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Bulletin

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From the Editor

In the engagement of philosophers with clinical psychiatry the pre-eminent figure has been Karl Jaspers, who was a psychiatrist before turning to philosophy, and who wrote the justly acclaimed *General Psychopathology*. Less known is the engagement of his one-time friend and colleague, Martin Heidegger. In the post-war years Heidegger responded to a letter from a Swiss psychiatrist and psychoanalyst, Medard Boss. A friendship and collaboration followed that lasted to the end of Heidegger's life in 1976. For a ten-year period from 1959-1969 Heidegger traveled to Boss's Zollikon residence outside of Zurick several times per year for two-week seminars with fifty to seventy psychiatrists and psychiatrists in training. In writing about the beginning of their relationship, Boss notes: "Only much later did I discover the most important motive for Heidegger's prompt answer to my first letter. From the very beginning, as he himself once admitted, Heidegger had set great hope on an association with a doctor....He saw the possibility that his philosophical insights would not be confined merely to the philosopher's quarters but also might benefit many more people, especially people in need of help."

In 1987 Boss published in German a volume that includes the seminar protocols, corrected and emended by Heidegger, notes of conversations between Heidegger and Boss outside the seminars, and extensive excerpts from Heidegger's letters to Boss from 1947-1971 (*Zollikoner Seminare. Protokolle—Gespräche—Briefe. Herausgegeben von Medard Boss*. Frankfurt am Main: Vittorio Klostermann, 1987). The volume was translated into English by Frantz Mayr and Richard Askay and published, with afterwords and notes by the translators, in 2001 (*Martin Heidegger: Zollikon Seminars. Protocols—Conversations—Letters*, Edited by Medard Boss. Evanston: Northwestern University Press). The volume has not attracted a lot of attention, an exception being William Richardson's "Heidegger among the Doctors" (in *Reading Heidegger: Commemorations*, ed. John Sallis. Indiana: 1993), which should be read as another preface to the volume.

Reviewing the *Zollikon Seminars* poses several questions. Who is the intended or possible audience? Does the volume offer something to clinicians without previous familiarity with Heidegger's philosophy? Do the discussions offer something to clinicians who do enjoy a familiarity with the philosophy? Given the frequent discussion and critique of psychoanalytic concepts by Heidegger, does the volume have a place in the ongoing discussion of the status of psychoanalysis? Finally, for those (like this writer) who are not enamoured by Boss's writings, which were very directly influenced by Heidegger (as is quite evident in this volume), do the discussions by Heidegger provide more than can

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President's Column

(Our president, Jerry Kroll, is currently on medical leave, and this column is written by our ex-president, Jennifer Radden. – Ed.)

The findings of President Bush's New Freedom Commission on Mental Health were announced earlier this year: the Commission recommends "transforming how mental health care is delivered in America," and speaks of overcoming barriers through "resolve and leadership." The Commission's 100-page report has received praise from several quarters, including the Health and Human Services Secretary Tommy Thompson. What's not to like about it, at first sight? In reforming mental health care policy the states are charged with replacing the present uneven and inadequate system of care with a comprehensive, community-based network of services sufficient to transform every mentally ill person into a productive, independent citizen rising above disability in an atmosphere where stigma and discrimination are things of the past.

Well, amen to that. But the report offers a hodge-podge of observations, case 'demonstrations,' recommendations and platitudes about mental illness which, on closer scrutiny, proves much stronger on pious hopes than realistic goals. And—though responsibility for mental health policy has been placed squarely in the hands of the states—the kind of 'wrap around' community based care which it recommends is almost certainly going to impose a financial burden which the states cannot shoulder unaided.

I must also take issue with Secretary Thompson's characterization of this report as "thorough and thoughtful." It seems to me neither. It offers an uncritical embrace of ideas, assumptions and theories which, because they are the subject of ongoing controversy, require very careful explication and a reasoned defense. True, this was a report, not a scholarly dissertation. But at the least, a report which was thorough and thoughtful would have tempered its enthusiasm by acknowledging that controversy attaches to its claims. The application of the disability model to mental disorder, an application popular today through a convergence of interests of the consumer movement and the drug companies, but not without its problems and paradoxes, is an example. The disability model applauds and rests on the very rational autonomy which becomes dubious when we speak of mental illness. The ongoing controversy over the biological model in psychiatry, which goes similarly unacknowledged here, is another; the Commission's report lauds biological psychiatry unguardedly. The report emphasizes early screening and treatment, yet these are also controversial: there are many who are concerned over the early diagnosis of children and some, even among the researchers themselves, who question claims that earlier intervention improves outcomes. One of the most serious concerns about psychopharmacology, the question of its side effects and long term effects, is dismissed in a paragraph. Finally, the simplistic solutions to stigma (more public education) fail to address the deep

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historical and cultural roots of prejudice about a condition depriving its sufferers of traits valued in our culture, such as reasoning capability and self control. A passing look at reform movements since the eighteenth century suggests that the eradication of stigma and discrimination may not be so easy. The Commission's reform is in an historical vacuum. It is also in an international vacuum. Case 'demonstrations,' often on a tiny and impossibly modest scale, reflect no hint that anywhere else in the world useful policy solutions to these same problems might have been proposed, or even tried.

