Introduction: Just Getting Started

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Ten years ago the Royal Institute of Philosophy marked the establishment of the Society for Applied Philosophy with a series of public lectures, published in an earlier book in this series, under the title *Philosophy and Practice* (Griffiths, 1985). Looking back it is hard to believe this was only ten years ago. Applied philosophy still has its critics. But it is now so pervasive, so much the norm, that it seems to have been with us always. Law, medicine, education, nursing, the environment, politics, economics . . . almost it seems, no subject is quite respectable nowadays without its philosophy and its philosophical exponents.

Psychiatry is a relative newcomer to the applied philosophy party (Fulford, p. 5, this volume). There are evident historical reasons for this: as Jeremy Holmes (p. 41) notes, psychiatry has gained respectability as a medical discipline by identifying itself with empiricism. But now that it has arrived, psychiatry brings with it a new vision of what the party is all about.

The rise of applied philosophy is generally portrayed as a reaction to the supposed aridity of the analytical philosophy of the post-war period. Preoccupied as it was with questions of meaning, philosophy appeared to have lost its connections with questions of substance. Bernard Williams (1985) captures a poignant image of the impotence of the professor's arguments when the mob breaks down the door and tramples his glasses. Against this background, then, the ethical issues generated by the explosive growth of technological medicine were a life-line to philosophers. And so it was that medicine, as Stephen Toulmin (1982) first put it, 'saved the life of ethics'.

The conception of applied philosophy to which this story leads has had important results: in health care, and in other practical disciplines, there is a new awareness of the ethical aspects of practice; and in philosophy itself there has been a renewed interest in the real world, in case-centred reasoning, in virtue-ethics, and, in the philosophy of mind, attention to the findings of empirical psychology. But for all this it is an essentially negative conception, emphasizing substance *at the expense of* meaning, practice *at the expense of* theory, ethics itself *at the expense of* metaphysics. Indeed in medicine, bioethics is essentially bolted on, a prosthetic addi-

tion, important in practice perhaps, but peripheral to the biotechnology by which most doctors still take their subject to be defined.

Psychiatry has shared in the returns from applied philosophy, so conceived. Indeed to the extent that these have been mainly ethical returns, it has extended and enriched them. There is no shortage of real cases in this book. There is no shortage of real ethical dilemmas. Some of the topics would certainly be familiar to bioethicists—dangerousness (Walker, p. 179), consent (Devereux, p. 191), and autonomy (Holmes, p. 41). But bioethics, even when proceeding by case-centred reasoning, would standardly be concerned mainly with the applications of a relatively narrow range of broadly liberal-utilitarian values to issues arising in treatment. Whereas, applied to psychiatry, philosophy finds itself concerned also with morals (Taylor, p. 145; Wilkes, p. 115) and aesthetics (Storr, p. 213), tackling questions of diagnosis as well as treatment (Quinton, p. 197), meeting conceptual problems, problems of meaning, head on (Fulford, p. 5; Robinson, p. 159), and being drawn through these irresistibly into many of the deep problems of general metaphysics—the mind-brain problem (Papineau, p. 73); epistemology (Shotter, p. 55); rationality (Wilkes, p. 115); meaning and cause (Holmes, p. 41); the nature of consciousness (Boden, p. 103); and, linking several of the articles that follow, personal identity (Harré, p. 25; Binns, p. 83; Hope, p. 131; Boden, p. 103; and Taylor, p. 145).

Philosophical theory and medical practice come together in psychiatry at a number of levels. There may be direct transfers of skills and ideas between them. Thus Papineau (p. 73) shows the relevance of recent work in the philosophy of mind to the debate about the validity of mental illness; Binns (p. 83), on the other hand, draws conclusions about the nature of personal identity from the remarkable disturbances of volition found in schizophrenia. There may be a convergence of themes. The second cognitive revolution, described by Harré (p. 25), shares with family and group dynamics, a conception of agency as located not within the individual but in shared discursive practices. There may be a deeper sharing of models. Psychiatry, in showing that medicine has been too much influenced by the model of natural science (Fulford, p. 5), points also to the possibility, suggested by Wittgenstein (Lee, 1980), that philosophy, too, may have been too much influenced by this model.

