

9th International Conference on Philosophy, Psychiatry and Psychology

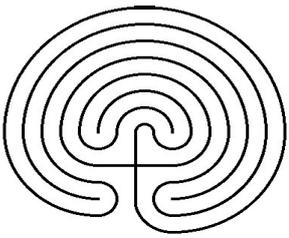
Philosophy, Psychiatry and the Neurosciences

June 28th - July 1st 2006

Leiden, The Netherlands

Organized by the
Section for Philosophy and Psychiatry of the Dutch Association for Psychiatry
Faculty of Philosophy, University of Leiden
in collaboration with
The International Network for Philosophy and Psychiatry
The Philosophy Special Interest Group of the Royal College of Psychiatrists (UK)





Labyrinths have been known to the human race for over 4,000 years. The oldest is thought to be the “Cretan Labyrinth”.

This classical Cretan labyrinth pattern has appeared for thousands of years in many variations throughout the world. The labyrinth can be found as both an image and metaphor in ancient myths, architecture, art, dance and indigenous rituals.

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Introduction

Dear colleagues,

Welcome to Leiden and the 9th international conference of the International Network for Philosophy and Psychiatry (INPP).

Leiden University is honoured to host this interdisciplinary conference on a rapidly expanding and increasingly important field of reflection and research.

This oldest of the Dutch universities was founded in 1575. Its motto Praesidium Libertatis (bastion of freedom) reflects core values of both the university and the city – values that were fostered during the city's long history of struggle for independence and tolerance.

Leiden is the city where the Pilgrim Fathers found refuge, it is the place where famous painters of the Dutch school lived and worked, and most notably, it is the birthplace of the illustrious Rembrandt van Rijn, whose 400th anniversary is commemorated this year.

We hope that the clarity and open skies that are so typical for Dutch art and landscapes, together with the calm and spontaneity of the city, and the reflective atmosphere of the Academia, will provide optimal conditions for fruitful discussion and encounter during our meeting.

The topic of the conference is 'Philosophy, Psychiatry, and the Neurosciences'. One of our aims is to clarify how philosophical reflection on current neuroscientific research may help psychiatry to broaden and enrich its conceptual frameworks. There are many promising developments to report in this respect. Let me only mention the rapprochement between (existential) phenomenology and cognitive neuroscience, the emergence of neurophenomenology, and experiments that try to include subjective experience in neuroscientific research.

In addition to contributions on this specific topic, there will be lectures on a wide variety of other issues, presented by eminent speakers from all continents of the world.

We are looking forward to an exciting and fertile meeting!

The organizing committee

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Introduction

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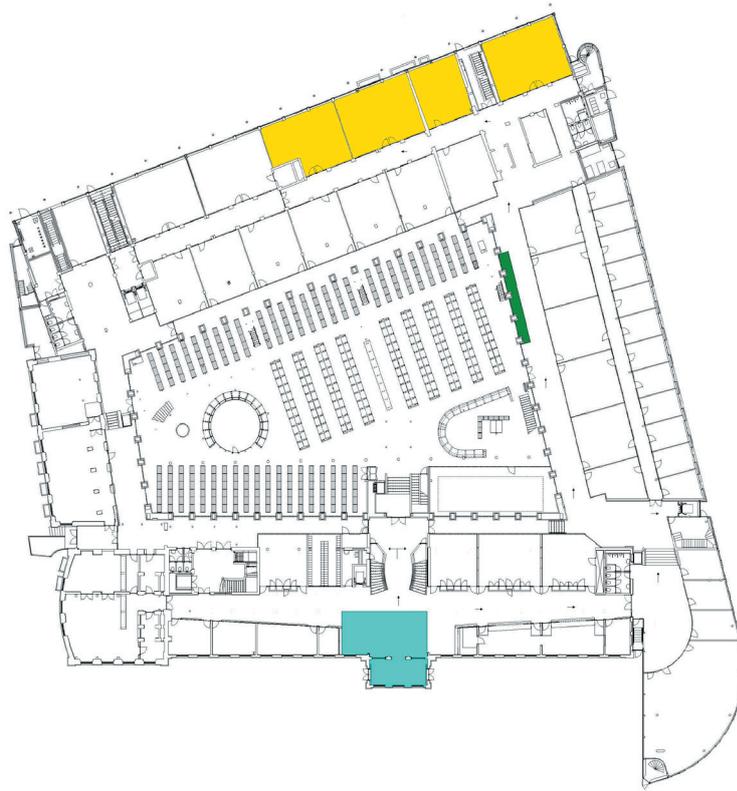
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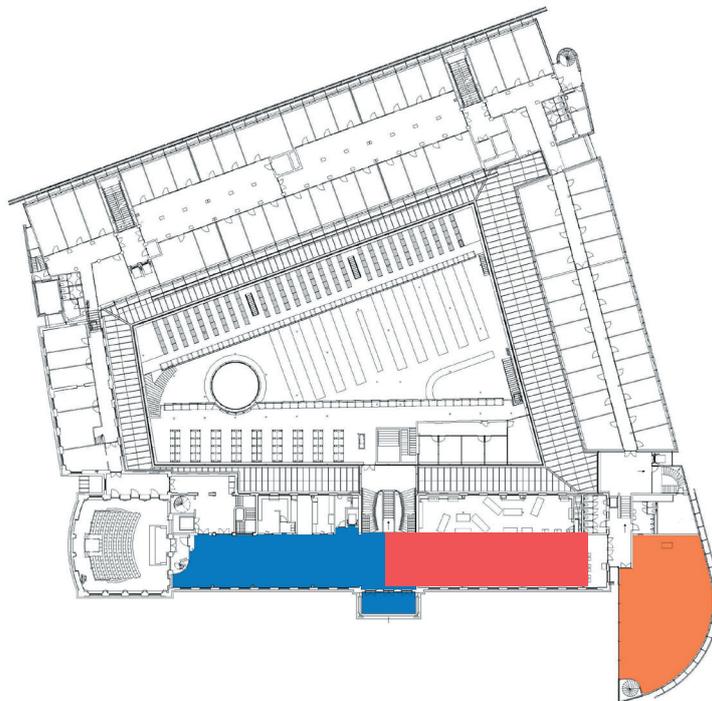
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Floor Plan



Ground Floor



First Floor

-  Parallel sessions
-  Exhibition area
-  Lunch/break area
-  Plenary sessions
-  Entrance & Registration

-  Dinner area

Program at a glance

Wednesday

17.00 - 21.00
18.00
19.45
20.00

Registration
Opening & plenary lectures
S. Gallagher & K.W.M. Fulford
H. I. Lenferink, mayor of the City of Leiden
Reception

11.00 - 12.30

S18 The status of verbal introspective reports
S19 Explanation, understanding and phenomenology
S20 Psychopathology (2)
S21 Conceptual issues (1)
S22 Philosophy and neuroscience (2)
S23 Pathologies in gesture, verbal interaction, and narrative

Thursday

9.00 - 10.30
10.30 - 11.00
11.00 - 12.30

Plenary lectures
V. Gallese & T. Metzinger
Break
Parallel sessions
S1 Auto- vs Heterophenomenology
S2 Schizophrenia (1)
S3 General Issues (1)
S4 Freedom, free will and autonomy (1)
S5 Psychopathology and psychotherapy

Friday

12.30 - 14.00
14.00 - 15.30
15.30 - 16.00
16.00 - 17.30

Lunch
Plenary lectures
G. Northoff & J.A. den Boer
Break
Parallel sessions
S24 Self and identity
S25 Phenomenology and anthropological psychiatry
S26 Conceptual issues (2)
S27 Classification and models of disease (2)
S28 Philosophy and neuroscience (3)
S29 Concepts and boundaries of mental disorder

19.00

Guided tour

Saturday

9.00 - 10.30

Parallel sessions
S30 The self, awareness of time, and its disorders: philosophical, neuroscientific critique of representational theories of mind
S31 Schizophrenia (4)
S32 History
S33 Philosophy and neuroscience (4)
S34 Philosophy, neuroscience, and cognitive psychology: variety and integration of methodologies for the study of higher mental dysfunctioning

19.30

Dinner

10.30 - 11.00

Break

Friday

9.00 - 10.30

Plenary lectures
D. Murphy & D. Bolton

Plenary lecture and closing address
A. Roepstorff & G. Glas

10.30 - 11.00

Break

Plenary Speakers

Derek Bolton

Institute of Psychiatry
Kings College London
United Kingdom

Reduction and causality; epistemological quandaries of the neurosciences

Johan A. den Boer

Department of Psychiatry
University Medical Centre Groningen
The Netherlands

Subjectivity and neuroscience

Bill (K.W.M.) Fulford

Professor of Philosophy and Mental Health
University of Warwick & Oxford University
United Kingdom

Neuroscience and values: Philosophy into practice in mental health

Shaun Gallagher

University of Central Florida
Department of Philosophy
USA

Experience and interpretation: Bottom-up and top-down explanations of schizophrenic symptoms of delusions of control.

Vittorio Gallese

Department of Neuroscience
University of Parma
Italy

Before and below Theory of Mind: Embodied simulation and the neural correlates of intersubjectivity

Thomas Metzinger

Department of Philosophy
Johannes Gutenberg University Mainz
Germany

Consciousness, the phenomenal self, and the first-person perspective

Dominic Murphy

California Institute of Technology
USA

Psychiatry and the natural science of the human species

Georg Northoff

Laboratory for functional imaging and neurophilosophy
Otto von Guericke University Magdeburg
Germany

Neuropsychiatry and neurophilosophy - how can we detect the neuronal basis of first-person phenomena?

Andreas Roepstorff

University of Aarhus
Denmark

Towards a research program on subjectivity in the neurosciences

Gerrit Glas

Leiden University Medical Centre
Department of Philosophy, Leiden University
The Netherlands

Concluding remarks: self-relatedness and intersubjectivity in neurophilosophy



Scientific Programme

Wednesday 28th June

Venue: Pieterskerk

17.30 - 18.00 Registration desk open

18.00 - 18.15 **Welcome address**

G. Glas, the Netherlands
Professor of Psychiatry and Philosophy, Leiden University, Leiden
Director of residency training, Zwolse Poort, Zwolle, The Netherlands

18.15 - 19.45 **Opening lectures**

P1

Experience and interpretation: Bottom-up and top-down explanations of schizophrenic symptoms of delusions of control.

Shaun Gallagher

P2

Neuroscience and values: Philosophy into practice in mental health

Bill Fulford

19.45 - 20.00 **Welcome address**

H. Lenferink, Mayor of the City of Leiden (also on behalf of the Executive Board of Leiden University)

20.00 **Welcome reception**

Scientific Programme

Thursday 29th June

Venue: Kamerlingh Onnes Building

9.00 - 10.30

Plenary Lectures

P3

Before and below Theory of Mind: Embodied simulation and the neural correlates of intersubjectivity

Vittorio Gallese

P4

Consciousness, the phenomenal self, and the first-person perspective

Thomas Metzinger

11.00 - 12.30

Parallel Sessions

S1

Auto- versus heterophenomenology

Chair: Gerrit Glas, the Netherlands

Auto- versus heterophenomenology. *Dan Zahavi*

Discussion. *Vittorio Gallese*

Discussion. *Shaun Gallagher*

Room: Plenary Room

S2

Schizophrenia (1)

Chair: Jan Dirk Blom, the Netherlands

An observational trial of assertive outreach: remission as outcome and benchmark. *Van Os, J.*

Sponsored by Janssen-Cilag

Motor awareness in schizophrenia: a specific deficit appears when internal representations are required.

Delevoeye-Turrell, Y. (and poster by C. Bobineau)

Deficit of a pre-reflective sense of agency in schizophrenia. *Bulot, V.*

Room: B013

S3

General Issues

Chair: Alan Ralston, the Netherlands

A puzzle regarding valence. *Charland, L.*

Client versus patient – the difference lies in suffering. *Latecki, B.*

Politics and ethics of psychiatric practice in the age of enthusiasm for neurobiological studies. *Hori, A.*

Room: B017

S4

Freedom, free will and autonomy

Chair: Gerben Meynen, the Netherlands

Vindicating freedom. Scotistic concepts in neurophilosophy. *Labooy, G.*

Complexity-thinking, ethics and the self: a new future for the biopsychosocial paradigm? *Kunneman, H.*

Room: B031

S5

Psychopathology and psychotherapy

Chair: Bill Fulford, U.K.

Neurobiology and psychotherapy: an emerging dialogue. *Fuchs, T.*

Memory, identity and the care of the soul after Lacan. *Gillett, G.*

Room: B041/43

Scientific Programme

Thursday 29th June

12.30 - 14.00

Lunch

14.00 - 15.30

Parallel Sessions

S6

Philosophy and the possibility of psychiatric imaging

Chair: Derek Bolton & Matthew Broome, U.K.

Room: Plenary Room

Why seeing the brain might not be seeing the mind. *Thornton, T.*

Anticipation and evaluation in action: evidence from the neural basis of performance monitoring. *Rietveld, E.*

The anatomy of the psychiatric image: onto-psychiatry through the back door? *Fielding, M.*

S7

Freedom, free will and autonomy (2)

Chair: Nancy Potter, U.S.A.

Room: B013

Free will in the era of neuroscience. *Callender, J.*

Degree of autonomy and neuropsychiatric disorders. *Höglund, P.*

Ascribing responsibility to ourselves. *Sie, M.*

S8

Schizophrenia (2)

Chair: Thomas Fuchs, Germany

Room: B017

Talking about hearing voices: the subjective experience of auditory hallucination through narratives. *Leal, E.M.*

Meditation-induced acute transient psychotic disorder. *Kuijpers, H. & Heijden van der, F.*

The integrative control of time and force in voluntary movement in patients with schizophrenia.

Ameller, A. (and poster by Wilquin, H.)

S9

Psychopathology (1)

Chair: Dan Zahavi, Denmark

Room: B031

Autism and the phenomenology of bodily limits: integrating competing theories of autism beyond the “specific deficits” debates. *Sauvagnat, F.*

Theories of autism and experience. *Sizoo, B.*

Symbolic form and mental illness - An altered approach to psychopathology. *Andersch, N.*

S10

Philosophy and neuroscience (1)

Chair: Shaun Gallagher, U.S.A.

Room: B041/43

An embodied and non-reductive concept of agency in the neurosciences. *Bruin de, L..*

The embodied dimension of experience in psychopathology. *Davila, J.*

The complexity of it all: why neuroscience and phenomenology must work together. *Schwartz, M.*

S11

Psychiatry and society (2)

Chair: Hans den Boer, the Netherlands

Room: B025

Values and truth in psychiatry. *Cooper, R.*

MTV or MRI: Images of the brain and the rise of visual culture. *Prenelle, I.*

Core and periphery of male patients with gender identity disorder. *Furuhashi, T.*

15.30 - 16.00

Break

Scientific Programme

Thursday 29th June

16.00 - 17.30

Parallel Sessions

S12 Taking group disorders seriously

Chair: Jennifer Radden, U.S.A.

Room: Plenary Room

Suicide copy cats: social contagion or rational persuasion? *Radden, J.*
Learning to be thin, learning to be sick. *Potter, N.*
Bipolar disorder: a communal disorder? *Healy, D.*

S13 Ethics

Chair: Grant Gillett, New Zealand

Room: B013

Botox for the brain? The ethics of cosmetic psychopharmacology. *Schermer, M. & I. Bolt*
Is there a place for values in neuroscience? *Engstrom, I.*
The two R's in psychiatry. *Karayalcin, C.*

S14 Schizophrenia (3)

Chair: Hans den Boer, the Netherlands

Room: B017

Conceptual aspects of empirical research on psychosis. *Blom, J.D.*
Delimiting delusions: a conceptual critique and research agenda. *Horn, P.*
Is schizophrenia a brain disease? *Malmgren, H.*

S15 Psychiatry and society (1)

Chair: A. Roepstorff, Denmark

Room: B031

Psychopathology of autonomy: the place of psychopathological knowledge in the community mental health in Brazil. *Leal, E.M.*
Does reputation-based reciprocity and a link between psychosis and altruism account for the increased incidence of psychosis in urban areas? *Murray, V.*
Attentive awareness and adaptation in emotional problems. *Sherlock, C.*

S16 Classification and models of disease (1)

Chair: Derek Bolton, U.K.

Room: B041/43

The disease model of mental illness: not to be discarded. *Mullen, R.*
Fibromyalgia and the therapeutic domain. A philosophical study on the origins of fibromyalgia in a specific social setting. *Hazemeijer, I.*
"Do you think I'm really sick?" A philosophical approach to madness and its definitions. *Schultz, C.*

S17 General issues (2)

Chair: Louis Charland, Canada

Room: B025

Child neuropsychiatric nosology is challenged by empirical data that rather support a dimensional and complementary model. *Anckasäter, H.*
Bodies, minds and concepts. *Wyllie, M.*
Of course it is (not) me, or how to read the newspaper? The moral dimension of psychotic experience. *Arends, P.H.*

Scientific Programme

Friday 30th June

Venue: Kamerlingh Onnes Building

9.00 - 10.30

Plenary Lectures

P5

Psychiatry and the natural science of the human species
Dominic Murphy

P6

Reduction and causality; epistemological quandaries of the neurosciences
Derek Bolton

11.00 - 12.30

Parallel Sessions

S18

The status of verbal introspective reports

Chair: Joel Anderson

Phenomenology, heterophenomenology and situated cognition. *Nul de, L.*
An embodied anatomy of mind: Me, my self and you. *Keijzer, F.*
Verbal introspective reports in view of motor theories of social perception. *Slors, M.*

Room: Plenary Room

S19

Explanation, understanding and phenomenology (1)

Chair: Derek Bolton, U.K.

Understanding and explanation in psychopathology. *Kapusta, A.*
Explaining the brain, understanding the person. *Kimball, R.*
Hearing voices: "first-person methodology" and psychopathology. *Oliveira, I.*

Room: B013

S20

Psychopathology (2)

Chair: Gerben Meynen, the Netherlands

The indeterminacy of translation – application to the psychopathology of psychosis? *Schoenknecht, P.*
Clinical use of the mirror sign. *Heide van der, D.H.*
Personal memory and abnormal belief. *Shanks, M.*

Room: B017

S21

Conceptual issues (1)

Chair: Jennifer Radden, U.S.A.

"Insight" in psychiatry. *Rabovsky, K.*
Madmen, lions, and the difficulty of telling the difference. *Brassington, I.*
Concepts matter! *Veening, E.*

Room: B031

Scientific Programme

Friday 30th June

11.00 - 12.30

Parallel Sessions

S22
Philosophy and neuroscience (2)
Chair: Georg Northoff, Germany

Room: B041/43

Neuro-imaging, neuro-engineering and neuro-ethics: a plea for precaution. *Hoven van den, M.J. & Lokhorst, G.J.C.*

How much brain energy does a mind use? *Korf, J.*

Neuroscience and the natural sciences- some thoughts on theoretical integration. *Eriksson, J.*

S23
Pathologies in gesture, verbal interaction, and narrative
Chair: Shaun Gallagher, U.S.A.

Room: B025

Speech and psychopathology. *Pachoud, B.*

Gestures, time, and schizophrenia. *Duncan, S.*

Narrative in autism. *Björne, P.*

Narrative and folk psychology. *Hutto, D.*

12.30 - 14.00

Lunch

14.00 - 15.30

Plenary Lectures

P7

Neuropsychiatry and neurophilosophy - how can we detect the neuronal basis of first-person phenomena?

Georg Northoff

P8

Subjectivity and neuroscience

Johan A. den Boer

15.30 - 16.00

Break

16.00 - 17.30

Parallel Sessions

S24
Concepts and boundaries of mental disorder
Chair: Matthew Broome, U.K.

Room: Plenary Room

What does mental disorder mean? *Bolton, D.*

A study of Maudsley psychiatrists views on the nature of mental illness and the mind-body problem. *Harland, R.*

The phenomenology of hysteria. *Kanaan, R.*



Scientific Programme

Friday 30th June

16.00 - 17.30

Parallel Sessions

S25

Phenomenology and anthropological psychiatry

Chair: Osborne Wiggins, U.S.A.