On the positive side, emphasis on the consumer movement fits with the latest thinking in this and other countries. Involving consumers in their treatment is the first step, as this report rightly sees, and some of the small experiments in 'wrap around' care are proving an exciting and promising alternative model of mental health care. Even if it is overly optimistic and unrealistic, and if the states cannot be expected to go it alone, the President's Commission on Mental Health offers a laudable set of goals for twenty-first century psychiatry.

Jennifer Radden, D. Phil.

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AAPP Annual Meeting 2003

The Fifteenth Annual Meeting of the Association for the Advancement of Philosophy and Psychiatry which met May 17-18, 2003, provided audiences with a diverse range of approaches to its theme 'Psychopharmacology and the Self,' in a series of thought provoking presentations representing several different disciplines - not only philosophy and psychiatry, but also psychology, psychoanalysis, literary criticism, the history of medicine, and the social sciences.

The meeting was arranged around presentations by two keynote speakers, distinguished philosopher Richard Wollheim, Professor Emeritus at the University of California at Berkeley and author of many works on psychoanalysis, the mind and the self, and Professor W. John Livesley, MD, PhD., of the University of British Columbia, renowned researcher and editor of the *Journal of Personality Disorders*.

After providing a breathtakingly succinct précis of psychoanalysis, Wollheim settled onto a series of questions about ideals of self knowledge, self identity, and desire. Believing is "transparent on" belief in a way not shared by desiring and desire, he showed (I may desire P without believing P worth desiring). Thus, questions about self knowledge which involve our desires are more complex, and more integral to identity than those involving belief, engaging our sense not only of how we are, but how we would like to be, and the two ideals of self acceptance, and self improvement, respectively.

Livesley's focus was the unity and coherence of the self understood as the product of hierarchically organized schemas developed over time and necessary for functioning. Presenting the self as an organizing construct, he expounded on the structural and functional features providing the sense of the self's coherence, and the failures of these mechanisms which result in the fractured self of personality disorders. Illustrating such failures of integration with case material, Livesley cited data suggesting that psychopharmacology sometimes can effect this integration.

The papers which followed ranged between the highly abstract and theoretical, the concrete and case based, and the socially informed and political. They reflected the distress of clinicians forced, in the words of Phil Sinaikin, MD, under "the looming and constant presence and control of the DSM model."They acknowledged, in their various ways, the lessons of 'listening to Prozac' in an 'anti-depressant era.'

Some of the implications of psychopharmacology to the self were raised by Jim Phillips, MD who, in clarifying the relation between the affective and cognitive self pointed to the profound effect of antidepressants on mood, and thus on the deeper, affective self.

In his exploration of personal identity and personal agency, Christian Perring evaluated degrees of personality change in light of questions like "Would it still be me ?" and "Which of your actions are really your actions ?" In doing so he highlighted the complexity of the identity criteria employed in such judgements. Gerrit Glas also examined personal identity using Ricoeur's distinction between idem or sameness identity, and ipse, or selfhood identity, and showing that idem rather than ipse identity is affected by psychopharmacology.

Using the film 'Requiem for a Dream' together with another literary work, Wurtzel's *More, Now, Again*, Alison Mitchell attempted to identify a sense of self distinctive to and, in her analysis, resultant from drug addiction: a self as materialistic, passive and fleeting.

Some of the ethical concerns arising from the use of forced psychotropic treatments to change identities for the criminal law purposes of readying a defendant to stand trial and a prisoner for execution were introduced by Jennifer Radden, Ph.D. and Al Freedman, MD.

Two discussions provided a welcome historical context for today's psychopharmacological practices. Vincent Gerard and Jean Naudin brought us back to the long relationship humans have had with mind changing substances. Louis Charland, Ph.D. reminded us of "moral treatment" in nineteenth century psychiatry, putting forward the argument that one cluster of the DSM-IV personality disorders, including hysterical, antisocial, narcissistic and borderline, invite not pharmacological but moral treatment aimed at a change of moral character.

Neil Scheurich M.D. mapped the professional division of labor wherein the psychiatrist medicates while a non-psychiatrist practices psychotherapy, insisting that in each and every act of prescribing, the psychiatrist too must "weigh what it means to have a self and to conduct a meaningful life."

A group of papers dealt with antidepressants. Even handedly and carefully, Jennifer Hansen, Ph.D. laid out the debate over medication for depression, contrasting the position of the psychopharmacological hedonists with that of the psychopharmacological Calvinists. Her conclusion: the use of psychopharmacology with depression must be evaluated within a larger, societal context. Russell Downham, Ph.D.'s paper was concerned with medicating away depression inasmuch as he uncovered the normative structure of the decision to reduce suffering, arguing that suffering has a particular value and epistemic function. Deprived of suffering we would be, as he puts it, without a reliable indicator of our true narrative commitments. In a related discussion, Charles Henry, MD., explored the way medications can diminish feelings of distress. Particularly the feeling of anguish, he argued, is so central to the experience of consciousness that only medications taken in bad faith will serve to eliminate it. But then, the "responsibility of human self creation" is lost.

Rather than focusing on depression, Nassir Ghaemi, MD raised some troubling ethical issues around treating mild mania, his goal to emphasize that the treatment of mania raises philosophical and ethical problems of its own, quite as important and importantly analogous to those raised by the treatment of depression.

Finally, Douglas Heinrichs MD in-