Association for the Advancement of Philosophy and Psychiatry
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Keynote Presentations

Tanya Luhrmann, Stanford University: Is the Shaman Schizophrenic, After All? How Religious Practice May Change Psychotic Experience

When anthropology was a young discipline, people smitten with the romance of cultural relativism argued that those who were diagnosed with schizophrenia in our society would simply be artists or shamans in another. When the biomedical model began to dominate psychiatry, it seemed clear that this romantic vision was a mistake. In recent decades, however, not only anthropologists but also psychiatrists have begun to wonder whether forms of cultural practice might alter the experience of even so profound an illness as schizophrenia in powerful ways. In this talk I present the best evidence for this possibility that I have yet encountered by examining a spirit possession practice in Ghana.

Jacob Stegenga, University of Cambridge: Sex, Drugs, and Disease Creep

The charge of medicalisation has been leveled at disorders of low sexual desire. The presumption behind the charge is that such conditions are not real diseases. On philosophical grounds, however, this cannot be generally true: on any conception of disease, low sexual desire can, in principle, be a disease. However, there is a related phenomenon that is apt: disease creep. Disease creep involves the development (and loosening) of disease categories such that more people become diagnosable with the disease. The most pressing issue about these kinds of disease categories is not whether or the condition is inappropriately medicalised, but rather, whether or not we can effectively intervene on the conditions. Evidence now suggests that we can intervene on low sexual desire in men but not women. This, in turn, might shed light on debates surrounding models of sexual arousal and evolutionary theories about sexual desire.

Presenter Abstracts (in order of presentation)

The Unconscious as a Private Language
Jeff Bedrick
Drexel University College of Medicine
The dynamic unconscious has been a difficult concept for philosophers to make sense of. Philosophers from the continental tradition, such as Sartre, as well as from the analytic tradition have struggled with the notion of repression, arguing that if something is to be repressed it must be known to the repressing agency, and then that knowledge must be repressed by an agency that is aware of it, and then that knowledge must be repressed, leading to an infinite regress. The alternative of an unconscious that is not dependent upon repression is easier to make sense of but does not seem to be able to carry the weight that Freud and the analysts wanted it to bear and does not account for the everyday phenomena such as slips of the tongue, not to speak of the clinical ones that, since Freud, have come to be recognized by the culture at large. I suggest a different model for understanding the unconscious, one that avoids the problem of an infinite regression while, at the same time, pointing to ways of understanding the every-day and the clinical phenomena that we want to understand. We can develop such a model by making use of Wittgenstein's discussion of the impossibility of a private language along with Ricouer's, and others', work on the narrative construction of self and identity. The use of Wittgenstein may seem surprising, as he thought of the Freudian unconscious as a myth, but I will show that he did not see how one of his most famous arguments could help us make sense of the concept of

the unconscious. The paper will sketch the outlines of this model and show how it avoids the problems philosophers have posed while maintaining the clinical relevance of the dynamic unconscious.

Psychedelics, Epistemic Benefit, and Philosophical Naturalism about the Mind
Benjamin Lewis
University of Utah

Scientific research on the therapeutic potential of psychedelic drugs is experiencing a renaissance. While modern psychedelic science can be traced back to the 1943 synthesis of lysergic acid diethylamide, a prolonged political and social moratorium on the scientific and psychotherapeutic study of this class of compounds is only recently lifting. Recent work in psychiatry- while involving small studies and limited control groups - has nonetheless been remarkably promising with large magnitude therapeutic effects after even single drug administrations, particularly for existential distress or anxiety in cancer patients, smoking cessation, and treatment-resistant depression. While the therapeutic potential of 5HT-2A agonists is incompletely hashed out, it appears that we are on the verge of game-changing therapeutic breakthroughs in psychiatry as well as innovations in treatment that challenge certain elements of current biomedical approaches. Accompanying these therapeutic developments are a host of ethical, epistemological, and ontological questions within the philosophy of psychiatry. A prominent explanatory model for the effects of classical psychedelics involves alterations in the default-mode network (DMN). Overactivity in DMN circuits is linked to a range of psychopathological conditions. Diminished activity in DMN circuits accomplished through ingestion of psychedelics, or meditation, is associated with not just reduction in ruminative depressive symptoms or anxiety symptoms but with well-defined and replicable experiences of so-called mystical states and experiences of 'ego-dissolution.' Interestingly, recent clinical research suggests that the magnitude of healing response and personality change (the latter understood as higher levels of the dimension of openness) following the use of classical psychedelics is predominantly related to the intensity of this subjectively reported mystical experience. For this reason, psychedelic therapy has been described as a form of pharmacological psychotherapy or existential therapy, the emphasis being on this particular kind of altered state of consciousness (ASC) as the causal mechanism for therapeutic change .At the same time, mystical experiences associated with the use of classical psychedelics often involve reproducible metaphysical perceptions that appear difficult to square with philosophical naturalism about the mind, leading to the question as to what extent these compounds simply produce metaphysical illusions that, while comforting and anxiety-alleviating, are nonetheless false. This possible 'Pascal's Wager' with psychedelic administration has ethical implications, particularly in the context of vulnerable populations. Lisa Bortolloti invokes the concept of 'epistemic innocence' to explore possible psychological or motivational benefits incurred by delusions or sub-optimal cognitive processes, the idea being that non-veridical beliefs may nonetheless convey advantages within a personal emotional or motivational economy, as well as represent the only available option at the time to maintain cognitive coherence. Taking these concerns seriously, Chris Letheby employs the concept of 'epistemic innocence' to make room for the reasoned therapeutic use of psychedelics despite assumed epistemic costs. While this strategy captures some elements of the risk-benefit assessment requisite for responsible psychedelic use/prescription it is not clear that Bortolloti's framework - employed primarily in the literature to explore systematized or motivated delusions- is an appropriate tool for understanding psychedelic states and their possible therapeutic benefits. My argument is that psychedelic states are not intrinsically (directly) epistemic and that associated mystical qualities of psychedelic experience do not necessarily involve belief states about the world that directly conflict with naturalism. Given the amplified response to set and setting with psychedelic administration likely due to increased neuronal signal diversity and brain entropy there may nonetheless be some degree of justified epistemic paternalism insofar as offered explanatory frameworks for the therapeutic effect of

these compounds. I go on to argue that the therapeutic benefits of psychedelics do not require direct epistemic benefits and that it is possible to account for positive therapeutic change with these compounds within a scientifically-informed philosophical naturalism about the mind.