Room: B013

The problem of freedom in obsessive-compulsive disorders. *Kraus, A.*
Time travelling: psychosis as detachment from human time. *Kusters, W.*
Organism, body, subjectivity and social being. *De Serpa, D.*

S26

Self and identity

Chair: Arnoldi Ballerini, Italy

Room: B017

Foundations and transitions of the self. Clinical phenomenology, neuroscientific research and philosophical investigation: psychophysical transitions of the self in the work of O. Sacks, G.M. Edelman and D. Henrich. *Hische, E.*
Philosophical aspects of human identity and psychosis. *Ballerini, A.*
We cannot but conceive of ourselves as ourselves. *Seidel, C.*

S27

Classification and models of disease (2)

Chair: Bill Fulford, U.K.

Room: B031

Modalities of the sick. *Martinsen, E.H.*
Psychiatric classification and the use of phenomenological types. *Lösaus, D.*
On the taxonomy of human psychopathology: main ontological views. *Oulis, P.*

S28

Philosophy and neuroscience (3)

Chair: Andreas Roepstorff, Denmark

Room: B041/43

Emotion and neurophilosophy – new perspectives on feeling, intentionality and bodily perception. *Pott, H.*
The nature of consciousness: subjective facts and the functional identity hypothesis. *Laar van de, T.*
Bennett and Hacker – freedom missing? *Meynen, G.*

S29

Conceptual issues (2)

Chair: Dominic Murphy, U.S.A.

Room: B025

A conceptual analysis of the stress-vulnerability model of schizophrenia. *Rudnick, A.*
Stress and recovery – a new conceptual framework. *Eriksson, J.*
Biological species as autonomous subjects of cognition and their communication with individuals. *Alyushin, A.*

Scientific Programme

Saturday 1st July

Venue: Kamerlingh Onnes Building

9.00 - 10.30

Parallel Sessions

S30

Room: Plenary Room

**The Self, awareness of time, and its disorders:
philosophic-neuroscientific critique of representational theories of mind**

Chair: Aaron Mishara, U.S.A.

The self and its brain - cortical midline structures as neural correlate? *Northoff, G.*
Neuroimaging the self as vulnerability: Abnormalities in schizophrenia and other neuropsychiatric disorders. *Mishara, A.*
In-depth body and the origins of the subjective perspective: representation or auto-constitution? *Preester de, H.*

S31

Room: B017

Philosophy, neuroscience, and cognitive psychology: variety and integration of methodologies for the study higher of mental dysfunctioning

Chair: Derek Bolton, U.K.

Rationality and the formation of delusions. *Broome, M.*
Emotion and the sense of self: neuroimaging studies in depersonalization disorder. *Medford, N.*
Kant and mental capacity in psychiatry. *Owen, G.*

S32

Room: B031

History

Chair: Antoine Mooij, the Netherlands

Psychosis and subjectivity – what psychiatrist can learn from Friedrich Hölderlin. *Schlimme, J.*
Motor intentionality and the case of Schneider. *Jensen, T.*
Julius Ludwig August Koch (1841-1908): Christian philosopher and psychiatrist. *Gutmann, P.*

S33

Room: B041/43

Philosophy and neuroscience (4)

Chair: Thomas Metzinger, Germany

Neuroscience and moral responsibility. *Wouters, A.*
Retroactive effect and concealment of media: phenomenological foundation of a neurophysiological model of schizophrenia. *Tsuda, H.*
The importance of concepts in neuroimaging: understanding auditory verbal hallucinations. *Huber, C.*



Scientific Programme

Saturday 1st July

9.00 - 10.30

Parallel Sessions

S34
Schizophrenia (4)

Room: B025

Chair: Jan Dirk Blom, the Netherlands

On thought disorders in schizophrenia. A phenomenological analysis of neuropsychological findings.
Wada, M.

Pathological aspects of “awakening” phenomena in schizophrenia – from viewpoints of epistemological philosophy and Zen psychology. *Sumida, K.*

Why the idea of framework propositions does not help account for delusions. *Thornton, T.*

10.30 - 11.00

Break

11.00 - 12.30

Plenary Lecture & Closing

P9

Towards a research program on subjectivity in the neurosciences
Andreas Roepstorff

P10

Concluding remarks: self-relatedness and intersubjectivity in neurophilosophy
Gerrit Glas



Congress Information

Registration

Upon registration you will receive your conference badge, bag and documentation.

All information related to registration, accommodation, social activities and sightseeing tour is available at the registration desk.

The registration area will be located in the Pieterskerk on Wednesday 28th June 2006 and in the entrance hall of the Kamerlingh Onnes Building from Thursday June 29th up to and including Saturday July 1st 2006.

Registration- / Information desk opening hours:

Wednesday 28 June 17:00 – 20:00 hrs

Thursday 29 June 08:00 – 18:00 hrs

Friday 30 June 08:30 – 18:00 hrs

Saturday 1 July 08:30 – 13:00 hrs

In case of emergency the Kamerlingh Onnes Building can be reached at phone: +31 (0)6 18 22 43 12

Badges

Identification badges are required for admission to all sessions, social events and exhibits. Participants who lose their badges can come to the registration desk to re-register using the confirmation letter and photo-identification.

Lunch, Coffee & Tea

Lunch, coffee & tea during the breaks are provided to those registered congress participants wearing a badge.

Language

English is the official language.

No translation arrangements will be made.

Liability

The organisers cannot assume liability for changes in the programme due to external circumstances.

Insurance

The organisers do not accept responsibility for individual, medical, travel or personal insurance and participants are strongly advised to take out their own insurance policies.

Participants with disabilities or special needs

If you have a disability or special need, please apply to the ICPPN registration desk to discuss your requirements.

They will do their utmost to improve your comfort during the attendance of the meeting.

Photographs and tape recording

Individuals desiring to take photographs or make tape recordings during a session must obtain permission prior to the session from the speaker as well as the session chair/moderator.



Social Programme

Welcome reception and opening lectures

Date: Wednesday 28 June 2006

Time: 18.00 hrs

Location: Pieterskerk Leiden

Price: included in the registration fee for conference delegates

Immediately following the Opening Ceremony a welcome drink will be offered to delegates and registered accompanying persons. While enjoying drinks and a snack you can meet old friends and get to know other participants.

Dinner

Date: Thursday 29 June 2006

Time: 19.30 hrs

Location: Kamerling Onnes Building

Price: € 50,-

Attendance to the dinner is upon separate registration through the registration form. Upon availability, registration and payment for the dinner is also possible on site at the registration desk.

Guided City Tour

Date: Friday 30 June 2006

Time departure: 18.15 hrs

Location departure: Pieterskerk

Price: € 10,-

During a guided tour history comes alive in the old Dutch city of Leiden, the city where Rembrandt was born and learned how to paint and where Holland's first university was founded. A circular cruise through the canals of Leiden will tell the history of the stately mansions, the Academy Building of the University, the Weighing House and the Citadel.

Registration and payment for the guided tour is also possible on site at the registration desk upon availability.

General Information

Leiden

Leiden is a small city located midway between Rotterdam and Amsterdam, near to The Hague and the coast. It has a rich history in the areas of Science, Culture and International relationships. It has a beautiful historical City Centre with some 3000 monumental buildings. There are a number of quality museums such as the National Museum of Antiquities, The Naturalis National Museum of Natural History and the Boerhaave Museum.

Local travel

Most locations in the city centre are easily reached on foot. If you want to “go native”, rent a bicycle at the train station, it’s a great way to see the sights. Make sure you lock it though. Local buses make use of the “Strippenkaart”. This can be purchased from the airport, the train station, most newsagents and some hotels for around 6 euros, and will allow you multiple journeys on public transport including trams.

Smoking policy

According to Dutch law smoking is not allowed in public buildings. Therefore, smoking in the conference venue is not permitted.

Electricity supply

Electricity is supplied at 220 V – 50 Hz AC.

Currency

The official currency in the Netherlands is the Euro.

Banking/exchange

Banks in the Netherlands are generally open from 10.00 – 16.00 hours Monday to Friday. Banks are closed all day on Saturdays and Sundays. Exchange facilities will be available in most of the hotels.

Shops

In Leiden most shops are open on Monday between 14.00 – 18.00 hours and from Tuesday through Saturday between 09.00 – 18.00 hours. On Thursday shops are open until 21.00 hours in the centre.

Weather

The weather in June/July in Leiden is usually mild with temperatures ranging between 17 and 21C° (average daily high 17C°). Rain is certainly possible so, in addition to medium light clothing, a raincoat is recommended.

Gratuities/Tips

Service charges are included in the bill at a restaurant. An over tip up to 5% is appreciated. A similar percentage is normally added to taxi fares: fares are always indicated on the taximeter.

You may also wish to tip hotel porters.

The Web

More information on Leiden can be found on the conference website: www.ppp2006.nl

Other recommended sites are <http://stadsportal.leiden.nl/> and <http://www.leiden.edu/index.php3?c=161>



Sponsors and acknowledgements

The Organizing Comite of the ICPPN 2006 conference would like to express their gratitude towards the contributors and sponsors of the 9th ICPPN 2006 conference in Leiden. Without their generous contribution it would not have been possible to organize this meeting.

Contributors

University of Leiden
Leiden City Council
Dutch Society of Psychiatry
Royal Dutch Academy for Academic Science (KNAW)
Zwolle Poort
Kamerlingh Onnes Building



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Abstracts of Plenary Speakers

P1

Experience and interpretation: Bottom-up and top-down explanations of schizophrenic symptoms of delusions of control.

Shaun Gallagher

University of Central Florida, USA

There are several interpretations of the experience or sense of agency in the philosophical, psychiatric, and experimental literatures. I'll delineate three such interpretations and show how they lead to

(1) different explanations of pathological symptoms, such as delusions of control and thought insertion in schizophrenia, and

(2) confusions in the experimental literature. Contrasts are made between

(a) a pre-reflective first-order phenomenal experience of agency thought to originate in efference signals or in the integration of afferent and efferent information in specific brain areas;

(b) an experience of agency that is tied to intentional aspects (tasks, goals) of action;

(c) an sense of agency based on reflective attribution.

If a coherent sense of agency consists in a number of contributory elements, the loss of the sense of agency in various cases - schizophrenia, anarchic hand syndrome, obsessive-compulsive behavior, or narcotic addiction - may in fact be different sorts of loss - the sense of agency might be disrupted in different ways depending on what contributory element is disrupted.

P2

Neuroscience and Values: Philosophy into Practice in Mental Health

Bill (K.W.M.) Fulford

Professor of Philosophy and Mental Health, University of Warwick and Oxford University, United Kingdom

The 1990s, although rightly celebrated as the decade of the brain, was also the decade that witnessed a remarkable renaissance of cross-disciplinary work between philosophy and psychiatry in many countries around the world. This paper will briefly review developments in philosophy and psychiatry and then ask the question 'why?'. Why should philosophy have sprung into prominence in psychiatry at just the time that the scientific basis of the subject was finally being put on a firm footing?

Using a case example – involving experiences at the borderland between spiritual experience and psychosis – a number of possible answers to this question will be outlined. The conclusion will be drawn that the neurosciences, far from dehumanising psychiatry, as they are commonly assumed to do, actually drive us back to a clear recognition of the importance of values in what psychiatry is all about, ie the uniqueness and diversity of individual people.

The practical implications of this conclusion will then be outlined drawing on experience in the UK and internationally, of a clinical-skills based approach to working with diversity called values-based practice. Derived from work in analytic philosophy, values-based practice has been adopted as the basis of a number of policy, training and service development initiatives for front-line mental health staff in the UK.

Finally, these 'philosophy into practice' developments will be set in their historical context, focusing particularly on parallels between the current renaissance in philosophy and psychiatry at the end of the 20th century, and the work of Karl Jaspers during psychiatry's 'first biological phase' at the beginning of the century. This historical context will suggest a trajectory for the future development internationally of a psychiatry that, building equally on neuroscience and philosophy, will be increasingly both science-led and patient-centred.



Abstracts of Plenary Speakers

P3 Before and below Theory of Mind: Embodied simulation and the neural correlates of intersubjectivity

Vittorio Gallese

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The automatic translation of the Folk Psychology-inspired “boxology” – endorsed by functionalism and by some quarters of cognitive science – into newly formed brain modules specifically dedicated to mind reading abilities should be carefully scrutinized. Searching for the brain location of the neural correlates of intentions, beliefs and desires – as such – might not be the best epistemic strategy to disclose what social cognition really is. A more promising and potentially fruitful strategy lies in the integration of multiple approaches to the study of the role played in social cognition by the sensory-motor systems of the primate brains.

A direct form of “experiential understanding” of others is achieved by modelling their behaviors as intentional experiences on the basis of the equivalence between what the others do and feel and what we do and feel. This modelling mechanism is embodied simulation. By means of embodied simulation we do not just “see” or “recognize” an action, an emotion, or a sensation. Side by side with the sensory description of the observed social stimuli, internal representations of the body states associated with actions, emotions, and sensations are evoked in the observer, as if he/she would be doing a similar action or experiencing a similar emotion or sensation. Mirror neurons and other multimodal “mirroring” circuits in the brain are likely the neural correlates of this mechanism. Recent neuroscientific evidence will be discussed within the theoretical frame of an embodied simulation account of intersubjectivity.

P4 Consciousness, the phenomenal self, and the first-person perspective

Thomas Metzinger

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In my contribution I will offer a solution to the most difficult aspect of problem of consciousness: The subjectivity of subjective experience, the fact that consciousness is always experienced from an individual first-person perspective. If one wishes to understand what phenomenal consciousness actually is, one of the most important explananda will be what Thomas Nagel has called the “perspectivalness” of consciousness: The fact that conscious experience always appears to be experience for an experiencing ego, being bound to a subjective first-person perspective.

I will very briefly sketch the background theory as a strategy of accommodating the perspectivalness of consciousness within an empirically plausible theory of mental representation. An important step in adopting this strategy will consist in introducing a new theoretical entity: The phenomenal self-model. The model of the self differs from every other mental model in an essential point. It possesses a part, which is exclusively based on internally generated input: the part of the body image activated by proprioceptive input. The part of this neural activation pattern which is independent of external input produces a continuous representational basis for the body model of the self and in this way anchors it in the brain by generating a persistent functional link. In almost all situations when there is phenomenal consciousness at all, there also exists this unspecific, internal source of input. It is the most “certain” and stable region within the model of the self. In this way our consciousness becomes a centered consciousness.

However, in order for the functional/representational property of centeredness to become the phenomenal property of perspectivalness, the model of the system must become a phenomenal self. The pivotal question is: How does that which we commonly call the phenomenal first-person perspective emerge in a centered representational space? A first-person perspective - I would suggest - emerges if the system no longer recognizes the model of the self which it itself activated as a model. If it did, representational and functional centeredness would remain, but the global phenomenal properties of selfhood and perspectivalness would disappear. In short: the system would have a self-model, but no phenomenal self. The representational correlate - the self-model - is a functional module, episodically activated by the system in order to regulate its interaction with the environment. One can also develop a “teleofunctionalist” approach: The model of the system then appears as a kind of organ which emerges through the binding of a certain set of micro-functional properties and enables the system to represent itself in its environment to itself. So the self-model is a transient computational module, possessing a long biological history: It is a weapon, which was developed in the course of a “cognitive arms-race” (Andy Clark, 1989). A real phenomenal self however, only emerges if the system, metaphorically speaking, “confuses” itself with the internal model of itself which it itself has generated. I claim that the activation of a transparent self-model is the most important necessary (but not sufficient) condition for the instantiation of what philosophers like to call the “first-person perspective”: While activating a special type of representational object, the system gets caught in a naive-realistic self-misunderstanding and in this way generates a phenomenal subject.

In the optional third part of my lecture I offer some brief considerations of the role the humanities, and of philosophy in particular, may have to play in the current naturalization of the mind. The general anthropological, normative, and cultural consequences of the research now being done on the neural implementation of mental functions are dramatic.

Abstracts of Plenary Speakers

P6

Psychiatry and the Natural Science of the Human Species

Dominic Murphy

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I suggest that the logic of the medical model commits us to a particular pattern of explanation, rather than to an explanation at a particular level of ontological organization. Any species is routinely studied by biologists in ways that attend to its social organization, forms of learning and other high-level properties: this form of explanation is exemplified by the multi-level perspective of contemporary cognitive and affective neuroscience, which integrates explanations at many levels, from the molecular up to the social. Any claim that psychiatry should be reductive in order to be truly biological is unsupported by wider scientific practice.

I start by looking at David Marr's famous model of explanatory levels in cognitive psychology, and suggest a couple of ways in which Marr's picture needs to be modified to take into account both the nature of theory building in cognitive neuroscience and the explanatory demands of psychiatry. Then I sketch an account of what explanation in psychiatry might look like if it adopts the explanatory methods of cognitive neuroscience. On my view, we should see attempts to explain exemplars, which are stereotypical representations of a disorder at many different levels that will vary - perhaps greatly - in actual patients. But constructing an exemplar allows to identify causal pathways that account for the chief features of a condition across patients, even if not all pathways are always present. This strategy suggests many different ways to intervene therapeutically.

P5

Reduction and causality; epistemological issues in the neurosciences

Derek Bolton

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It is evident in current models of psychopathology that they are characterised by a diversity of kinds of explanation, ranging between – in alphabetical order – behavioural and molecular genetics (including gene-environment interactions), cognitive psychology (representations and associated affect), cultural factors, developmental pathways (of all kinds), family factors, neurochemistry, neuropsychology, structural and functional neuroimaging. Particular research programmes inevitably concentrate on one or no more than a few kinds of causal pathway, but this is generally if not invariably accompanied by recognition that they will make up a small part of a complex jig-saw puzzle, as becomes explicit in theoretical and review papers. There is no fixed start-place in the interacting systems of causal pathways: the place to start is a methodological choice, commonly associated with disciplinary background or increasingly the kind of causal pathway being investigated. It is not obvious that assertions or worries about reductionism can survive much longer in this contemporary climate. Claims associated with reductionism include that psychological explanations can be replaced by neurological (while preserving explanatory power), genetic determinism, that neurological or genetic explanations are genuinely causal while the psychological or the social or not. None appear to be valid in relation to current models of psychopathology. Subjective experience along with behaviour is apparently the subject-matter of psychiatry and as such figures in scientific models, but to the extent to which it does, it will not be 'reducible' either.

P7

Neuropsychiatry and neurophilosophy – how can we detect the neuronal basis of first-person phenomena?

Georg Northoff

Laboratory for functional imaging and neurophilosophy

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Though the brain and its neuronal states have been investigated extensively, the neural correlates of mental states remain to be determined. Since mental states are experienced in first-person perspective and neuronal states are observed in third-person perspective, a special method must be developed for linking both states and their respective perspectives. We suggest that such method is provided by First-Person Neuroscience. What is First-Person Neuroscience?

We define First-Person Neuroscience as investigation of neuronal states under guidance of and on orientation to mental states. An empirical example of such methodological approach is demonstrated by an fMRI study on emotions. It is shown that third- and first-person analysis of data yield different results. First-person analysis reveals neural activity in cortical midline structures during subjective emotional experience. Based on these and other results neural processing in cortical midline structures is hypothesized



Abstracts of Plenary Speakers

to be crucially involved in generating mental states. Such direct linkage between first- and third-person approaches to analysis of neural data allows insight into the “point of view from within the brain”, that is what we call the First-Brain Perspective. In conclusion, First-Person Neuroscience and First-Brain Perspective provide valuable methodological tools for revealing the neuronal correlate of mental states.

P8 **Subjectivity and Neuroscience**

Johan A. den Boer

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Interpretation of subjective experience by psychiatrists is pervasive in determining clinical diagnosis. Subjectivity implicates that self-determined action is possible through subjective processes of deciding which require an intentional, and not a naturalistic explanation.