There are many dangers here, of false analogy (of a new 'psychiatrism' in place of earlier psychologisms), of conflation (philosophy and psychotherapy really *are* different), of a slide from philosophy to philosophising (from rigorous metaphysics to meta-

physical system building). These dangers are the more real for the continuing needs of practitioners to find 'answers', and of philosophers to make themselves 'useful'.

Analytical philosophy, among other possible approaches, avoids these dangers. In confining itself to conceptual difficulties it tackles local problems with the modest objective of improved understanding. Linked with a discipline like psychiatry this is far from being practically empty. As the range of contributions to this book shows, psychiatry is beset with conceptual (as well as empirical) problems in all aspects of diagnosis, treatment and research. It was indeed the richness of this range of problems which J. L. Austin—the personal target of much of the attack on post-war analytical philosophy—had in mind when he pointed philosophers to psychiatry over thirty years ago (Austin, 1956/7). Here, then, in psychiatry, analytical and applied philosophy are one and the same! Work in so limited an area, as Austin was the first to emphasise, can never be the last word in philosophy. But it may be the first word. It may be one way of getting started with certain kinds of philosophical problems (Warnock, 1989, ch. 1). In psychiatry, we are just getting started.

Mind and Madness: New Directions in the Philosophy of Psychiatry

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These are exciting times for philosophy and psychiatry. After drifting apart for most of this century, the two disciplines, if not yet fully reconciled, are suddenly at least on speaking terms. With hindsight we may wonder why they should have ignored each other for so long. As Anthony Quinton pointed out in a lecture to the Royal Institute of Philosophy a few years ago, it is remarkable that philosophers, in a sense the experts on rationality, should have had so little to say about the phenomena of *ir*rationality (Quinton, 1985, ch. 2). There have been partial exceptions, of course. Descartes and Kant both touched on madness; and there were, notably, important philosophical influences on the development of modern psychiatry in the late nineteenth and early twentieth centuries (Zilboorg and Henry, 1941). Yet even John Locke, who was a doctor as well as philosopher, confined himself to a fairly superficial distinction between what we should now call mental illness and mental defect—those with, in Locke's view, respectively too many ideas and too few (Locke, 1960).

The question that now arises is where do we go from here? Is this a brief conjunction of the two disciplines, a *fin de siècle* phenomenon, like that experienced at the end of the last century? Or is it the beginning of a more enduring relationship?

Things could go either way, I believe. On the one hand, there are a number of factors, both practical and theoretical, which could work against the relationship. We will be returning to some of these later. On the other hand, though, philosophers and psychiatrists really do have a great deal to offer each other. In their clinical work and in research, psychiatrists face practical problems which, as we will see in this chapter, are often as much conceptual as empirical in nature. These conceptual problems, moreover, may turn on difficulties of a more general philosophical kind—the nature of causation, of rationality, and so forth. In helping us to tackle such problems, therefore, philosophers, besides making an important contribution to practice, could gain access to a considerable treasure trove of material for philosophical analysis.

In this article, then, I want to consider what will be needed if the relationship between philosophy and psychiatry is to prosper. I will be reversing the usual procedure in philosophy, though. Instead of arguing the general case and then illustrating it with particular examples, I will start with a particular example, Descartes' Cogito and the schizophrenic symptom of thought insertion[1], and then come back to the relationship between philosophy and psychiatry.

Thought Insertion and Descartes' Cogito

Descartes' Cogito, his famous aphorism 'I think, therefore I am', was the pivotal step in his search for a secure foundation for knowledge. Even if I am deluded, he argued, or deceived by an all powerful 'evil demon', the one thing I cannot be wrong about is that I *think*, for to doubt *is* to think. As Ayer put it, 'if one doubts whether there are acts of consciousness, it follows that there are, since doubting is itself such an act' (Ayer, 1973). Hence, since I must exist to have a thought, I exist.

