument is a valid argument with, in addition, true premisses. The conclusion of a sound argument must be true.

◆ One way to assess a deductive argument is to see whether it shares the same structure or form as a known valid argument.

◆ Syllogism is one family of forms of deductive argument whose codification dates back to the Greeks; however, more recently propositional and predicate logics have been formulated.

◆ Propositional logic is the logic of simple logical connectives such as 'and', 'or', 'not'. These can be represented using truth tables, which can be used as a mechanical test for the validity of an argument in propositional logic.

Session 2 **An introduction to the philosophy of logic: What underpins deductive logic?**

◆ The strength of deductive argument is that the conclusions do not 'add anything' to the premisses. The corollary is that such argument is, strictly, uninformative: it does not tell us anything not contained in the premisses.

◆ But that does not undermine its usefulness in testing knowledge claims. The purpose of logical argument is to avoid reaching false conclusions from true premisses.

◆ Although forms of valid argument are well known, there remains some philosophical dispute about how exactly logical inference is underpinned.

◆ An influential approach connects logical inference to the meanings of terms used as codified in truth tables; however, using truth tables to justify inferences is typically circular.

Session 3 **Implication and entailment**

◆ Formal logic has a clear structure that enables clear-cut assessment of whether arguments are valid or not. One cost of this, however, is that there are some seemingly paradoxical aspects of logical inferences associated with implication and the connective 'if . . . then'.

◆ A central paradox of formal logic is the 'paradox of material implication': for any statement A, if A is false then, if A then B is true for any statement B. In other words, *any* statement can be derived from a *false* statement.

◆ How to resolve this paradox remains an area of active discussion. Attempts to tighten the relationship between the meaning of statements in an implication (A and B, in the above) through strict implication and 'relevance logic' still face similar difficulties.

Chapter 6 **Philosophical outputs in mental health practice and research**

Session 1 **'I wonder if this headache is mine?'**

◆ In conceptually difficult areas (such as mental health) testing what we take to be self-evident is an important part of improving practice (although not in the face of an immediate practical emergency!)

◆ As a young man, Bertrand Russell represented the overoptimistic approach to the practical returns from philosophy (broadly along the lines of providing necessary foundations).

◆ Kurt Göedel showed that even mathematics cannot be put on totally secure foundations in logic (his 'undecidability' theorems).

◆ Ludwig Wittgenstein is among philosophers who have been too pessimistic about the practical value of philosophy, his work suggesting that philosophical problems are an artefact of philosophy itself.

◆ A balance between overoptimistic and overpessimistic views of the practical pay-off from philosophy, is that it gives us a *more complete understanding* of the meanings of the complex higher-level concepts in terms of which we organize and make sense of the world around us and of other people (noting that 'more complete' does *not* mean 'complete'!).

Session 2 Adding value to fact

- People have shared values over some things but often very different values over others: the degree of agreement falls on a spectrum.

- R.M. Hare suggested that a value *term* (e.g. 'good' in 'this is a good strawberry') expresses a value *judgement* (e.g. I commend this strawberry) the criteria for which are *descriptions* of the object of the evaluation (e.g. the descriptive criterion 'this strawberry is sweet').

- Hare showed that value terms may come to look like purely descriptive terms where the descriptive criteria for the value judgements they express are very widely shared. A non-medical example is 'good apple'; a medical example is 'disease'.

- *Ill*ness, *dis*ease, *dys*function, and other terms of *dis*order, as evaluative expressions, appear purely descriptive (hence purely 'scientific') to the extent that they are used of aspects of experience (e.g. bodily pain) over which people's values are very largely shared.

- Correspondingly, mental illness, and related concepts of mental disorder, are more value-laden than their bodily counterparts, not because they are less 'scientific' but because they cover aspects of human experience and behaviour (emotion, desire, volition, etc.) over which human values are highly diverse.

- This conceptual insight adds values to facts: it puts people's values on an equal footing with the scientifically derived facts emphasized by the traditional medical model of disorder.

Session 3 Adding illness to disease

- Adding values to facts in our understanding of the conceptual structure of medicine is important but not sufficient because the medical concepts express a *particular kind* of negative value judgement (illness is different from, e.g. foolishness).

- Moral descriptivism, the theory that in some circumstances, evaluations may be reduced to descriptions, would provide for a value-free way of defining the medical concepts while still allowing them to express evaluative meaning.

- In a non-descriptivist account of the relationship between illness and disease, disease processes *cause* experiences of illness, but (negatively evaluated) experiences of illness *define* which underlying causal processes are (negatively evaluated and hence) diseases.

- Asymptomatic diseases, according to this non-descriptivist account, are defined secondarily, i.e. as changes in bodily structure or functioning that tend to *cause* experiences of illness. (Recall that as A.J. Ayer said, causal connections in general are 'connections of tendency'.)

- A non-descriptivist account of the relationship between descriptive and evaluative meaning adds patients' experiences of illness to the professionals' knowledge of disease as emphasized in the traditional medical-scientific model.

Session 4 Adding action to function

- Among the features that mark out an experience as being one of illness are: (1) negative evaluation; (2) intensity and duration; (3) that it is not a 'done or happens to' type of experience; and (4) that, at the same time, it is not a 'done by' type of experience, i.e. something that the person concerned experiences as something that they are doing.

- The experience of illness (as incapacity) can be understood as a failure of what Austin called 'ordinary doing', i.e. a failure of the things that we are normally able to do without thinking about them.

- An analysis of the experience of illness as a failure of a particular kind of agency might be thought (1) to be little different from the medical model analysis of disease in terms of failure of function, and (2) to be appropriate only for illnesses involving disturbance of movement.

- An analysis of the experience of illness in terms of a particular kind of disturbance of agency is related to the analysis of disease in terms of disturbance of functioning in the same way that the actions of whole agents are related to the functioning of the parts and systems of which they are made up.

- An analysis of the experience of illness in terms of a particular kind of loss of agency can be generalized from illness experiences involving movement (and lack of movement) to other kinds of illness experience (including the rich variety of psychopathologies) by drawing on the fact that different illness experiences involve different parts (sensations, perceptions, memory, appetites, etc.) of what Austin called the 'machinery of action'.

- An analysis of the experience of illness as a particular kind of disturbance of agency completes a 'full-field' model of the conceptual structure of medicine by adding to the scientific resources of the traditional medical model, concerned with failures of functioning of bodily parts and systems, the resources of philosophical analysis concerned with failures of action as reflecting the agency of whole organism.

Part II A philosophical history of psychopathology

Chapter 7 A brief history of mental disorder

Session 1 Introduction and overview

- Mental disorders have been recognized across most cultures and historical periods back at least to classical times (with Plato).

- Interpretations of mental disorder over this period have swung to and fro between medical-scientific and moral-spiritual models.

Session 2 **The main historical periods**

◆ Examples of moral conceptions of madness in classical Greek and Roman thought include, respectively, Plato ('harmony of the soul') and the Stoics. Corresponding medical conceptions include, respectively, Hippocrates and Galen ('harmony of the humours').

◆ In the early Mediaeval period, moral conceptions of madness were dominant in the Christian West and medical conceptions in Islamic cultures.

◆ The Renaissance and Reformation were the period of the 'witch trials' in Europe.

◆ The Enlightenment saw a reassertion of medical conceptions of madness and the early asylums.

◆ This was followed by rapid expansion of the asylum movement over the mid-eighteenth to mid-nineteenth centuries, coinciding with the Industrial Revolution.

◆ Karl Jaspers' work in the philosophy of psychiatry was a response to psychiatry's first biological phase (at the turn of the twentieth century).

◆ Current developments in the philosophy of psychiatry are (in part) a response to psychiatry's second biological phase (at the turn of the twenty-first century).

Chapter 8 **Karl Jaspers and General Psychopathology**

Session 1 **The clinical context of Jaspers' thought**

◆ Experiences and behaviours associated with mental distress and disorder come in a wide variety of different kinds.

◆ Jaspers sought to categorize and order these experiences drawing on four key distinctions, namely between: (1) meaningful and causal connection; (2) understanding and explanation; (3) objective and subjective phenomena; and (4) form and content.

Session 2 **Karl Jaspers the man**

◆ Karl Jaspers (1883–1969) worked for much of his life in the University of Heidelberg.

◆ As a young man at the time of psychiatry's first biological phase, Jaspers wrote a textbook, *Allgemeine Psychopathologie* (or *General Psychopathology*). First published in 1913, this was to have a formative influence on modern descriptive psychopathology.

◆ Jaspers was a philosopher as well as psychiatrist and for much of his life, he was better known as a philosopher.

Session 3 **Causal and meaningful connections**

◆ A particular influence on Jaspers' work was the 'Methodenstreit', a debate about method in the social sciences that ran through much of the nineteenth century.

◆ Responding to the challenges of the new 'biological psychiatry', Jaspers wrote two key papers, (1) on causal and meaningful connections (arguing that both are needed in psychopathology), and (2) on phenomenology (arguing that this is a method of enquiry uniquely adapted to exploring subjectivity and, hence, psychopathology). The themes of these two papers run through *Allgemeine Psychopathologie*.

Session 4 **Phenomenology**

◆ The second of Jaspers' two key papers written in response to the challenge of biological psychiatry, his paper on phenomenology, introduces the distinctions between (1) objective and subjective symptoms, and (2) form and content.

◆ The distinction between form and content in modern descriptive psychopathology is derived from Jaspers' work.

◆ This distinction is subject to a number of different philosophical interpretations—particularly in Kant and in Husserl—and the philosophical influences on Jaspers himself have correspondingly been much debated.

Chapter 9 **Phenomenology and psychopathology**

Session 1 **Jaspers' phenomenological approach to psychopathology**

◆ Objective symptoms are those that are either manifest physically or grasped (understood) through rational thought without the need for empathy; subjective symptoms are accessed only through the exercise of empathy.

◆ Empathy is spontaneous understanding of 'what it's like' from the other's point of view (as opposed to understanding through rational reflection).

◆ Phenomenology is part of subjective psychology; it is concerned with both 'static' (i.e. cross-sectional) and 'genetic' (i.e. longitudinal) understanding of mental symptoms.

◆ The aim of phenomenology for Jaspers is to make as vivid as possible the diversity of mental life (this was in reaction to the tendency of objective science to reduce phenomena to the smallest number of kinds).

◆ Phenomenology (as Jaspers uses the term) is limited to the description and understanding of mental states (as opposed to explanations of the kind provided, for example, by neurophysiology).

Session 2 **The background to Husserl's phenomenology**

◆ Husserl's early work was in the philosophy of arithmetic and the 'problem of psychologism'.

◆ Psychologism is the view that logical and/or mathematical truths ultimately have a psychological basis.

◆ Husserl argued that logic is normative while psychology is not and hence that psychologism is mistaken.

◆ There none the less remains debate about the extent to which Husserl's work is psychologistic in character.

Session 3 **Husserl's conception of phenomenology**

◆ Husserl's phenomenology seeks to define the essential features of experience (in contrast to psychology, which studies particular instances of experience). Husserl thus conceives of phenomenology as an a priori discipline such as logic or arithmetic.

◆ Husserl argued that phenomenology precedes abstract thinking by analysing the 'essential types' of mental acts from which the wide variety of *particular* acts are derived. Again, he had in mind a parallel with the way in which the abstractions of geometry related to particular objects in the world.