The aim of this paper is a) to highlight why there has been such an ambivalent relationship in psychology and psychiatry with introspection as a method of inquiry, and b) to investigate the possibility to use subjective introspective data into actual neuroscientific experiments.

According to the view espoused by Varela (Varela, 1995, Varela and Shear, 1999) neurophenomenology offers a method to guide reflexive examination of ongoing subjective experience. When subjects were trained according to this neurophenomenological method, during an EEG experiment the subsequent brain-response to a visual stimulus was different, depending on the subjective state the subjects were in before the stimulus was presented (Lutz et al 2002).

In our own study using PET, we found significant correlations between Methylphenidate (MP)-induced changes in binding potential of 11C-Raclopride and the degree to which subjects subjectively felt ‘at ease’ before the experiment. We found this without any ‘neurophenomenological’ training, which raises questions concerning the added value and validity of neurophenomenological training.

In spite of these theoretical discussions, the above described empirical studies have shown that using the method of introspection, small variations in subjective state may have profound effects on the outcome of neuroscientific experiments and thus constitute the right model of how subjective data can be incorporated into neuroscientific experiments.

P9 **From neurophilosophy to neurocosmology: Towards a research program on subjectivity in the neurosciences?**

Andreas Roepstorff

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Developments both in cognitive science and in philosophy appear to suggest new grounds for research which straddle the objectivity - subjectivity boundary. Through brain imaging experiments and neurophenomenological investigations, ‘personal experience’, be that of patients, volunteers or experts, is becoming an issue. In these discussions, ‘the brain’ appears sometimes as a grounding feature, sometimes as the unknown to be determined. I will argue that embedded in this tension is a confusing mixture of epistemology and ontology - and that this affects both the ‘subjective’ and the ‘objective’ evidence. Disentangling these levels allow for a conceptual triangulation which, I think, may at times be translated into a pragmatic correlation between the different types of evidence. However, this comes at a price, since it appears to move the discussion out of neurophilosophy in a narrow sense and into a field which may be labelled ‘neurocosmology’.



Abstracts of Plenary Speakers

P10

Concluding remarks: self-relatedness and intersubjectivity in neurophilosophy

Gerrit Glas

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Department of Philosophy, Leiden University, The Netherlands

In my lecture I will give a brief summary of different methodological and philosophical approaches to the issue of whether and how to build subjective experiences into neuroscientific research. I will try to point out the conceptual knots in the discussion on models of ‘integration’ and flesh out where approaches diverge and how bridges could be built (and are in fact built). I will refer in this context to different contributions at the conference.

I will particularly focus on two or three out of four themes:

- * the issue of how to conceptualize the relationship between everyday understanding of the world and oneself (common sense) and forms of knowledge that are produced in contexts that are defined by experimental boundaries and abstract reasoning; I will, more specifically, highlight the hidden scientism of some approaches;
- * the issue of how and in what way phenomenological ‘invariants’ of subjective experience and cognitive neuroscience could fruitfully be brought together within the framework of dynamic systems theory, especially its mathematical underpinnings; or, in other words, the topic of how to evaluate the philosophical qualities of the notion of ‘isomorphism’ between subjective experience, neural network theory, and mathematical underpinnings of systems theory;
- * the issue of how to evaluate attempts to empirically grasp phenomena such as self and agency that once were thought to be beyond empirical comprehension and to have a transcendental or ontologically ‘fundamental’ status (with Kant and Heidegger as paradigmatic examples);
- * the issue of whether first- and third-person approaches are dependent on a second-person perspective, not only from a developmental perspective, but also from a more fundamental philosophical point of view.

I will conclude with some statements on the importance of the concepts of self-relatedness and intersubjectivity. When self-relatedness presupposes alterity (or, in other accounts, intersubjectivity) and when self-relatedness is reflected at all levels of human existence (from the physical to the spiritual), this implies a new way of thinking about the brain – a way that views brains – instead of as reified entities or supermachines – as self-related entities that in their self-relatedness relate to a world and a body from which they also form parts, and this in spatially, temporally and modally numerous ways. It is one of the intriguing challenges for today’s philosophy to further delineate and conceptualize these different forms of (self-) relatedness.

Such understanding could be of great value for contemporary psychiatry, to counteract mechanistic views of brains that are said to ‘produce’ behavior, to bridge the divide between understanding (meaning) and explanation (cause); and to enrich psychiatry’s view of how the subtle qualities of subjective experience are embedded and rooted in our bodily existence and, therefore, may be subject of scientific research.



Abstracts

S1 Auto- versus heterophenomenology

Auto- versus heterophenomenology

Dan Zahavi

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Can phenomenology contribute to the burgeoning science of consciousness? Dennett's reply would probably be that it very much depends upon the type of phenomenology in question. In my talk I will discuss the relation between Dennett's heterophenomenology and the type of classical philosophical phenomenology that one can find in Husserl, Scheler and Merleau-Ponty. I will in particular be looking at Dennett's criticism of classical phenomenology. How vulnerable is it to Dennett's criticism, and how much of a challenge does his own alternative constitute? I will argue that there are some rather marked differences between these two approaches to consciousness, but as I also hope to make clear, Dennett's own account of where the differences are located is off target and ultimately based on a somewhat flawed conception of what classical phenomenology amounts to.

S2 Schizophrenia (1)

An observational trial of assertive outreach: remission as outcome and benchmark

Jim van Os

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A 2002 review article in the prestigious journal *Science* (2) stated that "once the symptoms of schizophrenia occur (usually in young adulthood) they persist for the entire lifetime of the patient and are almost totally disabling". This statement flies in the face of evidence, collected over a century of research, that there is a high level of heterogeneity in the course and outcome of schizophrenia and that symptomatic remission is common (3). However, even though the DSM criteria for schizophrenia have remained essentially similar over the last decade, a degree of therapeutic pessimism in the context of an informal redefinition of schizophrenia as a permanent "deficit" brain disorder is noticeable. While there is certainly evidence that a proportion of patients with schizophrenia have poor outcome, and it is possible to apply criteria of "deficit" to these, it could be argued that patients and clinicians are also in need of criteria for remission that, if patients do not fulfil them, represent something that patients and clinicians can work towards.

Motor awareness in Schizophrenia: a specific deficit appears when internal representations are required

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Background. Motor deficits in schizophrenia may be associated to a fundamental problem in the fluent integration of motor representation ("what do I want to do") with motor action ("what did I do"). The aim of our study was to test the hypothesis that the link between motor representation and motor action is weak in schizophrenia.

Methods. Twenty patients lifted a load cell (50g) that was loaded with a light (150g), medium (350g) or heavy weight (750g). The subjects' task was to lift the object at a natural pace 30cm above the table top and to maintain the object in mid-air for 3 s. Then, subjects were required to replicate the force level "they thought they had used in the previous motor trial", without lifting the object from the table. There were two conditions: (1) subjects truly lifted the light, medium and heavy objects (automatic); (2) subjects lifted the none-loaded load cell and were required to apply finger forces as if they were lifting the light, medium and heavy objects (voluntary).

Results. The individual correlation parameters were computed between the motor and the replication trials. For the controls, the correlation parameter was significantly greater in the voluntary (.82) than in the automatic condition (.70). For the patients, the correlation parameters were similar for the voluntary condition (.71) and the automatic condition (.68).

Conclusions. Our results suggest in schizophrenia a deficit in motor awareness but only when the access to an internal motor representation was necessary. This may be due to a problem in the formation of a coherent internal representation for action, an integrator function that is thought to strongly depend on the parietal lobe.

Deficit of a pre-reflective Sense of Agency in Schizophrenia

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Background. In schizophrenia, passivity phenomena may be due to a deficit in the sense of agency, which has been described theoretically as a pre-reflective process that is distinct from motor prediction (Gallagher 2004; Tsakiris and Haggard 2005). Nevertheless, pre-reflective behavioural tasks have yet to be conducted. Here, a simple motor task was used to obtain an implicit indicator of the working status of the pre-reflective sense of agency in schizophrenia.

Methods. Twenty-four patients used a hand-held object to stop the fall of a pendulum that was released either by the Subject (task S) or by the Experimenter (task E). The indicator of the sense of agency was taken as the difference in efficiency level measured between tasks S and E, before afferent information from impact. Qualitative feedback was provided to half of the subjects to assess the top-down effect of explicit information.

Results. Controls were more efficient in task S than in task E. Patients showed similar efficiency levels in both tasks. Grip modulation was as precise in patients than in controls. Explicit information improved grip efficiency in both groups but it did not stimulate an efficiency difference between the two tasks.

Conclusions. Our results argue for the existence of two distinct processes, one for the pre-reflective sense of agency, which is impaired in schizophrenia and resistant to top-down control; another for motor prediction, which is preserved in schizophrenia and significantly improved with explicit information from the environment.

Abstracts

S3 General Issues

A Puzzle Regarding Valence

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Moods and emotions are often said to be valenced and accordingly labeled 'positive' or 'negative'. Indeed, the concept of valence is so prevalent in theoretical and experimental work in psychiatry, neuroscience, and psychology, that it is hard to imagine those disciplines without it. Yet for all its proclivity, the philosophical status of valence is extremely puzzling in one respect. The puzzle becomes evident when one asks whether the positive and negative character of affective states is a feature of the states themselves, or whether it is instead an interpretative feature which is attributed rather than found in those states. In this presentation, I argue that while the concept of valence undoubtedly reveals many interesting regularities in a wide range of clinical phenomena, there are instances where it is impossible to measure objectively, because it is strangely indeterminate. In these cases, there is no objective fact of the matter about what the valence of a particular affective state or process is, apart from its elaboration and interpretation in conscious awareness. The puzzle is that in such cases, we invariably alter valence as we attempt to measure it; a finding reminiscent of early interpretations of quantum mechanics. Valence, then, is sometimes strangely indeterminate, even though we talk as if it were an objective feature of affective states like moods and emotions and the stimuli that prime them. This finding seriously weakens the empirical validity of many studies that are based on the concept of valence.

Client versus patient - the difference lies in suffering

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“Everything should be made as simple as possible, but not simpler.” - Albert Einstein

The presentation discusses the overt and hidden meaning of the terms “patient” or “client” regarding persons undergoing psychotherapy and implications of using these terms. Some historical and recent opinions and points of view are presented. As the outcome of the discussion, it is concluded that to weigh pros and cons and to decide on which name would be more appropriate, one must resort to taking into consideration the definitions of therapy, suffering, and healing. It is suggested that the criterium should be the level and nature of suffering experienced by the “taker” and the level and nature of care performed by the “giver” (provider). The relations between both parties are also discussed in terms of existential phenomenology – as opposed to dualistic approach - and holism versus atomism. It is the intention of the author to deliver some practical and not only theoretical contribution to clinical practice.

Politics and ethics of psychiatric practice in the age of enthusiasm for neurobiological studies

Arinobu Hori

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As a psychiatric clinician, I wonder what kind of attitude is the most appropriate to the recent neurobiological findings. Scientific practice essentially intends to discover a new finding which has a universal application. Researchers examine their hypothesis in many cases closely to make a proof. Reliability is an essential requirement of a scientific statement.

On the other hand, each psychiatric practice, such as to make a diagnosis, is a unique event. In a specific situation psychiatrists must make their decision. Medical practice is not only scientific investigation, but inevitably social and economic action. It is sometimes difficult for clinicians to stay in a neutral position. Doctor's action necessarily influences related people. Ethical and political aspects should be considered in order to apply a scientific statement validly to a specific case.

I would like to show my respect to Aristotle's distinction of academic investigation between physis (Nature) and nomos (Law). In Aristotle's *Ethica Nicomachea*, he clearly notified that in a study of politics or ethics, what we must aim for is to describe rough sketches of realities, rigorous and accurate description should not be required. It is very different from study of mathematics. Those studies necessarily deal with human actions and learner's life experiences are valued.

Therefore psychiatric practice can never be a mere application of scientific findings, but be a human action in a complicated situation. This present moment of enthusiasm at neurobiological researches, we must adhere to the study of proper methods of valid application of new findings.

Abstracts

S4

Freedom, free will and autonomy

Vindicating freedom. Scotistic concepts in neurophilosophy.

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As a former physician specialized in psychiatry who wrote a thesis in philosophical theology on the concordance of freedom and (neurobiological) dispositions, I try to enrich the debate in the Philosophy of Mind with Scotistic ontological and conceptual tools. These highly technical philosophical instruments can break new ground in the Philosophy of Mind. To highlight their significance I state the following views:

* In philosophy of psychiatry, the theory of the self is crucial. Nowadays, most theories of the self ignore or even try to wipe out free will. This is detrimental to man and so it is to psychiatry.

* Apart from ontology (e.g., a theory of contingency), we need a conceptual analysis of freedom able to account for both the Principle of Alternative Possibilities and neurobiological dispositions.

* Because of its failure to account for free will, physicalism (NRP included) is a blind alley (a compatibilist account being merely a euphemism for determinism).

* Cartesian dualism, however, is of no refuge (for it has to be rejected on the accepted criticisms).

* Thomas' frequently invoked dualism is not helpful either, because individuality and freedom can not be elucidated in Thomism (observed by Armstrong e.g.).

* Scotism represents a firm alternative: Scotus (1308†) invented synchronic contingency, offers a lucid conceptual analysis of freedom able to account for dispositions, and has a sophisticated ontological theory of the person as a composition of body and mind: two ontologically distinct yet essentially composed entities. This hinges on his seminal concept of individuality.

Complexity-thinking, ethics and the self: a new future for the bio-psycho-social paradigm?

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The developments of the last decades within the neurosciences have not only given rise to very high expectations with regard to the scientific and therapeutic possibilities of biological psychiatry but also to serious concerns about the one-sidedness of the biological paradigm: Can this paradigm do justice to all those elements encountered by psychiatrists in their everyday practice which bring ethical considerations into play, both concerning the relational quality of the relations between psychiatrists and their clients and the therapeutic import of this quality, and with regard to questions of social exclusion and of rehabilitation?

I will argue in this paper that these concerns are justified, but threaten to block our view on the new possibilities offered by the advances in the neurosciences to strengthen the importance of ethical considerations on the level of psychiatric theory and practice. These new possibilities come into sight when – following a suggestion by Paul Cilliers - complexity theory, as developed within evolutionary biology, neural network-theory and neurobiology, is broadened to complexity thinking, by incorpo-

rating central insights from deconstructivist and hermeneutical thinkers (especially Derrida and Ricoeur) into the conceptual universe of complexity thinking. In this way a middle-ground becomes visible between the one-sidedness of reductionist approaches within biological psychiatry on one hand and the complementary one-sidedness of strictly ethical and social-critical approaches on the other hand. Could this middle-ground provide a basis for a revitalization of the bio-psycho-social paradigm?

S5

Psychopathology and psychotherapy

Neurobiology and psychotherapy: an emerging dialogue

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Research in neuroplasticity, in the role of explicit and implicit memory systems, in early attachment processes, as well as in the biological underpinnings of mental disorders has considerably influenced psychotherapeutic concepts, shifting the emphasis to implicit learning in the therapeutic relationship. Recent neuroimaging studies also have demonstrated that psychotherapy significantly changes functions and structures of the brain, in a manner that seems to be different from the effects of pharmacotherapy. These results as summarized in the paper give rise to some conceptual issues which are finally dealt with. It is argued that neurobiology may be helpful in assessment before therapy, but that psychotherapy is essentially based on its subjective and intersubjective dimension that cannot be turned into an "applied neuroscience".

Memory, identity and the care of the soul after Lacan

Grant Gillett

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The identity of a human being is sometimes thought by philosophers to reduce to a combination of autobiographical memories and present psychological states. This is an inadequate view and the associated video-recording view of memory is not sustainable in the light of current research. There is a formative effect of history and discourse operating both on memory and on identity such that the mind is layered in ways that are susceptible to the care of the self. Taking together our current understanding of memory, the conception of the unconscious that springs from the work of Jacques Lacan, and the conception of ethics as care of the self (Foucault), I will examine the role of memory and narrative identity in transforming the self.

Abstracts

S6 Philosophy and the possibility of psychiatric imaging

Why seeing the brain might not be seeing the mind

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Neuro-imaging generally proceeds on the assumption of the close connection between the brain states imaged and the mind. The connection is often implicit and unargued but has been methodologically fruitful. One of the most influential philosophers of the C20, Ludwig Wittgenstein, however, notoriously argued against the relevance of investigation of brain states to shed light on the mind. I will present some of Wittgenstein's key negative claims and sketch arguments for them. Whilst Wittgenstein's hostility may be overstated I will argue that it rests on the normativity of thought and that this feature of the mind cannot be depicted by neuro-imaging.

Anticipation and evaluation in action: Evidence from the neural basis of performance monitoring

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While engaged in action, often we simply respond to 'affordances', understood here as perceived possibilities for action in the environment (Merleau-Ponty, 1945/1962; Gibson, 1979/1986; Michaels, 2003). I suggest that such unreflective, yet skillful action is supported by the ability of the organism to flexibly anticipate the long-term value of affordances.

What are the brain's contributions to this ability? According to Goldberg (1985) a medial frontal network functions as an anticipating system when the individual operates in familiar domains. Thanks to a history of past learning this neural system is able to use a predictive mode of action control.

Recent literature on the neural basis of performance monitoring (Holroyd and Coles, 2002; Ridderinkhof et al., 2004; Rushworth et al., 2004) and action selection (Shima and Tanji, 1998; O'Doherty et al. 2004) confirms the importance of anticipation and sheds light on its mechanisms. Moreover, these two fields of research share the innovative hypothesis that on-line monitoring and action selection are based on expected (reinforcement) value.

Work in animal decision making (Schultz et al., 1997) and computational neuroscience (for a review see Montague et al., 2004; Barto, 1995; Sutton & Barto, 1998) provides additional support for this latter hypothesis and stresses the role of the midbrain dopamine system in updating expectations of long-term reinforcement value. The dopaminergic system is an integrated part of the anticipatory medial frontal system (Goldberg, 1985). Dopamine increases the likelihood that an action that is 'worth doing' (Walton et al., 2004) for the organism gets chosen now (thanks to its fast –about 100ms– impact) and in the future (as a result of the role it plays in actor-critic reinforcement learning).

The Anatomy of the Psychiatric Image: Onto-Psychiatry through the Back Door

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Biomedical software ontologies provide a means of representing facts gathered through biomedical research and clinical observation. At the foundation of good software ontology design lays a sound philosophical realism which supplies the basic framework required to support the management of this information. Take, for instance, the construction of ontologies focused on biomedical sub-domains such as anatomy, surgical procedures, or molecular biology; in each of these areas, a good degree of success has been achieved through the realist approach. In the field of psychiatry, however, realism is challenged to account for subjective mental experiences that typically lay beyond its scope.

While psychiatric symptoms may be too difficult to account for in terms of a realist ontology, by focusing on psychiatric signs, such as images of the human brain (themselves ontological structures), we may be able to make some in-roads towards an onto-psychiatry – through the back door, as it were.

With the help of the Polish phenomenologist Roman Ingarden, and his seminal work "The Ontology of the Work of Art", we have a framework for an imaging ontology that may provide for these tools. In this paper, we will discuss the differences between the ontology of the body and the ontology of the image, and how the diagnostic act may bridge the gap between them. Modelling Ingarden's ontology of the image, we aim to demonstrate how some portions of psychiatric knowledge may be successfully embedded in this image ontology and the scientific benefits application ontologies afford may subsequently be attained within a portion of this particularly difficult domain.

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S7 Freedom, free will and autonomy (2)

Free will in the era of neuroscience

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The concept of free will has been under attack for as long as human behaviour has been subject to scientific study. The pioneer behavioural psychologist B.F. Skinner concluded, "It is the autonomous inner man who is abolished and that is a step forward". A more recent challenge has come from neuroscience and, in particular, the work of Benjamin Libet (2002). He has conducted experiments on intentional behaviour, which appear to show that electrical changes in the brain not only precede action but also precede conscious awareness of an intention to act.

