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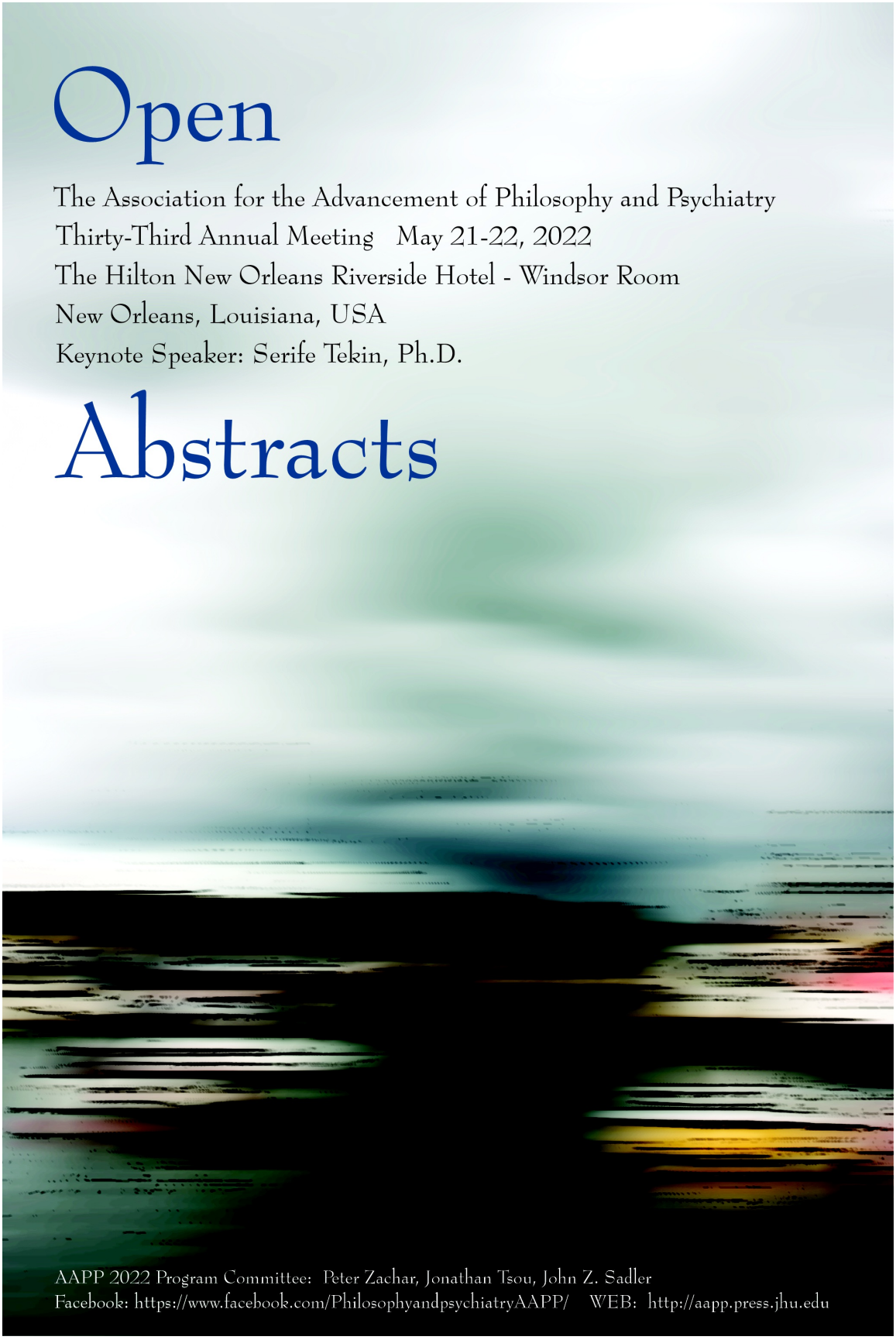
Abstracts



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AAPP 2022 Program Abstracts

Session 1 - Saturday

How feminist standpoint theory can explain the new activism in psychiatry

Sarah Arnaud and Anne-Marie Gagne-Julien

Activism has always played an important role in the understanding of numerous psychiatric categories. This is evidenced by recent movements such as Neurodiversity, Mad Pride, service users' advocacy groups, and by significant movements in the history of psychiatry, such as the struggle for the depathologization of homosexuality, and the recognition of Post-traumatic stress disorders by war veterans. This type of political engagement has been met by several authors as reflecting a strong opposition to medicine as a scientific enterprise. In this paper, we want to criticize two wrong dichotomies: one between natural kinds and social constructs that has been discussed for decades, and one between scientific investigation and social, political and normative claims that is sometimes mistakenly taken as identical as the former.