◆ Husserl called his method, his way of using phenomenology 'ideational abstraction': this involves reflecting on one's mental states (e.g. *reflecting* on 'seeing a chair' as opposed to simply *seeing* a chair).

◆ For Husserl, the 'knowing subject' is the object of phenomenology.

◆ In Husserl's later work he introduced the idea of 'bracketing'. This is nowadays often used to mean setting aside our pre-suppositions in an attempt to get to the pure essences of things.

◆ Husserlian 'bracketing' is a more subtle concept that involves treating our pre-suppositions as an object of phenomenological study in their own right.

◆ Phenomenology (following Brentano) identifies 'intentionality' as the key and characteristic feature of mental states. Mental states are intentional in the sense that they are always *about* or *of* something.

Session 4 **Assessment of Husserl's influence on Jaspers**

◆ Debate continues about the extent of Husserl's influence on Jaspers.

◆ There are a number of important differences as well as similarities between their phenomenologies.

◆ An important difference of particular relevance to psychopathology is that Jaspers' phenomenological method is partly empirical, whereas Husserl regarded phenomenology as entirely a priori.

Session 5 **Conclusions: the contemporary reference of the phenomenological tradition in psychiatry**

◆ Besides Jaspers, the German philosopher, Martin Heidegger, had an important influence on psychotherapy through the work particularly of Ludwig Binswanger and Medard Boss.

◆ A key concept in Heidegger's phenomenology is 'dasein', literally 'being there'.

◆ Heidegger employed the concept of 'dasein' in an attempt to bridge the Cartesian separation of subject from the world, by focusing attention on our normally seamless engagement with everyday things through embedded practices.

◆ A rich diversity of other phenomenological traditions developed through the twentieth century particularly in Continental Europe, Japan, and South America.

Chapter 10 **Psychopathology and the 'Methodenstreit'**

Session 1 **Understanding, explanation, and the 'Methodenstreit'**

◆ At the heart of Jaspers' psychopathology is a distinction between understanding the meaning of an experience and explaining it in causal terms.

◆ While our uses of 'explain' and 'understand' overlap in everyday language, there are also differences between causal explanations (invoking laws as in the natural sciences) and making sense of social phenomena (by intuitive understanding as in disciplines such as history).

◆ Both sides of this distinction continue to raise many conceptual difficulties. What counts as 'understandable', in particular, has increasingly been recognized to be more complex than Jaspers had realized and continues to resist simple analysis.

◆ Philosophers such as Mill have argued that there is no fundamental difference between understanding and explanation.

Session 2 **Understanding and explanation in Jaspers' psychopathology**

◆ Jaspers takes from Wilhelm Dilthey (1833–1911) the idea that empathy is important to understanding.

◆ However, Jaspers was also influenced by Heinrich Rickert (1863–1936) and by the sociologist Max Weber (1864–1920), neither of whom believed that empathy is important to understanding.

◆ Weber believed that understanding involved evaluation rather than empathy.

◆ These and other conflicting influences in Jaspers' thinking are reflected in inconsistencies in his treatments of empathy and understanding.

◆ Jaspers also employs Weber's concept of an ideal type: a normative model incorporating current values and beliefs as opposed to the causal models of natural science.

◆ The evaluative model of ideal types derived from Weber feeds into Jaspers' account of 'meaningful' as distinct from causal explanation.

◆ A further unresolved tension in Jaspers' work is between the view that meanings are in *principle* irreducible to causes or only irreducible in *practice* (i.e. because of the limitations of the neuroscience of the day).

◆ The unresolved tensions in Jaspers' work continue to be reflected in modern philosophy: in the philosophy of science, for example, on the role of values in the natural sciences (see Part III); and in the philosophy of mind on the relationship between meanings and causes (see Part V).

Session 3 Conclusions: Jaspers, the *Methodenstreit*, and psychiatry today

◆ A first tension in Jaspers' thought is broadly that between a Dilthean (empathy-based) approach to understanding and a Rickert–Weber (evaluation-based) approach.

◆ A second tension is between different (empathy-based and evaluation-based) types of understanding.

◆ A third tension is around whether the difficulty of reducing meanings to causes is a difficulty of principle or only a contingent difficulty, a difficulty of practice.

◆ A fourth tension is between Jaspers' 'values out' account of understanding and what in the terminology of Part I, we may now call the 'values in' account of Weber and Rickert.

Part III Philosophy of science and mental health

Chapter 11 Psychoanalysis: an introduction to the philosophy of science

Session 1 Science: What is it and what's the problem?

◆ The conceptual difficulties about the scientific status of psychoanalysis (and psychiatry) suggest, following Austin (in Part I), (1) that these are relatively difficult (not deficient) sciences, and (2) that exploring these difficulties in psychoanalysis (and psychiatry) may shed light on the nature of science as a whole.

◆ 'Science' is a higher-level concept (in the terms of Part I). Hence when people try to 'define' it, they come up with different definitions reflecting different parts of its 'logical geography' (Ryle's term, Part I).

◆ The four stages of the traditional model of science are,

  ● *Stage 1*: Data collection

  ● *Stage 2*: Theory building, by

   ■ *Substage (A)* defining patterns, and/or

   ■ *Substage (B)* identifying underlying causes.

  ● *Stage 3*: Theory testing (involves further data applied either at Substage A or Substage B),

  ● *Stage 4*: Advancement of knowledge
  (negatively if the theory fails, positively if it succeeds).

Session 2 Psychiatry as science

◆ A traditional model of 'science' is strongly reflected in psychiatry's core textbooks in the second half of the twentieth century, in such words and phrases as 'observation', 'fact', 'hypothesis', 'explanatory', and 'prediction'.

◆ In these same textbooks, science (concerned with generalizable knowledge) in medicine and psychiatry is often contrasted with 'art' and the humanities generally (concerned with individuals).

◆ Science was seen as, (1) a barrier against bias and prejudice, and (2) the basis for focusing on medical rather than other kinds of mental problems.

◆ Contrary to expectations, while neuroscience has indeed made dramatic advances since these textbooks were written, the humanities, far from becoming less important in psychiatry, have flourished.

◆ This suggests a future for psychiatric science in which, as in other complex sciences, empirical and conceptual methods will go increasingly hand-in-hand.

◆ Negative reactions to the greater conceptual complexity of psychiatry have included, denial (ignoring it), proscription (placing it outside psychiatry's professional remit), and displacement (pushing it on to a related discipline, such as psychoanalysis).

Session 3 Scientific psychiatry and the case of psychoanalysis

◆ Psychoanalysis is unscientific, so its critics have claimed, at each of the four stages of the traditional model: its data are subjective (Stage 1); its theoretical terms have different meanings for different 'schools' (Stage 2); it is not experimental (Stage 3); and it shows few signs of a progressive consensus (Stage 4).

◆ Although rejecting his early neurological model (in the unpublished 'Project'), Freud remained committed to a traditional model of psychoanalytic science.

◆ Dora was an 18-year-old woman brought to Freud by her father (between 1896 and 1900) because she was troubled by obsessive thoughts about a friend of the family, Herr K.

◆ Freud's initial 'data collection' in his account of Dora differs from Stage 1 of the traditional model in being, (1) theory dependent, and (2) goal directed.

◆ In psychopathology, the pattern recognition required by Stage 2A of the traditional model, is complicated, among other ways, (1) by difficulties of separating the parts (of a mental state) from the whole, and (2) by value-norms (defining pathology, e.g. by epistemic values).

◆ The explanatory theories of Stage 2B of the traditional model are (in general) in the natural sciences, causal theories; but in the human sciences (including psychiatry) the explanations we give of why people do things are also in terms of reasons.

Session 4 Theory testing and the progress of knowledge

◆ The equivalent of 'testing' a theory, broadly construed, in Freud's report of his work with Dora, is the interpretation: the therapist interprets the patient's experiences and behaviours in terms of a hypothetical (partially repressed, hence hidden)

mental 'cause' and gauges the success or otherwise of the theory according to how the patient reacts.

◆ The dominant account of how science tests its theories at the time of Dora was verificationism, essentially that scientific theories are confirmed (verified) by evidence. Sir Karl Popper argued that a theory could never be confirmed because there could always be disconfirming evidence waiting to be discovered.

◆ Thomas Kuhn was an American historian of science who showed that sciences do not progress continuously but through a series of paradigm shifts between which there may be relatively long periods of 'normal science' governed by the paradigm of the day.

◆ A paradigm (as it has come to be interpreted) has four components: (1) a set of symbolic generalizations (e.g. the definition of the Watt); (2) a set of metaphysical beliefs (e.g. the atomic structure of matter); (3) a set of values (e.g. epistemic values); and (4) a set of exemplars for problem-solving (e.g. the 'double helix' discovery).

◆ Kuhn's work (and subsequent work by Rom Harré and others), shows the extent to which, contrary to Popper's falsificationist criterion, scientists are in practice resistant to disconfirming evidence during periods of 'normal science' governed by a given paradigm.

◆ This, (1) brings psychoanalysis closer to sciences such as physics than Popper believed, and (2) illustrates the general point that the difficulties of developing a science of the mind point to difficulties in science as a whole, but (3) this neither proves nor disproves that psychoanalysis is a genuinely scientific theory of the mind.

Session 5 Psychoanalysis without science

◆ A sustained hermeneutic reconstruction of psychoanalysis was developed by the French philosopher, Paul Ricoeur.

◆ Ricoeur's hermeneutic account of psychoanalysis is part of a wider hermeneutic reconstruction of science (as in the work of Jurgen Habermas).

◆ Hermeneutic reconstructions of science emphasize the interpretative nature of science within a local discourse as distinct from the universal explanations of the traditional model.

◆ The American philosopher Adolf Grunbaum has argued (contra both Popper and Ricoeur) that psychoanalysis is a science but a *failed* science.

◆ 'Folk psychology' is our everyday understanding of people's psychology (our own and others): it includes attributing reasons for actions.

◆ Sebastian Gardner (building particularly on the work of James Hopkins and Richard Wollheim) has drawn on analytic work in the philosophy of mind to argue that psychoanalysis is properly understood as an extension of folk psychology.

Chapter 12 Psychopathology and the theory dependence of data

Session 1 The theory dependence of everyday observations and psychopathology

◆ Even a straightforward observational exercise reveals that observations have to be selected from a potential infinity according to one's needs and purposes. The practical context of an observation sets standards of, for example, the right level of precision. Thus even in a case as simple as this, observation is not merely a matter of 'drinking in' the data.

◆ The PSE is a thorough going attempt to place observation at the heart of clinical practice and to codify its role so as to maximize reliability. It can thus be seen as a sophisticated version of the traditional model of science from Chapter 11.

◆ One prima facie difference between observation in psychiatry and in other sciences is the active engagement of both parties to the observation: it is not a passive process.

Session 2 An Empiricist model of scientific theory

◆ Logical Empiricism was a sophisticated attempt closely associated with members of the Vienna Circle to articulate a broadly traditional model of science developed from the 1920s, which made space for, as a form of empiricism, a central role for observation.

◆ Observations might be used to confirm or according to 'Falsification' to refute scientific theory.

◆ Logical Empiricism attempted to underpin the objectivity of science both by stressing the role of public observation statements and by arguing that the language of observation should be separable from and prior to the language of theory. This is a two language model of theory and observation. A semantic distinction between the languages is used to defend the epistemological claim of the independence of observation.

