Are There Philosophical Answers to Psychiatric Questions?

Paul B. Lieberman, Leston Havens

Contemporary psychiatry has only one generally accepted model, that of biological – materialist explanation and treatment. But clinicians recognize that this model omits much that is important and they therefore confront a dilemma: either limit their practice to an incomplete model, or use other models which seem unfounded and speculative. Philosophical considerations may help clinicians find a way out 1) by showing the inherent limitations of biological – materialist explanations, and 2) by grounding other (psychotherapeutic) approaches on general considerations of how the mind, and in particular language, works. These general considerations include: the dependence of meaning upon environmental context, the attribution of meaning as involving sets of skills, capacities and reactions, the multiplicity of language games and therefore their individual limitations, the dependence of meaning upon our shared interests, the largely unconscious nature of mind and our necessary limitations to public criteria for mental events and processes.

1. The Hegemony of the Biological – Materialist Model in Contemporary Psychiatry

American psychiatry is now firmly committed to a nearly exclusive focus on biological – materialist models of psychiatric conditions and their treatment. This hegemony of biological approaches, and the 'descriptive' approaches which are intended to lay the groundwork for biological explanation and treatment, has been commented upon by many authors – both inside and outside of psychiatry.

Pharmacological and other biological treatments, such as electroconvulsive therapy, are often effective, particularly for more severe disorders where other types of treatments, such as psychotherapies, have not shown consistent benefit. But this exclusive focus has also created unease among psychiatrists and their patients. Psychiatry, after all, purports to be the branch of clinical practice which treats the whole person. The exclusive focus on biological – materialist interests has excluded many areas of patients' lives from clinical compass.

Despite these reservations, however, for the working clinician, biological approaches seem to possess an important advantage: a clear model which is easy to understand and use. This is the model of the interlocking biological sciences: chemistry grounding physiology, physiological systems organized anatomically, disorders localized at particular points in the causal chain located inside the body. It has been spectacularly successful throughout medicine.

By contrast, there is no generally accepted, readily teachable and empirically grounded model to guide other therapeutic approaches in psychiatry. Thus, the clarity and convincingness of the biological model, and the absence of any accepted and validated alternative among the psychological therapies, have contributed to the hegemony of biological approaches in clinical work. This leaves psychiatrists with a dilemma: either adhere to the biological – materialist model which seems logically invincible but clinically incomplete, or use other clinical methods (the psychotherapies) which are felt to be more hypothetical, less scientific and even, from a biological perspective, superfluous or frivolous.

In what follows, we shall attempt to use recent philosophical considerations to support two conclusions: 1) the biological – materialist model, rather than being necessarily valid, is in fact incomplete and inadequate, and 2) other psychological approaches to clinical understanding and treatment can be founded on very general features of mental life, and, therefore, should not be considered "hypothetical."

2. Problems with the Biological – Materialist Model in Psychiatry

If the biological – materialist view of mind is inadequate or wrong, we should expect that there might be many ways in which it fails to fit or represent reality. And, in fact, philosophers have noted several.

First, the biological or materialist conception of mind cannot explain or model human action. Action seems to involve the causal efficacy of psychological events or processes: our thoughts, beliefs and wishes. But if such thoughts, beliefs and wishes are identified with biological states of the brain, then it is those material states which are causal, and the experienced psychological states merely 'drop out' in terms of their causal efficacy. Moreover, it is completely obscure how a thought, belief or wish, conceived of as a mental experience could interact with or influence any physical state, such as the movement of a limb or the forming of a word. This set of age old problems has not received any successful or generally received solution. (Kim, 1998)

Second, psychological states such as thoughts, beliefs or wishes have the property of intention: they refer to things, frequently objects outside the person whose thoughts, etc. they are. But how can one material thing – a brain state – *refer* to another material thing – the object outside? The brain state is merely, we imagine, an inscription; we might as well try to imagine a scratch, or a mark on paper, as referring. (Putnam, 1981) Perhaps the brain state refers because of a complex causal chain which has linked that state to previous encounters with the referred-to object. (Putnam, 1975) But this, too, is difficult to imagine. Suppose that science allowed us to establish that, after a number of exposures to an object, a correlation is set up between the appearance of that object and a pattern of brain activity. And now suppose that that brain pattern were stimulated, for example by an implanted electrode. Is it possible, whatever my ensuing psychological state, that when that brain activity occurred I *meant* that object? Suppose I said, "A" (the name of A): would I be *meaning* A? It seems clear that we would not say this: whether I meant A would depend on much else (for example, whether A was present, whether I responded to it in certain ways, whether I handled certain related concepts 'appropriately'). Only if all these other things were true could we say that, when the appropriate brain activity is stimulated, that I meant A. And therefore, only if all these other requirements were met could we claim that the appropriate causal chain had established the object –

meaning connection. By contrast, for many objects we can readily imagine multiple ways they could be meant or referred to – and no single pattern of brain activation would be necessary.