Now, at first glance it might seem that there is not likely to be much in common between Descartes, the arch rationalist, and schizophrenia, a serious form of mental illness marked by a particularly severe degree of irrationality. The schizophrenic symptom of thought insertion, however, represents a direct challenge to the Cogito.

To see this, we need to look, first, a little more closely at both the Cogito and thought insertion. Thus Descartes' move from 'I think' to 'I am' is intuitively persuasive because of the strength of the bond between our sense of self and our experience. This has been discussed in the context of philosophical work on the nature of personal identity (Glover, 1988). The claim that one is *having* an experience which at the same time is not one's *own* experience seems to be almost self-contradictory. Indeed the 'adhesiveness' of experience makes it, as Ryle said, as 'inescapable as a shadow' (Ryle, 1949). I can imagine myself separated from parts of my body, perhaps even from my body as a whole. But I cannot imagine being separated from my conscious experiences. Yet this is exactly what the schizophrenic patient with thought insertion *does* experience.

Thought insertion is defined in the textbooks as having

[1] Descartes, 1968. This example is also discussed in Fulford, K. W. M., forthcoming [a].

thoughts in your own head, thoughts consciously present to you, and thoughts which in this sense *you* are thinking, yet which you experience at the same time as the thoughts of some *other person or agency*. C. S. Mellor, a psychiatrist, has given us a number of excellent case descriptions of this and of other remarkable schizophrenic symptoms (Mellor, 1970). One patient, a 29 year old housewife, reported her experiences thus:

> *I look out of the window and I think the garden looks nice and the grass looks cool. But the thoughts of Eammon Andrews (a famous 'media personality' at the time) come into my mind. There are no other thoughts there, only his. He treats my mind like a screen and flashes his thoughts on to it like you flash a picture.*

So this patient, it seems, would have disagreed with Descartes. For this is a case of the self and conscious experience becoming separated, of the adhesiveness of experience breaking down. This patient *has* conscious experiences but they are those *of* Eammon Andrews. In Descartes' terms, then, this is 'I think, therefore Eammon Andrews is', or 'Cogito ergo es'!

There is thus a clear *prima facie* link between thought insertion and the Cogito. We will come back later on to what we should make of this link. But granted that there is such a link, we might reasonably have expected it to provide a point of contact between philosophers and psychiatrists. Yet until recently the symptom has been neglected even by those philosophers who have taken an interest in psychopathology, and, conversely, even by those psychiatrists who have taken an interest in philosophy. Karl Jaspers, one of the founders of modern psychopathology, and no mean philosopher (he actually wrote a monograph on Descartes—see Jaspers, 1963), had nothing to say about the significance of thought insertion for philosophy, or vice versa.

We will be returning to the reasons for this later, when we look at what is required if philosophy and psychiatry are to establish a permanent relationship. But we must first consider whether, appearances notwithstanding, the two sides, philosophers and psychiatrists, have indeed anything useful to say to each other. We will take this question initially from the psychiatric side, looking at the conceptual problems raised by thought insertion and at whether these are problems of a kind with which philosophy can help. We will then look at thought insertion from the philosophical side, asking whether the symptom has any points of interest for philosophy.

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The conceptual problems raised by thought insertion and related symptoms

From a psychiatric perspective the knee-jerk response to the question whether philosophy can help us to understand thought insertion might well be, what is there to understand? We know little enough about the causes of schizophrenia, it is true; our treatments are far from adequate; the syndrome itself is unsatisfactory—it is defined by one or more of a list of symptoms, even the exact extent of which is disputed, and it will probably turn out to include a variety of quite different disorders. But at least this key symptom, the symptom of thought insertion, is well-defined and (objectively) capable of reliable identification in practice, that is with a good degree of agreement between different observers, and in a variety of different social and cultural contexts (Wing, Cooper and Sartorius, 1974). Compared with many of the more elusive phenomena with which psychiatrists deal, then, thought insertion, far from being poorly understood, is surely one of our sheet anchors.