◆ The aim of separating observation and theory has also played an influential role in psychopathology. However, while the Logical Empiricists aimed to separate observation and all theory, in psychopathology the aim is usually the more modest separation of observation and aetiological theory.

Session 3 Arguments for the theory dependence of observation statements

◆ There are a number of related claims that are made under the label of the theory dependence of observation.

◆ Duhem powerfully suggests that scientific observation statements are typically theory-laden. However, he does not preclude falling back to neutral observations in the case of disagreement.

◆ Paul Churchland shows that consideration of how we would translate alien languages emphasizes the role of theories held by speakers rather than their inner sensations in the case of

perceptual reports. Nevertheless, there remains at least the possibility that such theories might concern observational properties of the world.

◆ Hesse, however, provides a powerful challenge to any such split. She suggests, partly on the basis of historical example, that while a distinction can be drawn at any particular time between theoretical and observational properties, the distinction drawn depends on the theories held. Thus it cannot serve as a neutral arbiter in the case of theoretical disagreement.

◆ This suggests that, to the extent to which there can be observations underpinning scientific claims, they are not unconceptualized raw data. So whatever the division between observation and aetiological theory in psychopathology, psychiatric observations cannot be a matter of raw data.

Session 4 Arguments for the theory dependence of the content of the process or experience of observations

◆ It is well known that expectations can change what people report they see or hear; however, this does not necessarily imply a fundamental connection between concepts and experiences.

◆ The duck–rabbit figure, introduced by Gestalt psychologists and discussed by Wittgenstein, suggests a more fundamental connection between what we can experience and our concepts. 'Seeing as' is conceptually structured. Possession of the concepts of 'duck' and 'rabbit' affect the experience of observers of the duck–rabbit figure.

◆ The dawning of an aspect, however, involves an immediate phenomenological effect, which appears to be a contingent feature of human experience over an above the idea that experience is conceptually structured. But attention to this phenomenon enables a better understanding of Hanson's and Churchland's disagreement about Kepler and Tycho observing the sunrise.

◆ There is a more general Kantian idea that suggests experience is never a matter of receiving brute raw data but is always, instead, conceptually structured. The argument, in a nutshell is that that is the only way experience can have a rational effect on our beliefs. This provides a way of connecting experience and observation statements: both are conceptually structured.

Session 5 The consequences for observation in psychiatry and physics

◆ Recent theoretical work in physics (as in the EPR paradox) suggests that the nature and role of observation is itself a contentious scientific issue.

◆ The analogy with work on observation in physics suggests that there is a middle ground between denying that observation is a complex matter and denying it any role at all. Efforts such as the PSE's to underpin the reliability of observation against a theoretical background are part of this work.

Chapter 13 Natural classifications, realism, and psychiatric science

Session 1 Hempel and two new agendas for psychiatric classifications

◆ The 'big issue' in the Research Agenda for DSM-V, as reflected in the Editor's introduction, is *validity*, i.e. the development of an 'aetiologically based, scientifically sound' classification.

◆ *Conceptual issues*, although prominent in the Research Agenda for DSM-V, are not named as such, it being assumed that a valid classification can be developed on the basis of empirical research alone.

◆ The feature of the Logical Empiricist account of what it is to be scientific by which modern psychiatric classifications have been most deeply influenced, is the separation of observational statements (i.e. descriptions of symptoms being the basis of modern classifications) from statements of theory (i.e. aetiological theories being the basis of earlier classifications).

◆ The influence of Logical Empiricism on modern psychiatric classifications was mediated by the American philosopher, Carl Hempel, the British psychiatrist, Aubrey Lewis, and the WHO official, Norman Sartorius.

◆ The first classification to reflect the influence of Logical Empiricism, by switching from a theoretical (aetiological) to a descriptive (symptom) basis, was the ICD-8.

◆ Subsequent classifications have added, (1) operationalized inclusion and exclusion criteria and a dimensional (axial) structure (especially DSM-III), and (2) an explicit evidence-based process for changing criteria and categories (especially DSM-IV).

◆ The 'big issue' on the agenda of psychiatric classification in the run-up to ICD-9 (and right through to DSM-IV) was *reliability* (inter-rater and test–retest agreement).

◆ Three limitations of operationalism in psychiatry (pointed out by Hempel) are:

1. '*mere observation*'—that clinical observation rather than an operational procedure is the basis of clinical assessment;

2. '*partial criteria of application*'—that different operational definitions are needed across different ranges of severity and for use in different contexts;

3. '*antecedently understood terms*'—that for an operational (or any other) definition to be meaningful, the terms in which it is cast must already be understood.

Limitation 1 applies particularly to psychiatry; Limitations 2 and 3 are generic.

◆ The major respect in which psychiatric classifications have developed differently from Hempel's expectations as a Logical Empiricist philosopher, is that they have become more *descriptive* (symptom-based) rather than more theoretical (aetiology-based).

Other respects include: (1) the greater emphasis on reliability; (2) the greater reliance on operationalism; and (3) the persistence of qualitative (rather than quantitative) criteria.

Session 2 **Values, natural classifications, and the Absolute Conception**

- Hempel (writing in 1959) argued that value terms were evident in psychiatric classifications of the day; that this risked reducing their scientific status (particularly though not only through reduced reliability); and hence that value terms would become less prominent in future psychiatric classifications as psychiatric science advanced.

- Szasz argued (like Hempel) that the prominence of values in psychiatric diagnostic concepts showed them to be 'unscientific'; but (unlike Hempel) he took values to show psychiatry to be unscientific primarily because (he believed) they undermined the *validity* (hence the 'reality') of its diagnostic concepts rather than (as Hempel argued) their reliability.

- Crispin Wright has argued that humour is not objective because it lacks 'cognitive command'.

- Bernard Williams' Absolute Conception is the conception of the world as it really is 'anyway', i.e. as distinct from how we may see it. It is a conception that we reach through progress in science.

- Williams employed the distinction between primary and secondary qualities to define 'progress' in science. He argued that progress in science consists in progressively stripping away the secondary qualities that we are aware of from this or that particular perspective (or 'local' conceptions, as determined by our sense organs, psychology, etc), in favour of the primary qualities that are there 'anyway' independent of any such local conception of what the world is like.

- J.L. Mackie, and others, have taken Williams' Absolute Conception to show that values (like secondary qualities) have no place in science.

- John McDowell's three arguments (noted here) against Williams' Absolute Conception are:

  1. that secondary qualities may, contrary to the assumption guiding the Absolute Conception, be *both* subjective (in McDowell's sense of being conceptually connected with our experiences) *and* part of the fabric of the world;

  2. that there is a tension within the idea of the Absolute Conception itself, namely, that we cannot even know what it is that the Absolute Conception is designed to explain without adopting the local perspective (essential to knowing what a secondary quality is) that is precluded by the Absolute Conception; and

  3. that invoking the progress of science to resolve a dilemma generated by the Absolute Conception merely leaves us with a new dilemma in essentially the same form, generated by the progress of science itself.

- The implication of John McDowell's arguments is that Williams' Absolute Conception fails to provide, as Mackie and others have suggested, a 'knock-down' argument against values having a proper place in science. (Others, e.g. Dancy, have provided free-standing arguments to the same conclusion.)

Session 3 **Scientific realism in physics**

- Van Fraassen developed an account of science that aimed to replace Logical Empiricism with what has come to be called 'constructive empiricism': this combines three elements:

  1. *semantic realism*—the theoretical statements of science really do (literally) make claims about the world;

  2. *ontological realism*—the theoretical statements of science are true or false to the extent that they correspond with how the world really is;

  3. *epistemological antirealism*—we can never have sufficient evidence to know, finally, which of science's theoretical statements actually are true or false.

- Constructive empiricism suggests that scientific theories should be judged by criteria of 'empirical adequacy', i.e. we should accept theoretical statements to the extent that, in Duhem's phrase, they 'save the phenomena'.

- Boyd and McMullen are among those who have sought to retain a traditional realist stance based on the idea that science shows us what is really there by way 'inferences to the best explanation'.

- Cartwright is a realist about causal entities.

- Hacking is a realist about what we can manipulate.

- Fine attacks the traditional realist/antirealist opposition arguing that we should adopt the attitude of practising scientists and accept local criteria for theory choice as they are developed within each discipline (his Natural Ontological Attitude or NOA).

- Recent debates about realism in science have been focused particularly on physics. They, (1) show that there are no simple unambiguous criteria of validity even in physics, and (2) suggest a number of fruitful aspects of validity for further exploration (e.g. Hacking's 'manipulability') in psychiatric science.

- Fine's work suggests that whatever we can learn from other sciences, local considerations will always be relevant to developing criteria of validity in psychiatric (as in any other) science.

Session 4 **The Third New Agenda—an Agenda modelled on the philosophy of physics**

- The Agenda (developed here) for an *Extended Family of Classifications* carried over from the Agenda for ICD-9 the 'big issue' of *reliability* as a small but important step towards the 'big issue' on the Agenda for DSM-V, *validity*.

- Conceptual issues are recognized to be important in psychiatric classification in the Agenda for ICD-9 *and* named as such. Conceptual issues are even more evident in the Agenda for DSM-V but are *not* (generally) named as such.

◆ The big issue on our Agenda for an Extended Family of Classifications is *good process* aimed at basing our classifications more securely, not on received authority, but on observation.

◆ Making explicit the importance of conceptual as well as empirical issues, and focusing on 'good process' based on the principles of observational science, in the development of an Extended Family of Classifications leads to:

(1) rejection of a deficit model of psychiatric science in favour of a strengths model;

(2) an opening up of psychiatric science to conceptual alongside empirical research methods; and

(3) a more equal relationship between patients and other users of services, as 'experts by experience', and professionals as 'experts by training', as the basis of a genuinely *scientific* classification.

Chapter 14 **Diagnosis, explanation, and tacit knowledge**

Session 1 **The Deductive-Nomological model of explanation**

◆ One way to understand what diagnosis adds to a description of a patient's signs and symptoms is to think of it as an explanation of them and hence an inference from them.

◆ At least some forms of diagnosis are also explicitly causal. Others might be 'merely' a matter of pattern recognition when there is no clear aetiological theory developed.

◆ Hempel provides a logical model of explanation that likens it to a sound logical argument for what it explains. His model suggests the possibility of a formal model of diagnosis.

◆ Hempel's model is formal in that it gives clear necessary and sufficient conditions for an explanation, including the idea that general laws play an essential role. Hence the label 'covering law' model of explanation.

◆ These conditions make explanation and prediction symmetric.

◆ However, Hempel's model faces a number of counter-examples, many of which turn on the implicit idea that explanation is causal. This really seems to be an aspect of our everyday understanding of explanation brought out in the counter-instances to Hempel's model that causes cannot be explained in terms of their effects.

Session 2 **A causal model of explanation**

◆ Building on the counter-examples to Hempel's models outlined in the previous session, Lewis suggests that explanation of why events happen is always a matter of providing causal information.

◆ However, given that different aspects of the causal history can be given depending on the context of interest, there is no one explanation. Good explanation is a matter of judgement in selecting relevant causal information.

◆ Despite the differences, Lewis suggests that something like Hempel's models might be one way of providing that information.

