

**PHILOSOPHY 483E**  
**PHILOSOPHY OF PSYCHOLOGY**

Section AB 1 — May – June, 2009

**INSTRUCTOR:** Dr. Peter B. Raabe

**CLASSROOM:** A261

**TIME:** Tuesdays and Thursdays 1:00 pm to 3:50 pm

**OFFICE:** D3089

**OFFICE HOURS:** after class

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**OBJECTIVES:**

This course will examine the current understanding of the relationship between normal and abnormal human psychology, especially as it relates to the diagnosis and treatment of so-called mental illness. Our work will aim for two things: *first*, to come to an understanding of various philosophical issues examined in the assigned readings, and *second*, to discover and deal with some of the philosophical problems and questions left unresolved in the fields of psychology and psychiatry.

**Required text:**

*The Philosophy of Psychiatry*. Oxford UP: 2004. Edited by Jennifer Radden

**Also Required:** A folder in which to collect your written work.

**EVALUATION:**

\* **Answers to the questions:** (60%)

Read the assigned chapters and answer the questions for each chapter on pages 3 to 5 of this handout. Max length 2 pages double spaced.

Your answers are each worth 2% adding up to a total of 60% for the semester.

Answers are submitted for marking twice during the semester and once at the end.

\* **Final essay:** (40%)

Max 10 pages double spaced

Your thoughts, discussion, and critique of psychology and psychiatry.

This is to be a philosophical essay that makes an argument.

(see page 6 of this handout “How to write a good philosophy paper”).

This essay may be on any topic you wish to write about stemming from the readings you have done. Don't just write a summary or description of what you've read.

NOTE: Assignment sent by e-mail will **not** be accepted.

All assignments must be *word processed*. Please no hand-written work.

### **OUTLINE OF TOPICS AND READINGS**

Week

- 1) Mon. May 4 Welcome and Introduction
- 2) Wed. May 6 Introduction & Chapters 1 & 2
- 3) Mon. May 11 Chapters 3, 4 & 5
- 4) Wed. May 13 Chapters 6 & 7 **Submit answers to questions**
- \*) Mon. May 18 \* NO CLASS \* Victoria Day Holiday
- 5) Wed. May 20 Chapters 8, 9, & 10
- 6) Mon. May 25 Chapters 11, 12 & 13
- 7) Wed. May 27 Chapters 15 & 16
- 8) Mon. June 1 Chapters 18, 19 & 20
- 9) Wed. June 3 Chapter 21 & 22 **Submit answers to questions**
- 10) Mon. June 8 Chapters 23, 24 & 25
- 11) Wed. June 10 Chapter 26 & 27
- 12) Mon. June 15 Chapters 28, 29 & 30
- 13) Wed. June 17 No assigned reading **Submit answers and final essay**

QUESTIONS for PHILOSOPHY of PSYCHOLOGY: PHIL 483 (IS1)  
Independent Study Course (answers **max. 400 words**)

**Week 1**

Chapter 1

On page 29 the author says "...attention is a social rather than biological mechanism."  
Based on your reading of this chapter, explain what the author means.

Chapter 2

What is wrong with the claim that depression is the cause of suffering?

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**Week 2**

Chapter 3

Why does the author argue that the diagnoses of paraphilia is often value-laden?

Chapter 4

Note how a "disorder" gets into the DSM: the diagnoses of symptoms comes *before* the disorder is officially classified, and the symptoms *are* the disorder. How does this compare to disorders classified by medical science?

Chapter 5

Do you think alcoholism is a volitional disorder that should absolve a person from moral or legal responsibility of harmful acts committed while intoxicated?

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**Week 3**

Chapter 6

Instead of "thought insertion" why not go with the old diagnosis of demon possession?

Chapter 7

Explain the "Humpty Dumpty Fallacy" which the author uses to argue against multiple personality theories.

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**Week 4**

Chapter 8

(p. 123) Are feelings of alienation from the body because of stroke and brain lesions the same as psychological feelings of alienation?

Chapter 9

Do you agree that a person's manic and depressed phases could be classified as distinctly different selves? If so, which self is the "real" self?

Chapter 10

On p. 151 the author says that "... parents have the right to raise their children according to their own standards and values." Should parents with "radical" religious standards and values have that right?

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**Week 5**

**Chapter 11**

What would it mean to *value* some mental illnesses?