The Aspirations for a Paradigm Shift in DSM-5: An Oral History
Peter Zachar
Auburn University Montgomery

I will present a history of the aspirations for a paradigm shift in the DSM-5. This history draws on interviews with one DSM-5 Task Force co-chair, two American Psychiatric Association presidents, eleven workgroup chairs, and members of the various oversite committees. Enough time has passed that the participants in the revision have gained critical distance from what occurred, making it an opportune historical moment to present a consensus, internal history of the DSM-5 development process and its outcome. Two major participants in the revision are co-authors for the project on which this talk is based. I will describe the better publically known parts of the story but also review some behind the scenes aspects of the story that have been less public. One highly public aspect of the story includes the protests of first Robert Spitzer and then Allen Frances, including Frances' role in organizing an opposition to what he and many others considered the more problematic proposals for the DSM-5 that, from their perspective, medicalized normality. The role of four oversite committees have also been discussed in the public domain, but their charges and the threads connecting them are less well known. Not often discussed is how the planning for the revision process began in 1999 with the NIMH and other NIH agencies funding sixteen conferences to prepare for the DSM and ICD revisions. This was followed by a rupture between the DSM-5 revision and the NIH, which, in a break with past practices and contrary to the expectations of the DSM-5 leadership, the NIH agencies did not provided further funding once the revision began. Also less discussed is how the plans for a paradigm shift began with the intention of adding biomarkers to the DSM-5, but by the time the DSM-5 workgroups began meeting in 2008, the leaders realized that adding biomarkers would play at the most a minor role in the DSM-5 revision. This was confirmed by most workgroups after their first few months of work - before the protests began. What remained of the paradigm shift once the intention of adding biomarkers lost steam, given that the revision had begun and there was no turning back? I will briefly discuss three remaining goals. The first was to reorganize how disorders are grouped in the DSM so that the groupings represent coherent diagnostic spectra (the metastructure initiative). The second was to classify developmental variations of disorder expressions across the lifespan – which included eliminating the section titled "disorders usually first diagnosed in infancy, childhood, or adolescence." Third, after goal of adding biomarkers was de-emphasized, the most important and promising attempt at a paradigm shift was to integrate dimensional constructs into a categorical system. Within the overall DSM-5 process there was strong disagreements about whether a shift to dimensions was empirically justified, but within the workgroups themselves, concerns about how best to implement dimensions in clinical settings became the more important barrier to their inclusion in the manual.

Epistemic Injustice and Psychiatric Classification
Anke Büter
Leibniz Universität Hannover

Psychiatric classification is a highly controversial epistemic practice, as could be witnessed again in recent years with the latest revisions of both the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA 2013) and the International classification of Diseases (ICD-11, WHO 2018). While many critiques point out problems on the content level of these taxonomies, such as a lack of validity of individual diagnoses or diagnostic criteria, a growing amount of literature now targets the actual processes of revising psychiatric classifications. In particular, the DSM revision process has been

criticized as lacking diversity in terms of different theoretical and disciplinary perspectives as well as ethnical and cultural backgrounds. Another emergent controversial topic has been whether to increase the participation of laypersons, in particular patients and patient-advocates, in the revision process. My paper provides a new argument in favour of such an increased integration of patients into taxonomic decision-making in psychiatry by drawing on resources from social epistemology. It argues that the exclusion of patients from these processes constitutes a special kind of epistemic injustice: Pre-emptive testimonial injustice, which precludes the opportunity for testimony due to a presumed irrelevance or lack of expertise on the side of patients and advocates. This presumption is misguided here for two reasons: (1) the role of values in psychiatric classification and (2) the epistemic potential of first-person knowledge in this case. (1) Psychiatric classification currently involves value-judgments at several points, due to the insecure state of our knowledge of psychopathologies and the need for decision-making under uncertainty resulting from the DSM's/ICD's application in clinical practice. For example, this can concern decisions on the disorder-status of conditions or behaviors and the weighing of associated risks. As taxonomic decisions always trade between risks of over- versus underdiagnosis, the perspective of patients is a relevant input regarding whether it would be better to err on the side of being too rigid or too inclusive in the criteria for particular mental disorders. (2) In this situation characterized by significant uncertainty and error risks, patient perspectives can moreover function as a corrective means against implicitly value-laden, inaccurate, or incomplete diagnostic criteria sets. This argument falls in line with critiques that the DSM's/ICD's diagnostic criteria fail to sufficiently represent the clinical reality and phenomenology of mental disorders, which leads to a lack of clinical utility and has negative impacts on the treatment of patients. Including first-person accounts of the phenomenology of mental illnesses is therefore not only a matter of social justice, but can provide a helpful epistemic means here. To sum up, patients' perspectives are relevant and contribute valuable viewpoints to the revision of psychiatric classifications, and their exclusion constitutes a case of pre-emptive epistemic injustice. This injustice not only harms patients in their capacity as knowers, but also leads to preventable epistemic losses in the practices of psychiatric classification, diagnosis, or treatment.