We propose a new framework to conceptualize and legitimize what we think is a new activist turn in the world of mental health, through the import of a feminist standpoint theory framework. Feminist standpoint theory is the view that marginalized perspectives (such as that of gender, but also race, class, etc.) can provide a productive critique of the dominant scientific paradigms (Wylie 2003, Intemann 2010, Harding, 2015). It encompasses three main theses: 1) the thesis of situated knowledge: our social location influence the way we get to know things and the knowledge we possess, 2) the thesis of epistemic advantage: the social situations of oppressed or marginalized groups can give a better access to knowledge in certain contexts, and 3) the thesis of achievement: the epistemic advantage linked to a standpoint is not automatic, it is revealed with critical awareness over the way power structures limit or constrain knowledge production. Recently, it has been convincingly shown that following this framework, the valorization of first-person knowledge is necessary, giving credence to many claims of mental health activists (Friesen and Goldstein, in press). However, the type of political action that mental health activism involves has not yet been discussed from this perspective. It is most often expressed through thinking outside the academic world, often in the form of blogs, newspaper articles, the creation of political associations, and which is primarily aimed at political and social claims rather than demands in terms of epistemic benefits. In other words, while the content of activists' claims has been discussed and often acknowledged as valuable, the place and role of activism as a means of political advocacy in psychiatry have been left unaddressed.

To fill this gap, we propose to consider Sandra Harding's notion of "strong objectivity" (2006, 2015) to begin an exploration of activism in psychiatry within feminist standpoint theory. Harding (2015) claims that scientific knowledge production should be guided by social justice ideals which will benefit the most vulnerable social groups. In this sense, science should produce knowledge in support of justice for marginalized social groups. We argue that according to this view, activism in mental health could be seen as a legitimate form of criticism of science, in that it questions its research orientations and its implications for society in terms of social justice. We discuss two activist movements in psychiatry, Mad Pride and the Neurodiversity movement in order to show how Harding's thesis could apply to them. While the framework of feminist standpoint theory has the potential to legitimize the influence of activism in mental health, we will end this talk by suggesting that it also normatively constrains activism for psychiatry. By specifying the epistemic and ethical ideals towards which psychiatry should strive, this framework allows us to exclude movements that convey ideas of oppression (such as white supremacists movements) or fixation of differences in brain structures (such as essentialist movements about identities).

Delusions, Epistemic Injustice, and Epistemic Vigilance

Eleanor Harris

Epistemic injustice occurs when a person is wronged in their capacity as a knower (Fricker, 2007), for example when we distrust a speaker's testimony for prejudicial reasons. It has already been argued that mental health service users are vulnerable to experiencing epistemic injustice, in both everyday and clinical settings (see, for example, Crichton et al. 2017, Lakeman 2010, Scrutton 2017). Here, I focus more narrowly on epistemic injustice specifically as it arises in relation to people with delusions. Sanati and Kyratsous (2015) suggest that people with delusions are particularly vulnerable to

experiencing epistemic injustice because of negative stereotypes associating delusional cognition with irrationality and bizarreness. These stereotypes can deflate our perceptions of a speaker's epistemic credibility; as a consequence, the speaker suffers a 'credibility deficit' (Fricker, 2007: 17). In this talk, I provide an account of the mechanisms that give rise to epistemic injustice in relation to delusional cognition – namely, *epistemic over-vigilance*. I draw upon an evolutionary account of epistemic vigilance, put forward by Sperber and colleagues (2010), according to which it is biologically adaptive to be on our guard against misinformation.

I present the two types of epistemic vigilance that Sperber and colleagues (2010) distinguish between – vigilance against the *source* of the information (the speaker with delusions), and vigilance against the *content* (the content of the delusional speaker's claims) – and apply this to delusional cognition, paying particular attention to the role of generalisations and negative stereotypes in both cases. I provide an account of what I call *epistemic over-vigilance*, which picks out cases where we are over-vigilant against accepting a speaker's testimony on trust alone. On my account, epistemic over-vigilance is what causes the credibility deficit that constitutes epistemic injustice. I return to the case of delusions and argue that epistemic over-vigilance is present: we distrust information issuing from delusional informants more than we should. Specifically, I suggest that we are over-vigilant because of (i) negative stereotypes about the source of information (the speaker with delusions) and (ii) the generalisation of irrationality from delusional testimony to non-delusional testimony.