Third, not only do thoughts, etc. refer to things, they refer to them in particular ways: they apply predicates to them, or embody a stance toward them. As Austin noted in connection with action (Austin, 1956), a crucial aspect of cognitive functioning, one which is too little considered, is the process of appraisal or appreciation. Not only do I recognize that someone is grieving, but I appreciate the depth and even the quality of his sorrow; I share his experience. Could this 'appreciation' be a biological – materialist event or process? If there are problems in my meaning A, for example, in the thought 'A is f,' there are exactly the same problems, it would seem, in my meaning 'is f.' For appreciating or appraising that A is f is at least as complicated and ramified a set of activities as simply recognizing the presence of A.

Fourth, it seems clear that people *experience* things: there is something it is like to be a person, and to be the particular person one is. (Nagel, 1974) Now it may not at all be true that this is a unique experience – my being me and you being you may or may not be similar or comparable – but it is at least clear that some experiencing is involved. It at least seems to be the case that, *pace* James, consciousness does exist. But just how consciousness arises from or supervenes on biological processes remains unknown.

These considerations are familiar to philosophers, and some of them were also discussed by Freud (who held a 'dual-aspect theory' of the relationship between mind and brain). But most contemporary psychiatrists rarely ponder them. What would happen if they did?

They would not have to give up an appropriate interest in the biological influences upon or causes of mental states. But they might feel more comfortable in thinking "outside the box" of biological – materialist explanations. If such explanations are inadequate to explicate our ordinary notions of mental life, they may be inadequate for clinical work, as well. When biological factors are recognized as causes or influences upon particular psychological states or processes, rather than as identical to them, psychiatrists may feel more justified in using other explanations and perspectives, including ones involving meaning, action and experience.

But this conclusion lacks either content or conviction. Psychiatrists may be justified, but are they? And what 'other explanations and perspectives' are available to compete convincingly with the biological?

3. Wittgensteinian Considerations and the Psychiatric Encounter

A useful model in psychiatry must be prescriptive: it must help the clinician to handle complex clinical situations. The biological-materialist model does guide clinicians, but only so far. Psychological models – psychoanalytic, cognitive, supportive – cover areas which are left out of biological – materialist approaches, but are also incomplete, and do not have the *prima facie* plausibility that the biological-materialist model seems to have.

Much of Wittgenstein's work, of course, concerns our mental life. Phillips has spoken of Wittgenstein's subject as being "the possibility of language." (Phillips, 1999) Diamond has characterized his work as involving "*the* mind" but not "empirical psychology." (Diamond, 1991) Cavell has developed Wittgenstein's views in many ways which, I think, emphasize his relevance to our self-understanding, and to psychological concerns. (Cavell, 1979)It does not seem too much of a stretch to wonder whether Wittgensteinian considerations might provide psychiatrists with an orientation toward mental life which is more encompassing, and more true to it.

The question I wish to ask is: If we try to collect some of Wittgenstein's observations and reminders, can we do so in a way, or ways, which can interest or help the psychiatric practitioner?

What might a clinician learn from Wittgenstein, and from other contemporary philosophers who have followed his lead? Here are several key ideas which, I believe, are commonly identified as being 'Wittgensteinian'. (Wittgenstein, 1958)

1. The meaning of what we say depends upon the context, or environment, in which words are uttered. Any word or group of words takes its meaning from how it is used: in what context, to achieve what purposes. This means the interpersonal context as well as the non-personal.

2. When we ascribe a thought to someone, including oneself, we are attributing to that person not the presence of an inner picture or silent sentence, or even an unconscious model. Rather, we are attributing to him or her a set of skills, capacities and reactions. Thus, someone's knowing the meaning of a word means that she can use it appropriately and can use related concepts appropriately: that, in other words, so far as that word or set of words is concerned, she responds more or less as we all do.