Psychiatric Diagnoses as Recipes for Constructing Models of People
Sam Fellowes
Lancaster University

Critics are concerned that psychiatric diagnoses fail to accurately describe patients and therefore should be abandoned. Most patients do not have all symptoms associated with their diagnosis and most patients have symptoms which are not associated with their diagnosis. Knowing someone has a diagnosis seems to convey much less useful information compared to knowing what symptoms someone has. This situation has lead critics of psychiatric diagnosis to claim diagnoses make no contributions to understanding individuals, they are harmful distractions and should be abandoned (e.g. Timini, Gardner & McCabe 2011). Psychiatrists should instead establish what symptoms an individual has rather than give them a diagnosis. In this paper I will employ Ronald Giere's account of scientific theories to show that those critics are mistaken to see psychiatric diagnosis as making no useful contribution. Giere's account of scientific theories has previously been applied to psychiatry (for example, Murphy 2006) but one aspect has not been explored. Giere describes how scientific theories are abstract generalisations which lack specific detail. For example, Newton's laws, by themselves, make no claims about the world. Rather, they guide the building of more specific models and these specific models can be used to make claims about the world. He describes scientific theories as "recipes for constructing models" (Giere 1994, p.293). This notion of scientific theories as recipes which guide the building of less abstract models has not yet been explored within philosophy of psychiatry. Psychiatric diagnoses should be seen as recipes for constructing models of people. I argue they guide the construction of models of people, making contributions to understanding individuals which are absent

when simply focusing upon what symptoms are being presented by specific individuals. Firstly, many symptoms can be subtle and difficult to spot. A patient may be unaware of the symptom and psychiatrists cannot practically investigate for every possible symptom. However, knowing that a patient either has a diagnosis or partly meet the criteria for a diagnosis gives good reason to check if the other symptoms of the diagnosis are present. Thus the diagnosis guides investigating for the presence of symptoms. Secondly, patients fluctuate in the symptoms they present over time. The symptoms which are presented to a psychiatrist at time of interview may not cover symptoms previously exhibited or those exhibited in the future. However, knowing the individual has a diagnosis which is associated with a range of symptoms, more than any one diagnosed person actually exhibits, guides awareness towards a range of possible symptoms not present in a diagnosed person at one specific time. The diagnosis guides awareness towards alternative symptoms that may present at other times within diagnosed individuals. Thirdly, symptoms themselves have a level of generality and may manifest in quite different ways. For example, the low social skills of autistic individuals are typically quite different to the low social skills of schizophrenic individuals. Thus knowing the diagnosis of an individual can lead to greater understanding of how specific symptoms manifest. The diagnosis guides building more realistic models of ways individuals manifest symptoms. By framing psychiatric diagnosis in terms of Giere's account of scientific theories I have shown how psychiatric diagnosis make a contribution to understanding individuals. Thus critics of psychiatric diagnosis are mistaken to believe psychiatric diagnosis make no contribution and are mistaken to believe they should be abandoned.

For a Pluralistic Approach to Psychiatric Kinds: The Case of Social (Pragmatic) Communication Disorder

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Andréanne Bérubé, CHU Sainte-Justine

As communication and language are two broad developmental spheres, a real challenge arises when identifying related neurodevelopmental disorders, due to their uncertain etiology and their overlapping symptoms. A manifestation of this challenge appears with the publication of the DSM-5, as a new and controversial diagnostic category has been included under the Communication Disorders in the Neurodevelopmental Disorders section: the Social (Pragmatic) Communication Disorder (SPCD). SPCD is characterized by an impairment in social communication, with difficulties in using communication for social purposes, matching communication to the social context, following rules of communication, and understanding what is not explicitly stated (APA, 2013: 47-48). In fact, SPCD diagnostic criteria are on some points similar to traits observed in social communication in autism (ASD) (Mandy & al., 2017) and other pragmatic language impairments (e.g. Swineford et al., 2014; Norbury, 2014; Amoretti & Lalumera, personal communication, June 7 2018, for a philosophical stance). This presentation aims to explore the validity of SPCD within clinical psychiatry. We first offer a reconstruction of the debate as it unfolds in the psychiatric and speech therapy literature. Then we propose to adopt Tabb's (2017) pluralistic approach to psychiatric kinds to make sense of the disagreement over SPCD. This will help in finding a way out of the controversy that psychiatry and speech therapy are facing, but also in underscoring the need for a pluralistic approach to psychiatric kinds in the philosophy of psychiatry that matches psychiatric practices. The ongoing debate between clinicians about the existence of a distinct category of SPCD takes root in the diversity of profiles observed during evaluation in clinical settings. While some argue that there are pure cases of pragmatic impairment (Reisinger & al., 2011) and others see SPCD as a profile within a larger continuum, all agree about the need to identify communication symptoms associated with SPCD in order to establish a treatment linked to this specific impairment (Norbury, 2014). In parallel to these debates in psychiatry, the validity of diagnostic categories has greatly occupied philosophers of psychiatry since the early 2000s (e.g. Zachar 2000, Haslam 2003, Cooper 2005, Kendler et al. 2010, Kincaid and Sullivan 2014, Tsou 2016). However, the nature of psychiatric kinds is still under

debate, some arguing that the validity of these kinds should be vindicated by the discovery of shared causal mechanisms, while others have developed more permissive views. To overcome this dichotomy, Tabb (2017) has recently made an interesting proposal, conceiving psychiatric kinds in a pluralistic way. Because our approach is mainly focused on the clinical needs of patients, Tabb's (2017) recent proposal seems promising as it allows to elaborate a way out of the dilemma over the creation of SPCD. Building on Tabb's pluralistic proposal, we argue that SPCD could be seen as a discrete kind if the population it refers to needs specific treatments that would not be given without the diagnostic, and if it allows to better study this specific clinical population. This is supported by the well-known facts that children with social communication disorders have problems with developing relationships and making friends, and face considerable obstacles in their educational path and career (e.g. Mackie and Law 2010), whatever the etiology. SPCD could then be seen as a discrete kind although there is not so to speak an underlying causal mechanism explaining SPCD symptoms that have been discovered yet, nor even a consensus over the clinical validity of SPCD. The case of SPCD also illustrates the need for a conception a psychiatric kinds more in line with the way clinical psychiatry is done.