◆ Van Fraassen goes further in suggesting that explanation always presupposes a particular context. For that reason he concludes that science itself which is not context independent does not contain explanations.

◆ If context does play an essential role in explanation, this suggests that it will not be possible to draw up a formal, context-free, model. Explanation will depend on good judgement.

Session 3 **Clinical skills and tacit knowledge**

◆ Collins' empirical work suggests that there is an element of tacit knowledge at the heart of a central aspect of scientific process: replication. Further, he describes this in the context of hard physical or engineering science.

◆ Collins suggests that one reason that tacit knowledge is present is that replication involves doing things that are relevantly similar although not the very same (because that would be impossible); however, it is impossible to specify all the relevant factors.

◆ Kuhn outlines the role of tacit knowledge in an intellectual, rather than practical, context. Puzzling solving in scientific education involves tacitly learning how to extrapolate from examples.

◆ Collins and Kuhn's arguments are mainly empirical and thus mainly suggest that tacit knowledge is, as a matter of fact, important in science. Wittgenstein, whom Collins invokes, provides a principled reason for there to be an ineliminable aspect of tacit knowledge, or judgement, in applying concepts or following rules. Explicit knowledge rests essentially on implicit practical skills. Thus all science, including scientific psychiatry, rests on tacit knowledge or judgement.

Session 4 **Tacit knowledge, diagnosis, and a possible link to phenomenology?**

◆ Kraus argues that psychiatric diagnosis is more a matter of a 'top-down' recognition of a patient's whole state than a 'bottom-up' recognition of individual symptoms. If true, this suggests that the expertise involved cannot be codified as involving more basic elements.

◆ Phenomenology has in general emphasized the importance of holism. This complements the approach taken in this chapter that emphasizes the role of implicit knowledge or judgement in general.

Chapter 15 **Causes, laws, and reasons in psychiatric aetiology**

Session 1 **An introduction to philosophical accounts of causation**

◆ As Chapter 14 began to outline, causation plays an important part in diagnostic reasoning and manipulating cause–effect

relations is central to treatment and management but the concept of causation is itself surprisingly complex.

◆ The modern philosophy of causation begins with Hume's sceptical and unsuccessful search for the source of our idea of a necessary connection between events: a kind of causal glue. This reflects Hume's general philosophical method that ideas can be traced back to corresponding impressions. However, in this case, there does not seem to be any such impression either by looking to 'outer' events such as billiard ball collisions or 'inner' events.

◆ Failing to find an impression, Hume gives different definitions of causation—although he implies they are the same—based either on the idea of regularity or constant conjunction or on a 'counterfactual conditional': had the cause not occurred then neither would the effect, all other things being equal. The definitions are:

1. an object, followed by another, and where all the objects similar to the first are followed by objects similar to the second. (p. 76)

2. or in other words where, if the first object had not been, the second never had existed. (p. 76)

3. an object followed by another, and whose appearance always conveys the thought to that other. (p. 77)

◆ More recently Mackie has offered a definition of causation based on the logical ideas of necessity and sufficiency: causation is an INUS condition. However, although it uses the word 'necessary' it is also consistent with Hume's failure to find the source of that idea in the context of causation and based instead on Hume's regularity approach to causation.

◆ Humean regularity theories owe an account, however, of which regularities correspond to laws of nature and can underpin causal connections, and which are mere accidents. One proposed solution depends on balancing the simplicity and universality of scientific theories. Another connects it to the justification of induction.

Session 2 **A probabilistict view of causation?**

◆ Hume's two definitions of causation provide the clue for two different modern approaches: regularity theories based on laws (described in Session 1), and Lewis' account based on counterfactual conditionals. A counter-factual conditional is a conditional whose antecedent runs counter to the facts.

◆ For Lewis' account to be a real alternative to a regularity theory, he needs to able to analyse counter-factual conditionals in a way that does not presuppose laws of nature.

◆ However, it is not clear that his analysis in terms of possible worlds really is more basic than the terms he is trying to explain.

◆ The connection between causation and raising the probability of effects suggests a different approach. It fits with the use of statistical tests for causal relations in medicine.

◆ However, Cartwright argues that it is not possible to *define* causation this way because cause only raises the chances of its

effects if there are no other causal factors present. Specifying that condition makes use of, and thus does not define, causation.

◆ Even if it is possible to define causation in a way that does not presuppose regularities or, more precisely, natural laws, there is still a plausible argument for a connection between them. The kind of events that stand in need of causal explanation can only be specified against a background of law.

Session 3 **The realm of law and the space of reasons**

◆ McDowell suggests that a consequence of the success of the rise of the natural sciences in modern times has been the assumption that nature is fully captured using their characteristic tools including explanation by subsumption under natural laws. This leaves phenomena which are normally interpreted as belonging to the 'space of reasons' looking less real. This in turn has led to a variety of approaches to reconcile them, including the attempted reduction of the 'space of reasons' to the 'realm of law'.

◆ McDowell himself advocates accepting a distinction between the 'realm of law' and 'space of reasons' but expanding our conception of what is part of nature to include the latter.

◆ Winch outlines a number of Wittgenstein-inspired differences between the natural and human science, which turn on the role of rules in making sense of social science phenomena.

◆ Bolton and Hill argue that the gulf between reasons and laws can be bridged with the assumption that meanings or reasons are encoded in the brain; however, this leaves the challenge of explaining how.

◆ Brown and Harris suggest a more practical rapprochement: devising a causal model of depression that includes meaningful elements.

◆ It remains an open question whether there can be a more principled reconciliation of these central and apparently distinct aspects of psychiatry.

Chapter 16 **Knowledge, research, and evidence-based medicine**

Session 1 **Evidence-based medicine, Hume, and the problem of induction**

◆ The basic aim of evidence-based medicine is to articulate the best ways of learning from past experience to guide future practice. It is thus part of a long-standing debate that evidence from the past can be brought to bear on the future. The modern philosophical discussion begins with Hume's problem of induction.

◆ Hume's Fork is the distinction between 'matters of fact' and 'relations of ideas'. The former, unlike the latter, requires experience. The latter, unlike the former, are necessary truths.

◆ Hume questions the status of some matters of fact: not matters of direct experience or perception but rather reasoning about, e.g. future events from past events.

◆ The problem of induction arises from the fact that there seems to be no non-circular justification of its use as a form of inference. A deductive justification of induction seems impossible. However, an inductive justification of induction seems to be circular.

Session 2 Philosophy of science responses to the problem of induction

◆ The philosophy of science has responded to Hume's problem of induction by attempting to articulate a model of scientific rationality for theory appraisal. The problem is not itself undermined but practical methods for side-stepping it are outlined.

◆ Falsificationism is an influential approach. It side-steps the problem of induction by suggesting that science should aim at the refutation of false theories, using deduction, rather than the confirmation of true theories, using induction.

◆ However, even falsification is more complex than it might at first seem. Theories can only be refuted in conjunction with other assumptions and observation statements themselves are fallible. Thus a realistic falsificationist methodology cannot offer clear-cut prescriptions.

◆ Kuhn argues that science proceeds through periods of occasional revolution interspersed by cumulative phases of problem solving. While there is no rational measure of progress across revolutions, there are agreed standards between such disruptions.

◆ Sociological study of science suggests that there is no context-independent account of scientific rationality and argues that it has to be studied in its historical setting. This need not be taken to undermine scientific rationality so much as to suggest that there is no simple model of it.

Session 3 Epistemological responses to the problem of induction

◆ Epistemological responses to the problem of induction have generally attempted to diagnose why there is not really a problem.

◆ One proposal is to deny an intuitive idea that to know something requires that one also knows that one knows it. By denying that, Hume's scepticism is, in part at least, defused. Thus Mellor argues that knowledge by induction is possible providing that there are causal connections from past to future, whether or not we also know that additional general fact.

◆ McDowell agrees with Mellor's 'externalist' approach to knowledge but stresses the idea that knowledge still requires reasons. However, he suggests that having good reason need not involve

being able, single-handedly, to offer an argument from first principles for every piece of knowledge. Knowledge can rub off on other people.

◆ Wittgenstein suggests that our knowledge is founded on a motley of inherited claims and background certainties.

Session 4 Evidence-based medicine and clinical trials

◆ The chapter has shown that the context of evidence plays an important part in assessing theory.

◆ The evidence-based medicine hierarchy of different forms of evidence can be given some support by looking at Mill's Method of Difference. These provide an a priori model of rationality. But Mill's Methods cannot be applied in practice without approximations that undermine their a priori status.

◆ The evidence-based medicine hierarchy itself contains an implicit empirical claim. It is thus subject to the same kind of evidence-based scientific assessment as any other claim. And this suggests the need for boots-strapping and hence judgement in assessing its status.

Part IV Values, ethics, and mental health

Chapter 17 Tools of the trade: an introduction to psychiatric ethics

Session 1 Ethical and conceptual issues in psychiatry: aims and objectives

◆ Just as in Chapter 2 conceptual issues were found to be not always self-evident, so, here, in Chapter 17, a first point to note is that ethical issues are not always self-evident.

◆ Also as in Chapter 2, philosophy (as distinct from other disciplines basic to ethics, such as the social sciences and religion) can help to give us a more complete picture particularly of the conceptual difficulties underpinning ethical problems in mental health.

◆ Four intermediate objectives for training in mental health ethics are: raising awareness, changing attitudes, increasing knowledge, and improving thinking skills. Of these, increasing the knowledge base of ethical reasoning is particularly important for strengthening the user voice because it puts the facts about what users of services really value at the centre of decision-making.

◆ Hare distinguished Level 1, spontaneous 'reflex' ethical reasoning appropriate for day-to-day practice, from Level 2, the more measured reflective reasoning that we are able to undertake in training and research by way of preparation for practice. Conceptual analysis is part of Level 2 reasoning.

Session 2 **Conceptual difficulties and mental health ethics**

- Bioethics, like biomedicine, has tended to neglect mental health issues, and in part for the same reason, namely that both have neglected the *conceptual* issues that are at the heart of the particular difficulty of mental health.

- Most authors define two conditions for consent: information and voluntariness (with freedom from coercion sometimes split out as a third condition). Both conditions are made more complicated in mental health by the effects of many different kinds of psychopathology.

- Delusion, historically and cross-culturally, has been the mark of the particular kind of irrationality that has been taken to undermine a person's responsibility for his or her actions: it is thus, equally, an *invalidating* condition for consent and an *excusing* condition in law.

- In addition to issues of consent, confidentiality, as an ethical problem, is complicated conceptually in mental health by the fact that the 'locus' of disorder may be distributed (e.g. within a family) rather than confined within a particular individual.

- In practice, the value of confidentiality (in mental health and in other areas) has to be balanced against the value of sharing information as the basis of multidisciplinary and multiagency teamwork.

Session 3 **Conceptual difficulties and mental health law**

- The philosophical fieldwork with which we started this session was our own response to a series of case vignettes involving (possible) involuntary treatment.

- The overall result was that (consistently with everyday practice) it was people particularly with psychotic symptoms who were most likely to be picked out as warranting involuntary treatment.

- This result is consistent across many different groups, including user groups; it is also a stable pattern historically and cross-culturally.

- The result is not sufficiently explained by mental health law, which, as standardly drawn, requires only two conditions for compulsion, (1) mental disorder, and (2) risk. These two conditions are thus considerably over-*inclusive* (allowing for too many people to be subject to compulsion).