3. There is not one type of language game, but there are many. While many words are names, many others are not. While the purpose of some propositions is description, the purpose of others is not. A poem is not a theorem of logic or a newspaper account.

From this it follows that words and concepts have *limited* uses. This observation is of singular importance to psychology. Wittgenstein emphasized that psychological concepts are heterogeneous. By this, I think he meant, for example, that while the report of an event, the report of a dream and the report of a pain may all appear similar, the grammars of these various 'reports' are different in ways that may have clinical importance. (For example, if there is some detail missing from your report of yesterday's event, I might look for another witness; but that would not be possible for your dream or pain.)

4. What we mean follows our interests and what we care about: what we care about is shown in what we do. Wittgenstein emphasized that words take on meaning as parts of our practices and ways of living. The words we use thus reflect our natural and learned reactions; in fact, communication requires that we share such reactions. It seems a natural extension that what we care about includes other people's interests.

5. Mind is largely unconscious. This may seem inappropriate in a list of Wittgensteinian themes, since it is a point made by Freud, not Wittgenstein. But if meaning and communication depend upon our shared reactions, and such reactions are shown only through or in our overt behavior, including speaking, then these all-important reactions and dispositions are unconscious: they are shown only by their effects; they are hypothetical entities, but necessary ones.

6. An 'inner process' stands in need of outer criteria. I think it is not clear how Wittgenstein intended us to take this famous dictum: I imagine that he rather grudgingly accepts that this way of talking has its uses. The importance of this for psychiatry is that at least one kind of uncertainty in attributing psychological predicates to people (the kind that can be formulated in the question: "How can you know whether A is really imagining, remembering, projecting, incorporating, etc., since you would have to see inside him?") is itself made unstable and of uncertain, questionable sense. If you look for evidence of criteria being satisfied *there*, you will not find them. It still leaves wide open, of course, how such words in fact are used, how difficult it can still be to know such things, or why you are "tempted" to feel shut out as you do.

How might these Wittgensteinian considerations be of use to a psychiatrist? When psychiatrist and patient meet, the psychiatrist begins to react: she hears what the patient says and how he presents himself according to her (the psychiatrist's) orientation. If that orientation is biological – materialist, the psychiatrist will be led in certain directions: to elicit symptoms, make a diagnosis, consider medication. But a clinician wanting to use other, perhaps psychotherapeutic, orientations lacks an equally clear and accepted model. It is this gap which, I believe, Wittgensteinian considerations may help to feel. Wittgenstein's investigations into the nature of the mind can orient the psychiatric clinician in several important ways.

First, it can attune him or her to the fact that every communication, every expression, receives its content or meaning, from the context in which it is uttered. Every statement is a 'move' in a language game. This means that every communication, every statement involves the relationship of at least two people – and 'involving the relationship', itself, depends upon certain usually implicit appraisals and motivations. Behind or under every 'chief complaint' and expression of distress, this feature of meaning is present. It is, therefore, always a potential focus of clinical interest.

Second, it is acceptable, in fact necessary, to keep in mind a mixture, not a synthesis or unified structure, of multiple language games. These may involve making a biological-materialist diagnosis, but they may also involve thinking about what the patient is doing, where she is coming from (psychologically, what her history has been) or what she is intending. These multiple approaches do not necessarily form a unity, although we may learn, empirically, that they share certain connections and associations.

Third, what we say and mean depends upon our interests and what Cavell has called our "routes of feeling (Cavell)." Clinically, this means that when the psychiatrist listens, what he can hear, through or in the patient's words, are his or her latent, underlying interests or intentions. This is not a hypothesis, for example, of the existence of transferential elements in our current day interpersonal relationships. Rather, it is a feature of communication itself.

Fourth, the clinician is provided with certain methods or ways of focusing, which permit him or her to get to know the patient better. Understanding fully what the patient means requires knowing his or her history. For example, if we want to know *why* someone did some particular action, we must look at his or her reasons, and that means knowing about his or her past (Anscombe, 1957) Historical understanding is thus necessary to a full understanding of human behavior.