The Problems for Philosophical Counselors
Yujia Song
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As philosophical counseling is a fairly young field – the two major organizations in America providing professional training in it were established in the 1990s – there is little critical discussion of its assumptions, methodologies, and efficacy.1 This paper examines one of the fundamental assumptions underlying philosophical counseling: that the problems it treats are in a significant sense different from those more suitably treated by psychologists or psychiatrists. Examining this assumption is not only crucial for understanding the nature of philosophical counseling and evaluating its legitimacy as a distinct form of counseling, but it also sheds light on the nature and scope of the more familiar forms of counseling offered by psychologists, psychiatrists, and other mental health professionals. Although most, if not all, advocates and practitioners of philosophical counseling maintain that the problems they treat fall outside of the medical, psychological, or psychiatric realm, there is much confusion over just what sorts of problems those are. Sometimes they are called "problems of living" or "problems of our everyday life," which typically include a wide range of problems stemming from struggles at various stages in life such as academic problems, relationship issues, choosing a career or losing a job, midlife crisis, aging, and end-of-life issues. On the other hand, some practitioners think of the problems they treat as "philosophical in nature" as opposed to psychological, having to do with ethical, spiritual, existential, or political questions that the client wrestles with. It should be noted that the two approaches do not point to the same set of problems – an academic or relationship problem may come down to a weak will rather than what one thinks. Moreover, psychologists worry that some of these life problems may in fact be mental disorders in disguise. So long as philosophers are right to be skeptical of medicalization of "problems of life," i.e., of mental health professionals overstepping their scope of practice, there is a case to be made of mental health professionals being equally wary of what could be called "philosophicalization" of mental disorders. Then there are cases that seem to lie in between the two forms of counseling. What about the academic whose perfectionism prevents her from writing and publishing, a failure that she broods over as she dwells in the shadow of severe depression? Or a recently unemployed father undergoing midlife crisis and resorting to substance abuse? The philosophical counselor could respond that this is no objection to the assumed division between "problems of living" and psychological or psychiatric problems, for they can simply overlap – occurring in the same individual at the same time. However, the worry seems to go deeper. Could the academic's depression be one and the same problem as her inability to write (rather than merely as the cause or effect of the latter)? Could the father's substance abuse be one and the same problem as his midlife

crisis? The latter case is particularly interesting, for it is not just a "problem of living," but involves a paradigmatically "philosophical" problem, one about the meaning of (one's) life, one's identity, and perhaps one's values as well. If the philosophical and the psychological problems in such cases are really two sides of the same coin, this would have important implications not just for philosophical counseling, but for psychology and psychiatry as well.

Psychopathology in the Cyber-Century: Virtual Self and Digital Depersonalization
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The digital revolution challenges psychopathology, undermining its traditional foundation, forming new psychopathological phenomena and changing the very way mental presentations are experienced by a person and understood by a mental health care professional. The digital dimension of psychopathology is centered on a new mode of a person's relationships to herself in a digitally transformed world. This puts the problem of self in the center of the cyber-psychopathology. This paper describes three phenomena of cyber-psychopathology of self that were observed in my long-term clinical work with people who experience digitally-related disturbances. They are: digital ontological insecurity, virtual self and digital depersonalization. Digital ontological insecurity is characterized by the experiences of "loss of reality" or "zero mental gravity." These experiences vary from deep reflection on digital interplay between real and virtual to a pronounced panic-like attack of "broken reality." A patient describes "shocking insight from the disappearance of truth: everything is illusion: you in front of computer and world in your head." Life in digital a world blurs the boundary that grounds the everyday sense of reality and being. These experiences stem from the striking challenge of uncertainty – perceptual, cognitive, existential and ontological – that occur in cyber space. The well-defined difference between objective vs subjective, fact vs image or reality vs fantasy stand as the pillars that keep our mind sane and safe. But this – the old predigital world paradigm – does not work in cyber space. Internal reality from the time of Freud designates purely subjective constructs of dreams, fantasies, delusions, obsessions, phobias or traumatic memories. Cyberspace of virtual reality makes these subjective constructs being experienced as if they are real. Dreams of travel in space or in time as well as phobias of insects or aliens, can literally come true, being experienced with remarkable perceptual presence. The perspective of using such ontological fluidity for therapy of phobias, posttraumatic stress disorder and other conditions are discussed. The second phenomena of digitally related disturbances is Virtual Self. Introduced by Winnicott, True and False self presented two forms based respectively on spontaneous authenticity and defensive façade. Real life with its relationships navigates the True Self -False Self dynamics. Digital world challenges this dynamics, with new forms of relationships or pseudorelationships. The result can be metaphorically described as a way from Self, based on real relationships with real people, to Selfie, based on a self-crafted masquerade of wish-fulfillments and anxieties. The cyberspace provides that new imagery of relatedness which forms Virtual Self. Some people – mainly teenagers – develop remarkable skills utilizing unlimited possibilities of digital reality to cultivate this Virtual Self. The third phenomenon of digitally related disturbances is digital depersonalization. Depersonalization appears to be the phenomenon that is most relevant to understanding the principal characteristics of cyberspace. Depersonalization is a feeling of "as if" unreality. A person experiences herself and world around unreal, at the same time knowing that it is just subjective experience and that matter-of-factly she is real and the world is real. But it is this particular dissonance between "feeling unreal" and "knowing real" that makes depersonalization so painful and unbearable. Virtual reality is a mirror image of depersonalization. A person experiences herself and world around as if real, at the same time knowing that all this is just digital tricks and there are not jungles or medieval castle, but that she is in her room with VR goggles, gloves, etc... This important "as if" phenomena brings together brain generated disorder of depersonalization and computer generated