- Strengthening the standard mental health law criteria, of mental disorder and risk, by adding a bioethical criterion of 'immediately life threatening' as a measure of seriousness, fails to explain the result, because, this time, it would be too *exclusive*, i.e. it would exclude those who (in the vignettes as in practice) would be subject to compulsion.

- The Butler criteria were, essentially, the presence of psychotic symptoms used as a measure of 'seriousness' appropriate to the particular issues of loss of responsibility raised by mental disorder. Proposed by a Government Committee in the UK in the 1970s, they fit the results from our philosophical fieldwork, the case vignette questionnaire, perfectly. However, this begs the key question practically, namely, of what lies behind the cases where people's responses are split.

- Among the many possible reasons for the neglect of mental health issues by bioethics, the specifically *conceptual* reason is that bioethics has (implicitly) adopted the same medical-scientific, 'left-field', model as biomedicine: hence it has assumed (wrongly, we have argued) that the 'tools' for ethical reasoning developed in bodily medicine can be applied essentially unchanged in mental health.

Chapter 18 **From bioethics to values-based practice**

Session 1 **Bioethics and health care**

- Among a number of historical factors, modern bioethics developed as a response to advances in the sciences and technology underpinning medicine: this prompted the need for the shift from 'medical beneficence' to 'patient autonomy' which is at the heart of modern bioethics.

- Although an important development, the growth of ethical rules and legal regulation as the principal 'tool' for connecting bioethics with practice, has had three downsides: (1) code inflation; (2) practitioner deflation; and (in some cases) (3) problem conflation (in particular, disadvantaging users of services).

- Code inflation reflects a failure to recognize that conceptual difficulties cannot be fully resolved by explicit rules (this is an aspect of the difference between definition and use explored in Part I).

- Practitioner deflation arises from a failure to acknowledge the importance of tacit knowledge and skills derived from experience as a key contribution to health-care decision-making (we covered implicit knowledge in Part III).

- Problem conflation shows the need for other tools in the ethical 'toolkit' in addition to rules and regulation.

- Three methods of ethical reasoning have been found to be particularly helpful in practice: principles (top-down reasoning), casuistry (or case-based bottom-up reasoning), and perspectives (focusing on the different perspectives of those involved in a particular situation).

- Each of these has strengths and weaknesses but used together they offer complementary ways of reasoning about ethical issues in health care.

Session 2 **Bioethics and mental health**

- The 'four principles', introduced by Beauchamp and Childress, are autonomy, beneficence, non-maleficence, and justice.

◆ Beauchamp and Childress are unusual (in the bioethics literature) in focusing on the particular conceptual difficulties of consent in mental health. They analyse involuntary treatment as being justified where the competencies for autonomous decision-making are impaired by psychopathology: the principle of autonomy is thus outweighed (mainly) by the principle of beneficence (doing good).

◆ However, Beauchamp and Childress' analysis of the relevant psychopathology, which is in essentially cognitive terms, although fitting their own case example (of dementia), fails to fit the functional cases picked out in the responses to our case vignettes in Chapter 17.

◆ Casuistry (case-based) reasoning 'works', i.e. people come to agreed ethical conclusions, because and to the extent that their implicit values are shared.

◆ This makes casuistry a possibly dangerous tool in mental health ethics because mental health, as we saw in Part I, is an area in which people's values are particularly diverse. Hence if used unreflectingly, casuistry could be used to impose the values of the majority on minorities.

◆ The emphasis on individual differences of values in perspectives reasoning is helpful in mental health ethics. But some of the most difficult problems (including involuntary treatment) arise where (as with 'loss of insight') the perspectives of the person concerned differs radically from the perspectives of everyone else.

◆ All three methods, principles, casuistry, and perspectives, thus have strengths and weaknesses for mental health ethics, but, neither separately nor together, do they offer a panacea.

Session 3 **Philosophical ethical theory**

◆ Deontology is rights-based ethics, involving rights and responsibilities. It is the basis of legal and regulatory ethics.

◆ Consequentialism focuses on outcomes. Utilitarianism (the 'greatest good of the greatest number') is a form of consequentialism that is the basis of health economic models aimed at fair distribution of resources (e.g. QALYs).

◆ Analytic ethics focuses not on substantive ethical conclusions (about what is right, fair, etc.) but on the meanings and implications (the 'logic') of value terms.

◆ Analytic ethics is important generally in mental health because of the extra conceptual difficulties with which mental health is associated.

◆ The extra 'tools' that analytic ethics delivers are a set of ideas about working with differences of values (called Values-Based Practice—see next Session), such differences representing a particular aspect of the greater conceptual difficulty of mental health ethics.

◆ Substantive ethical theory seeks to provide 'answers', i.e. substantive outcome values, such as autonomy, by which decisions should be guided. Analytic ethical theory focuses rather on good process. The key shift required to work equally effectively with both types of ethical theory, substantive and analytic, is thus a shift from 'right outcomes' to 'good process'.

Session 4 **Values-based practice**

◆ Values-Based Practice is the theory and skills base for effective health-care decision-making where different, and hence potentially conflicting, values are in play.

◆ Where substantive ethics start from particular values (such as autonomy), Values-Based Practice starts (like a democracy) from respect from different values and relies (again, like a democracy) on good process for effective decision-making.

◆ Good process in Values-Based Practice includes three principles linking it closely with Evidence-Based Practice: the 'two feet' principle (all decisions rest on values as well as facts); the 'squeaky wheel' principle (we notice values, or facts, only when they cause difficulty); and the 'science driven' principle (that the increasingly complex values involved in health care are a result of scientific progress opening up ever-wider choices).

◆ Good process in Values-Based Practice depends on a model of service delivery that is user-centred (starting from the values of individual service users, families, etc.) and multidisciplinary/ agency (different disciplines/agencies providing different value perspectives as the basis of balanced decision-making where values conflict).

◆ Four particular clinical skills are required to support good process in Values-Based Practice: (1) raised awareness of values (and of differences of values); (2) knowledge of values (including 'evidence-based' research knowledge); (3) reasoning about values (using ethical reasoning to explore differences of values rather than to get the 'right' answer); and (4) communication skills (both for exploring values and for resolving differences).

◆ Bioethics, as an extension of medical law, has tended to see itself as a 'guardian' of patients' rights against the exercise of medical power. Combining Values-Based with Evidence-Based approaches to health-care decision-making seeks to restore partnership is decison-making between users and providers of services.

Chapter 19 **It's the law! Rationality and consent as a case study in values and mental health law**

Session 1 **The legal basis of consent**

◆ The law on consent in health care is derived from the need to balance patient autonomy (the right to self-determination) with medical beneficence (the duty to act in the patient's 'best

interest'). The roots of these two principles lie in the moral and cultural traditions of medicine back to the Hippocratic 'Oath'.

◆ The legal embodiment of these two principles is often in the form of 'rights'.

◆ Legal consent may be: (1) express; (2) implied; or, in English law at least, (3) by 'estoppel' (a form of 'reasonable person' test).

◆ Current legal doctrine requires that for consent to be valid: (1) the person concerned has the *capacity* to consent; (2) they have sufficient *information* on which to base their consent; and (3) they made their decision *voluntarily*.

◆ A 'status' test is one that determines whether a person's consent is valid according to their status: e.g. a child below a certain age (and/or maturity) may not have the status to give (or withhold) valid consent; more contentiously, in many administrations a person with a mental disorder may not have the status to give (or withhold) valid consent for their mental disorder.

Session 2 Capacity, information, and causes of action

◆ The four key elements of decision-making capacity defined in *ReC* are: (1) understanding and retaining the relevant information; (2) believing it; (3) weighing the information; and (4) arriving at a clear choice.

◆ Although intended as an objective test of capacity, i.e. one that is independent of the 'rights or wrongs' of the actual decision the patient makes, values come into this test, *inter alia*, implicitly in the concept of rationality underlying the element of 'understanding', and explicitly in the element of 'weighing'.

◆ Causes of action for unlawful treatment without consent include, in criminal law an action for battery, and in civil law an action either for trespass (civil battery) or negligence.

◆ Battery involves three elements: (1) touching; (2) damage; and (3) reasonable forseeability of damage.

◆ The elements of negligence are: (1) duty of care; (2) breach of the relevant standard of care; and (3) causation.

◆ The Bolam test is an example of a 'prudent doctor' standard of care: a doctor will not be liable for negligence if he or she acted '. . . in accordance with a practice accepted as proper by a responsible body of medical practitioners' skilled in that particular area.

◆ A prudent patient test asks only what a 'prudent' or 'reasonable' patient would want to know in the circumstances.

◆ The courts in recent rulings have been clear that, while retaining a prudent doctor test, medical opinion in a given case has to be in the court's view, reasonable, responsible, and respectable.

Session 3 Consent, voluntariness, and best interests

◆ Cases of enforced Caesarean section focus on issues such as capacity and rationality as vehicles for the exercise of (implicit) judicial values.

◆ So long as judicial values remain implicit, they may be problematic where the values, respectively, of the courts, of doctors and of patients, are all likely to be different (cf. Part I).

◆ Generic incapacity legislation seeks to reconcile different tests of capacity developed in different contexts for different purposes, within a single test.

◆ The legal concept of 'best interests', although rightly requiring decision-makers to consider a range of relevant information about the actual (or likely) values of the person(s) concerned, makes explicit the deep issues of value lying behind legal judgments.

Chapter 20 Values in psychiatric diagnosis

Session 1 The central place of values in psychiatric diagnosis: the case of Simon

◆ A values-based model of medical diagnosis adds values rather than subtracting facts.

◆ The PSE defines a delusional perception as a delusion that is 'based on sensory experiences' and involves 'suddenly becoming convinced that a particular set of events has a special meaning'.

◆ In the ICD-10 diagnostic manual, a delusional perception is among the symptom-criteria that (with other criteria such as a particular duration) are sufficient for a diagnosis of schizophrenia (or related psychotic disorder, depending on other co-present symptoms).

◆ DSM adds to the (otherwise essentially similar) criteria for schizophrenia in ICD, a Criterion B of 'social/occupational dysfunction'.

◆ The DSM-IV explicitly claims to be strongly evidence based. It *is* strongly evidence based. But, like the ICD it uses many terms with clear evaluative connotations. Further, with the introduction of criteria of social/occupational *dys*function into the diagnosis of psychotic disorders, the DSM-IV in effect puts values at the heart of psychiatric diagnosis. The DSM-IV is thus both evidence based and values based.

Session 2 Generalization: the pervasiveness and importance of values in psychiatric diagnosis

◆ Values are all pervasive in DSM: in its definition of disorder; in the value-laden terms used in many criteria; and centrally in the explicitly evaluative judgements involved in applying criteria of social/occupational dysfunction (such as Criterion B) for psychotic disorders.

◆ DSM's criterion of 'clinical significance' does not provide an escape route for the medical model from values because the criterion is not defined (other than as being 'an inherently difficult clinical judgement'—which might well itself involve one or more *value* judgements).

◆ Positing underlying (actual or hypothetical) bodily causes does not provide an escape route from values for the medical model because, as we saw in Part I, it is the (negatively evaluated) experience of illness that marks out an underlying bodily cause of that experience as a *pathological* cause, not vice versa. (*All* experiences, normal and pathological, being caused.)