Strawson (2002, 441) has argued that moral responsibility is "the only really troublesome question when it comes to the problem of free will..." and that the central issue is that of moral character. The idea that we are the authors of our own personalities is vulnerable to the criticism of vicious regress i.e. if one's present personality can create a future personality, then what created one's present personality?

I will argue that much of the literature on free will errs by trying to locate this phenomenon within the individual. Concepts like moral responsibility and desert only make sense in the context of social network. Drawing on Kantian theory, I will argue that free will is only possible in a context in which there is a) free exchange of ideas and b) a moral order to which individuals are not subject only but which they also help to create. The implications of this for psychiatric practice will be discussed.

Degree of autonomy and neuropsychiatric disorders - a question of accountability?

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Meeting and treating mentally ill people involves a number of difficult ethical and clinical decisions. I would like to address one of them here: on which theoretical and/or empirical grounds do we allot autonomy to mentally ill persons in general and people with neuropsychiatric handicaps in specific?

Before trying to answer that question, one could ask the following:

(i) How do different mental disorders influence a person's ability to take responsibility for his/her actions? (ii) Do we have different attitudes towards patients depending on which mental disorder they are affected by? (iii) Do these attitudes influence our way of meeting these people and does our meeting influence the result of the clinical treatment? (iiii) If we change the term "mental disorder" to "neuropsychiatric handicap" - will this also change the answers to these questions, and in that case, in which way?

Sixty MDs, psychologists, nurses and staff were asked to assess a number of different mental illnesses/handicaps in terms of degree of accountability (the ability to take responsibility of his/her actions, measured by a scale 0-5).

Taking off from the study results, I will suggest an outspoken balance between degree of accountability and degree of autonomy within every kind of healthcare where psychiatric diagnoses are involved. I therefore want to discuss by which standards someone should be assigned a certain degree of autonomy in

terms of joint-decision-making - should there for example be a difference in how we allot autonomy to temporary mentally ill people and life-long neuropsychiatrically impaired persons?

Ascribing Responsibility to Ourselves

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Research in the human and brain science shows that we are sometimes mistaken about our 'agential input' when something happens. We might believe we acted whereas it can be shown we did not; we might believe we did not act whereas it can be shown that we did. In this paper we argue that research results like these-contrary to what is often assumed (or concluded)-do not invalidate our common practices of responsibility. Here is the reason why. The function primarily served by our everyday ascriptions of responsibility is the communication (and determination) of our normative expectations of one another (the expectations regarding the appropriate way to behave in certain circumstances). The efficacy of this general function, as we will argue, does not depend on any specific counterfactual assumptions about our agential capacities-such as, e.g. free will or originating powers, and ultimate agential control. Our default ascriptions of responsibility to one another are justified even though it might turn out that we are much less in control of our bodily movements than we previously assumed. In this paper we will argue that the above argument-with some adjustments-is also valid in the intrapersonal case. Our ascriptions of responsibility-our taking responsibility-can also be understood as primarily serving the function of communicating and determining the normative expectations we want to 'live up to'.

S8 Schizophrenia (2)

Talking about hearing voices: the subjective experience of auditory hallucination through narratives

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Introduction: The Laboratory of Psychopathology and Subjectivity - Federal University of Rio de Janeiro/ Brazil - is nowadays doing a research about "hearing voices". A clinic investigation is done through therapeutic groups with schizophrenic patients who hear voices. This paper will discuss a therapeutic group that occurs in a public daily service for psychosocial attention, mainly in its technical management aspects.

Aim: Some concepts, such as comprehension and empathy, which are the basis to a kind of phenomenological approach, will be critically discussed. The preliminary results show that the phenomenon of auditory hallucination should be taken more properly considering the patient's own descriptions, what means, necessarily, that the phenomenon is, in its origins, effect from the relationship subject - world.

Methodology: Theoretical investigation concerning a critical review of phenomenological field is done, in order to discuss the limits and possibilities of phenomenological approach. Some clinical examples were selected from the therapeutic groups with schizophrenic patients done during the 2005.

Results: The stories told in this therapeutic group are very good material to demonstrate that there is an important knowledge

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that comes from the patients and that it is possible, sharing experiences, to produce a collective knowledge about hearing voices.

Conclusion: To give voice to them who hear voices is a clinical strategy. Its main proposal is to promote a knowledge that helps people to deal with voices. This kind of skillness is different from the knowledge of the traditional psychiatric field. It is also important to produce knowledge about the hearing voices experience, which is still a reason to segregation.

Meditation-induced acute transient psychotic disorder

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Introduction and method: Meditation is common practice in many traditional cultures. At the same time the incidence of acute transient psychoses is much higher in these cultures as compared to modern Western cultures (Susser 1994). Supposedly meditation could have therapeutic benefits for psychotic patients, however provocative properties have as well been reported (Sethi 2003). A case report about a meditation-induced psychosis is described and a literature search in the databases PubMed and PsychINFO on the words “meditation” OR “yoga” AND “psychosis” is performed.

Results: A 24-year old West-European male artist with no psychiatric history was presented to us with an acute brief psychotic episode induced by intense meditation. He soon recovered during treatment with haloperidol, however mild negative symptoms persisted. A total of 12 case reports about meditation-induced psychosis was found in the literature. Meditation-induced psychosis appears to be rare. Possible risk factors for psychosis during meditation are sleep deprivation, fasting, personality disorder and psychotic episodes in the medical history.

Conclusion: Meditation is a risk factor for psychosis, particularly in a vulnerable subgroup of patients with serious psychiatric disorders. The category Acute Transient Psychotic Disorder shows cross-cultural differences in prevalence, symptoms and outcome.

The integrative control of time and force in voluntary movement in patients with schizophrenia

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Background. People diagnosed with schizophrenia have been shown to be impaired in the fluent execution of action sequences. The aim here was to assess whether these deficits might be due to a problem in the timing of action, or rather in the more complex problem of integrating information from multiple sources.

Methods. Ten patients with schizophrenia, ten patients with personality disorder and 10 healthy controls participated in the study. The subjects' task was to squeeze a load cell in its center in order to produce 4 different rhythms lasting each 36 s, with

[a] equal time intervals (500 ms) and equal force-squeezes (12N); [b] equal time intervals (500 ms) and alternating force-squeezes (8N/16N); [3] alternating time intervals (300/700ms) and equal force-squeezes (12N); [4] alternating time intervals (300ms/700ms) and alternating force-squeezes (8N/16N).

Three trials for each rhythm were performed with each hand. To assess the influence on performance of self versus external pacing, each trial was constituted of a 12s period of synchronisation followed by a 24s period of continuation.

Results. Controls were more precise in producing time intervals than force-squeezes. Performance was similar for synchronisation and continuation but was less variable during continuation. Patients with affective disorder were impaired in basically all aspects of the task. Schizophrenic patients revealed normal performance levels for the equal time intervals. Performance dropped for alternating force-squeezes; performance dropped significantly when both time and force were required to be alternated (rhythm 4). Most patients with schizophrenia found the continuation task much more difficult to execute than synchronisation.

Conclusions. These preliminary results suggest that schizophrenia is characterised by a specific problem in force-time integration. This deficit becomes even more marked when subjects are to act upon an internal representation of the rhythm to produce.

S9 Psychopathology (1)

Autism and the phenomenology of bodily limits: Integrating competing theories of autism beyond the “specific deficits” debates.

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Although the most diverse biological hypotheses have been explored in the past years in order to account for autistic symptomatology, three neurological hypotheses have proven to be more convincing, on the ground of their alleged proximity with three well-recognized traits of autistic psychopathology:

A- a lack of activity in both temporal lobes centered in associative auditory and adjacent multimodal cortex (Zilbovicius)
B- an over-excitation of the amygdala in situations where autistic individuals are confronted to direct gaze (Davidson)
C- Various applications of the F5 mirror-neurons (MN) hypothesis (Rizzolatti; Gallese; Theoret; in Williams 2001), whereby specific versions of alleged the lack of a “theory of mind” in autistic individuals found biological support.

We will confront these three fascinating discoveries with the phenomenology of autism such as it has been witnessed by high-functioning autists (Donna Williams, Temple Grandin) and therapists engaged in close interpersonal relationship with autistic individuals (Sauvagnat 2005)

We will argue that whereas all three mechanisms have been demonstrated in a number of cases, none of them can separately claim to establish a sufficient causality of autistic disorders, especially on the basis of therapeutic practice. The popularity of these explanations may be due to the fact that each seemed to confirm specific “research traditions” (behavioral hypotheses for A; emotional and psychodynamic hypotheses for B; imitation hypotheses and Theory of Mind for C) and also specific therapeutic techniques. We will advocate a more comprehensive view of the genesis of autism focusing on “pre-thetic”

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difficulties in primary body integration, a line of research that rests on such crucial clinical issues as automutilation, pronominal reversion, stereotypies and specific autistic creativity.

Theories of autism and experience

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Within the domain of psychopathology, autism spectrum disorders (ASD) are among the least understood, especially in the adult population. Until the 1990's it was considered to be a non-progressive disorder of childhood. There is controversy over the reasons for the apparently increasing prevalence rates; some claim that the absolute number of new cases of autism is really more, others ascribe the trend to a bias caused by increased interest in adult manifestation of developmental disorders like ASD and ADHD. Diagnostic instruments have centered on the childhood symptoms and are not always of value when assessing adults. Informants are required to retrieve detailed and unbiased observations from more than 20 years before, parents can no longer be interviewed, families have broken up, medical and school reports no longer exist, or memories are just too blurred. In addition, the subjects of investigation may indeed have autistic features, hampering their ability to accurately report and assess the parts they played in social situations in general. These diagnostic difficulties are even more problematic in the face of unsatisfactory etiological theories. The prevailing theories are cognitive in nature and none can explain the full range of symptoms. New neuroimaging data have provided the discussion with a wealth of important and appealing data, but bring an increased risk of confusing correlation with cause. Genetic research is developing very fast, yet the number of candidate genes have increased to over 50 in number, shattering hopes of finding 'the' gene responsible for autism. In an attempt to shed new light on the origins of autistic features, too little attention has been paid to the narratives of those whom it concerns. Supported by sound phenomenological observing, listening, and reasoning and by what can be deduced from our clinical practice in Zwolle, experience based information from people with autism may well lead to novel ways of understanding and assessing the enigma.

Symbolic form and mental illness - An altered approach to psychopathology

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German Jewish philosopher Ernst Cassirer who died in 1945 in exile in New York centred his whole philosophical approach around the emergence of symbolic form as the missing third link between the individual biological being and his environment. He felt that it is this specific human self-creation of magic, myth, language, religion, politics, science, art and others that form the new human dimension we now experience as consciousness and civilisation. It allows both individuals and groups to escape the mere instinctive and auto-regulative mechanisms to develop those different levels of world-making which help you ascend into a realm of possibility, potential and choice.

Looking at the pathological process, it seems to be the loss of symbolic formation on different levels of world-making which only then enforce isolation, fear, compulsive action, hallucination and organic engrams and finally may descend into chronic forms of mental illness. On the other side, in group behaviour, intolerant and protective speculations result.

Cassirer's ideas were picked up by psychiatrists, psychologists and neurologists in the Weimar republic; they seemed to make way for a more integrative model for understanding psychopathology. Further developments were brutally interrupted by German fascism which forced Cassirer and most of the scientists who had picked up his ideas to leave the country. After his death in 1945 concepts of symbolic formation have not won back a substantive position in psychiatric mainstream discussion. It is only now that his focus on the missing link between neurobiology and civilisation has opened an approach to an integrative model of psychopathology which might even unite seemingly contradictory results of biological and social psychiatry research. Focus on symbolic formation could also shift the approach to clinical treatment: it would reinforce group therapies, symbolic settings and transformation rituals as treatment concepts which might help psychiatrists to regain their position as a healing mediator, and turn inpatient experience from a frightening anxiety-driven isolated stigma into a creative process of a new level of mutual acceptance.

S10 Philosophy and neuroscience (1)

An embodied and non-reductive concept of agency in the neurosciences.

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Traditionally, the cognitive sciences have conceived of the human mind as a central conceptual system, dedicated to the interpretation of neural input and the assignment of meaning to it. For cognitive philosophy, the question of human agency has been how exactly this mental system, with its so called propositional attitudes like beliefs, desires and intentions, could put the physical body into motion; in other words, how downward causation could be possible.

Over the last couple of decades, however, consensus has grown that the contribution of embodiment to cognition is inescapable. There's a rapidly accumulating body of findings from the neurosciences about the physical brain mechanisms that seem to be necessary to make human cognition possible. This suggests that human agency is fundamentally embodied in the brain. Furthermore, there's a growing awareness that human cognition is embedded, in the sense that it is 'situated' in the world (in the broadest sense). Human agency, therefore, should be conceived of as a form of situated interaction with this world. Altogether, these developments appear to encourage a radical break with the old Cartesian mind-body paradigm.

However, for neurophilosophy the question of human agency still remains unanswered. The introduction of the idea of embodiment only forces us to phrase it in a different way. In this paper, I intend to show: (i) that this is mainly the case because we still cherish some old Cartesian presuppositions, (ii) what may be needed to get rid of these presuppositions, and (iii) how we can articulate an embodied and non-reductive concept of agency that does justice to neuroscientific findings.

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The embodied dimension of experience in psychopathology

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In this presentation I will explore some central aspects of the phenomenological conception of affect (following the ideas of Husserl and other phenomenologists devoted to this topic), with special emphasis in the analysis that they advance about the role that affection plays in the constitution of object and intersubjectivity. On the other hand I will try to articulate some of the proposals arising from those phenomenological elaborations with recent findings in the field of the development of “affective styles” which can be found mainly in the research of the early interactions between infants and caregivers and in some recent findings of affective neuroscience.

If we take into account the available findings about the development of infants and their earliest patterns of interaction with the world that has been advanced by developmental psychology, it will be possible to delineate a “naturalistic constraint” (Roy et al.) for the findings of such a “constructive phenomenology”.

With those elements in mind, I will illustrate that the primary kinetic and kinaesthetic patterns of infants, can be conceived as the ground of a very early “affective style” in the infant. The movements and actions of babies can be studied with much detail and from many different points of view, arising a group of categories which, to some extent, can bring congruences and conceptual circulations between phenomenology and developmental psychology. At the same time, if we try to conceive in depth the “early affective style” that grows in those stages of the infant, it can be suggested its potential psychopathological interest. How is that? It has been sufficiently proved (from both the conceptual and empirical perspectives), that those early interaction patterns are in fact highly tuned to the “affective valence” of experience from the beginning of life and, by this means, with the most early form of intersubjectivity and embodiment.

The complexity of it all: Why neuroscience and phenomenology must work together

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During its productive and still unfolding history, phenomenological psychiatry has developed numerous detailed studies of a great variety of mental conditions. This history, however, has been marked by a neglect of theoretical interest in brain processes. With the successful development of the fields of neuroscience and psychopharmacology this neglect on the part of phenomenological psychiatry must end. Recent investigations of the genetic basis of mental disorders have disclosed its immense complexity. The articles by Kenneth S. Kendler that appeared in the American Journal of Psychiatry in 2005 make this point and lay out a “philosophical structure for psychiatry.” In brief, emerging empirical research is presenting a far from simple picture of the genetic and neurobiological bases of mental disorders. We shall argue that the classifications of mental disorders provided by DSM-IVTR and similar documents fail to provide guidelines adequate for fruitful neuro-

scientific studies. What is needed instead is a psychopathology that can provide the fine-grained and detailed analyses that phenomenological psychiatry can furnish. On the other hand, these phenomenological descriptions need to be informed by the implications of genetics and neuroscience, such as those outlined by Kendler. Only by reasoning from “both sides at once,” i.e., the side of the complexity of the neurosciences and the side of a subtle phenomenology, can we begin to construct a philosophical framework for conceiving of mental disorders.

S11 Psychiatry and society (1)

Values and Truth in Psychiatry

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In this paper I examine various ways in which psychiatry is value-laden, and consider whether and when value-ladenness should reduce our faith in psychiatric theory. I argue that psychiatric theory is value-laden in so far as values shape the topics chosen for study, they shape decisions regarding who counts as reliable witnesses, and they shape the language used to express theories. In discussing these issues I will focus on the debates about race, I.Q and insanity that occurred in the U.S. in the first half of the twentieth century. Other writers have taken these debates to show that psychiatry is unavoidably and perniciously value-laden (Gould 1983, Hayes 1995). I will draw different conclusions and will argue that these debates show that scientists who look honestly at the world are capable of discovering that things are not as they expect or want them to be (eg psychiatrists who hypothesised that Black people suffer from higher rates of mental illness revised their claims in the light of empirical evidence). I take these cases to demonstrate that value-ladenness, though harmful, is not as awful as many writers have suggested. Value-ladenness is at least corrigible.

MTV to MRI; Images of the Brain and the Rise of Visual Culture

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Walter Benjamin’s essay ‘The Work of Art in the Age of Mechanical Reproduction’ describes a historical change in the value and function of art. Overtaken by photography and the proliferation of technologically produced images, the individual artwork lost its aura of uniqueness and authenticity. Whilst this democratised art through the increase in access and the removal of art from the special preserve of social or professional authorities, it also risked the loss of imagination and reflection. The new technology of functional brain imaging has revolutionised psychiatric research and seems to promise a future in which our understanding of the nature of mental illness, diagnosis, treatment response and the stigma of madness undergo a radical change. A picture will speak a thousand words, laying waste to the old discursive ‘art’ of psychiatry, based on direct individual communication, the authority of the medical narrative and the clinical perception of phenomenology at a unique moment in history. In the words of John Berger, “The art of the past no longer exists as it once did. Its authority is lost. In its place is a language of images. What matters now is who uses the language for what purpose.” Psychiatry always was an aesthetic practice, with narrative cri-

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tiques leading to diagnosis. Now there is a new aesthetic, that of the brain image; seductive, unambiguous and compelling.

Core and periphery of male patients with gender identity disorder

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Studies of gender identity disorders are conducted from various perspectives, biological to psychosocial standpoints. However, at present, there is no coherent opinion as to the etiology of such disorders. There are many arguments whether one should provide support for patients with a given disorder, but in male cases in particular, the clinical images vary; it is necessary to first identify “what happens in this disorder.” When we diagnose a gender identity disorder, the function of the self itself expressing his or her own gender identity is normal, and we must confirm that an expression of a gender identity is not “a delusion” in the diagnosis of DSM.

For example, one may consider that the expression, “I am an alien” to be delusion of schizophrenia. The expression of a delusion of patients with schizophrenia is the performance of act. But, there is an intentional “misfire” (Austin) in performing this act. On the other hand, paranoid delusion may be taken to be compatible with reality. And, the expression, “I(male) am a woman” in gender identity disorders does not always “misfire.” Why not?

Here, we present 20 examples of male patients from this point of view.

The core group of gender identity disorders can be said to be subjects primarily formed with the expression that “I am a woman.” On the other hand, the periphery group signifies the pathology of disgust in relation to “being a man” and to the meaning that a male body has within a social context. We recognized this periphery group in homosexual, transvestism, paranoia, and certain neuroses. In this case, it may be said that the expression, “I am a woman” is meant to cope with this disgust at being male. At first, with the periphery group, it seemed that in the psychotherapeutic approach, the task of investigating what this “disgust for being male” is derived from is necessary.

S12 Taking group disorders seriously

Suicide copy cats: social contagion or rational persuasion?

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In this paper, I want to explore the presumption, shared alike by mainstream diagnostic psychiatry and neurobiology, that whether understood as psychiatric disorders or neural functioning, psychic states are best explained and treated in terms of separate, monadic, human systems. While it accommodates the paradigms of psychiatric disorder such as schizophrenia and mood disorders, because they are strongly idiopathic and individualistic, I want to test this presumption against disorders apparently belying an individualistic analysis and explanation, for example, conditions such as eating disorders and suicidal behavior that can often be understood as the emergent properties of groups.