phenomenon of virtual reality. The form of digital depersonalization that is most common is a painful dissociation between self-representation of professional sites, dating networks, private chats and other platforms. The feeling of reality fades while the "as if" quality dominates. The person is trapped in digital depersonalization. The paper includes clinical vignettes to illustrate each type of digitally related disturbances.

Born Which Way? Disentangling Etiology, Ontology and Responsibility in ADHD
Polaris Koi
University of Turku

Debates around what Attention Deficit/Hyperactivity Disorder is, how it is caused, and what our clinical and social responses to it should be like, revolve around claims concerning its ontology. The heritability of ADHD often plays a large role in these claims. Put briefly, the etiology, and ontology of ADHD are often bundled up with any disadvantage associated with it, and all three of these are construed as a single explanandum, to be solved with a single explanans. To give examples of the above pattern, discussions around the moral and criminal responsibility of people with ADHD often propose a neural and genetic etiology and ontology of ADHD. Robert Eme (2016), for example, believes that ADHD ought to be treated as a mitigating factor in criminal sentencing, because "the diminished capacity for self-control in ADHD is caused (at least in part) by a dysfunction in the [dual systems]. […] in the case of ADHD […] the dysfunction is due primarily to genetic factors". That is, ADHD entails a dysfunction on the level of systems neuroscience, a dysfunction that is genetically caused, and is an exculpating or mitigating factor *because* of its biological etiology and ontology: we cannot help the way we are born. Likewise interested in the genetic causes of ADHD, Vehmas & Mäkelä (2009) argue that since no unitary genetic cause for ADHD has been found (such as has been found for Down's syndrome), ADHD is a wholly social construct. The approaches referenced above are evidence that recent debate remains influenced by a polarized nature/nurture debate between the so-called social and medical models of disability. In this paper, I argue that views conflating genetic etiologies of ADHD with its ontology and any resultant decreased criminal responsibility are founded on false assumptions of genetic essentialism (cf. Dar-Nimrod 2012). Using findings in behavior genetics to clarify the often muddled notions of heritability and genetic causation, I demonstrate that the causal factors in the generation of individual traits do not determine the ontology of these traits. I then argue that the extent to which ADHD does, in fact, decrease self-control and therefore plausibly diminish criminal responsibility cannot be inferred from its ontology, i.e., from whether a 'medical' or 'social' model is correct. I do this by presenting what I call an Access Theory of Self-Control. Building on Neil Levy's (2011) externalist account of self-control, I present an account of self-control as a set of behaviors that is multiply realizable and environment-sensitive: the self-controlled individual is one who *has access* to self-control behaviors. Differences in our biology and in our environment together modulate what kinds of behaviors we can access. Similarly to how wheelchair users as a group have diminished access to mobility, but this disadvantage doesn't pertain to individual wheelchair users who live in areas that are well-designed with, e.g., ramps and elevators, people with ADHD as a group have diminished access to self-control behaviors, but this disadvantage doesn't pertain to individuals in circumstances that sufficiently facilitate their access to self-control. Likewise, it may be that the circumstances that facilitate access to self-control for 'neurotypical' individuals fail to do so for people with ADHD, like doors and stairs facilitate mobility for people who walk. Since assessment of culpability is always done on an individual basis, whether an individual with ADHD is diminished in their capacity for self-control and hence for responsibility hinges on the self-control-conducivity of their environment.

Mentalization and Embodied Selfhood in Borderline Personality Disorder
Eli Neustadter
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Selfhood has been considered an organizing construct for theorizing Borderline Personality Disorder (BPD). Aberrant self-experience in BPD is characterized by dramatic changes in self-image, shifting goals and values, and feelings of emptiness, dissociation, and non-existence. These experiences are distressing and dangerous: in a qualitative study, Brown et al. found that >50% of interviewed women with BPD endorsed disturbances in self-experience as reasons for non-suicidal self-injury. A prominent developmental account of BPD, the mentalization approach (e.g.[4]), appeals to the interpersonal constitution of "self" structure in infancy. The caregiver's mentalization of her child's behavior—i.e., her ability to adopt an intentional stance and represent her child as having feelings, desires, and intentions—fosters the child's capacity to mentalize his own internal experience and sense of self. This occurs via his caregiver's re-presentation, or "mirroring," of these states during infant-caregiver interactions. While the mentalization approach seeks to explain "pathologies of selfhood" in BPD, such as affect dysregulation, identity diffusion, and unstable self-other boundaries, it relies on a concept of self that is not explicitly articulated. Other influential accounts of BPD focus on the "narrative self". In this view, the self is a narrative constructed by the individual through the integration of memories, present experience, and future goals into a coherent story. Indeed, narrative coherence is lower in life story interviews of people with BPD compared to non-BPD narrators. Fuchs goes a step further, writing that aberrations in self-experience are "*caused* by the inability to integrate past and future into the present and thus to establish a coherent sense of identity." I argue that while fragmented narrative identity is a feature of borderline pathology, anchoring self-disturbance in BPD only on narrative accounts risks minimizing the important role of embodied experience. Abnormal bodily experiences in BPD are common, including bodily dissociation, alexithymia (lack of words for felt emotions), and deficits in interoception (awareness and processing of bodily signals). Furthermore, recent empirical and theoretical advancements in mentalization theory highlight the *intercorporeality* of mentalizing activity, such that embodied subjectivity in early infancy develops through a "co-construction of somatic experience within attuned bodily interactions with the caregiver". In this paper, I present the claim that disordered self and interpersonal functioning in BPD result from impairments in "embodied mentalization" that manifest foundationally as alterations in minimal embodied experience, i.e. the first-person experience of being an individuated embodied subject. Predictive coding accounts of brain function claim that perceptual experience results from probabilistic calculations that are updated based on the discrepancies between expected and actual events. Constant adjustments are made to decrease the need to account for such surprises ("prediction errors"). We can construe minimal embodied selfhood as the phenomenal manifestation of interoceptive inference, i.e. the generative mental model of one's physiologic states. Employing Fotopoulou & Tsakiris's concept of "embodied mentalization," I will explain the foundations of bodily self as shaped through infants' embodied interactions. Progressive integration of interoceptive and sensorimotor signals result in stable mental representations of self. This process of embodied mentalization may be impaired through known etiologic risk factors for BPD, including disorganized attachment, trauma, and neglect. I will also review data on aberrant interoception in BPD in relation to self-disturbances and difficulties in social cognition. This account of BPD, which engages early (pre-verbal) intersubjective experiences and links them to predictive coding models of brain function, has the potential to integrate phenomenological, developmental and symptomatic findings in BPD, and can offer mechanistic hypotheses regarding the entwinement of self and interpersonal pathology.