◆ Moral descriptivism is the claim in philosophical value theory that at least in some circumstances values can be redefined in terms of facts.

◆ There is no escape route from values for the fact-only medical model in moral descriptivism. This is because, in addition to the general arguments against moral descriptivism outlined in Part I, the moral descriptivist redefinition of values in terms of facts depends on people's values being *shared*, whereas psychiatry, and hence psychiatric diagnosis, is concerned with areas in which people's values are highly *diverse*.

◆ A moral descriptivist 'escape route' for the medical model, like other attempts to mask the importance of values in psychiatric diagnosis, risks abusive consequences arising either from overuse or underuse of psychiatric diagnostic concepts.

◆ The alternative is not to seek an escape route at all, but to adopt a *non*-descriptivist logical framework in which fact and value, description and evaluation, are understood to have equal and complementary roles in psychiatric diagnosis.

Session 3 Bioethics and values in psychiatric diagnosis

◆ Reich identifies (explicitly or implicitly) a number of important positive points about psychiatric diagnosis: (1) that it is ethically laden; (2) that it is indeed ethically central; (3) that misdiagnosis can take several distinct forms; (4) that non-purposeful misdiagnoses are even more significant ethically than purposeful misdiagnosis; (5) that there are many empirical difficulties also; (6) that the misuse of psychiatric diagnosis in the former USSR has lessons for us all; (7) that psychiatric diagnosis may have a number of positive and helpful implications; and (8) that the problems of psychiatric diagnosis have their origins in our common human nature. (*Note*: each of these really *is* a key learning point!)

◆ Reich presents each of these points not as positive but as negative points about psychiatry: it is ethically laden, hence unscientific, etc.

Chapter 21 From bioethics to values-based practice in psychiatric diagnosis

Session 1 Philosophy, values, and psychiatric diagnosis

◆ In her review of philosophical issues in psychiatric classification and diagnosis, Radden focuses particularly on the philosophy of science.

◆ Like Szasz and Kendell, on opposite sides in the debate about mental illness (in Part I), Reich assumes in relation to psychiatric diagnosis, (1) that mental illness is *the* problem, and (2) that physical illness, relatively speaking, is *not* a problem.

◆ As with medical diagnosis (see Chapter 20, Session 1), a values-based understanding of psychiatric classification and diagnosis, adds values rather than substracting facts.

Session 2 From fact-only to fact+value model of psychiatric diagnosis

◆ Behind Reich's essentially negative take on psychiatric diagnosis lies his (implicit) adoption of the fact-only medical model.

◆ If the problems of psychiatric diagnosis arise (at least equally) from its evaluative as from its descriptive aspects, an approach guided by the fact-only (or fact-centred) medical model may be blind to these problems.

◆ Reich, along with many others in 'Western' bioethics, assumes that Soviet psychiatric science was peculiarly deficient: this is why, the assumption goes, abuses of psychiatric diagnosis became widespread in the former USSR.

◆ Closer inspection, however, suggests that Soviet psychiatric science was not essentially different from the corresponding psychiatric sciences of the day in Britain and North America.

◆ Guided by a fact-only medical model, Reich implies that the 'cure' for misuses of psychiatric diagnosis lie in strengthening its scientific basis in particular *by excluding values* from it.

◆ An alternative approach to reducing the misuses of psychiatric diagnosis is to *focus on its evaluative aspects* and to take seriously the implications for diagnosis of the particular diversity of human values in the areas with which psychiatry is concerned.

Session 3 Reversing Reich

◆ All of Reich's points in his list of the (ironically named) 'beauties' of psychiatric diagnosis, could, in principle, though sometimes to a lesser degree, be made as points about diagnosis in bodily medicine.

◆ In the terms of a 'diagnostic formulation' (Chapter 2), (1) Reich's 'diagnosis' of the abuses of psychiatric diagnosis is that it offers a way out for people trying to evade problems, (2) his 'aetiological theory' is thus that such abuses arise from the frailty of human nature, and (3) his 'treatment' is to stiffen up standards with (a) ethical and legal rules and regulation, and (b) tighter scientific standards.

◆ Stiffening up scientific standards in itself can only make abuses less likely. However, focusing on the scientific side of diagnosis *at the expense of* its evaluative side, could lead to neglect of an important source of the difficulties of psychiatric diagnosis (i.e. differences of values) and hence increase the risks of abuses.

◆ While a framework of law and ethics is always important, such a framework (in reflecting shared values) could increase the risks of abuses if applied unreflectingly across areas (such as mental health) where values are inherently diverse.

Session 4 Practical applications: values-based practice and psychiatric diagnosis

◆ Values-based psychiatric diagnosis involves: (1) identifying and understanding the values of the person (or family) concerned; (2) being able to draw on different value perspectives (as represented by the multidisciplinary or multiagency service models) to come to a balanced judgement where values conflict; and (3) an 'open society' of mental health stakeholders in which a dynamic of mutual checks and balances is maintained.

◆ In research, values-based practice involves drawing on a wide range of methods—philosophical, empirical and mixed—to explore the values actually operative in different situations.

◆ Values-based (as well as evidence-based) approaches to diagnosis are relevant in all areas of psychiatric research, including the neurosciences.

◆ Adopting a values-based as well as evidence-based approach to classification would not alter the *descriptive* elements in the criteria in existing classifications (though there might be other reasons for altering them). Rather, a values-based approach would, (1) make the existing *evaluative* elements in these criteria more fully explicit, and (2) indicate key features of the 'good process' required to work with both evaluative and descriptive elements equally effectively.

Part V Philosophy of mind and mental health

Chapter 22 Mind, brain, and mental illness: an introduction to the philosophy of mind

Session 1 The mind–body problem in ordinary usage

◆ Among other adverse effects on mental health, the difficulty of the mind–body problem has: (1) been the basis of (some) antipsychiatry attacks, particularly by way of the contrast between 'real' bodily diseases and mental illnesses that are ' all in the mind'; (2) deepened divides between different models adopted by different 'schools' of psychiatry (e.g. psychoanalytic versus biological); and (3) encouraged slides towards eliminativist positions (mind-only or brain-only), that are both, (a) equally conceptually untenable, and (b) practically dangerous (leading to unbalanced and abusive practice).

◆ People have drawn equal and opposite implications from putative neuroscientific discoveries of the brain basis of particular behaviours; some reject, while others embrace, the idea that such discoveries show that people are not responsible for the behaviour in question.

◆ It is a feature of the logical geography of our ordinary usage that the concept of a 'person' involves both brain-talk and mind-talk. Strawson argued that persons are (logically) primitive, i.e. that brain-talk and mind-talk are both dependent on the concept of a person.

Session 2 The mind–body problem: the case of Mrs Lazy

◆ 'Mrs Lazy' decided to give up housework because she was fed up with it.

◆ Her family thought she was ill because this was so out of character; her doctors agreed because diseases affecting the brain (especially the frontal lobes) can cause changes of personality.

◆ Causal stories of this kind, although called in medicine 'psychosomatic', depend on brain–body dualism not mind–body dualism.

◆ When a tumour in Mrs Lazy's frontal lobes was found, this was consistent with the medical–causal explanation of the change in her personality.

◆ But this account of her decision, in neglecting Mrs Lazy's values, experience, and agency, left out the person, the real Mrs Lazy.

◆ The wider significance of Mrs Lazy's story is this: it is *above all* where we can give a causal explanation of someone's behaviour, important *not* to neglect the values and other aspects of their experience that are essential to who they are as unique individuals.

◆ In other words, Mrs Lazy's story shows the increased danger that arises when we are able to explain the brain basis of some aspect of a person's experience or behaviour, of neglecting the values and experiences of that person, and thus failing to relate to them as real people.

Session 3 The mind–body problem: from ordinary usage to philosophy

◆ In the seventeenth century, rationalists and empiricists both conceived of the mind as a vessel for knowledge: rationalists believed the vessel had in-built tools ('rational capacities') for making sense of the world; empiricists believed the vessel started off empty and that knowledge was based on experiences gained through the senses.

◆ Descartes' philosophical project was a response to scepticism (especially Montaigne's scepticism) about the very possibility of (secure) knowledge.

◆ His 'method of doubt' led him to his *cogito*, 'I think, therefore I am'.

◆ The supposed indubitable nature of the (mental) *cogito* seemed to suggest that mind must be different in kind (a different *substance*) from matter (including brains). It is this 'Cartesian dualism' and the many responses to it that have generated together the mind–body problem in its modern form.

- Among the best known early responses to Descartes' dualism are:

  1. Malebranche's *Occasionalism* (an extension of dualism to include God's interventions),

  2. Geulincx's '*two clocks*' (that mind and brain tick together),

  3. Spinoza's *Monism* (that mind and matter are two aspects of the same substance),

  4. Leibniz's *Psychophysical Parallelism* (a version of the 'two clocks' in which mind and brain function harmoniously in parallel),

  5. Berkeley's *Idealist Monism* (that the essence of things is to be perceived—thus resolving dualism in favour of the mind), and

  6. Hobbes' *materialism* (that 'I think' depends on knowledge of the author of thought—thus resolving dualism in favour of matter).

- In his *Critique of Pure Reason*, Kant sought the logical preconditions that make all conventional arguments (from premises to conclusions) possible.

- The nub of Kant's argument against Descartes is that the apparent force of the 'cogito' depends on an equivocation between two senses (a logical and an empirical sense) of the self.

Session 4 **A modern response to the Cartesian problem**

- Psychology was a growth industry in the nineteenth century but there was relatively little interest in the philosophical mind–body debate.

- The re-igniting of the debate is generally attributed to Gilbert Ryle's book *The Concept of Mind*.

- Ryle's position is generally (and Wittgenstein's by some) considered to be a form of *logical behaviourism*, i.e. the claim that meanings are nothing more than publicly observable behaviours, as distinct from *psychological behaviourism*, i.e. the claim that psychology should be concerned with nothing more than publicly observable behaviours (as in the work of J.B. Watson and B.F. Skinner).

- Ryle argued that mind–body dualism arises from a *category mistake* equivalent to the visitor to a university, who, having seen all the parts of the institution (the university library, etc.), still insists on being shown '*the* university'. He has made the mistake of thinking that the 'the university' is a thing of the same kind (category) as 'the university library'.

- Ryle characterized mental states as '*dispositional statements*', i.e. statements of the dispositions (the propensities, capacities, etc.) of things to show certain behaviours or to react in certain ways.

- More recent commentators have argued that Ryle's position, his denials notwithstanding, is behaviourist. It thus exploits one side of the mind–body dualism (the body side) rather resolving the problem of how they might be related.

Chapter 23 **The mind–body problem and mental health, a philosophical update**

Session 1 **The mind–body problem in clinical neuropsychiatry**

- Work in psychiatry, especially in neuroimaging, suggests close and specific connections between the mind and the brain; however, it does not, of itself, suggest a perspicuous account of how the mind and brain are related.

- That the connection is thought to be close is suggested by the fact that Posner provides no argument to connect seeing the brain with the mind: he merely assumes it.

- Mind and brain may be connected according to a particular analysis of mental states such as a cognitivist analysis that analyses mental states as information states.

Session 2 **Functionalist accounts of the mind**

- Functionalism compares the relationship of mental states and brain states with computer software and hardware. Mental states are functional states: defined by their inputs (perceptions and other mental states) and outputs (behaviour and other mental states).