I then present a *prima facie* ethical-epistemic dilemma for those engaging with people with delusions, particularly in the therapeutic context. I consider how the epistemic goods of epistemic vigilance might be in tension with the ethical costs of epistemic injustice, entailing a dilemma between avoiding misinformation on the one hand, and avoiding epistemic injustice on the other. Avoiding the ethical costs of epistemic injustice (such as impeding effective treatment and perpetuating negative stereotypes) seems to require that we avoid epistemic over-vigilance and take the testimony of delusional speakers seriously. However, given the nature of delusional cognition, this of course might run the risk of us being misinformed and epistemically worse off. On the other hand, the pursuit of epistemic goods, such as forming true beliefs, seems to encourage us to discount the testimony of speakers with delusions, since they are often perceived to be unreliable and irrational informants. Resolving this dilemma is vital in order to mitigate the harms of epistemic injustice without compromising the attainment of true beliefs.

However, I argue that that this *prima facie* dilemma between epistemic goods and ethical costs can be diffused by recognising that epistemic injustice also incurs distinctly epistemic costs, as well as ethical costs, by discounting testimony that might be genuinely informative. Therefore, avoiding epistemic injustice might further, rather than hinder, the pursuit of true beliefs. Finally, I present an account of *epistemic justice*, which foregrounds the importance of *reciprocity* between truthfulness and trustworthiness (Geuskens, 2018), and between epistemic vigilance and epistemic trust.

Humane Understanding and the Dangers of Medicalization and Pathologization:

Riana Betzler

Psychiatry has long been critiqued for medicalizing and pathologizing ordinary life experiences. But within the philosophical literature, there remain important questions about (a) what medicalization and pathologization are; and (b) when and why they are problematic. On the first question, Jonathan Sholl (2017) helpfully distinguishes between the two as follows: Pathologization is a process whereby certain conditions come to be labelled as pathological, whether by medical institutions or by oneself. Medicalization is a process whereby conditions that are seen as undesirable or of concern come to be treated using the tools and techniques of medical science. Medicalization and pathologization are typically closely intertwined, but medicalization can, as Sholl convincingly shows, occur without pathologization. I adopt Sholl's basic dichotomy between medicalization and pathologization in this paper, which primarily targets the second question: When and why are medicalization and pathologization problematic?

This paper defends the thesis that medicalization and pathologization in psychiatry are problematic when they violate our need for humane understanding. Humane understanding, as defined by Olivia Bailey "consists in the direct apprehension of the intelligibility of others' emotions" (Bailey 2020, p. 2). Intelligibility has to do with the idea that our emotional responses to events make "human sense"—are comprehensible and accessible to others—even if they are irrational. Intelligibility tends

to go hand-in-hand with judgments about the appropriateness of an emotion to a particular situation—their aptness, evaluative justification, or fittingness—but they need not. Others' emotions become intelligible to us, on this picture, through empathy. For example, we can resonate with the experience of anger that a friend might experience at a perceived slight, even if we judge that their anger is unjustified within the situation. Intelligibility, then, involves "getting it." As Bailey (2020) argues, humane understanding is a non-instrumental value because it is a deep human need; we need those around us to get us, else we will end up feeling alone in the world, as though our emotions are alien.

In this paper, I expand upon Bailey's work by showing how violating humane understanding can be understood as committing a form of epistemic injustice. I then show how medicalization and pathologization sometimes, but not always, violate humane understanding. In particular, processes of medicalization and pathologization violate humane understanding when they intersect with systemic and structural injustice related to race and gender. I show how in both the case of Borderline Personality Disorder and the case of the pathologization of Black Americans' rage involves making marginalized groups' emotions unintelligible. I also suggest that violations of humane understanding occur on a large scale when societal problems are conceptualized as individual problems to be treated through psychiatric, rather than policy, interventions. Ending on a more optimistic note, I conclude with suggestions as to how clinicians can overcome these hurdles through empathic, social justice-oriented practice.

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Session 2 - Saturday

Therapeutic Theories, Placebos, and Transparency: Analytical and Ethical Considerations

G. Scott Waterman

In a recent publication (xxx, in press), I argue for epistemic humility in the face of the frequent failures of conventional medicine to explain and ameliorate a variety of common maladies. As those conditions typically entail subjective distress, this topic is of particular relevance to psychiatry. This shortcoming of conventional medicine is often adduced to explain the popularity of "complementary and alternative medicine" (CAM) approaches to suffering. In my above-referenced article, I use craniosacral therapy (CST) – an intervention applied to ailments both within and outside of the psychiatric realm – as an exemplar of CAM modalities. As its purported mechanism of therapeutic action is highly implausible, I referred to its reported benefits for some patients as likely "placebo" effects. In this presentation, I analyze that formulation with reference to rigorous philosophical efforts at defining the placebo phenomenon. I then examine the ethical implications of the tentative conclusions I reach regarding the applicability of the placebo concept in this context and conclude by comparing the ethics of employment of CST with those of a conventional psychiatric intervention whose mechanism of therapeutic action remains obscure.