The features of such ³group² disorders are not well understood. But a slowly emerging body of research about forms of social

contagion, including mass (group) “hysteria,” sociogenic (psychogenic) illnesses and epidemics, ³copy-cattin² behavioral pathology, internet and media-driven conditions (and, on a smaller scale, folie a deux), invites causal hypotheses and preventive strategies - primarily from epidemiology - unlike those found within traditional, individualistic, diagnostic psychiatry.

Ontologically, such group disorders are no less compatible with a neuro-scientific account than are more standard psychiatric disorders, of course. Indeed, things like the recent discovery of ³mirror neurons² look to be going to shed enormous light on the mechanisms underlying some group disorders. But the neurobiological substrate that grounds every psychic condition in every individual, whether a disorder or not, may not rank as salient when it comes to explanation and prediction. Thus, group disorders seem to call for something different, perhaps even the project explored in the present discussion - a rethinking of explanatory models within the neurosciences. And that, in turn, will have significant implications for practice, research, and resource allocation.

Learning to be thin, learning to be sick

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Studies show that young women in sororities are significantly more likely to become bulimic over time than young women in the general population. These clusters cannot adequately be explained by coincidence. Are women drawn to others who share similar characteristics? Are vulnerable young women imitating behavior of the more popular sorority women? This paper examines the phenomenon of social contagion, social inference, and social attitude shifts and inquires into what counts as the best explanation for group behaviors of bulimia. I argue that the unit of analysis, for phenomena like this, must be that of social psychology and then query how neuropsychiatry can respond to such a theoretical framework.

Bipolar disorder: A communal disorder?

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In recent years a divide has opened up between rates of diagnosis of bipolar disorder in America and Europe. In Europe, manic-depressive disorder remains, as it has been traditionally, a disorder that is not diagnosed before adolescence. In America, 1 and 2 year olds are now diagnosed as having bipolar disorder and up to 5% of children are thought to have the illness. There seem to be two drivers to this – one is an assiduous company sponsored marketing of bipolar disorder. The second is the creation of the notion of mood-stabilization. This very term is an advert.

In response to these two manoeuvres for bipolar disorder – and others for ADHD - a diagnostic market has opened up in childhood vicissitudes. The communal characteristic to disorders in this area lies in the fact that a large number of children have to become bipolar for any one of them to be bipolar. This talk will illustrate how, as part of this process, children are being taught a neuroscientific patois or biobabble by which to express themselves with uncertain consequences for the future.

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S13 Ethics

Botox for the brain? The ethics of cosmetic psychopharmacology.

Ineke Bolt

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The recent rapid developments in the fields of neuroscience and psychopharmacology increase the possibilities to enhance the mental functioning of humans; e.g. by improving memory, or attention, or mood. Concomitantly, the undesired side-effects of psychopharmacological substances will probably be minimized. This will further stimulate the use of such substances, both within and outside the medical care setting. Will this lead to 'cosmetic psychopharmacology', and if so, is this a morally desirable development?

We will give a brief review of the present and near-future possibilities for enhancing human mental functions. Next, we will review the various ethical concerns with regard to this type of enhancement. These concerns include the risks and safety of new medication; social equality and justice when certain groups get easier access to enhancement than others; coercion and abuse of such enhancements in children or in work-situations; the meaning and value of authenticity and identity if these are 'tampered with' by pharmacological means; the role of mood and happiness for a 'good life'; the imminent threats to our humanity that some see in enhancement technologies; and the fuzzy boundary between clinical therapy and enhancement practices. We will argue that it is as yet too early to give a definitive ethical evaluation of cosmetic psychopharmacology, but that discussion on the subject is timely, if we aim to influence these developments.

Is there a place for values in neuroscience?

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Psychiatry has changed during the last decades due to the rapid development of neurosciences. With the advent of new imaging techniques, better understanding of genome expression and more refined techniques for neurotransmission studies, psychiatry has tended to become more of a neuroscience-based discipline. This goes together with an emphasis on evidence-based psychiatry as well as more technically based psychotherapeutic methods.

This development necessitates a need for a new emphasis on values in psychiatry in order to keep the anthropological perspective alive and focusing the patient as a human person. This also necessitates that the psychiatrist is a reflective practitioner whose values are transparent and well grounded.

In this paper, the relation between facts and values in psychiatry will be discussed. What foundations should psychiatry be based on? Are evidence and experience competitive or complementary concepts in psychiatry? What experience is the point of departure in meeting a patient? Does the neuroscience emphasis mean a threat towards a humanistic psychiatry or not? I will argue that there is an urgent need for values in psychiatry, even more so in our neuroscience era. The reasons for this will be outlined as well as some ways of thinking about evidence and experience as complementary concepts.

The two R's in psychiatry.

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The point of departure in this presentation is a recurring situation in the seclusion room of a psychiatric emergency ward in the Netherlands. An agitated, incoherent manic patient who refuses medication is ultimately given an intramuscular antipsychotic drug against his will, while restrained by six nurses. Part of this sequence of events is the psychiatrist's attempts to listen to the patient, to make sense of his utterings, to try to establish a relationship with him within the context of an involuntary hospitalisation. At the same time he has to diagnose and start treatment.

As an emergency ward psychiatrist the author has been asking himself questions related to these tasks: how do I listen to the patient and establish a relationship, how do I justify my decisions about seclusion and treatment against the will of the patient?

This presentation is a first attempt to systematically reflect on the body of knowledge (medical, interactive) and values (personal/professional, institutional and social) that steer the sequence of events described above in a case study. An attempt shall be made to make explicit the epistemological, philosophical-anthropological and ethical suppositions underlying this knowledge and these values.

Professor G. Glas' theory of four levels of analysis will be used to order the material and to offer some practical advice. The conclusion is that the two R's (relationship and reflection) are the two most essential components of psychiatry as a profession and that we need tools to promote them in daily practice and in professional training.

S14 Schizophrenia (3)

Conceptual aspects of empirical research on psychosis

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Schizophrenia is an inescapable reality in the lives of patients and their families, and yet the biomedical concept which attempts to clarify it does not meet the criteria of scientific maturity. This insight has significant consequences for the way we design empirical research on the pathophysiology of psychotic disorders. In this session, an analysis of the historical and conceptual roots of the biomedical concept of schizophrenia will be presented, in which its indebtedness to 19th-century degenerationist thought is emphasized. In addition, a case will be made for the development of empirical research strategies that transcend the boundaries of such nosological categories as 'schizophrenia'. To illustrate the potential of those strategies, attention will be given to the preliminary results of an fMRI study of the physiological correlates of verbal auditory hallucinations which is currently underway in Utrecht and The Hague, the Netherlands.

Abstracts

Delimiting delusions: a conceptual critique and research agenda

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Mental health practice assumes a level of clarity and validity for its diagnostic labels. While delusions are an important class of symptoms for many disorders, the concept turns out to be less than clear. The presentation begins with an evaluation of various definitions of the concept of delusion. It considers conditions specified in definitions, from Jaspers, DSM and other sources. These conditions include, about the delusional beliefs, their purported: (a) falsity, (b) belief with subjective certainty, (c) being maintained as evidence-resistant, (d) having impossible content, (e) irrationality, and (f) being judgments with a transformed experience of reality underlying them. The paper evaluates what kinds of definition of delusion seem possible or desirable.

Case-examples frame examination of several questions, including whether delusions are distinguishable from obsessions by level of insight, and whether delusions are distinguishable from overvalued ideas by level of certainty. Difficulties will be seen in some attempts to contrast delusions from other forms of thinking that are irrational and dysfunctional.

In addition to the pursuit of clarity about the nature and scope of delusions, it would be important to establish a biological basis for these phenomena. A discussion of brain imaging of patients with delusions begins with an overview of studies based on imaging. A proposal is advanced for a systematic approach to imaging studies. It would consider studies classified by disorder or by type.

Is schizophrenia a brain disease?

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Recent advances in brain imaging techniques have made it possible to discern changes in brain morphology and function in several different psychiatric disorders. Should such results be taken as evidence for an “organic” etiology of these disorders? A well-known objection says that the visible physical changes could be effects instead of causes. An even more important possibility, which is usually overlooked, is that the observable anatomic or physiological changes may be the immediate biological substrate of the psychiatric condition. Even the paradigmatically “psychogenic” condition which consists in the possession of learned knowledge has such a substrate. This substrate has been observed by imaging methods, but no one (I hope) would draw the conclusion that the possession of learned knowledge is not a mental state, or that it is not mentally caused. Similarly, the observation that, e.g., schizophrenia is accompanied by observable changes of the brain must not be taken as proof that schizophrenia is not a mental disorder, or that the non-hereditary etiological component in schizophrenia (which accounts for some 50% of the variance) is “organic” in nature. For the latter conclusion, one would need support from independent findings of such exogenic or endogenic biological and physical events in the patient’s history as could lead to organic lesions. Notably, the evidence for an overrepresentation of such events in the history of schizophrenic patients is scarce. My conclusion is that the total evidence is quite compatible with the possibility that schizophrenia is a mental disorder with a strong psychogenic component.

S15 Psychiatry and society (2)

Psychopathology of autonomy: the place of psychopathological knowledge in the community mental health in Brazil.

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Introduction: What is, and what can be, the place of psychopathological knowledge in the community mental health services in Brazil? This question is investigated by the Laboratory of Psychopathology and Subjectivity – Federal University of Rio de Janeiro, Brazil. These services, called Centers of Psychosocial Care and developed by Brazilian Psychiatric Reform, are places in the community where patients with severe psychiatric mental disorders must be treated.

Aim: The main question is: is the framework of psychopathology as it is presented nowadays – in its descriptive perspective – a tool for professionals who work in these services? In this kind of service, the direction of the whole treatment must be to increase the capacity of these people to create new rules to their lives, considering their different ways of establishing relationship with the world.

Methodology: In order to discuss the limits of descriptive psychopathology and the possibilities of another approach that considers the mental disorder as an effect of the relationship subject- world, some clinical cases will be analyzed and interviews will be done using the “McGill Illness Narrative Interview”.

Results: The cases and interviews show that the descriptive psychology is not a proper tool to deal with the conception of autonomy, that is to say, the ability to keep one’s belonging to the world and at the same time to maintain one’s individuality.

Conclusion: The framework of descriptive psychopathology should be critically reviewed. A new perspective is really necessary, as a condition to take care of patients in community services, where the knowledge about these people’s everyday life is a crucial need.

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Does reputation-based reciprocity and a link between psychosis and altruism account for the increased incidence of psychosis in urban areas?

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Humans are unique in forming large groups of individuals who co-operate despite being unrelated, but accounting for altruism in evolutionary terms is difficult. Recent advances in reputation based theories and evidence accrued from public goods and other games indicate the importance of people who benefit others at a cost to themselves (altruistic rewarders) and punish others at a cost to themselves (altruistic punishers). Functional imaging studies of people undertaking such games strongly suggest that humans are hard-wired to gain reward from such actions.

The incidence of schizophrenia and other psychoses increases in a dose response fashion with urbanisation, suggesting causality. The nature of the environmental exposure which appears to act during childhood or adolescence is unknown but appears to act synergistically with familial liability. Consideration of the demands and importance of reputation based reciprocity, coupled with anecdotal clinical evidence of increased altruistic disposition in those suffering psychosis and their close relatives, lead the authors develop the theory of compelled reciprocation. It is proposed that the inclination to participate in altruistic exchanges varies within the population, but those predisposed to initiate or reciprocate at a cost to themselves are also those most likely to be genetically at risk of psychosis. The potentially toxic effects of urban living on those with a higher inclination to altruism are explored. Means of testing this theory are suggested for populations, groups and individuals.

Attentive awareness and adaptation in emotional problems

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Change is a major difficulty for us all. We can accept change intellectually but not emotionally. We cling to things in the vain hope that they will give us security and stability. We crave satisfaction and contentment but are repeatedly disappointed and frustrated. We torment ourselves with our ambitions, plans, fears and worries, trying to get what we want and to get rid of what we do not want. Not accepting the flux of life we become dissatisfied, frightened, depressed, anxious, angry and stressed. Striving to change our bodies and minds or to change the world is as futile as trying to put a fire out by blowing the smoke away. It is we who need to change: not our brains or thoughts or the rest of the world. Find the source and return to it. Having split apart and gone astray 'I' stands alone, isolated and alienated from all else. We then feel threatened by the very life which is our source and which we long to return to. Don't bother with the branches, stick to the root. Leave the thoughts and fancy ideas alone and stick to the reality of the senses and emotions. In this paper I describe the cause of depression, anxiety, anger and stress and suggest a way of dealing with them.

S16 Classification and models of disease (1)

The disease model of mental illness: not to be discarded

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The apparently increasing prevalence of mental disorder may be a consequence of abandoning the disease model of mental disorder, rather than its uncritical over application. The key feature of the disease model is not the assumption of a biological cause to mental disorder but that external symptoms, rather than constituting the illness itself, are pointers to an underlying disturbance. Psychological and social approaches to mental disorder can readily be included in such a model. The disease model can be contrasted with the criteria based approach to diagnosis exemplified by the DSM. By looking no further than the external symptoms the criterion based approach presents problems that a disease model does not.

One: a disease model, whether rooted in disturbed physiology or not, allows for some areas of deviant behaviour, protest, and eccentricity to remain outside of the ambit of mental health.

Two: In psychiatry symptomatology is predominantly subjective. Without a disease model any person can claim access to the sick role on the basis of their subjective report.

Three: a disease model locates the disease other than within the total behaviour of individuals, thereby limiting totalitarian levels of intrusion into people's lives.

A loose disease model is advocated, within which it can be recognised than an underlying biological, social or psychological disturbance may contribute to manifest mental disorder.

Fibromyalgia and the therapeutic domain. A philosophical study on the origins of fibromyalgia in a specific social setting

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Fibromyalgia – or pain disorder in terms of DSM-IV-TR – has always attracted controversy. Will she always exist regardless of the name given to the syndrome or is she a form of illness behaviour escalated by labelling? We state that fibromyalgia is not waiting below the surface until it becomes manifest by labelling. We developed our hypothesis on the relationship between a specific social setting (called the therapeutic domain) and fibromyalgia using empirical philosophical arguments based on Foucault and Hacking. A therapeutic domain is a real and heterogeneous medical domain in which people, their thoughts, words and practices, and medical technology in any form coexist and communicate. In this domain blood is aspirated, radiographs are taken and classification criteria are made and applied. This results in a looping effect between neurobiology, perception of self and assignment of meaning. We mean an effect of alterations in gene expression, where classification criteria and images give structure to perceptions, and form the description for human behaviour; the person thus diagnosed (!) constantly has to grow into the conformity of these classification criteria, which also have to be constantly revised as happened before with analogue syndromes like repetitive strain injury or an arc the cercle of the classical hysteria. It is not only a phenotype induced by the physician, but in this domain a certain power creates reality making the 'disease' become manifest. The only certainty in fibromyalgia is that it is still being diagnosed.

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"Do you think I'm really sick?"

A philosophical approach to madness and its definitions

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Madness exists in all times and societies, yet many individuals have been misdiagnosed and badly treated. To improve the reliability and validity of mental categorization, psychiatrists have created the DSM, consisting of a classification of mental disorders and a definition of mental illness. As the definition they proposed led to conceptual issues, philosophers have attempted to further it. I describe three main approaches, namely Boorse's (1976) scientific definition, Wakefield's (1992) partly scientific/partially value-laden definition, and Cooper's (2004) value-laden definition. I argue that all three suffer from significant conceptual flaws. I propose that the definition that comes closest to adequately defining mental illness is actually that found in the DSM III-R, which seems to have been largely misunderstood. I offer a clarified version with improvements regarding a last flaw. In order to find out whether the subject of this definition corresponds to anything real, the possibility of natural kinds in madness will be discussed. Two of Hacking's (1999, 2002) arguments leading to his claim that mental disorders are socially constructed are presented. I argue that both fail, and that therefore, madness may consist of natural kinds (groups of tokens that share given essential properties). To get a glimpse of what these natural kinds might look like, a glance on medical and neuropsychological theories of psychopathology will be offered. I conclude that the DSM IV should clarify and slightly revise their definition; I also conclude that madness consists of natural kinds even though they may not correspond to the DSM classifications.

S17 General issues (2)

Child neuropsychiatric nosology is challenged by empirical data that rather support a dimensional and complementary model

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The last decades have seen both controversy and important new research concerning childhood neuropsychiatric disorders (NPD), such as autism spectrum disorders and attention deficit/hyperactivity disorder. Arguments against today's medical model may not only come from critics of psychiatry but also from the neurobiological and neuropsychiatric research itself. Following behavioural or operational definitions, the NPD are not rare conditions, apply to several percents of all children, and are unspecific as "comorbidity" is the rule rather than the exception. There is a growing consensus, based on broader phenotypes described in relatives and the lack of data supporting taxonomic distributions, that the NPD represent dysfunctional extremes in variations of cognitive traits. Diagnostic decisions are arbitrarily made based on the functional impairment or personal suffering that result from the symptoms assessed. Brain imaging, neurological and genetic susceptibility factors seem to be general across the spectrum rather than specific for any one kind of disorder. This literature will be reviewed together with new data demonstrating negative associations between NPD and personality measures of conceptual maturity concerning

internalized control and cooperation. Naming medical syndromes puts the individual at risk of enhancing helplessness, irresponsibility and social oddity. It may also hamper aetiological research by "cutting nature" at joints that do not exist. A dimensional and complementary description of neurodevelopmental problems may provide the same advantages as today's diagnoses while eliminating some of their risks, and might open up for a new understanding of the role played by NPD-related abilities in functions such as empathy and impulse control.

Bodies, minds and concepts

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It is thought of as ethically wrong to reduce people to their physical characteristics whether it be colour of skin, height, sex, age and so on. People are not simply defined by their physical characteristics because people define and manifest themselves through their experience of the world in terms of thoughts, actions, plans, behaviour and feelings and so on. In short a person is characterised both in terms of their experience and their physical characteristics and physical processes. This will, however, prompt the following question within the mind of the neuroscientist: could human experience itself be defined in terms of thoughts, actions, behaviours and feelings and identified with specific brain processes or neural circuits? Successes in neuroscience, will prompt the neuroscientist into thinking that one day it may be possible to completely reduce and completely explain human experience by identifying distinct kinds of brain processes. Perhaps, here we have an attempt to reduce the human being to physical processes and this appears to be in conflict with the deep-seated intuition that human beings are not reducible to physical processes. Are there, however, any conceptual developments to support this intuition, which show, or at least suggest that human experience cannot be completely reduced to physical processes? Or is the intuition that we cannot reduce human beings to their physical processes a product of the very concepts we use in order to describe and define human experience.

Of course it is (not) me, or how to read the newspaper? The moral dimension of psychotic experience

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First, I will clarify a distinction between two types of moral experience: one type is based on a preverbal and collective understanding of the world and oneself; the other type refers to a reflective and individual way of relating to external reality and one's own existence. This distinction is based, among others, on the work of Piaget and Kohlberg. Then, I will argue that this distinction bears relevance to our understanding of psychotic experience. In the 'active' phases of the schizophrenic process the patient's self-understanding is characterized by absolute do's and don'ts with primitive, harsh, even tribal qualities. These do's and don'ts do not seem to be related to the subject, they appear as 'objective' and intrusive. These qualities may be seen as expression of the first, collective type of moral understanding. When the patient recovers, his self-understanding will gain some of the features of the second, reflective type of moral understanding. In the final part of the paper I will elaborate on this view from a

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clinical perspective. I will give some examples such as the deficiency of telling one's biography and the inability of the psychotic patient to read newspapers. Psychiatric understanding of psychotic experience would greatly be improved by including this moral dimension of self-relating and relating to the world into our diagnostic approach.