Self-Injury, Shame, and Agency

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In this paper, I analyze one dimension of self-injury through the lens of internalized oppression, self-objectification, and body shame. This analysis extends the discussion to include agents who self-injure that are typically overlooked in clinical research, including black women, black men, and members of the LGBT community, while also giving an account of the shame that many self-injurers report. I argue that internalized beliefs of inferiority, particularly inferiority over one's body, and the dehumanizing effects of self-objectification, may contribute to an orientation to one's body that sets the stage for self-injury for some agents. This inferiority and self-objectification also help explain some of the shame over self-injury: agents who are taught that their pain is socially unimportant may experience shame when trying to cope with that pain. First, I draw on Sarah Naomi Shaw's (2002) analysis of the gendered dimensions of self-injury—namely, that self-injury is a way for (white) women and girls to both reenact and resist the bodily objectification and violations they experience socially. I extend Shaw's analysis by incorporating research on groups that are at-risk for self-injury, particularly black women (Cooper et al., 2010), South Asian women (Chew-Graham et al., 2002), black boys (Gratz, 2012), and LGBT youth (Liu & Mustanski, 2012). I then turn to Sandra Bartky's (1990) conception of psychological oppression, focusing on the effects of internalized shame and self-objectification. Drawing on Luna Dolezal's (2015) conception of chronic body shame, I argue that some of the effects of psychological oppression can alienate agents from their bodies, causing them to regard their own bodies as problems. Marginalized agents who are at risk for self-injury may already experience chronic body shame due to oppressive forces. For these agents, the body is *already* a site of shame, which may lead set the stage for self-injury in times of distress since the destruction of the body via self-injury can be an effort to mitigate this body shame. Finally, I argue that the characteristic shame agents feel over their self-injury may be partly a result of a tension between internalized self-objectification and the experience of self-injury as an agential act of reclaiming the body and coping with pain. When one has internalized the belief that they are inferior and their body is a problem, an act of self-injury can be experienced, for some, as a resistance to this belief. At the same time, since self-injury can affirm to the agent that she is in need of care, it can *also* be a source of shame against this backdrop of oppressive beliefs. In addition to the body shame that may make self-injury appealing to those in distress, these agents face an oppressive double bind since the tactic that brings about relief from suffering is also experienced as shameful. I argue that this is partly explained by the mainstream invisibility of marginalized agents' pain as well as attempts to repress their agency. When the suffering of marginalized agents is silenced and resources for coping with it are limited, self-injury becomes physical evidence of a pain that would rather be ignored and an affirmation of agency that has been denied. Adding to the in-group shame brought about by shame over one's body is the shame that can arise when an agent's pain is not allowed to be visible and yet she feels she has no other way to cope but to self-injure. This discussion is intended to add to our understanding of self-injury by considering some of the effects of internalized inferiority on how agents view their own bodies while also paying attention to the diversity of agents who self-injure.

Psychiatric disorders and empathy: the limits of narrative

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Empathy is a topic of significant interest to both medical professionals and philosophers. Unfortunately, studies of empathy in medicine tend to be philosophically naïve. At worst, these studies treat empathy as a "black box," neglecting any mention of its inner nature and process (Sulzer 2016). Elsewhere, they treat the concept under the guise of simulation theory, i.e. the belief that we empathize with others through deliberately mirroring their thoughts and emotions, "putting ourselves in their shoes." This

