2 days session on "Metaphysics of Psychopathology"

Date : 1 - 2 December 2018
(Starting session at 2:00 pm on 1 December, and at 10:00 am on 2 December respectively)
Venue: The University of Tokyo, Komaba Campus, Building 18, 4F, Collaboration Room 2

Dec 1 (Sat)

Symposium on Metaphysics of Psychopathology

14:00-15:00 Talk on Metaphysics of Psychopathology

Psychiatric disorders: Kind concepts and the imperfect community

Peter Zachar (Auburn University Montgomery)

I will begin with a brief discussion of how I came to be interested in the philosophy of psychiatric classification. I will then offer two slightly different but related stories about how the domain of psychiatric disorder was mapped out and assigned the boundaries that it has. I argue that the result of each mapping is an imperfect community of overlapping conditions that are alike in many different ways, but there is no one way in which they are all alike. I will then explore different philosophical models on the nature of kinds and their advantages and disadvantages for psychiatry. I close with a brief discussion of scientific progress and psychiatric classification.

15:00-16:00 Comments

Between realism and social constructivism

Takayuki Suzuki (The University of Tokyo)

In Metaphysics of Psychopathology, Peter Zachar criticizes both realism and social constructivism about mental disease and proposes his own alternative. There seems to be at least two interpretations of his own view. On one interpretation, his main target is the essentialist version of realism. If this is the case, then we can still support a weaker version of realism, which claims that cases of a specific mental disease share many features because of a common biological mechanism, though there is no necessary and sufficient condition for the disease. On another interpretation, there is more radical relativity in the classification of mental diseases. The appropriate way of classification, according to this view, changes depending on context and our interest. This view, which would be rightly called pragmatism about classification, might end up either with an overly liberal view or with a biological

realism, depending on whether we admit plurality of interest in the practice of psychiatry.

On misplaced essentialism in psychiatry

Senkei Ueno and Toshiya Murai (Kyoto University)

Jerome Wakefield's harmful dysfunction model was proposed to demarcate valid psychiatric disorders from various non-clinical problems in living. In adopting this model, psychiatrists and psychologists have tended to adopt essentialistic view on psychiatric disorders. In "A Metaphysics of Psychopathology", Peter Zachar proposed the imperfect community model as an alternative, which is a non-essentialistic model. Both models seem to mainly concern with demarcation between disorders and non-disorders. Psychiatrists sometimes adopt essentialistic view not on psychiatric disorders as a whole, but on particular diseases. Essentialism about a certain disease need not to accompany with the idea that there is an inner nature shared by all psychiatric disorders. Having an essentialistic view on particular kinds of psychiatric disorders seems to be compatible with the imperfect community model about the whole domain of psychiatric disorders.

When dealing with a disease with a known etiology, such as Alzheimer's disease or anti-NMDA receptor encephalitis, an essentialistic view is likely to be more useful because of its simplicity. It means, it is not necessary to avoid all kinds of essentialism in our clinical practice of psychiatric diagnoses. Essentialism should be avoided when inappropriate, such as in case of depression in which multi-level complex factors play roles. This kind of essentialism can be called as a "misplaced essentialism".

Break

16:15-16:45 Reply by Professor Zachar
16:45-17:45 General Discussion

Dec 2 (Sun)

International Workshop on Philosophy of Psychiatry

10:00-11:00 Talk 1

Neuroenhancement and its neighboring concepts in psychiatric clinical practice

Eisuke Sakakibara (U Tokyo)

Enhancement is applying biomedical technologies to improve human capacities beyond therapeutic purposes. Among others, neuroenhancement, a subtype of enhancement that aims to improve one's cognitive or emotional capacities draws much attention, because neuroenhancement is continuous with the treatment of anxiety disorders with serotonin selective reuptake inhibitors (SSRIs), and with the treatment of attention deficit/ hyperactivity disorder with psychostimulants, for which the number of prescription has been increasing. In this presentation, I will propose that the notion of neuroenhancement neighbors not only on the notion of treatment, but also on other concepts, such as 1) prevention, 2) pain relieving, and 3) hedonic use of psychotropic drugs. About 1), when SSRIs is prescribed for preventing the relapse of depression when a patient undergoes stressful situation, it can be rephrased as the enhancement of the patient's mental endurance. As for 2), psychiatrists try to alleviate the distress of the patients who suffer from various kind of anxiety using medication. In this case, the alleviation of distress is equals to psychological pain relieving, and, at the same time, it is also an enhancement of client's temperamental trait. About 3), there is a slippery slope between neuroenhancement and hedonic use of psychotropic drugs. It is well known that psychostimulant is abused for recreational purpose. Furthermore, psychostimulants induce overconfidence in one's own performance. The ambiguity of purpose is derived from the fact that psychotropic drugs affects human sensibility. Therefore, In the psychiatric clinical practice, psychiatrists should be careful about the purpose of current psychotropic medication.