S18 The status of verbal introspective reports

Phenomenology, heterophenomenology and situated cognition

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The emerging paradigm of 'situated cognition' has enjoyed a great deal of interest in recent years. In the context of consciousness, it is frequently presented as a self-sufficient alternative to Dennett's 'eliminativist' approach and is said to be 'saving phenomenology' (Noë). In the context of intentionality, the discovery of mirror neurons and the development of simulation theory are likewise believed to provide a different and empirically grounded approach to the 'mere interpretationism' of Dennett's intentional stance (Slors). I will provide a brief but critical analysis of the main conceptual innovations introduced by the situated cognition movement, using Noë & O'Regan's 'sensorimotor theory' as a case study. The analysis will focus on the concepts of (1) externalism; (2) virtual presence; (3) dynamic vs. static systems; and (4) skill-based vs. propositional knowledge. It will be argued that these conceptual innovations provide new and important insights in subpersonal processes but in themselves do not constitute a philosophical explanation of how these processes give rise to personal level phenomena. The upshot is that Dennett's account, when understood as an attempt to naturalistically spell out how personal and subpersonal levels interrelate, should not be regarded as rivaling the paradigm of situated cognition, but as necessarily augmenting it on a fundamental level.

An embodied anatomy of mind: Me, my self and you

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Work in the domain of embodied and situated cognition has interesting implications for the position of introspective verbal reports. One of these is that the notion of mind is drawn much wider compared to how it used to be drawn. Not only intentionality and consciousness are considered as marks of the mental, but increasingly also perception and action. There are many implications of this change that deserve close attention. For example, in this view, mentality is no longer limited to human beings but to some degree present in, at least, all animals. Another implication is that the domain that verbal introspective reports are reports about is only a subset of mind. To mention several indications that point in this direction: First, the neuroscientists Milner and Goodale state that the online visual guidance of movement is a non-conscious process, and they contrast it with 'semantic' vision which leads to the conscious appreciation of what is seen in terms of objects. Second, the philosopher Metzinger, using reasoning and empirical evidence, claims that we do not really have a self, but rather a self-model. Our physical/mental system provides an internal simulation that generates the content which is accessed when each of us consciously thinks about our self. Finally, work on mirror neurons

suggests that such a self-model, and thus the first-person view provided by it, can plausibly be cast as a derivative of a second-person view: We learn to see ourselves as we see others first. While acknowledging the preliminary status of these claims, the pattern is suggestive of an anatomy of mind in which verbal introspective reports can be considered as truthful reflections of our conscious states, while at the same time not having to press the claim that they provide an accurate description of mentality in a wider, embodied sense.

Verbal introspective reports in view of motor theories of social perception

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Since the discovery of so-called 'mirror neurons' in the early 1990's, a plethora of so-called motor theories of social perception has been developed according to which attribution of mental states to others proceeds by empathically 'resonating' with the other's bodily movements. This resonating results in neural mimicry of the other's actions. And that, in turn, results in a nonconceptual rudimentary understanding of other people's motivations.

Though this rudimentary grasp of other's intentions and motives does not amount to full scale mental state attribution, it seems likely that this 'mirroring' provides the basis for such attribution. What seems required in addition is conceptual, folk-psychological interpretation of the initial grasp we have of someone's intentions and motives (there certainly is no consensus over how such interpretation works).

The debate tends to concentrate primarily on the attribution of mental states to others, but it seems more than likely that self-attribution of mental states is much like other-attribution. If mirroring others' behaviour results in an initial grasp of the mental reality behind that behaviour, neurally registering one's own behaviour will result in a nonconceptual initial grasp of one's own intentions and motives. Thus it seems to be at least an option that is supported by current research into the embodied mind that self-attribution of conscious mental states is a matter of interpreting one's awareness of one's own bodily actions and behavioural tendencies in folk-psychological terms. This option allows for a new position with regard the problem of introspection. The public observability of what is interpreted in introspective reports (actions are publically observable and behavioural tendencies may be detected through neuroscientific research) changes the epistemic status of such reports compared to earlier views: instead of having to take these reports at face value, we can now assess them in view of third-personal knowledge of what these reports are about.

Discussion

The panel of speakers will discuss the (in)compatibilities, problems with and advantages of the positions presented. The discussion will be chaired by Joel Anderson, Department of Philosophy, Utrecht University, The Netherlands

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Explanation, understanding and phenomenology (1)

Understanding and explanation in psychopathology

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An attempt is made to present the possible influence of the development of cognitive sciences on psychopathological conceptions. Presentation especially concentrates on the basic symptoms in dissociational and schizophrenic disorders (delusions). Analyzing the cognitive concept of mental causality, the author attempts to identify the consequences which derive from the concept for understanding of mental pathology. He pinpoints the limitations of the classical science of cognition, especially the lack of distinction between the functional and intentional level. He advocates that the concept of causality and subpersonal explanations be complemented with phenomenological and hermeneutic description of human experience. It is especially important in psychiatry in the context of the latter's practical and ethical aspects.

Understanding and explanation in psychopathology will be presented in the wider context of the controversy in the philosophy and social sciences (Hempel, Dilthey, Jaspers, Heidegger, Wittgenstein, Davidson, Dennett, Chalmers). This may help to develop the philosophy of psychiatry on the basis of continental and analytical traditions.

Explaining the brain, understanding the person: Perspectives from phenomenology & analytic philosophy

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We claim that advances in neuroscientific knowledge do not require that psychological and psychiatric explanations be eliminated. This claim can be justified from both the analytic and phenomenological philosophical traditions.

Kimball argues that ordinary psychological explanations in terms of an agent's beliefs and desires are compatible with neuroscientific explanations. Even so, one can endorse an entirely physicalistic ontology and maintain that all relevant causation is neurological. The key to this anti-reductionist but non-dualistic position is to separate explanation from causation. In an individual instance, the full causal story of a person's behavior could in principle be told at the neurological level, but behavior is explained by the law-like regularities which obtain between behavior and beliefs, desire, and other intentional states.

Wiggins claims that explanations developed by the psychological and neurosciences are based on our pre-scientific capacity to understand other human beings in the lifeworld. Scientific theories derive much of their intelligibility and plausibility from our pre-scientific understanding of people. Furthermore, there is no reason to strive for an entirely physicalistic ontology. Wiggins' phenomenological position embraces rather an ontological pluralism in which there are many ontologically distinct kinds of beings, among which are the mental being and the neurobiological being conceptualized by the psychological and neurobiological sciences. Moreover, we can gain scientific access to these different kinds of being only by use of methods and conceptual systems that differ significantly from one another.

Hearing voices: "first-person methodology" and psychopathology.

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Objective: The aim of this study is to emphasize the accounts of subjective experiences of an outpatient that "hear voices", from the "First-Person Methodology". His accounts, from this methodology, don't presume anything final or apodictic about subjective phenomena neither privileged access to his experience.

Methods: Single case study. The first author selected and attended on this outpatient who was at that time at the Instituto de Psiquiatria (IPUB) of the Universidade Federal do Rio de Janeiro (UFRJ), in Brazil, for two years. His data were collected from the patient's medical report and writings of his ideas, feelings and thoughts. Both reports were analyzed by a bibliographical review in reference to 1) the subjective experience of auditory hallucinations as M. Romme, for instance, describes; 2) the "First-Person Methodology" proposed by Francisco Varela and Jonathan Shear, and 3) the phenomenological method for psychiatric investigation according to Karl Jaspers.

Results: The analysis of the patient's accounts shows that the auditory verbal hallucinations is the relevant psychic process for him. His private (individual) intrasubjective experience of hearing voices, out of reach to the observer, characterizes what Varela calls a "first-person perspective".

Discussion: The applicability of the "First-Person Methodology" in clinical practices is opened to future investigations. In terms of the current developing discussion of the "first-person perspective", intersubjectivity arises as a pre-condition for a science of consciousness.

S20 Psychopathology (2)

The indeterminacy of translation – application to the psychopathology of psychosis?

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In this paper, the term intentionality will be differentiated in relation to Quine's hypothesis of the indeterminacy of translation. In order to substitute the none-referring space of unknown terms Quine suggested two principles. The maxim of indulgence requires that a maximum of true consideration has to be achieved by the final interpretation of a proposition. In addition to that, coherence has been introduced as a principle of successful translation of terms. It will be discussed how indulgence and coherence reflect successful intentionality performance in psychotic disorders. Obviously, the overall communicative process between any of the cited types of schizophrenia might be modulated by this. Starting with delusional conditions we rapidly are concerned with the patient's talk as pre-predicative consideration. Here, a pre-predicative consideration refers rather to the emotional or social state of the patient than to the concretistic meaning of his thoughts. One might argue that by

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talking about the potential of pre-predicative considerations in schizophrenia the principle of favorizing that concept which is true in as much as possible concerns has been applied. Under the headline of consistency and deductibility, the cognitive-emotional and social life complaints of the patient should be selected consecutively when they are getting object of therapeutic interventions. It is not the practical issue of what a patient has to consider during therapy e. g. drive and activity state to get started in some educational program but rather his overall commitment to his social interactions. These will not be achieved by dehospitalisation alone but require coherence of the therapeutic efforts. One may conclude successful communication in schizophrenia can be better understood using the core principle of indulgence and coherence.

Clinical use of the mirror sign

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The mirror sign is defined as a disturbance in self-identification when looking into a mirror, leading to either a frightening sense of self-alienation or even to a tendency to talk or gesticulate to mirrors. It is traditionally thought to be an early sign of psychosis. In an attempt to find out whether the sign is of any practical use to clinical diagnosis, all patients admitted to a psychiatric clinic for asylum seekers and refugees were routinely asked whether they had ever experienced anything unusual when looking at themselves in a mirror. Of the 75 patients 45 admitted to feelings of fear or disgust when looking into a mirror; 29 of these reported a significant discrepancy between their experiential self and their present reflection, of whom 25 said to have had some degree of doubt as to whether their reflection was actually their own, ranging from occasional doubt (in the majority) to frank delusional self-misidentification (in a few cases). Two patients who denied having the mirror sign were observed talking or gesticulating to mirrors. A surprise finding was that looking into mirrors also seemed to trigger trauma related memories in some patients, with a similar sliding scale in disordered reality testing ranging from an ill-defined feeling of threat to paranoid delusions concerning mirrors. Contrary to traditional view, in some patients the sign appears to be chronic, leading to a long lasting habit of avoiding or covering mirrors.

Personal memory and abnormal belief

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Interdisciplinary neuroscientific studies of abnormal mental symptoms allow a renewed study of the phenomenology of mental disorders. Early and distinctive neuropsychiatric symptoms accompany the alterations in higher cognitive functions seen in patients with mild or minimal Alzheimer's disease, and may even be the onset symptom. Neuropsychological and functional neuroimaging case and group studies of discrete personal (autobiographical) memory impairments, reveal an association with specific forms of delusion and confabulation in these patients. Delusions in personal memory are phenomenologically distinguishable from other forms of delusion and have specific neuropsychological and neuroimaging characteristics. Studies of spontaneous and provoked confabulation also reveal

a link with the episodic element of the structural organisation of autobiographical memory. The findings have implications for theories of abnormal belief and reality dysfunction in both organic and functional psychiatric disorders.

S21 Conceptual issues (1)

„Insight“ in Psychiatry

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Insight plays an important role in clinical and forensic psychiatry. The patient's insight into the disease strongly influences his or her compliance, and insight is crucial for assessing criminal responsibility. Conceptually it is closely associated with other complex terms, like judgement, reason and will. Current data about the effects of insight and its repercussions on the course of disease are inconsistent, most likely due to ambiguous and contradictory definitions and concepts. The same is true for "insight" in the overlapping field between psychiatry and law. Aiming at a clarification of the term with regard to its content and use in psychiatry, we carried out a literature search, using all psychiatry-relevant electronic data-bases (Medline, Psyn-dex, PsycInfo) as well as handbooks and monographs, focusing on theoretical reflections, study designs, measures and empirical results. Furthermore, the keyword and similar terms (i.e. anosognosia, awareness) were analysed on the basis of a review of the neurological, (neuro)psychological, neuroscientific, philosophical and legal literature, the latter being restricted to the German and German-Swiss context. Our preliminary findings clearly indicate that a theoretically well-founded concept or testable model of "insight" does not exist, neither in psychiatry nor in adjacent fields. How "insight" can be defined and how it may evolve remains unclear. Most of the numerous studies are restricted to the quantification of correlations with cognitive (sub-)functions. The necessity of innovative, integrative and interdisciplinary strategies for studying this multidimensional and clinically relevant phenomenon becomes increasingly evident. Promising attempts will be reported.

Madmen, Lions, and the Difficulty of Telling the Difference

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There is no simple diagnostic examination available for at least some psychiatric conditions; diagnosis requires an interpretation of clues provided in interviews and through observations of behaviour. Intuitively, sustained failure to make sense of a person "normally" counts as an indicator of disturbance. Yet a failure of interpretation is insufficient to entitle us to say anything about a person's mental state. I suggest that the only thing sufficient to entitle us to say that a person is, say, psychotic is the fact that he is psychotic. At the same time, though, the fact that someone is psychotic will potentially not suffice to be able truly to say so. In a nutshell, the only people whom we can safely diagnose as psychotic are those who aren't all that psychotic after all, and that it is possible for a person to be so psychotic that he is beyond diagnosis.

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Why Concepts Matter Some philosophical and psychological considerations based on Poppers Three-World-Theory

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Concepts matter in every debate and certainly in the debates on the “Mind-Body/Brain-problem”. In this lecture I will focus on two levels of abstraction.

The first is the philosophical level. I will demonstrate the relevance of not being naive about our concepts of “brain” and “content” and “mind” and more. Almost nothing is conceptually simple, or: there is no “straight semantics” for the Mind-Body-Problem. Concepts (and terms, of course) ask for a specific and systematic attention from philosophers and scientists. I will demonstrate a way to accomplish this with illustrations from literature and from other presentations on this conference.

The second is the psychological level. There is ample evidence for the relevance of “propositional attitudes” (considered as mental entities concerning conceptual entities) in personal narratives about illness and healing; for both “somatic” and “mental” complaints. This is recognized in the field of cognitive therapy.

Poppers Three World Theory (revised in some aspects) offers a simple and useful conceptual framework to link both levels and open new perspectives for research, science and medical and psychological treatment.

S22 Philosophy and neuroscience (2)

Neuro-imaging, neuro-engineering and neuro-ethics: a plea for precaution

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Neuro-imaging and neuro-engineering are increasingly being put to practical use. In forensics, marketing and human resource management, for example, neuro-images are interpreted in order to draw practically relevant conclusions. But it is often doubtful to which extent the evidence justifies these conclusions. William Uttal, in particular, has described modern neuropsychology as a wild goose chase in which unanalyzed notions from ordinary language—“attention”, “Schadenfreude”, “arousal”, and so on—are uncritically projected onto areas of the brain (The New Phrenology, MIT Press, 2001). If Uttal is right, modern neuropsychology lacks the theoretical vocabulary to describe its findings and their practical significance. This is also relevant from a medical point of view, because it will be clear that there is a tension between neuroscience along these lines and the requirements of evidence-based medicine.

Neuro-engineering is a booming discipline. Many established scientific institutions have embarked upon research in this field which may lead to enhancing the human brain. But the brain is a complicated system and it might be wondered whether we will ever be able to foresee the full effects of our interventions. It is therefore apparent that great care should be taken in this area.

When applying the results of modern neuroscience, prudence and restraint are obviously called for. Moral responsibility of professionals in this field requires precaution and constant reflection on the evidence which allegedly supports new neuro-practices and on the methodological and philosophical principles that are explicitly or implicitly invoked.

How much brain energy does a mind use?

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The human brain is less than 2% of the body weight, but consumes more than 20% of the energy. For more than a century neuroscientists, following Sir Charles S. Sherrington, have recognized that local brain activity affects local cerebral circulation. Modern functional brain imaging is based on the assumption that brain activity is coupled to cerebral blood flow and energy metabolism. The question I discuss is how high energy consumption is associated with “mental” functions. Neuroimaging shows that increased activity (“hot spot”) is seen only after at least a few seconds up to half a minute following stimuli. Electrophysiological experiments, however, show that coherent speaking, remembering or recognition and interpretation of visual stimuli are normally achieved within 50 milliseconds. Two implications: neuroimaging shows energy-restoring activity, and mental activity is independent from energy recruitment.

How does the brain then perform higher functions? Considering the speed of mental processing only neural action potentials (for fast transport of information over the brain) and 1 or 2 excitatory (glutamate) and inhibitory (γ -aminobutyric acid) synapses could be involved. I will discuss the idea that higher functions are (the “mind” is) a reflection of electrophysiological patterns and that “hot spots” are brain areas shaping these patterns. According to this idea, the “mind” does not use energy. This idea offers a conceptual framework to describe the apparent and puzzling interaction of the “mind” and the brain.

Neuroscience and the natural sciences – some thoughts on theoretical integration

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Neuroscience rests in the natural sciences. The latter is deeply rooted in the axiomatized science of mathematics. Earlier (Eriksson J. “Four Raisons d’Etre of a Hypothetical-Deductive Theory of Integrating Phenomenology, Psychiatry and Neuroscience”, presentation at the conference Philosophy, Phenomenology and Psychiatry, Gothenburg, November 15-16 2003) I have suggested that the relation between the natural sciences and mathematics is evident but not explained. The explanation craves a theoretical integration of physics and mathematics, an endeavour that calls for the axiomatization of science. Before that happens we cannot say how mathematics relate to the natural sciences by certainty. Analogously, non-measurable observations – say of consciousness – cannot be accounted for by a natural science – say neuroscience – without a theoretical integration of a theoretical structure that explains non-measurable observations and the theoretical construct of the natural sciences which explains measurable observations. Thus, the

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relation between mind and matter cannot be explained without the axiomatization of science.

S23 Pathologies in gesture, verbal interaction, and narrative

Speech and psychopathology

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No abstract available.

Gestures, time, and schizophrenia

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Language production makes use of speakers' ability to shape, direct, and locate their hands and bodies in space and in relation to interlocutors and the physical environment. Gestures are "material carriers" of linguistic conceptualizations that contribute to cohesion in discourse. Healthy individuals are compared to individuals with Parkinson's Disease, right hemisphere damage, and schizophrenia- illnesses with effects on motor function and temporal cognition. The discourses of the impaired are impoverished and fragmentary in ways correlated with diminished robustness and complexity of coverbal gestures. This is discussed as evidence in favor of models of language production as an embodied cognitive process.

Narrative in autism

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Individuals within the autism spectrum display an atypical pattern of social interaction, and communication as well as a restricted repertoire of interests and activities. They engage in stereotyped elaborate routines, which include both motor and cognitive behaviors. Although sensorimotor disturbances are not listed among the core symptoms of autism, they are ubiquitously found within the autism spectrum. Such sensorimotor disturbances are also seen very early in infants later diagnosed with autism. Considering the highly dynamic developmental interaction of the infant with its social as well as non-social environment, an impairment in the sensorimotor system might have a great impact on the cognitive development. The important issue is certainly not a quantitative lack of sensorimotor functioning, but the idea of reciprocity in interaction with the environment. Reciprocity is an interactive process, involving particular factors from the current context as well as memories of previous events. From very early on the infant actively explores her surroundings, and by this learns to detect relevant cues in context of reciprocal interaction. The infant rapidly learns what the effects of her actions are, and is guided by this feedback in her ongoing exploration, by both social and non-social feedback. A reduced exploration or diminished sensitivity to vague feedback, especially if this is temporally extended, might provide us with important clues as to the unusual development seen in autism. The talk will include examples of atypical sensory and motor functions in autism and the effects of these on learning and activating a relevant context. This offers an explanation of the apparent paradox that individuals

with autism are perfectly able to talk incessantly about some special interest of theirs, while the father of a boy with high-functioning autism complains that his son is unable to answer the question: "What did you do in school today?"