model has received diverse criticism from philosophers. Shaun Gallagher, writing from a phenomenological perspective, groups some of these criticisms into what he calls the diversity argument (2012): given the astounding variety of people, experiences, and life situations, how can we be sure we're actually simulating what others feel rather than merely projecting ourselves onto them? How do we even know what to simulate, when we decide to empathize? If we *do* already know, it seems there's no need for simulation; if we *don't* already know, it's unclear how we could begin the process of simulation. Gallagher's answer to this problem is to reframe empathy in terms of narrative, rather than simulation. Narrativity (along with classical phenomenology) provides an answer to the diversity problem by suggesting that we are not isolated, atomistic human beings, who must guess at the experiences of others based on our own private minds, but rather that we come to empathic understanding through our habitation in a shared world, with shared stories. This view accords well with the recent interest in narrative medicine and is no doubt particularly appealing to psychiatry, rooted as it is in a tradition of talk therapy. Yet psychiatric disorders seem to pose at least two problems for a purely narrative view of empathy. The first problem I will discuss in relation to a point made by Matthew Ratcliffe, who has written extensively about empathy and psychiatry. As Ratcliffe notes, what is lost in psychiatric disorders is often precisely the sense of a shared world, which grounds our common sense of meaning (2017). While Ratcliffe supports the role of narrative in understanding this lost world, there also seem to be occasions when narrativity leads us astray, where the very impulse to narrate can obscure rather than clarify. Furthermore, Ratcliffe's analysis does not appear to adequately address the second reason psychiatric disorders complicate a narrative view of empathy: psychiatrists frequently encounter patients who seem to lack a basic narrative competence, who do not or cannot relate their stories in the manner typically described by narrative theorists. How are we to understand empathy in these cases, where narrative itself becomes unrelatable, fractured, or even obliterated? The main substance of my talk will be in addressing this question. My goal is not to reject a narrative theory of empathy—which is a clear improvement over simulation theory and has special relevance to psychiatry—but to address the ways in which it falls short. My suspicion is that narrativity must be augmented with a good understanding of affectivity. In trying to distance themselves from a simple psychological view of "affective empathy" (which often goes with simulation theory), narrative theorists are perhaps overly dismissive of the kind of basic affective changes that make up our understanding of others. Without drifting back into simulation theory, I will propose a very straightforward and minimalist view of affective empathy, which I believe necessary to help narrative theory account for the unique problems posed by psychiatric illness.

Participatory Research in Psychiatry: Unpacking Epistemic and Ethical Justifications
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This paper examines justifications underlying the growing movement towards democratizing the production and implementation of knowledge in psychiatry. Both within politics and practice, the field is undergoing a significant transformation, as increasing emphasis is placed on the importance of involving those with lived experience in psychiatric research. While those promoting and regulating participatory research at the state level and within health research tend to focus on the epistemic benefits of such research, several commentators have argued that the justifications underlying participatory research are both epistemic and ethical. Drawing on this work, this paper unpacks six features of psychiatry that ground obligations related to participatory research in the field, and explores the ways in which these justifications ought to shape methodological choices. It is argued that too much focus on the epistemic benefits of participatory research can render some of the justifications underlying such research invisible, and that selling participatory research to scientists should only be one priority of many. One feature that grounds participatory research is the irreducible value of patient experience within

psychiatric research. While in many domains of medicine, reliable biomarkers allow clinicians to bypass subjective reports (e.g., tuberculosis testing), diagnosis and measurement in psychiatry rely heavily on patient reports. This suggests that the involvement of patients may be central to successful research in the field, especially research aiming to close the gap between efficacy and effectiveness. The extent of disagreement amongst professionals surrounding fundamental questions in psychiatry is another reason to promote participatory research. Involving those with lived experienced of receiving mental health services is one way to ensure that diverse voices can contribute to such debates and identify problematic assumptions that may be preventing the field from flourishing. Similarly, significant disagreement exists within and across c/s/x (consumer, survivor ex-patient) groups, the recovery movement, and patient advocacy organizations, with regards to how to mental disorders ought to be understood and which research questions ought to be prioritized. This suggests that participatory research should be responsive to the diversity that exists within service user communities and refrain from only involving professional or amenable users or groups in research. Another feature that justifies patient inclusion is the influence of industry within psychiatry, which can inappropriately skew research in favour of conclusions that increase profit. Participatory research can help to counteract such dominant forces within the field, as those who are not being rewarded for positive findings are less likely to end up with them. The well-documented history of abuse within psychiatric research and practice, which has led to a legacy of trauma and distrust and significantly reduced that faith that many communities place in psychiatric research, is another reason to democratize the research process. Participatory research, when successful, can help to rebuild trust and rebalance power relations between those being researched and those doing the research. Finally, another feature of psychiatry is the way in which psychiatric patients are often defined by a lack of agency or denials of decision-making capacity. This can be extremely troubling for individuals, and participating in research can offer an opportunity to restore agency and experience empowerment through contributing to knowledge about one's community. In closing, these six features are revisited alongside reports related to the impact of service user involvement on epistemic aspects of research (e.g., recruitment and attrition). It is argued that a narrow focus on the instrumental benefits of participatory research in psychiatry can be harmful, in that it fails to acknowledge the larger justifications underlying the democratization of research.

Institutional Corruption and Medical/Psychiatric Ethics: A Case Study and Implications for Reform
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The discipline of medical/psychiatric ethics, traditionally conceived, addresses physicians' behavior toward patients in their care. Thus, the first sentence of the Preamble to the AMA Principles of Medical Ethics notes, "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient." Recently, this framework has been broadened to encompass, among other things, relations with the pharmaceutical industry, reflective of growing recognition of the adverse effects on patient care of conflicts of interest and of reliance on biased information sources. This presentation will argue that the scope of professional ethics needs to be widened further to reflect the varied roles played by physicians in society. It will describe an episode of educational-institutional dishonesty in which the author was intimately involved over a period of two years. That case study will illustrate the ways by which the behavior of leaders of medical institutions can undermine the trustworthiness of those institutions, thereby weakening their abilities to fulfill their legitimate purposes. While serving as a medical school associate dean, the author discovered that internal data were being manipulated for reporting to a national publication in an effort to augment the public standing of the medical school. When the author discovered the problem and brought it to the attention of other members of the administrative leadership, he was met with a pattern of non-responsiveness, hostility, and trivialization of the discrepancy it entailed. The determination of a few