This point of view is important. It is important to see that with thought insertion we are not dealing with a marginal symptom, a dubious phenomenon. It is one of the corner stones of modern psychiatry. If we look more carefully, however, we find that we (in psychiatry) understand thought insertion considerably less well than we like to think.

I am going to fill this claim out a little, the claim that we don't understand thought insertion, by looking at the symptom in a way which will be familiar to doctors, the standard medical procedure of differential diagnosis. Looking at it this way has the advantage that if we run into problems, they are inescapably *medical* problems. A difficulty in differential diagnosis can't be 'written off' as philosophical neurosis.

The differential diagnosis of thought insertion can be considered at two levels, the patient's actual experience, and the structure of beliefs within which the experience is set. Thus, at the first level, so far as the patient's experience of inserted thoughts is concerned the point is simply that the textbooks have no satisfactory way of characterising this very odd but important symptom. A negative line is generally taken, thought insertion simply being contrasted with other, less odd, phenomena with which it might be confused (Gelder, Gath and Mayou, 1983). Thus, it is *not* simply one's own thoughts being influenced by others, whether by ordinary means (that is, as I am influencing your thoughts now) or delusionally (e.g. by telepathy). Again, thought insertion is different from obsessional thoughts. Obsessions, as symptoms of mental

illness, are like a bad case of getting a tune stuck in your head—you know it's ridiculous but you can't get rid of it. Now obsessional thoughts may take the form of excessively violent or sexual images. In such cases the patient will often say 'that's not me' or 'they're not my thoughts'. But as the psychopathologist Andrew Sims emphasises, what the patient means by this is only that the thoughts are out of character (Sims, 1988). The patient retains a clear recognition that the thoughts as such are their own. In contrast to thought insertion, there is no suggestion that the thoughts are those of someone else.

At the level of the patient's experience, then, the standard textbook characterisation of thought insertion is essentially in these negative terms. This would not be too bad, however, if the differential diagnosis could none the less be carried right through to completion. But, and this brings us on to the second level, the level of the beliefs within which the experience is set, it cannot.

The difficulty, essentially, is that odd though thought insertion is, it is not quite unique: that is to say, the experience of 'inserted thoughts' can occur in other conditions. The most striking example of this is the 'forced thoughts' which can occur during the aura of a particular kind of epilepsy. Now the crucial difference between forced thoughts and thought insertion, crucial from the point of view of differential diagnosis, is that the epileptic readily accepts the doctor's explanation that the thoughts are due to their epilepsy, whereas the schizophrenic with thought insertion does not.[2] The schizophrenic patient may be well aware that their experience is odd. A colleague of mine was asked by one of his patients if the technology had been invented to put thoughts into people's minds. When he replied that it had not, the patient said 'well, I can tell you its jolly well happening to me!' (Walker, 1993). So the patient with thought insertion may have full understanding that their experiences are very peculiar, and yet, uniquely to thought insertion, they lack insight into what must surely be the most likely *explanation* of their experience, namely that it is a symptom of something wrong with them.

It is on this lack of insight, then, that the diagnosis of true thought insertion turns. It is this which marks out thought insertion as a symptom of what is called in psychiatry a psychotic disorder, like schizophrenia, from non-psychotic disorders. In schizophrenia (and occasionally in 'organic' psychotic disorders such as dementia) the patient with thought insertion lacks insight; in the

[2] Lishman, 1987. An aura in epilepsy is a set of (usually) highly stereotyped symptoms which immediately precedes a fit.