Autism, mindblindness and narrative practice

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Autistic individuals have much studied difficulties passing 'false belief' tests, of both the basic and more complex varieties. Although no one supposes that this incapacity adequately characterises the syndrome or points to its root cause, some hold that 'mindblindness' is the "core and possibly universal abnormality of autistic individuals" (Baron-Cohen 2000, p. 3). Supporters of this view claim that malfunctioning 'theory of mind' mechanisms (or ToMMs) are responsible for the poor performances of autistic persons in a range of interpersonal interactions - and, especially, for failures in false belief tasks. Against this background, debates have ensued over which the nature of faulty ToMMs - whether they are of the theory-based or simulative variety. In this paper, I develop the claim that a deficit in a more basic imaginative capacity is what leaves autistics without the resources to engage properly in conversations. This matters because conversation is the means by which we develop a practical understanding of the concept of belief; for it is in intersubjective space that we are able to distinguish ourselves as believers in contrast to other believers. If a more basic imaginative disorder robs those with autism of this developmental opportunity, then this fact alone would suffice to explain why they are unable to pass false belief tasks. This obviates the need for a 'mindblindness' explanation. Since mastering the concept of belief is a pre-requisite for mastering folk psychology, according to my Narrative Practice Hypothesis (NPH), I hold that the proponents of the mindblindness proposal have things pretty much exactly backward. It is not that autistic individuals fail to apply the concept of belief because their metarepresentational ToMMs are not working properly. Rather, because they are unable to grasp the concept of belief they are prevented from properly engaging with the relevant narratives needed for mastering folk psychology.

S24 Concepts and boundaries of mental disorder

What does 'mental disorder' in the DSM and ICD mean?

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The editors of the DSM and ICD have long pondered the meaning of 'mental disorder' and no doubt will continue to do so in preparation for the new editions. The straightforward 'harmful dysfunction' analysis does a lot of good work, capturing the problematic nature of the clinical syndromes, and the distress/impairment criterion that is (often but not always) required for diagnosis. But of course it all gets difficult defining 'dysfunction' especially if we want to avoid the spectre of social construction at the foundation of psychiatric science. One way of apparently preserving a hard scientific base for the notion of mental disorder is invoking biological diagnostic markers, but this is unlikely to work satisfactorily, and is in any case conceptually misplaced. The best conceptual attempt to preserve a hard scientific base for the notion of mental disorder is Wake-

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field's proposal that 'dysfunction' can be tied to evolutionary design. However this fails to capture the use of 'mental disorder' in the DSM and ICD. Implications are discussed.

A study of Maudsley psychiatrists views on the nature of mental illness and the mind-body problem

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Background: In 1979 Toone et al. measured the attitudes of psychiatrists in training at the Maudsley and Bethlem Royal Hospitals (MBRH), UK, towards the psychoanalytical, biological, social, behavioural, and anti-medical models of mental illness. They found a relative independence between these paradigms (i.e. respondents endorsing one of the views and rejecting others), with the psychoanalytic model being defined most clearly. In 1980 George Engel formulated a biopsychosocial model of medicine in general and psychiatry in particular, recognising that pathogenesis and course of most disorders are better understood as an interaction between biological, psychological, and sociocultural factors.

Aims and Objectives: We wished to investigate the present state of the relationship between the main psychiatric paradigms by conducting a follow-up of Toone et al's (1979) study of psychiatrists at the MBRH. We also wished to extend the original research by examining whether psychiatrists' views change as a function of the mental illness under consideration. Finally, we examined whether psychiatrists' views are influenced by their attitudes towards the mind-body problem.

Method: We designed a questionnaire measuring the agreement of psychiatrists with biological, social, psychoanalytical, behavioural, cognitive, anti-medical and folk/religious models of mental illness on the basis of how adequately the model conceptualises pathogenesis, classification, the method of study, and treatment of four common psychiatric diagnoses: schizophrenia, major depression, generalised anxiety disorder, and antisocial personality disorder. The questionnaire additionally measures the attitudes towards the mind-body problem. Demographic and biographical data have been collected.

Results: We will present the data on: a) the mind-body component and issues that arose in the genesis of this section of the questionnaire; b) the relationship between the mind-body position and the agreement with psychiatric paradigms; and c) the relationship between the mind-body positions and demographic/biographical background of the respondents.

Discussion: We will discuss how well the data fit our prior hypotheses.

The phenomenology of hysteria

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Some of the most baffling phenomena seen in psychiatry are those relating to hysteria. It still languishes within the Freudian metaphor, partly for socio-political reasons perhaps, but also because of the great difficulty in otherwise conceptualising the disorder. Much of the difficulty comes in accepting the presence of such powerful, pathological forces operating beyond the awareness of a person who appears cognitively intact, and is not thought to be psychotic. The question of the veracity of the subject's self-report is inevitably raised, either by the hysteria model (unconscious processing), the alternative explanation (factitious illness), or the motivations of the interview (opposi-

tion to a psychiatric model). Clinically, there are a number of strategies one can adopt to deal with this, but the psychiatrist who wishes to understand the phenomenology of their patient's illness may find this obstacle insurmountable. Behaviourist and anti-realist approaches may consequently offer significant advantages over the cognitivist model as a basis for understanding hysteria.

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Phenomenology and anthropological psychiatry

The problem of freedom in obsessive-compulsive disorders

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J.P. Sartre in his existential psychoanalysis amongst other things developed a kind of existential symbolism of stickiness, to which we relate in our presentation for a better understanding of compulsive washing.

With the case report of an obsessive-compulsive patient, comparing her symptom of compulsive hand washing with her biography, we show how her freedom was compromised by the adhesion of dirt. Her sexual wishes, aggressive tendencies as parts of her being reified as dirt, came to the exterior, starting an expansive independent existence.

In a similar way, obsessive ideas can also be understood as being founded in a kind of reification. Thus compulsive acts can be seen as an attempt to reintegrate the above mentioned exterior parts of the self into the self again, to get rid of this quasi material determination and to gain back motivational freedom. Consequences for the psychotherapy of obsessive-compulsive disorders and general problems of freedom and autonomy are discussed.

Time traveling: psychosis as detachment from human Time

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Since Minkowski (1933) we know what it is like for psychotics to live in a spatialised temporal dimension: Tomorrow becomes a place you can visit. Minkowski argued that psychotics have lost vital contact with time and reality. In German phenomenological psychiatry too psychotics were described as being unable to experience authentic temporality, or being "deformed in their synthesis of temporal relations" (Binswanger 1965). These approaches suggest that psychotics lack an insight or ability to experience and deal with essential aspects of time. However, since Conrad (1958) and Sass (1992) the idea has won ground that psychotics do not lack reflexivity. Instead, the psychotic world is better characterised by a too high level of consciousness or hyperreflexivity.

To apply the concept of hyperreflexivity to temporality, I will use Ricoeur's (1984) conception of a three way division of time: subjective, objective and narrative time. While the former two aspects feed on reflexivity, the latter, instead, is threatened by too much reflexivity. In my talk I will discuss several first person accounts that show that psychotics indeed withdraw from narrative time and end up in both extremes of subjective and objective time. The advantage of this approach is that the criterion of acute psychosis of 'disorientation in time' becomes

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more naturally related to other criteria, because the dimension of narrative time involves a common intersubjective ground and symbolic world. Moreover, it takes into account that psychotic experiences of time are – contra Minkowski – rich in their formal structure though poor in their intersubjective content.

Organism, body, subjectivity and social being

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The authors aim to discuss the possibilities of appropriation by clinical psychiatry of the knowledge produced by neurosciences without eliding subjectivity. In doing so, they intend to criticize the eliminative reductionism that characterizes the mainstream of psychiatric thought nowadays and propose that the tenets which characterize the clinical experience should order this appropriation. The authors discuss critically the epistemological principles – representationalism, operationalism, emphasis on reliability – of descriptive psychopathology, characterized as third-person psychopathology, and the clinical consequences of its use. In contrast to this approach, a first- and second-person psychopathology, chiefly based on phenomenological approaches, is presented. This perspective is examined in its epistemological principles and clinical consequences, especially the access to the subjective and intersubjective dimensions – necessarily embodied and embedded – of the psychopathological phenomenon. Historical antecedents – mainly Minkowski, Goldstein and Blankenburg – and contemporary developments of first- and second person psychopathology are discussed and clinically illustrated.

S26 Self and identity

Foundations and transitions of the self Clinical phenomenology, neuroscientific research and philosophical investigation: psychophysical transitions of the self in the work of O. Sacks, G.M. Edelman and D. Henrich

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„We have argued throughout this book that consciousness arises from certain arrangements in the material order of the brain. ... What is the difference? It is that conscious thought is a set of relations with a meaning that goes beyond just energy or matter (although it involves both).

And what of the mind that gave rise to that thought? The answer is, it is both material and meaningful.“ (GM Edelman, *A universe of consciousness* 2000, 219)

O. Sacks (*1933) was a Professor of neurology at Albert Einstein College of Medicine N.Y., and is well known due to his literature of ‚clinic tales‘. Core concept of his work is a ‚neurology of self or identity‘, which allows a clinical integration of physiological and psychological processes in neuropsychiatric diseases. G.M. Edelman (*1929) was a Professor at Rockefeller

University N.Y., director of The Neurosciences Institute in San Diego and founder of The Neurosciences Research Foundation. He presented an empirical neuroevolutionary conception for a dynamic interpretation of brain and mind processes. The ‚theory of neuronal group selection‘ allows to introduce ‚memory‘ and ‚self‘ into neurosciences. D. Henrich (*1927) was a Professor of philosophy at Free University Berlin, University of Heidelberg and Munich, and permanent visiting-professor at Columbia and Harvard University. He is founder and leading figure of the ‚constellation research‘ -programme on philosophy of the ‚german idealism‘ (Kant to Hegel).

He developed a philosophy of subjectivity based on fundamentals of idealistic german philosophy. The structure of modern philosophy is based on self-relations of selfconsciousness and selfpreservation: the stoic principle of ‚syneidesis‘ is still modern.

We will present the basic lines of these concepts in respect to transitions of the self between ‚physis‘ and ‚psyche‘ - the psychophysical problem.

Philosophical aspects of human identity and psychosis

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“Mais je ne connais pas assez clairement ce que je suis, moi qui suis certain que je suis” (R. Descartes). The famous formula “Cogito ergo sum” falls into a new question: “I exist, but who am I?”, even if Descartes’ formula refers to an identity that is ahistorical, so to speak, since cogito is instantaneous. But the issue of personal identity poses at least two problems that admit paradoxical solutions: the problem of persistence in time and that of how we define ourselves. It seems that our identity is subjected to constant dialectic tension: between continuity and change, for there is no identity without duration, but neither does it exist without the constant incorporation of new events which can cause a change to come about; between identity as being-the-same and being-oneself (P. Ricoeur), and this relationship contains the possibility of telling one’s story; finally between the person’s original individuality and everything that depends on the inter-subjective context.

From the study of a series of patients, I observe that the splitting apart of these different components of identity, in particular the evanescence of being-the-same, the idem, is due to the loss of the sense of belonging to the I of experiences, and the vain pursuit of a being-oneself, of an unreachable ipse, mark the psychotic crisis of identity. The possible declinations of a new delusional identity will often take on the aspect of the puzzling cases that philosophical speculation on the question of identity has constructed.

We cannot but conceive of ourselves as ourselves

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People can dissociate themselves from aspects of themselves, for example from certain desires that they regard as resulting from an addiction. Or they can have dissociative experiences, think of pathological cases of ego-alien thoughts. The extreme case of such self-regarding dissociation that we can think of – or rather, that we can formulate – is a person’s dissociation from her herself qua self. But is that extreme case conceptually possible?

The question is not of theoretical interest only. After all, patients suffering from Dissociative Identity Disorder (the so-

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called multiples) seem to be able to switch between two or even more selves - a phenomenon that calls for empirical research. And clinicians and experimenters who speculate about these matters might import the assumption into their deliberations that persons can have more than one self and that those persons might be able to dissociate themselves from what might be called the 'current self'. This gives rise to a conceptual question regarding the limits to a person's dissociation: Can a person dissociate herself from herself qua self, or experience herself as dissociated from herself qua self?

The issue calls for conceptual clarification and analysis, namely in the light of a concept of a person and the self. I will therefore first present a brief outline of my account of being a person and then use the distinctions made to argue that dissociation from oneself qua self is conceptually impossible.

S27 Classification and models of disease (2)

Modalities of the sick

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Medicine possesses a comprehensive theoretical framework for coping with the organic aspects of human disease. But how do we encounter and cope with the the person embodying imbalanced neurotransmitters, mutated gene sequences, or structural pathology depicted by high-technological imaging techniques? How do we learn to know the sick person himself or herself? In this paper I will try to flesh out a perspective on the sick person based on my reading of the clinically related works of the German neurologist and philosopher Viktor von Weizsäcker: *Klinische Vorstellungen* (1941), *Fälle und Probleme* (1947) and *Der kranke Mensch* (1951). Weizsäcker calls for a medicine which also has the sick person – or the human in need (*Mensch in Not*) – on its teaching agenda. Through an interpretation of Weizsäcker's works - which contain a record of a large number of clinics that he held for medical students - I will try to illuminate important conceptual clues in Weizsäcker's thinking about the human in need (*Mensch in Not*), about pathic existence and the pathic categories; will (*das Will*), can (*das Kann*), may (*das Darf*), shall (*das Soll*) and must (*das Muss*). By employing clinical examples I will try to illustrate how these categories can be said to represent different modalities of the sick. The paper also aims at offering a discussion and evaluation of this perspective viewed from contemporary theoretical contributions in the field.

Psychiatric classification and the use of phenomenological types

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How can phenomenology contribute to psychiatric classification and what kind of scientific meaning does phenomenology have when applied to psychiatric diagnosis? What does it mean to have knowledge about a person who suffers from a personality disorder? Are there different ways of knowing a person and if so is the difference merely conceptual? Different versions of phenomenological psychiatry are defined and the possibility of combining them with criteriological ways of classification and diagnosis used in DSM and ICD is discussed. A critique of the

semantic status of the criteria in DSM is introduced and Malmgren's concept of indirect operational criteria is considered to be a better alternative. The concept of phenomenological and existential type, introduced by Alfred Kraus, as a diagnostic entity and the scientific meaning of such an entity are further examined. One proposal, namely that the phenomenological type has the character of an ideal type in the sense of Max Weber is rejected. Finally the combination of the concept of phenomenological type with the criteriological way of making diagnosis is considered to be unproblematic if the semantic status of the criteria is indirectly operational.

On the taxonomy of human psychopathology: main ontological views

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The scientific classification of human psychopathology raises a host of important philosophical issues ranging over all major areas of philosophical inquiry; logic, semantics, ontology, epistemology and ethics. Our presentation will focus on the major views of the ontological status of our psycho-diagnostic constructs; idealism, nominalism and conceptualism. Idealism holds that our psycho-diagnostic constructs represent ideal essences, instantiated imperfectly by individual mental patients of the same psycho-diagnostic class. These ideal essences are construed as either abstract forms dwelling in a realm of eternal abstract objects – platonist idealism – or ideal intentional objects created by a pure transcendental consciousness through eidetic reduction – husserlian idealism. By contrast, nominalism claims that our psycho-diagnostic constructs are nothing but conventional common names of sets of individual mental patients, invented and adopted on purely pragmatic grounds such as their practical utility, especially in predicting their clinical course and outcome under various types of treatment. Finally, conceptualism holds that, though our psycho-diagnostic constructs are concepts, and thus of our own making, they are not arbitrary ones, but grounded on objective features shared by individual mental patients of a given psycho-diagnostic class. In our presentation, we shall argue that both idealism and nominalism are flawed and thus untenable – though for different reasons – and defend a refined version of conceptualist realism.

S28 Philosophy and neuroscience (3)

Emotion and neurophilosophy – new perspectives on feeling, intentionality and bodily perceptions

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Over the past 3 decennia the majority of emotion researchers have rejected William James' feeling theory of emotions. Most of them did not deny that emotions have feelings as their components, but they insisted that cognitions are far more important. Recently however, neurobiological approaches by Damasio and LeDoux, and neurophilosophical studies by Jesse Prinz have argued for a qualified version of the feeling theory. They have presented evidence in support of James' conjecture that emotions are perceptions of patterned changes in the body, neurobiologically-ingrained potentials of the nervous system,

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which are triggered by life experiences. In my paper, I will explore what these new neurobiological insights imply with respect to emotional intentionality, cognition and the phenomenology of emotional experience. In the process, I will also show that James' account of emotion as a feeling of bodily changes has much in common with various cognitive theories that are explicitly opposed to it.

The nature of consciousness: Subjective facts and the functional identity hypothesis

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The purpose of this paper is to formulate a minimal theory on the nature of consciousness that: (1) allows for it to be scientifically investigated, (2) allows for it to have a function, and (3) allows for there being a fact of the matter as to what people experience.

The ingredients of the theory are mostly provided by work of Crane (2003) and Clark (1997, 2005). I use the work of Crane, because his notion of subjective facts accounts for demand (3) posed above. Furthermore, I use Clark's functional identity hypothesis to account for demand (2). My specific interest in Clark's theory is due to the fact that although he explicitly takes several pages from Dennett - which in my opinion is a good idea - he does not succumb to Dennett's interpretationist account of consciousness (Dennett 1991, 2005).

The structure of the paper is as follows. I briefly introduce Crane's notion of subjective facts and Clark's functional identity hypothesis. Next, I merge Crane's subjective facts with Clark's functional identity hypothesis. Clark's theory allows for embedding the notion of subjective facts in a broader theoretical context, but this will not work without some terminological tuning on my part.

The main obstacle in reconciling Clark's view with Crane's notion of subjective facts is showing that the latter are not in conflict with Clark's firm rejection of the idea that we have categorically private, subject-specific, first-person unsharable knowledge concerning facts about our experiences. If this reconciliation can be achieved we have a workable - in the sense of allowing for further clarification by means of scientific investigation (demand 1) - theory on the nature of consciousness.

Bennett and Hacker - Freedom missing?

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Together with mind-body and "the self" related issues, freedom appears to be pivotal in any philosophical debate on neuroscience, notably with regard to psychiatry. For neuroscience confronts us with the question: how can man be free, whereas the brain is obeying the laws of causality? Neuroscience, in other words, confronts us with the problem of causality versus freedom. It is, therefore, surprising to find that in a recent work of Bennett and Hacker, *Philosophical Foundations of Neuroscience*, freedom does not have a central position. In fact, 'free will' or 'freedom' will not even be found in the index of the book.

The word that comes closest to 'free will' is 'volition', to which topic only 6 of the 450 pages are devoted, implicating that freedom and free will (volition) are just peripheral in exploring the 'philosophical foundations of neuroscience'. Could Bennett and Hacker be right about this peripheral position of freedom

in neurophilosophy? We will try to elaborate this question and trace back the roots of the issue to Immanuel Kant, and follow the track to the modern freedom debate. We will also discuss Heidegger's response to Kant's philosophy of freedom and we will discuss what it could mean for neuroscience if the issue of freedom would in fact turn out not to be peripheral at all.

S29 Conceptual issues (2)

A conceptual analysis of the stress-vulnerability model of schizophrenia

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The stress-vulnerability model of schizophrenia is contemporary psychiatry's consensual explanation of how the symptoms of schizophrenia develop and evolve over time. Although the model has variants, its fundamental tenets are that the onset and course of schizophrenia result from a person's vulnerability, usually argued to be genetic, in conjunction with sufficient stress, as perceived by that person. In this paper, I present conceptual problems of the stress-vulnerability model of schizophrenia as currently formulated, and I argue that the model is not sufficiently helpful - appearances to the contrary - so long as these problems are not resolved. One such problem is that the distinction between stress and vulnerability may not be clear, and is certainly not absolute, as a vulnerability could be a vulnerability to perceive stress, making stress dependent on the vulnerability rather than independent of it (the latter being a mainstay of the model as currently formulated). This could result in the notion of stress being redundant in this context, and then scientific attempts to study stress and vulnerability as separate factors in schizophrenia would be misleading. One way to try to resolve this problem is to suggest that both stress and vulnerability are continuous variables, and that even if the vulnerability is a vulnerability to stress, it may not fully determine perceived stress, e.g., if a particular vulnerability threshold is not crossed. After presenting additional conceptual problems of the model, I conclude with an argument that most if not all such problems can be resolved by general methodological considerations.