members of the medical school hierarchy to tout, in highly conspicuous ways, the ill-gotten institutional accolades to which their strategy had led continued long after its discovery and was only halted once the author enlisted the interest of the highest levels of the university leadership. Recent work by Lawrence Lessig and others has defined institutional ethics in a way that facilitates understanding of this event, its likely causes, and its potential remedies. That definition will be reviewed and its application to the present case examined. Through that lens, the ingredients of institutional corruption will be recognized and the modern phenomenon of institutional "branding" will be identified as a focus around which otherwise-decent individuals compromised their integrity and that of the institution in whose interest they saw themselves operating. In addition to explicating the paradigmatic hallmarks of institutional corruption and the harms that might have resulted from this instance of it, this case study will be brought to bear on the question of the obligations of academic physicians under the circumstances confronted by the author. Suggested remedies will entail interventions at both the individual and the institutional levels. Considering the trend among psychiatrists and other physicians to work as employees of institutions rather than as independent practitioners, the need to broaden the scope of medical ethics to encompass institutional behavior is all the more pressing. The author's experience will inform recommendations for closing "windows of opportunity for corruption" as well as for formulating an ethical code that accounts for the multiple roles physicians play and that protects their varied constituencies.

Wraiths of the Mind: Cognitive Feelings and Psychopathology
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Patients with psychopathologies are often diagnosed based on the unusual beliefs (i.e. delusions) they report and the atypical behaviours they display. An often neglected while central aspect of many psychopathologies is the fact that accompanying pathological beliefs and behaviours are the *consequence* of something that is harder to observe and communicate: distorting *experiences*. Prominent among these experiences are hallucinations and aberrant emotions. Less well known are the experiences that determine what a subject experiences as right or wrong, what she feels confident or uncertain about and what she considers to be known or not known and familiar or unfamiliar. Importantly, alterations in these experiences appear as potent explanatory elements in many psychopathological contexts: Patients undergoing psychotic episodes common to bi-polar disorder, schizophrenia, Capgras syndrome, Cotard syndrome etc. often exhibit highly atypical patterns in what they are confident about and consider right or wrong, familiar or unfamiliar – and is this atypical pattern that leads to the adoption of symptomatic beliefs and behaviours in turn. Such feelings of rightness or wrongness, of confidence, knowing and familiarity are known in the literature as cognitive feelings (sometimes also meta-cognitive, epistemic or noetic feelings). On the one hand, empirical work on meta-memory and meta-cognition is the primary source of what we know about these feelings. This work, however, lacks a coherent analysis of the general nature of cognitive feelings and has not yet been applied to the context of psychopathology. On the other hand, some recent philosophical work has invoked cognitive feelings in the explanation and characterization of certain mental illnesses and psychopathological symptoms such as delusions. However, this promising work has not provided a satisfactory characterization of cognitive feelings themselves. Here I aim to provide such a characterization. The idea is that cognitive feelings can be understood to be a sub-class of *affective* feelings not unlike bodily or emotional feelings. All affective feelings share certain characteristics. Among them the fact that they are conscious and possess the phenomenal qualities of valence and arousal. What is specific to cognitive feelings is that their primary domain of concern is not the body as is the case for bodily feelings or the external world as is often the case for emotional feelings. Instead cognitive feelings rather inform us about our cognitive processing or about what is going on in our mind. After spelling out the nature of cognitive feelings in some detail I will outline the implications of the

emerging account of cognitive feelings for the understanding and treatment of psychopathological cases and their dynamics.

Thought Insertion in Schizophrenia
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Thought insertion, a first rank symptom of Schizophrenia, is a fascinating phenomenon precisely because it is so confounding: experiencing a thought that one attributes to an outside force. Along with other first rank symptoms, it challenges the often implicit boundaries that we draw around 'the self'. Many have offered accounts of it which focus either on features of the thought in question or features of the process(es) used by the subject to determine that it is 'inserted'.[1] Although these features are important components of accounts of thought insertion, these accounts often pay insufficient attention to the role of the subject's experiences and understanding of herself – these experiences and self-knowledge together form her self-narrative. Such accounts may mention the importance of the self-narrative, but their failure to provide or draw upon a robust account of its construction and maintenance limits their ability to more fully account for instances of thought insertion. One such well-known account is that of George Graham and G. Lynn Stephens. I propose that theirs and other similar accounts would benefit from including a more developed account of the self-narrative. In order to most clearly present my proposal, I will focus on the ways in which it can inform their account specifically; however, I believe my proposal can also fruitfully interact with many other mainstream theories of thought insertion. I sketch a view according to which the subject's self-narrative serves as a standard (of sorts) for the evaluation of the thought in question, to determine whether or not it was self-originated. And then go on to address important ways in which the processes involved in the construction or maintenance of this self-narrative may be undermined in those with Schizophrenia. Importantly, I address malfunctions which might occur in the mental processes underlying the self-narrative, as well as those which might occur in the bodily processes underlying it. These are malfunctions which often occur in those with Schizophrenia, and by addressing their impact on the self-narrative we can provide a more robust account of instances of thought insertion. In my paper, first, I introduce in detail the phenomenon of thought insertion and present a paradigmatic example of it. Then, I sketch the specific contours of Graham and Stephens' account, and relevant features of the set of mainstream accounts I address – noting the relevant inadequacies of these accounts. After that, I draw on current philosophical work and empirical research concerning the self-narrative, including recent work on Embodied Cognition and the self, to develop my account of self-narrative. I highlight particular mental and bodily processes which underlie and maintain the self-narrative which are often undermined in Schizophrenia. Finally, I detail how my proposal might be incorporated into Graham and Stephens' account, sketch ways in which it might contribute to other mainstream accounts, and highlight the benefits of these expanded accounts.