Because what we say gains its meaning only within a network of activities (forms of life) which are extended in space and time and not directly present, the clinician is attuned to the fact that what the patient means may not be obvious – to the patient or to the clinician. Even apparently simple reports of direct experiences need to be explored for their uses, their roles in patterns of activity. For example, when the patient says he feels anxious, this may appear to be a simple report of a feeling. But in fact, identifying it *as* anxiety already presupposes the mastery of this concept. Exploration of how this concept 'works' may provide important insight into the patient's meaning, and, therefore, world. Nussbaum, for example, has suggested, following the Stoics, that emotions are appraisals of our relationships to essential aspects of the world which are outside of our control. (Nussbaum, 2001)

Fifth, the clinician is provided with what we might call a 'meta approach' to understanding how patients change, and, therefore, how we may help them to change. To influence what the patient thinks and means must be to influence what he or she intends: his interests and routes of feeling. As Havens has pointed out, our language is rich in resources for doing this. Simple empathic statements ("How awful!") or what Havens calls "extensions" ("You must have missed him very much") are not intended to convey information, but to elicit, amplify and thus change certain reactions. (Havens, 1986)

The same may also be said for reconstructions of the past. Much debate in and about psychiatry has focused on whether the past can be truly known, for example, whether the events patients report actually occurred. But in many clinical situations there is little real doubt about the truthfulness of patients' reports of the past. The clinical question is, rather: what does it mean to be aware of the influence of the past? What role can an awareness of the past play in one's life? This question echoes one suggested by Anscombe: how do we so much as develop a concept of the past, and what does it mean to have one? (Anscombe, 1950). Her answer was that it means being able to appreciate and participate in certain activities, for example, referring to events in particular ways. More fully appreciating our own past changes our ways of seeing it, and that is another example of our changing our dispositions, reactions and "routes of feeling."

Sixth, this approach allows the clinician to keep what is valuable in empirically validated treatments, for example cognitive – behavioral approaches to various symptoms, while continuing to see them as useful techniques *within* a larger context – the context of human life, with its structures of meaning and forms of activity.

Seventh, the clinician is provided with a map of the normal, and ways of identifying and localizing the abnormal (Havens). What is normal is encoded into our ordinary uses of words: *these* ways of living, with *these* words have been found, for the most part, to 'work.' Others might work better, equally or less well. The clinician listens to the patient's uses of words and compares them with his own – his own as benchmarks for the normal. But the clinician is also always aware that a) he, too may be misusing language, b) disagreements are not usually resolved by proof or disproof, and c) many forms of life are possible.

In summary, philosophical explorations might help clarify what it means to say that the psychiatric encounter is a meeting of two people – one seeking and one offering help. Recognizing the nature of our language games helps define the broader human compass by which any, particular clinical technique is supported and sustained.

References

Anscombe, G. E. M. 1950 “The reality of the past”, reprinted in Anscombe, *Metaphysics and the Philosophy of Mind: Collected Philosophical Papers, Volume II*. Minneapolis: University of Minnesota Press, 1981, pp 103 – 119.

Anscombe, G. E. M. 1957 „Intention“, reprinted in Anscombe, *op cit*, pp 75 – 82.

Austin, J. L. 1956 “A plea for excuses”, reprinted in Austin, *Philosophical Papers*, J. O. Urmson and G. J. Warnock (eds.), Oxford: Oxford University Press, 1970, pp 175 – 204.

Cavell, S. 1979 *The Claim of Reason: Wittgenstein, Skepticism, Morality and Tragedy*, New York: Oxford University Press

Diamond, D. 1991 “Philosophy and the mind”, in C. Diamond, *The Realilstic Spirit: Wittgenstein, Philosophy and the Mind*, Cambridge: The MIT Press.

Havens, L. L. 1986 *Making Contact: Uses of Language in Psychotherapy*, Cambridge: Harvard University Press.

Kim, J. 1998 *Mind in a Physical World: An Essay on the Mind-Body Problem and Mental Causation*, Cambridge: The MIT Press.

Nagel, T. 1974 “What is it like to be a bat?” reprinted in Nagel, *Mortal Questions*, New York: Cambridge University Press, pp 165 – 180.

Nussbaum, N. C. 2001 *Upheavals of Thought: The Intelligence of Emotions*, New York: The Cambridge University Press.

Phillips, D. Z. 1999 *Philosophy's Cool Place*, Ithaca: Cornell University Press.

Putnam, H. 1975 “The meaning of ‘meaning”, reprinted in Putnam, *Mind, Language and Reality: Philosophical Papers, Volume 2*. New York: The Cambridge University Press, pp 215 – 271.

Putnam, H. 1981 *Reason, Truth and History*, New York: The Cambridge University Press.

Wittgenstein, L. 1958 *Philosophical Investigations, Third Edition,* G. E. M. Anscombe (trans.), The Macmillan Company.