Stress and recovery - a new conceptual framework

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Stress is a widely used term that lacks an exact definition. In this paper recent biopsychological conceptualisations are combined with the Yerkes-Dodson law to define stress as "the projection on the x-axis of the vector need of recovery within the boundaries of the Yerkes-Dodson law". This allows exact definitions also of maximum level of stress and the point where wear and tear sets in on the biological organism due to stress. The definition permits an integrative view on stress concerning biology and psychology.

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Biological species as autonomous subjects of cognition and their communication with individuals

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I consider the phenomenon of a rapid and involuntary recollection of events of one's whole life in the face of the close death. I suggest that the real nature of this subjective effect is that a species swaps to its data bank the information stored in the dying person's brain. Personal reports show that predominant in the recollections is ethical content. A person renders unbiased judgments of one's own deeds throughout life: were they good and right or bad and wrong. Ethics in recollections is solicited by a species itself. It seeks to fetch information on ethicality or non-ethicality of a conduct, i.e. whether a person acted in favor of the species or to its harm. The acquired corpus of information is used to correct a species' strategy in directing future individuals' conduct. It fosters favorable behavioral patterns and inhibits harmful ones. The overall aim is evolutionary propagation of a species. The other form of the species – individual communication is prompts from the species "headquarters" in response to requests from newborn animals on how to apply instincts in unfamiliar perplexing situations. My further hypothesis is that semiotics of the species – individual communication might be geometrical patterns of the moiré origin. Moiré patterns are as universal as all geometrical forms. They can develop themselves on any type of the regular wave substrate. Being fractal, they can reproduce themselves in exact self-similarity at many hierarchical levels at once. A set of moiré patterns generated by overlap and interference of regular wave oscillations in brain is in a ceaseless meaningful change according to uniform geometrical and mathematical algorithms of transformation. The moiré patterns flux is the inherent language of brain both in its self-discourse and in the inter-level communication with the species an individual belongs to.

S30 The Self, awareness of time, and its disorders: philosophic-neuroscientific critique of representational theories of mind

The self and its brain - cortical midline structures as neural correlate?

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The question of the self has intrigued philosophers and psychologists for a long time. More recently distinct concepts of self have also been suggested in neuroscience. However, the exact relationship between these concepts and neural processing across different brain regions remains unclear. This presentation reviews neuroimaging studies comparing neural correlates during processing of stimuli related to the self with those of non-self-referential stimuli. All studies revealed activation in the medial regions of our brains' cortex during self-related stimuli. The activation in these so-called cortical midline structures (CMS) occurred across all functional domains (e.g., verbal, spatial, emotional, and facial). Cluster and factor analysis indicate functional specialization into ventral, dorsal, and posterior CMS remaining independent of domains.

Taken together, our results suggest that self-referential processing is mediated by cortical midline structures. Since the CMS are densely and reciprocally connected to subcortical midline regions, we advocate an integrated cortical-subcortical midline system underlying human self. We conclude that self-referential processing in CMS constitutes the core of our self, and is critical for elaborating experiential feelings of self, uniting several distinct concepts evident in current neuroscience.

Neuroimaging the self as vulnerability: abnormalities in schizophrenia and other neuropsychiatric disorders

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Disturbances of the experience of self comprise one of the most puzzling challenges in neuropsychiatry. Recently, fMRI has made inroads in studying the brain systems underlying self-representation. However, human self is not merely self-representation which is fundamentally retrospective and late in cognitive processing. It is also prospective or oriented to a future which is unknown.

Existentialist philosophers define the self paradoxically (as a process): maintaining identity while, at the same time, extending ecstatically beyond oneself into an unknown future. In these terms, the I is prospective while the me is retrospectively based. The temporal nature of self may provide a key to understanding its disruption in neuropsychiatric disorders. We discuss experimental and theoretical reasons to consider that this prospective self is compromised in schizophrenia and other neuropsychiatric disorders. By accident, it was discovered that one way to study disruptions of prospective self-experience is to examine abnormalities of the coherent default mode network or so-called daydreaming mode, i.e., brain areas which consistently become deactivated during focal cognitive tasks. Invariably, these involve the same midline structures that have been shown to play a role in retrospective construction of self as self-representation. We present data from meta-analyses as well as original data which make a compelling argument to reconsider the self in neuropsychiatry.

In-depth body and the origins of the subjective perspective: representation or auto-constitution?

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In this presentation, we pay attention to the way in which the in-depth body and its interoceptive dimension is presented as constitutive for the subjective perspective. We borrow material from the neurosciences (Craig, Damasio), and approach this material from an epistemological point of view, inspired by Husserl's account of inner-time consciousness. More in particular, we investigate whether a (re-)representation of the in-depth body can eventually lead to a subjective perspective. In the neurological account of Damasio, such is the case, although a number of difficulties arises. From a phenomenological account, it can be doubted whether a perspective can be based on representations, since the content of a representation is constituted (from within a perspective) and not constitutive (for a perspective). Starting from Husserl's account of the auto-constitution of consciousness, we provide an account in which the subjective perspective has interoceptive 'thickness', but is not based on representations. However, we do not follow Husserl's

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account of auto-constitution as a matter of formal constitution, but add content to it.

S31 Philosophy, neuroscience, and cognitive psychology: variety and integration of methodologies for the study higher of mental dysfunctioning

Rationality and the formation of delusions.

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In his important paper Campbell discusses both empirical and rational models of delusion formation. The empirical approach is characterized by the notion that a delusion is the rational response to some anomalous experience, and is hence termed by Campbell as 'bottom up'. The rational approach to studying the formation of delusions, by contrast sees delusion as 'a matter of top down disturbance in some fundamental beliefs of the subject'. This paper will present data from a cohort of subjects referred to the Outreach and Support in South London (OASIS) clinic at the Maudsley Hospital in London. This clinic was explicitly created to access clients who were in the prodrome of psychosis and as such exhibited the 'at risk mental state' (ARMS). In general, the ARMS clients demonstrate abnormalities that are consistent with the description of anomalous experiences but are necessarily not deluded (as they are all pre-psychotic). Further, despite not meeting formal criteria for a psychotic illness such as schizophrenia the ARMS clients share many abnormalities with those who have already experienced their first episode of psychosis. In conclusion, the work from OASIS, and from cognitive psychology and therapy more broadly, supports Campbell's conceptual analysis. Empirical factors are not sufficient for the genesis of delusions and the transition to psychosis. Thoughts relating altered rationality to biology will be discussed in light of McDowell's work and the neurodevelopmental model of schizophrenia.

Emotion and the sense of self: neuroimaging studies in depersonalization disorder.

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This talk will present findings from a series of fMRI studies of primary depersonalization disorder (DPD). Patients with this condition report a persistent and unsettling disturbance in their sense of self, and their interactions with other people and their surroundings. The symptoms typically include a loss or diminution in emotional reactivity. These studies focus on this aspect of the condition, and aim to probe abnormal emotional function in the context of a pervasive disturbance of the sense of self. The overall pattern of results suggests that patients with DPD show little distinction in neural response to aversive or neutral material. This is consistent with self-reported changes in qualitative emotional experience. Patients with DPD do not show activations in amygdala or anterior insula seen in healthy controls in response to aversive stimuli, and prefrontal cortical areas appear to play a key role in inhibition of normal emotional processing. More recent data indicate that a positive response to pharmacotherapy is associated with normalisation of neural response to aversive stimuli. These findings will be interpreted in the light of current biological and psychological

models of DPD. More generally, I will argue that emotional "colouring" of subjective experience is a key element of healthy psychological functioning, and that the dissociated sense of self described by patients with DPD hinges, at least in part, on an altered quality of emotional experience.

Kant and mental capacity in psychiatry

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The medico-legal concept of Mental Capacity is increasingly discussed in medical law and there is growing attention to its role in psychiatry (Grisso and Appelbaum, 1998; Richardson, 1999; Dawson, 2005). Mental Capacity is closely tied to the concept of autonomy. The concept of autonomy was given its fullest meaning within the philosophy of Immanuel Kant. In this paper I will attempt to trace the way in which the concept of mental capacity appears to have its grounding in the Kantian concept of autonomy. I will discuss some strengths of this grounding as well as some possible unintended consequences in relation to psychiatry. A key issue here is the nature of the disorder seen in psychopathological states and whether this is primarily deficit in the ability to represent things; or rather biases of the meaning and value of the things represented. I will also discuss how the concept of mental capacity in psychiatric research is developing and how conceptual work can improve the quality of empirical work and vice versa. I will draw on examples taken from research underway at the Institute of Psychiatry, London on Mental Capacity in psychiatric settings.

S32 History

Psychosis and subjectivity – what psychiatrists can learn from Friedrich Hölderlin

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Friedrich Hölderlin (1770-1843) is known as an important and most influential German poet of the 18th century. Being a student of Johann Gottlieb Fichte (1762-1814) in Jena Hölderlin wrote a philosophical fragment „Urtheil und Seyn“ (Judgement and Being) between 1794 and 1795. In this fragment Hölderlin puts forward a philosophical method that can be described in the sense of Michel Henry's statement (1922-2002): „It is not thought that gives us access to life; life itself allows thought this access to it.“ This way of thinking seems especially significant for psychiatry since it offers a fundament for the understanding of subjectivity. It will be shown that Hölderlin also offered an understanding of the subjective experience of schizophrenia in an acute psychotic state and especially in the chronic state of schizophrenic alienation. As is well known the acute psychotic state can be understood phenomenologically as inunderstandable caused by an oversaturating with meaningfulness. In his late work Hölderlin expressed incomparably the enlivening of the schizophrenic alienation. His offer for understanding is based on the dwindling away of a previous oversaturated meaningfulness and an alienation in the sense of an uninvolved view on everyday life.

Abstracts

Motor intentionality and the case of Schneider

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Merleau-Ponty's *Phénoménologie de la Perception* proceeds through an immanent critique of psychological theories. Merleau-Ponty argues that psychological concepts like "body schema" and "motor intentionality" are ambiguous as long as a dichotomy between an intellectualist and an empiricist interpretation is not transcended. In my paper I critically examine Merleau-Ponty's claim to have disambiguated the notion of motor intentionality.

Merleau-Ponty develops his notion of motor intentionality through an interpretation of certain psychopathological cases, in particular the case of Schneider. Schneider was diagnosed with the condition known as apperceptive visual agnosia. Recently it has been proposed that we should reclassify Schneider as an example of integrative agnosia.

In my paper I present an inconsistency in Merleau-Ponty's interpretation of the Schneider case, originally identified by Zaner (Zaner 1964, p. 186, n. 1). The inconsistency is analysed in terms of the ambiguous methodological role of the case:

To display motor intentionality both by its presence and by its absence. I argue that the case does confront an intellectualist conception of intentionality with a real dilemma but that the dilemma is offered as two distinct arguments in Merleau-Ponty's presentation. To make a convincing case against intellectualism we should stick to the second of the two arguments. To reconstruct the arguments of Merleau-Ponty coherently and to make coherent use of the concept of motor intentionality we must make explicit the difference between the aspect of motor intentionality present and the aspect absent in the pathological cases.

Julius Ludwig August Koch (1841-1908): Christian philosopher and psychiatrist

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Julius Ludwig August Koch was born 1841 in the small town of Laichingen (Württemberg) in Germany. He studied medicine in Tübingen from 1863 to 1867. He then worked as a physician and later in a private mental hospital in Göppingen. 1974 he became director of a state mental hospital in Zwiefalten (Württemberg). After a long period of hard and engaged work for his hospital, Koch retired from his directorship in 1898 and died in 1908 in Zwiefalten.

Being deeply rooted in a Christian faith Koch published some philosophical works at first, i.e. "Epistemological investigations" (*Erkenntnistheoretische Untersuchungen*, 1882), "Outline of philosophy" (*Grundriss der Philosophie*, 1885) and "Reality and its knowledge" (*Die Wirklichkeit und ihre Erkenntnis*, 1886).

From 1887 on he turned to clinical psychiatric questions. In 1888 he published a "Short Textbook of psychiatry" (*Kurzgefaßter Leitfaden der Psychiatrie*), where he the first time mentioned the terminus "psychopathic inferiority" (*Psychopathische Minderwertigkeiten*). The following work focusing on this issue with the title "psychopathic inferiority" (*Die psychopathischen Minderwertigkeiten*, 1891-1893) became one of fundamental texts concerning the concept of disorders of personality which are in use today. In this book he tried to describe the hole field between psychic normality and psychoses. Although psychiatric disorders are classified different today, Kochs work keeps its great importance for the concept

of personality disorders. Further more one can find very exact and detailed descriptions of a multitude of psychopathological symptoms which are worth reading them today.

S33 Philosophy and neuroscience (4)

Neuroscience and moral responsibility

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In his new book on neuroethics, *The Ethical Brain*, the well known cognitive neuroscientist Michael Gazzaniga argues, among other things, against the use of neuroscientific knowledge to exculpate criminals on the ground that they suffered from disorders of their brain. Gazzaniga is worried about the claim that deterministic neuroscience leaves no room for free will and personal responsibility. He seeks to reconcile the two by claiming that neuroscience and personal responsibility belong to incommensurable ways of looking at our behavior. Moral responsibility is a social construct that falls outside the competence of neuroscientists. "The brain is determined, but the person is free" (p. 99).

In this paper I will examine this kind of argument in detail and show that it rests on a number of confusions, such as the failure to distinguish between the general issue whether human beings can be held responsible for what they do and issues concerning the culpability of specific human beings for specific actions in specific circumstances. I will argue that the view of moral responsibility as a social construct (with which I agree), does not imply that neuroscience and the law should be kept apart. On the contrary. The justification of the social practice of holding people responsible rests on the extent to which this practice is an effective way to steer individual behavior in the right directions. This practice works only if certain conditions at the individual level are satisfied. Neuroscience should contribute to this practice both by studying under what conditions this practice will have the desired effect and by passing judgment on whether or not these conditions apply to individual cases.

Retroactive effect and concealment of media: Phenomenological foundation of neurophysiological model of schizophrenia

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Phenomenological investigation of schizophrenia has been linked with an anthropological approach in its efforts to delineate the crisis of patients' self in their life history. More recently, it is beginning to treat minute symptomatic manifestations and attempt to link with neurophysiology. Some of these new approaches are based on an "analysis of passive synthesis" by Husserl and consider that the failure of automatic, synthetic function of constitution plays a key role. However, if such approaches do not fully take into consideration the significance of life history, they will have distinct limitations.

A discussion by Husserl himself on passive synthesis may help overcome such limitations. He wrote that unexpectedly encountered things retroactively evoke the transformation of the "pre"-figuring in the retentional sphere corresponding to them.

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If, on encountering a specific event in life history, this retroactively acting effect is made impossible, the event will appear as what enigmatically shows the gate to the world one cannot pass through, instead of as a given event in the world. This may evoke an awareness that one's self, not entitled to enter the world, suffers from a fundamental deficit.

Regarding this point, I address myself also to Nitta's phenomenology of mediacy. Nitta opined that the emergence of things is made possible through the concealment of such media as "body" and "others". It can be considered that in schizophrenic patients, whose initial drive in the body is arbitrarily interfered with by others, these media are not fully concealed.

These considerations lead to the conclusion that a neurophysiological model of schizophrenia must appropriately define the failure in the above-mentioned retroactive effect and concealment of media.

The importance of concepts in neuroimaging: understanding auditory verbal hallucinations

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Hearing voices is one core symptom of schizophrenia spectrum disorders. On the other hand, this phenomenon seems to be part of a continuum of perception dysfunctions that can easily occur in day-to-day experience.

After differentiating between the psychopathology of auditory verbal hallucinations (AVH), dissociative symptoms, disturbances in auditory perception, inner monologue and remembering previously heard sounds, explanations neuroimaging studies give for AVH will be presented. Two concepts dominate the current scientific discussion: (1) AVH arise from erroneous activation of the auditory cortex without proper stimulus.

(2) AVH are the result of missing self-attribution to the inner monologue, thereby perceiving self-created inner speech as foreign. The relevance of findings from volumetric, structural and functional neuroimaging studies for these concepts will be discussed. Experiments using transcranial magnetic stimulation (rTMS) are used to gain further information on the functional importance of identified cortical areas.

These results provide the basis for re-evaluating the theoretical models and integrating AVH into the framework of systems neuroscience. At the same time, they affect our concepts of understanding the phenomenon of "hearing voices".

S34 Schizophrenia (4)

On thought disorders in schizophrenia
A phenomenological analysis of neuropsychological findings

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Schizophrenic thought disorders have mainly been studied as disorders of language. However, the pragmatic reason that one can easier deal with spoken language than with thought itself may not lead to the conclusion that language and thought are one and the same process. In most of the recent studies on thou-

ght disorders in schizophrenia, neuropsychological methods were applied which have been developed from research on aphasia (e.g. Andreasen 1979, McGrath 1991, Frith 1992, etc). However, it should be taken into account that schizophrenic thought disturbances may also reflect processes of thinking without language. From this point of view, the neuropsychological findings may receive an integrated understanding as disturbances of goal-directed mental processes in general that serve to pursue meaningful interests in one's life.

In a phenomenological perspective, this may be interpreted as disturbance in the synthetic function of internal time consciousness which integrates the sequence of single moments of past, present, and future into a sequential and intentional continuity, into an "intentional arc", as analysed by Husserl and Merleau-Ponty (cf. Fuchs 2006). On this basis, thought disorders in schizophrenia may be conceived as an expression of a more fundamental disturbance in the patient's capacity to achieve a meaningful, goal-directed course of mental life.

Pathological aspects of "awakening" phenomena in schizophrenia – from viewpoints of epistemological philosophy and Zen psychology

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"Awakening" in schizophrenia is often critical in the clinical context because of the risk of aggravation or suicide as well as the chance of recovery. Though the definitions of this term vary from withdrawal of side effects of neuroleptics to spontaneous arousal in the natural process of illness, the phenomenon caused by atypical antipsychotics has received particular attention recently. With whichever factor an awakening phenomenon may begin, its clinical manifestations usually proceed as follows: 1) sudden improvement of cognition, 2) confrontation with reality, 3) insight, confusion, or suicidality. The simple interpretation is that the patient is shocked at the reality of their miserable life and is subsequently thrown into despair. However, at this point the question arises whether the "reality" experienced by the patient in an awakening phenomenon is always the same as is held in common.

The author shall present three cases of schizophrenia in which pathological aspects were observed in awakening phenomena. The reality for the patients was tinted with specifically pathological meanings. Their insight went over their psychosis into the absurdness of existence. These aspects will be discussed from two viewpoints; one is of epistemological philosophy which has considered the reality of the world that the subject recognizes, and the other is of Zen psychology which has estimated the danger in addition to the value of awakening and insight obtained through ascetic practices.

Abstracts

Why the idea of framework propositions does not help account for delusions

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It has been suggested that Wittgenstein's discussion of 'framework' or 'Moore' propositions in *On Certainty* might shed light on the nature of delusions. Framework propositions are held immune from the game of doubting and justifying and instead structure empirical inquiry. They also form a heterogeneous set of quasi empirical claims. Both of these features promise to mirror features of delusions. Nevertheless, whilst the structural features may look similar, there is a fundamental disanalogy. There are no third person, as opposed to first person plural, criteria for belief ascription. The mark of a framework proposition is its role within the shared horizon of interpretation which turns on its content rather than a structural feature that can be recognised independently of the interpretation of content. But without that, it cannot help with the difficulty of interpreting delusion.





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