11:00-12:00 Talk 2

Understanding the symptoms of Taijin Kyofusho from an embodied perspective

Shogo Tanaka (Tokai University)

Taijin Kyofusho (TKS) is a form of social anxiety disorder that is considered to be a culture-bound syndrome, which is mainly found in Japan. Patients with TKS experience extreme

tension and fear during interpersonal interactions with others. Symptoms are experienced mentally as well as somatically and include the fear of blushing, making eye contact with others, emitting unpleasant odors, and acting awkwardly, among others. According to DSM-5, the important character that distinguishes TKS from the social anxiety disorder is the excessive concern about others; Patients with TKS experience a fear that their own appearance and behavior may offend others because of their symptoms, whereas patients with social anxiety experience fear as a direct reaction to the presence of others. However, this view is not adequate if we take into consideration the fact that only a subtype of TKS involves the characteristic of offending others. Rather, I would like to show that TKS is a continuation of social anxiety disorder by focusing on the symptoms of both disorders from an embodied perspective.

Lunch

13:30-14:30 Talk 3

Social Factors in Delusion Formation: Causation or Construction?

Kengo Miyazono (Hiroshima University) and **Alessandro Salice** (University College Cork)

Delusions are abnormal beliefs that can be seen in association with a variety of conditions including schizophrenia, dementia, brain injury, and drug abuse. Previous theories of delusion formation are individualistic; they explain delusions in terms of individualistic (i.e., non-social) factors, such as abnormal (perceptual) experience (e.g., Maher 1974), abnormal reasoning (e.g., Von Domarus 1944), or both abnormal experience and abnormal reasoning (e.g., Stone & Young 1997). However, the individualistic approach is potentially problematic. Recent developments in social epistemology reveal the importance of social factors (e.g., testimony, disagreement, etc.) in belief formation process in general. In this paper, we propose an account of delusion formation process in which social factors play a crucial role, in particular at the stage of the maintenance of delusional hypotheses. This account relies on a model of social impairment in schizophrenia, which one of us defended elsewhere (Salice & Henriksen 2015), and explains how the social impairment can lead to delusional beliefs. We also compare our account with social constructivist account of schizophrenia.

14:30-15:30 Talk 4

Philosophy of Mental Disorder: Diagnosis in Dialogical Approaches

Kohji Ishihara (The University of Tokyo)

Since its beginning, psychiatry has tried to reach a precise classification of mental disorders. Philippe Pinel believed that mental hospitals were ideal places for investigation where physicians could examine many patient cases successively. Until the early 20th century, psychiatry had developed closely in association with practice in mental hospitals. After mental health care approaches transformed to community- and needs-based approaches since the latter half of 20th century, the role of classification of mental disorders should have been reexamined. Meanwhile, in the 1970s and 1980s, mental health care approaches of "Dialogical Approaches" such as Trieste model in Italy and Open Dialogue Approach in Finland emerged which did not focus on diagnosis and classification. However, even in these approaches, diagnosis and classification should play some roles. In this presentation I would like to consider the possible roles of diagnosis and classification in Dialogical Approaches and seek ways to reorient the significance and role of classification in community- and needs-based mental health care approaches.

Reference: Kohji Ishihara (2018). Philosophy of Mental Disorder: From Classification to Dialogue, The University of Tokyo Press (Japanese).

Break

15:45-16:45 Closing Talk

Bereavement and depression: On the border of normal and disordered functioning

Peter Zachar (Auburn University Montgomery)

Beginning with the DSM-III in 1980, a person experiencing symptoms of depression within six months of the death of a loved one could be excluded from a diagnosis of major depressive disorder. The DSM-5 eliminated this "bereavement exclusion." In this talk, I will explicate the main arguments, scientific and conceptual, offered for deleting the bereavement exclusion and the main arguments in favor of keeping the bereavement exclusion. I will also try to make sense of the fact that advocates on both sides of the debate would typically make the same clinical decision for most cases of bereavement related disruptions in mood.