epileptic (non-psychotic) case insight into the nature of the inserted thoughts is preserved. And the difficulty this raises, the difficulty for differential diagnosis, is that psychiatrists have *no adequate way of defining* lack of insight of this particular, this *psychotic* kind. Aubrey Lewis, one of the founders of modern scientific psychiatry, was the first to point this out (Lewis, 1934). And so disenchanted was he in consequence with the notion of insight that he rejected the very distinction between psychotic and non-psychotic disorders. This rejection has become the official line, modern classifications claiming to have largely eliminated the psychotic/non-psychotic distinction.[3] This has turned out to be no solution at all, however. For the distinction continues to be employed, not only in everyday psychiatric usage (in medicolegal contexts, for instance), but, if we look carefully, it is still there even in our official classifications. Indeed I have shown elsewhere that the place of the psychotic/non-psychotic distinction in current classifications is exactly equivalent to the place it had in earlier classifications. All that has happened is that the categories concerned have been shuffled around (Fulford, 1994).

The standard medical response to this might well be to say, well we may not be able to define insight in any general sense, but at least we can define particular psychotic symptoms. In particular we can define delusion, and there is a clear sense in which it is the patient's *delusional* beliefs about their inserted thoughts which makes them genuinely psychotic symptoms. However, closer inspection shows that even this fails to meet the case. Thus, the standard definition of delusion generally goes like this:

> A false belief, held despite evidence to the contrary, and one which is not explicable in terms of the patient's educational and cultural background. It is held with complete conviction and cannot be shaken by argument. (Harré and Lamb, 1986)

The key element of this definition is *falsity* of belief.[4] But the difficulty is that delusions, as symptoms of mental illness, although commonly false are not always or necessarily so. Sometimes they turn out to be false after all—the patient who believed he was being persecuted by the CIA, and was! But, more interestingly, delusions may be known to be concordant rather than discordant

[3] See for example, World Health Organisation, 1992; American Psychiatric Association, 1980.

[4] The secondary clauses of the definition of delusion have problems of their own: e.g., most delusions are not culturally atypical, conviction is no mark of pathology, etc. See, generally, Flew, 1973.

with fact *at time the diagnosis is made*. The standard clinical example of this is the Othello Syndrome, involving delusions of infidelity.[5]

> *Mr A. Age 47—Publican. Seen by general practitioner initially because his wife was depressed. However, Mr A. complained of anxiety and impotence. GP suspected alcohol abuse. After some discussion, Mr A. suddenly announced that 'the problem' was that his wife was 'a tart'. Once started, he went on at length about her infidelity, drawing on a wide range of evidence, some of it bizarre [e.g., that she washed their towels on a different day; that the pattern of cars parked in the street had changed]. The diagnosis of Othello Syndrome was subsequently confirmed by a consultant psychiatrist. Yet both the GP and psychiatrist knew that Mrs A, although not promiscuous, was depressed because an affair she had been having had come to an end.*

Such cases are unusual though by no means rare (Vauhkonen, 1968). But if further, more logical, proof were required that delusions are not, essentially, false factual beliefs, there is the (on the standard definition) paradoxical delusion of mental illness![6] In a case like this, the standard definition of delusion as a false belief *can't* (logically can't) work. For if delusions were essentially false beliefs, the delusion of mental illness if true would be false, and if false would be true.

So delusions are not false beliefs, in the sense of being necessarily discordant with fact. And to make matters worse (worse from the point of view of the standard definition), delusions may not be beliefs at all, at any rate as to matters fact, but value judgments (Fulford, 1991a). Delusions of guilt in depression, for example, may be factual (I caused the famine in Africa), or, as in the case below, evaluative.

> *Mr S.D. Age 48—Bank Manager. Presented in casualty (with his wife) with a three-week history of 'biological' symptoms of depression [early waking, weight loss, fixed diurnal variation of mood] and delusions of guilt. He had forgotten to give his children their pocket money, but he believed that this was 'the worst sin in the world'; that he was 'worthless' as a father; and that his children would be 'better off' if he were dead.*

Similar evaluative delusions, though with a positive rather than negative sign, occur in the elevated mood counterpart of depression, hypomania.

[5] All the cases described here are based on real patients but with biographical and other details fully disguised.

[6] This case is described in Fulford, 1989a, ch. 10.