**Chapter 12**

On p. 185 the author says that in a 1994 journal there was “an official announcement of the death of psychoanalysis as an explanatory, causal science.” What does he mean by that?

**Chapter 13**

On p. 199 the author says that “...there is something generally wrong with the attempts to reduce intentional notions to purely causal ones.” What does he mean by that?

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**Week 6**

**Chapter 14**

Skip

**Chapter 15**

In this chapter, why is Nancy Potter’s writing biased?

**Chapter 16**

On p. 250 the author says that “Fanon indicts Western philosophy for ontologizing the human essence as white so that whiteness became a criterion for humanness.” Explain what he means.

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**Week 7**

**Chapter 17**

Skip

**Chapter 18**

On p. 279 the Court is quoted as saying that “States retain considerable leeway in defining the mental abnormalities and personality disorders....” And yet it also claims that psychiatry is “an ever-advancing science.” How or why is it that a science can be so subjective?

**Chapter 19**

A patient says he hears the voice of God. Should he or she be required to receive treatment for mental illness?

**Chapter 20**

Is a bad childhood, with parents who both spent time in jail for crimes they committed, an acceptable defence for their son or daughter who has just committed a crime?

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**Week 8**

**Chapter 21**

Is a child raised in a devoutly religious sect “normal”?

**Chapter 22**

How might religious beliefs and spirituality be explained within the three variations of the Darwinian evolutionary model?

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**Week 9**

**Chapter 23**

What problems are created for a theory of human nature and concepts of a self with free will by the postulation of “unconscious drives”?

**Chapter 24**

Is a scientific approach to psychopathology possible, given the definition of hermeneutic understanding?

**Chapter 25**

Why is neurobiological reductionism a problem in psychiatry?

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**Week 10**

**Chapter 26**

Behavior therapy has its use. But it’s usefulness as a psychotherapy is very limited. Explain why this is true.

**Chapter 27**

How are some mental illnesses dependent on particular social conditions?

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**Week 11**

**Chapter 28**

How should it be determined whether a person needs psychiatric treatment?

**Chapter 29**

Do you agree with the authors of the DSM that the use of drugs to treat so-called mental disorders suggests that “...there is no essential difference between mental and physical disorders”?

**Chapter 30**

A recent study (see pages 7 & 8 of this handout) has shown that anti-depressant medication has no more effect than a placebo. How can you explain the enormous increase in sales of anti-depressant medications over the last ten years?

# HOW TO WRITE A GOOD PHILOSOPHY PAPER

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## BEFORE YOU BEGIN TO WRITE ⇒ Think and Discuss

- Think about your topic before you start to write to clarify it in your mind.
- A good paper is a good **argument**, so decide which side of the issue you're going to argue.
- Organize your thoughts by making an outline of what you might want to say.
- Discuss your thoughts and outline with others; ask for feedback and input.
- Organize the source material you plan to cite to support what you say.
- Write in your own voice. Don't try to copy someone else's style (like Plato).
- Use simple and direct language.

## THE BEGINNING ⇒ Introduce

- When you begin to write, state the position for which you are going to argue. In a single, short, and precise sentence state the point you are trying to make, and of which you're trying to convince your reader. (This is the **thesis** of your essay). Don't expect the reader to understand the argument you're trying to make in your paper if you're not sure about it yourself.

## THE MIDDLE ⇒ Elaborate

- Give grounds, reasons, justifications, and facts which support your position. Support your opinions with **citations** from respected sources. Don't ask your reader to simply accept your unsupported opinion. Don't expect your reader to agree with everything you say just because you say it.
- Use a different paragraph for each new point in your argument.
- Anticipate objections. Offer the strongest **counter-arguments** against your position that you can think of, then argue against them to show how your position is more reasonable. Your job is to convince the reader that your point of view is better than all others. It's not necessary to dispute all the counter-arguments you can possibly think of. The three or four best ones are all you need.
- If your essay seems "too short" make sure what you've written is sufficient to justify your position. If your essay seems "too long" eliminate unnecessary filler passages and digressions to side issues.
- Make sure you cite every writer you quote. If you quote but don't cite it's **plagiarism**.

## THE END ⇒ Summarize

- Briefly restate your arguments in the conclusion to demonstrate how you have made your point.

## AFTER YOU FINISH WRITING ⇒ Review & Rewrite

- Check for spelling errors, poor grammar, incomplete sentences, sentences that are too long and complicated, and technical terms that need explaining. Don't leave sentences in your essay that don't make sense to you.
- Put your essay aside for a few hours or days; read it again later; then make changes and improvements. Don't assume your first draft is perfect. It never is! Careful editing and rewriting are the keys to achieving a first class mark.

# Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration

Irving Kirsch<sup>1\*</sup>, Brett J. Deacon<sup>2</sup>, Tania B. Huedo-Medina<sup>3</sup>, Alan Scoboria<sup>4</sup>, Thomas J. Moore<sup>5</sup>, Blair T. Johnson<sup>3</sup>

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## Editors' Summary

### *Background.*

Everyone feels miserable occasionally. But for some people—those with depression—these sad feelings last for months or years and interfere with daily life. Depression is a serious medical illness caused by imbalances in the brain chemicals that regulate mood. It affects one in six people at some time during their life, making them feel hopeless, worthless, unmotivated, even suicidal. Doctors measure the severity of depression using the “Hamilton Rating Scale of Depression” (HRSD), a 17–21 item questionnaire. The answers to each question are given a score and a total score for the questionnaire of more than 18 indicates severe depression. Mild depression is often treated with psychotherapy or talk therapy (for example, cognitive–behavioral therapy helps people to change negative ways of thinking and behaving). For more severe depression, current treatment is usually a combination of psychotherapy and an antidepressant drug, which is hypothesized to normalize the brain chemicals that affect mood. Antidepressants include “tricyclics,” “monoamine oxidases,” and “selective serotonin reuptake inhibitors” (SSRIs). SSRIs are the newest antidepressants and include fluoxetine, venlafaxine, nefazodone, and paroxetine.

### *Why Was This Study Done?*

Although the US Food and Drug Administration (FDA), the UK National Institute for Health and Clinical Excellence (NICE), and other licensing authorities have approved SSRIs for the treatment of depression, some doubts remain about their clinical efficacy. Before an antidepressant is approved for use in patients, it must undergo clinical trials that compare its ability to improve the HRSD scores of patients with that of a placebo, a dummy tablet that contains no drug. Each individual trial provides some information about the new drug's effectiveness but additional information can be gained by combining the results of all the trials in a “meta-analysis,” a statistical method for combining the results of many studies. A previously published meta-analysis of the published and unpublished trials on SSRIs submitted to the FDA during licensing has indicated that these drugs have only a marginal clinical benefit. On average, the SSRIs improved the HRSD score of patients by 1.8 points more than the placebo, whereas NICE

has defined a significant clinical benefit for antidepressants as a drug–placebo difference in the improvement of the HRSD score of 3 points. However, average improvement scores may obscure beneficial effects between different groups of patient, so in the meta-analysis in this paper, the researchers investigated whether the baseline severity of depression affects antidepressant efficacy.

#### *What Did the Researchers Do and Find?*

The researchers obtained data on all the clinical trials submitted to the FDA for the licensing of fluoxetine, venlafaxine, nefazodone, and paroxetine. They then used meta-analytic techniques to investigate whether the initial severity of depression affected the HRSD improvement scores for the drug and placebo groups in these trials. They confirmed first that the overall effect of these new generation of antidepressants was below the recommended criteria for clinical significance. Then they showed that there was virtually no difference in the improvement scores for drug and placebo in patients with moderate depression and only a small and clinically insignificant difference among patients with very severe depression. The difference in improvement between the antidepressant and placebo reached clinical significance, however, in patients with initial HRSD scores of more than 28—that is, in the most severely depressed patients. Additional analyses indicated that the apparent clinical effectiveness of the antidepressants among these most severely depressed patients reflected a decreased responsiveness to placebo rather than an increased responsiveness to antidepressants.

#### *What Do These Findings Mean?*

These findings suggest that, compared with placebo, the new-generation antidepressants do not produce clinically significant improvements in depression in patients who initially have moderate or even very severe depression, but show significant effects only in the most severely depressed patients. The findings also show that the effect for these patients seems to be due to decreased responsiveness to placebo, rather than increased responsiveness to medication. Given these results, the researchers conclude that there is little reason to prescribe new-generation antidepressant medications to any but the most severely depressed patients unless alternative treatments have been ineffective. In addition, the finding that extremely depressed patients are less responsive to placebo than less severely depressed patients but have similar responses to antidepressants is a potentially important insight into how patients with depression respond to antidepressants and placebos that should be investigated further.

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Full study report at: <http://medicine.plosjournals.org/perlserv/?request=index-html&issn=1549-1676>