- It is compatible with physicalism (the view that everything is ultimately physical); however, it need not be taken to imply physicalism.

- A type identity theory connects mental states and physical states as types. A type or generality of mental states is identified with a type or generality of mental states. A token identity claim merely claims that each individual mental state is a physical state. This distinction is akin to that between numerical and qualitative identity.

- Functionalism escapes an objection to behaviourism by loosening the connection between mental states and behaviour. But it maintains a relation between mental states and behaviour as a whole.

- One influential criticism of functionalism is that merely describing the relational properties of mental states omits their intrinsic qualities or qualia. This point is emphasized in arguments about the functional equivalence of systems with inverted or missing qualia.

- A second objection is that the rational character of mental states cannot be captured in functional relations. Davidson stressed the rational and normative basis of mental states and hence their irreducibility to physical patterns. McDowell stressed the different patterns of explanation that comprise comparison with an ideal (in the mental case) and subsumption under a law (in the physical).

Session 3 Davidson's Anomalous Monism

◆ Davidson aims to reconcile three plausible but apparently incompatible claims: (1) a nomological account of causation; (2) the claim that mental states have causal powers; and (3) the denial that there are psychological or psychophysical laws.

◆ He claims that each mental state is a physical state while denying that types of mental state can be reduced to or mapped on to types of mental state. Thus he calls his account: Anomalous Monism. It is monistic in that there is only one kind of stuff but it is anomalous because there are no laws linking physical and mental types. It is thus a form of token identity thesis.

◆ Supervenience is the thesis that determining or fixing the physical properties of a person (or possibly the person and their environment) determines or fixes their mental properties but the converse implication does not hold. It was first applied in the case of ethics.

◆ Davidson adds supervenience to his basic claim that mental states are token-identical to physical states in part to head off the charge that his is a form of epiphenomenalism: mental states are caused by physical states but have no causal powers themselves.

◆ However, there is some tension in the combination of a token identity thesis and supervenience.

◆ Consideration of functionalist and Davidsonian theories already suggest that there are a number of possible responses to the mind–body problem.

Session 4 Arguments against mind–body identity theories

◆ Kripke argues that some names are 'rigid designators', which pick out their referents essentially. Identity claims expressed using rigid designators express de re necessities: they are necessarily true, or true in all possible worlds, even if they can only be known through experience or a posteriori.

◆ Although Kripke explains these claims by talking of possible worlds it is not necessary to think that these are real. Nevertheless, strict rules have to be followed in describing them.

◆ Kripke argues that if identity statements expressed using rigid designators hold necessarily but if the putative identity of mind and brain is at best contingently true, as Descartes plausibly suggests, then there is no identity between mind and brain.

◆ Kripke does not himself suggest what relation this leaves.

◆ Assessing Kripke's argument depends on assessing the essential properties of mental states: centrally whether there is more to mental states than their felt qualities.

◆ There are ways of linking mental and physical states that are weaker than identity such as 'constitution' but even these are threatened by the difference between the rational pattern into which mental states fit and the law-like relations that are assumed to characterize physical states.

Session 5 Is there any reason to believe in supervenience?

◆ The claim that the mental supervenes on the physical can be made without there being any way of correlating mental and physical elements. The totality of mental events may supervene on the totality of physical events without the events correlating even at the level of tokens.

◆ Papineau suggests that the thesis that physics could be a complete account of the world implies the truth of the supervenience of mental events on physical events. His argument is based on the claim that physics can be complete.

◆ But, according to Crane, the claim that physics is complete is just as contentious and cannot justify supervenience.

◆ Crane argues that a dilemma can be outlined by asking, metaphorically, what God would have to do to fix the mental facts having fixed the physical facts. If he has to create further laws these will create further mental facts and thus the physical facts alone do not determine the mental. If he does not then, according to Crane, this undermines the idea that there are any mental facts. While not decisive, this argument makes supervenience less well founded than might first appear, and hence the mind-body problem remains open.

Chapter 24 Reasons and the content of mental states: 1. Reductionist theories

Session 1 Aphasia, deficit studies, modularity, and meaning in cognitive psychiatry

◆ While the modular approach to the mind helpfully explains the relations of mental abilities or deficits it raises the question of how mental states possess intentionality in the first place.

◆ Talk of representations of words and representations of their meaning merely disguises the problem of how representation of meaning is possible.

Session 2 Preliminaries to a philosophical account of content

◆ Since Brentano, intentionality or 'aboutness' has been a central focus of the philosophy of mind.

◆ At least some mental states can be thought of as propositional attitudes. A subject has an attitude towards a proposition. The attitude might be hope, fear, believe, etc. The proposition might be something like: that it is raining, that an election is coming, that the sun will rise, etc.

◆ Fodor suggests that mental states are semantically evaluable—that is, like other meaningful items they can be, for example, true or false—they have causal powers and are governed by common sense psychology.

◆ The central question of the philosophy of content is how intentionality so described is possible.

Session 3 Naturalized or reductionist accounts of content

◆ The attempt to reduce intentional concepts to more basic concepts raises a number of preliminary questions. Central is the question of whether linguistic meaning or mental content is more basic. Either could be explained in terms of the other.

◆ Reductionist approaches generally assume that mental content is more basic and that linguistic meaning can then be explained through the intentions of speakers: intention-based semantics.

◆ Fodor's representational theory of mind is an attempt, based on the idea that the mind is a kind of computer, to describe mental operations as operations of internal mental representations.

◆ But unlike functionalism, Fodor does not think that the fine-grained content of mental states can be explained in functional terms even though the difference between different sorts of attitude can be.

◆ Propositional attitudes are encoded in different functional attitudes towards different propositions, themselves encoded in mental representations.

Session 4 Descriptive causal accounts of content

◆ Reductionism about mental content needs to add a further ingredient to the computer metaphor. It needs to explain how internal mental representations—neural states, probably—have intentionality. Fodor advocates a causal theory: mental representations have the meaning or content they do because they are the effects of features of the world. They are about what causes them.

◆ However, a causal theory faces the disjunction problem: explaining how *false* beliefs are possible.

◆ Fodor's theory faces a number of different objections, however. The difficulties suggests the kind of problem any reductionist theory of meaning must face and thus the challenge for a thorough cognitivist psychiatry.

Session 5 Teleological causal accounts of content

◆ A more recent reductionist approach to meaning invokes evolutionary theory to account for the meaning of mental representations. It is sometimes called teleosemantics.

◆ Like the evolutionary theory approach to mental disorder it deploys the idea of biological or proper function. The proper function of a mental representation gives its meaning. The function is what a biological trait is selected for, now what is actually selected.

◆ Again, however, this approach faces difficulties crucially in specifying the biological function of mental representations in ways that mirror content without begging the question of what they mean.

◆ These objections suggest that the attempt to break the notion of meaning or intentionality down to something more basic may be mistaken. Instead it may be that it is an irreducible notion tied to the idea of personhood. If so it may be a mistake to think that meaning is encoded in mental representations.

Chapter 25 Reasons and the content of mental states: 2. Antireductionism and discursive psychology

Session 1 The discursive alternative

◆ Discursive psychology presents an alternative view of meaning and mental states to that provided more cognitivist psychiatric models of mind and brain.

◆ Discursive psychology links meaning and mental states to conversations or discourse: outer and public rather than inner and private phenomena. It thus avoids the challenge to cognitivist accounts of explaining how inner states can be about external states of affairs.

◆ As in the case of the latter, discussed in Chapter 24, there are philosophical models of meaning that help shed light on the issue.

◆ A question for assessment is, however, whether the discursive view of meaning merely places a different emphasis on social and public aspects of meaning or whether it is strictly incompatible with the cognitivist approach discussed in Chapter 24. One way to distinguish the claims is to construe discursive psychology as committed to a form of social constructionism: meaning is constructed in conversations. That is a radical view of meaning.

Session 2 Wittgensteinian approaches to mental content

◆ A social constructionist version of discursive psychology often looks to Wittgenstein for support.

◆ Wittgenstein's work has been interpreted as supporting a number of different, conflicting claims. However, all agree that because understanding a word means understanding how to use it correctly, there is an important connection between rules and meanings. Both are normative. There is also a connection to mental states because they prescribe what they are about.

◆ Kripke argues that Wittgenstein's discussion contains a sceptical attack on the very idea of meaning. He bases this claim on an argument about how we know what mathematical rules we have followed in the past. It seems that there is no evidence we can appeal to which will uniquely determine a mathematical

function. Also, similar considerations would apply to our knowledge of the rules governing the use of other everyday words.

◆ Wright suggests that Kripke's sceptical argument can be partially defused by an analogy with intentions. If asked how we know what we previously intended we would not hesitate to say we simply remembered the intention directly rather than via an inference.

◆ However, Wright suggests that intentions are philosophically baffling because they lie between dispositional states and direct avowals. As a result he suggests that they are constructed rather than reported by the utterances of speakers.

◆ Contrary to both Kripke and Wright, McDowell argues that Wittgenstein's target is not our everyday understanding of meaning. It is a particular explanation of meaning that postulates internal mental states that need interpretation. Without giving way to that, the sceptical argument can be defused using Wright's suggestion. However, it provides no support for social constructionism.

◆ The critical aspect corresponds to the challenge faced by cognitivist approaches described in Chapter 24: How can internal or neural states possess intentionality?

◆ The positive aspect suggests that meaning is publicly available; however, this idea can be expanded by looking to other recent philosophers.

Session 3   Dennett and the Intentional Stance

◆ Dennett aims to make sense of intentional mental states by articulating the explanatory stance that deploys them. The Intentional Stance is contrasted with two others: the physical stance and the design stance.

◆ On this view, mental states are abstract rather than concrete entities. They are real as are centres of gravity but they are not concrete entities and do not have causal powers.

◆ The bald initial claim that mental states are nothing but what are deployed in the Intentional Stance has to be modified to suggest that they have separate existence in the patterns of human behaviour that are there whether or not anyone deploys the Intentional Stance.

◆ Dennett claims that such patterns really exist independently of our describing them.

◆ Thus he does not support radical social construction of meaning and mental states.

Session 4   Davidson and Radical Interpretation

◆ Davidson's account of linguistic meaning and mental content is based on the idea of Radical Interpretation: interpretation by an anthropologist from scratch. This is derived from Quine's radical translation.

◆ Davidson assumes that the full facts about meaning are available to this public perspective. This is akin to discursive psychology.

◆ His theoretical approach emphasizes both the interdependence of meaning and mental content and the central role of rationality for both. The ideas of the Principle of Charity and the Constitutive Principle of Rationality mark the role of rationality in both detecting minds and meanings and in their very nature.

◆ Davidson's account may look to falsify everyday phenomenology. Normally our understanding of other people's speech proceeds without any conscious interpretation. However, it need not be construed as actually postulating the active interpretation of otherwise meaningless data. Rather it is a rational reconstruction to reveal what could justify ascriptions of mental states and meanings whether or not we normally appeal to it.

◆ Davidson argues that inner mental representations are unnecessary to explain mental states and meanings.

Session 5   Singular thought and the division between mind and world

◆ According to Russell, thoughts can latch on to objects through descriptions or through direct acquaintance. The Theory of Descriptions is designed to explain the meaning of sentences such as 'the present King of France is bald' where there is no object corresponding to the apparent subject of the sentence: no King of France.

◆ Thoughts that depend on direct acquaintance depend for their very existence on a contextual connection to real objects.

◆ While, for Cartesian reasons, Russell restricted such thoughts to sense data and I-thoughts, more recent philosophers have argued that they also apply to everyday singular thoughts based, e.g. on the perception of objects. The argument for this is that it is the only way to make sense of the speech and action of subjects. If so, however, it is possible to be in error about the kind of thought one is thinking if no such object actually exists. And this seems to run counter to Cartesian assumptions about the mind.

◆ If singular thoughts exist and depend for their existence not on inner representations—perhaps corresponding to Russell's Theory of Descriptions—but on contextual relations to real objects then they cannot be represented by any internal mental representation. They would thus comprise an objection to cognitivist accounts of the mind according to which thoughts can be encoded in mental representations.

Session 6   Discursive psychology and Alzheimer's disease

◆ The philosophical discussion of the chapter allows a distinction between two versions of a discursive approach to the mind.

◆ In one, meanings are constructed in conversations; however, this faces philosophical objections drawn from an interpretation of Wittgenstein.

- A more plausible alternative, however, is one in which meanings are necessarily publicly available, available to conversations, but not constructed in those conversations. There are a family of philosophical approaches to meaning that differ in detail but share this common approach.

Chapter 26 **Agency, causation, and freedom**

Session 1 **Agency, freedom, and neuropsychiatry**

- Although we might think of exercises of free will in action and thought as always conscious, there are both normal and pathological instances where we have thoughts or we act apparently deliberately, but do not experience those acts or thoughts as consciously willed by us.

- Libet's experimental work appears to imply that there is no such thing as a conscious exercise of free will because the timing of the conscious will seems to follow a prior brain event. This is a striking consequence and invites reflection on the general relation between freedom and causal determinism.

- Spence suggests that it may be possible to retain a notion of freedom but separate it from a conscious experience. Equally we might decide that there is no genuine freedom.

- Imaging a longer time lag between brain event and conscious experience reinforces the paradoxical nature of the case because it would seem to provide time to change one's mind, but that would in turn require another, again earlier, brain event.

- There is reason to doubt Spence's claim that he has taken a materialist analysis to the limit. Where in the materialist order of things is the conscious experience of making a decision, whether or not this is already determined by non-conscious brain events? Again, this calls for further reflection on the model of the relation of mind and brain.

Session 2 **Agency and volitions**

- Ryle criticizes an intuitive explanation of actions based on mental causes. According to the Myth of Volitions, actions unlike movements are brought about by volitions.

- Ryle lists four criticisms of which the most important is that it starts a vicious regress because volitions would themselves have to be deliberate mental acts and thus require prior volitions and so on.

- Ryle's positive account of the difference between actions and mere movements depends on broader social and environmental factors that might overturn the ascription of voluntariness. This might not seem to be a response to the central question of what is the difference between voluntary action and what is not so much as an attempt to turn that problem aside.

- Melden usefully compares action with meaningful speech and suggests that neither requires additional mental elements either to animate linguistic signs or to make movements into actions.

Session 3 **Arguments for a causal theory of mind**

- Davidson suggests that action-explanation involves a rationalizing element: a reason for the action. But, in addition, he suggests that something else needs to be added to the account to distinguish a reason for an action from the reason why the act is actually committed. He suggests that the only plausible extra ingredient is causation: the reason for an action not only justifies but also causes it.

- Although there are arguments based on the logical connection between descriptions of reasons and actions, which suggest that the connection cannot be also contingent and causal, Davidson argues that these do not undermine the causal connection of the events so described. He distinguishes between how events are described and the events themselves.

- Davidson's arguments for the causal connection of reason and action fits Lewis' arguments for a causal model of explanation more generally.

Session 4 **Event causation, agent causation, and irrationality**

- Even given a causal model of action-explanation, the basic idea can be 'unpacked' in more than one way. While Davidson's claim that actions are caused by mental states, there are other accounts in which actions are caused by the agents themselves (i.e. the subjects who act).

- The idea of 'agent causation', however, is different from a standard Humean analysis of causation and is difficult further to explain. This threatens the idea that it is really a form of causation rather than an unanalysed notion of agency that causation was supposed to help explain.

- Davidson's separation of the causal and rational powers of mental states suggests a model for weakness of will and other partial breakdowns of reason. The causal powers of some reasons can outweigh their rational powers.

- This account of irrationality raises the general question of what normally keeps the two powers in step in Davidson's account. This suggests that Davidson's account may not be stable.

Session 5 **A non-causal account of agency?**

- Although Davidson's arguments against non-causal theories of action seem plausible, his argument for a causal connection is less strong. Davidson's main argument for a causal analysis of action turned on distinguishing a reason for an action from the reason.

- But according to Tanney, the same work can be done by talking of the competing motivational powers of conflicting reasons rather than separating out their rational and causal powers.

- If we reject Davidson's in other ways attractive account of mind and body this might leave something more like Ryle and Melden's picture. But if so, what response can be given to

Spence's arguments from Session 1 about the compatibility or otherwise of causal determinism and freedom of the will?

Session 6 **Freedom and determinacy**

◆ Strawson argues that the debate between freedom and determinism is hampered by a lack of clarity about the thesis of determinism; however, he suggests that appeal to moral reactions helps clarify the issue. He uses such attitudes to investigate what taking determinism seriously would be like.

◆ As a matter of fact we sometimes suspend natural reactive attitudes such as resentment with those we do not think are responsible for actions that impinge on us. This may be because the action was carried out under external compulsion or because the subject is not generally responsible. In such cases we adopt an objective attitude.

◆ Strawson suggests that putting such reactions into abeyance in general by adopting an 'objective attitude' is not an option for us. Thus we could not give up the notion of freedom in the face of a thesis of determinism. Whether this really resolves the issue of whether freedom actually is immune to determinism remains open to question.

◆ Strawson's approach is akin to that of Ryle and Melden. Rather than giving a substantial answer to the question of what the difference between voluntary action and mere movement consist in they all instead attempt to remind us of how the everyday distinctions are made: both in ordinary life and clinical practice.

Chapter 27 **Knowledge of other minds**

Session 1 **An historical starting point: Cartesian theatres and the argument from analogy**

◆ The questions addressed so far in Part V have largely concerned the ontology of mind. This chapter concerns epistemology.

◆ Descartes' approach to the nature of mind makes the Problem of Other Minds particularly vivid. By characterizing mental states as states in a kind of private theatre Descartes casts doubt on our access to other people's mental states.

◆ One influential solution appeals to an argument from analogy. The idea is that one can infer that other people are in a particular mental state because of a connection in one's own case between the nature of one's mental states and one's behaviour. By analogy with that connection one can infer the nature of another person's mental state from their outward behaviour.

◆ But as the Wittgensteinian philosopher Norman Malcolm argued, the argument from analogy can only work if one already knows what it means to say that someone else is, for example, in pain. And it is unclear that even that is possible given Descartes' starting point.

Session 2 **Introduction to the 'theory-theory' approach**

◆ A more recent solution likens knowledge of other minds to knowledge of unobservable entities in the physical sciences. Knowledge of other minds is thus described as theoretical knowledge, based on a theory of mental function that we are all supposed to possess.

◆ Thus theory-theory uses a broadly functionalist approach to the ontology of mind to solve the epistemological problem of knowledge of other minds.

Session 3 **Simulation theory**

◆ Simulation theory is an alternative to theory-theory motivated in part by the complexity of the theory that the latter presupposes. Simulationists argue that the theory presupposed by theory-theory would, for example, have to have some way to represent every belief another person might have.

◆ Rather than having a theory of mind, 'simulationists' suggest that one needs merely to be in possession of mind. One can use this imaginatively to put oneself in the position of others, discover what one would think oneself under such circumstances and ascribe that thought to others.

◆ While defenders of simulation theory stress that it is not a version of the argument from analogy because it encourages instead a gaze towards the world rather than others' mental states, this remains a matter of debate.

Session 4 **The current state of the debate: evidence from autism**

◆ Although solutions to the problems of other minds such as theory-theory and simulation theory are philosophical models, evidence can be brought from psychopathology to assess their rival claims.

◆ Autism has played a central role in this case. Empirical evidence from the study of autism can be brought to bear by looking, for example, at the relative ease with which they explain Wing's triad of disabilities

◆ One complication, however, in assessing the choice between theory-theory and simulation theory is the danger of the two positions collapsing into one. If the theory described in the former position is known merely implicitly then it is not clear that it really is incompatible with simulation theory. The difference may be one of emphasis.

◆ In the case of simulation theory and theory-theory the opposing views become blurred if knowledge of the theory in question in the latter case is construed as implicit knowledge and if the ability to simulate in the former case can be described through a regimented theory.

Session 5 **Rationality and direct access to mental states**

◆ While the responding to the Problem of Other Minds has suggested theoretically promising work on autism, there is reason to doubt that it is really or empirically a pressing problem.

◆ A third option—in addition to theory-theory and simulation theory—suggests that mental states can be expressed in behaviour.

◆ Unlike other approaches, this approach does not take the description of behaviour to be independent of a description of underlying mental states. It is not, in other words, reductionist.

◆ On this approach, one can take in in experience the fact that someone else is, for example, in pain. This approach may reconcile our everyday untroubled talk of other minds with a philosophical model.

Chapter 28 **Personal identity and schizophrenia**

Session 1 **Personal identity: evidence and constitution**

◆ While they are distinct, there is a plausible connection between personal identity and the ability to identify oneself and one's actions.

◆ Self-identification and, arguably self-identity, can be fragmented in psychopathology.

◆ While evidence such as fingerprints can help identity people, such evidence does not *constitute* personal identity.

Session 2 **Four kinds of identity antirealism**

◆ There are a number of philosophical positions that hold that there is no such thing as personal identity.

◆ David Hume argues for a form of antirealism about personal identity on the basis of introspection. He only ever experienced particular thoughts and never a uniting subject of them.

◆ However, denying personal identity seems to be paradoxical and self-undermining.

Session 3 **Identity and mental illness**

◆ Psychopathology presents conditions that threaten the nature of the personal identity or self-identification who suffers them.

However, there are also conditions, such as Alzheimer's that may threaten the very possibility of the continued existence of a person.

◆ To settle whether severe dementia really does threaten the existence of a person depends on deciding what personal identity involves.
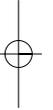
Session 4 **Theories of personal identity**

◆ There are a number of ways of answering the question: What does personal identity consist in? Approaches include: physical, spiritual, capacity, and what we called 'closure'.

◆ Locke's influential account places the burden on autobiographical memory. Possession of such memory is a necessary condition of identity through time. To be a person is to have self-awareness in action.

Session 5 **Identity and mental illness again**

◆ Alzheimer's disease threatens a subject's ability to think of themselves as the same through time and thus threatens the very idea of their continued identity as a person.

◆ Things are not so clear-cut in the case of schizophrenia. While thought disorder suggests some difficulty with self tracking it is possible to distinguish between identifying oneself as a subject and identifying oneself as an agent. If so schizophrenia may threaten only one aspect of personal identity, on a Lockean account.

◆ The impact of other conditions on personal identity depends on one's analysis of identity, which remains very much a matter of philosophical debate informed by clinical findings.