The most elaborated explication of the placebo concept in the literature is that of Grünbaum (1989, *inter alia*). His formulation dichotomizes all of the various elements that comprise therapeutic interventions into "characteristic features" and "incidental" ones. Crucially, Grünbaum's definition is relativized with respect both to the target disorder at which a therapy is aimed, as well as the therapeutic theory under which a given treatment is held to be indicated for a given disorder. Employing this terminology, a treatment is a placebo for a particular condition if none of its characteristic constituents, as identified by the applicable therapeutic theory, is remedial for the disorder..

As none of its characteristic constituents, as identified by the applicable therapeutic theory, is remedial for the disorder. Thus, for example, if a therapeutic theory of pneumococcal pneumonia holds that an effective treatment must be bactericidal, only the penicillin in the

prescribed tablet is a characteristic feature of the treatment, while the other constituents of the pill, the glass of water with which it is swallowed, the instructions from the pharmacist, etc., are incidental features. But what if the therapeutic theory that underwrites the use of a given intervention for a given disorder (or set of disorders) is likely spurious – albeit endorsed by those who provide the therapy in question? How, if at all, does the designation of a treatment as placebo depend on the *validity* of the relevant therapeutic theory?

Grünbaum's formulation has been helpfully augmented by Waring (2003) and Howick (2017), most relevantly by adding in the role of expectations in the placebo response and thus in the definition of placebo. This presentation will explore the application of Grünbaum's definition of placebo, as thereby modified, to CST. The possibility that CST (and arguably other such therapies) qualifies as a placebo will be examined in light of the AMA Code of Medical Ethics Opinion titled "Use of Placebo in Clinical Practice" (AMA), as well as empiric work that demonstrates that placebos can be administered without deception – the element of placebo use that appears most ethically problematic (Kaptchuk, 2010; Blease et al., 2016).

Finally, the links between a) a therapy's purported mechanism of action, b) its status as a placebo or non-placebo in a particular context, and c) the ethics of placebo administration, will be brought to bear on an examination of antidepressant pharmacotherapy and the commonly (mis)understood "chemical imbalance" therapeutic theory that is sometimes invoked to undergird it. I conclude that, across seemingly disparate clinical settings and interventions, the goal of minimizing suffering is most effectively and ethically served through humility and transparency.

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Hegel's Critique of Stoicism as Critique of Cognitive Behavioral Therapy

Richard DeSantis

This presentation aims to show that Hegel's critique of Stoicism as formulated in both the *Phenomenology of Spirit* and the *Lectures on the History of Philosophy* can be read as a critique of cognitive behavioral therapy (CBT), the so-called "gold-standard" of psychotherapy in the Anglophone world today (David et. al., 2018). I advance this thesis on the basis of three related claims.

The first and most basic claim is that while proponents of CBT have often attributed the framework's success to its empirical basis, CBT makes several metaphysical claims about the nature of the mind and is thus open to philosophical criticism. More specifically, Robertson (2020) and others have shown that Alfred Ellis (1962) and to a lesser extent Aaron Beck (1974) directly lifted several key tenets of CBT from the writings of the ancient Stoics. Most importantly, psychotherapies that fall under the heading of CBT propose that mental disorder is primarily the result of "irrational" or "maladaptive" thinking (the former in the case of Ellis, and the latter in the case of Beck), and further, that therapeutic intervention should follow the Stoic precept of turning the patient's attention towards what is most immediately within their control—namely, their relation to their own thoughts, i.e., self-consciousness.

Given this connection, my second claim is that Hegel's critique of Stoicism poses a fundamental challenge to CBT insofar as he shows this Stoic account of the mind to be based on faulty conceptions of interiority,

rationality, and intersubjectivity. More precisely, Hegel argues that self-consciousness is itself generated out of and sustained by something that is not within our control—namely, our relationship to and dependence on others. While Stoicism attempts to secure the mind against "external" concerns (e.g., anxiety about one's social standing) by making individual thought the ultimate determinant of reality ("*I* can control how *I* view myself"), Hegel argues that this mode of withdrawal proves to be an untenably one-sided account of selfhood that results in empty formalisms.

Finally, Hegel situates this criticism within a specific historical context that is relevant for thinking about the current status of CBT. Hegel diagnoses Stoicism's retreat into the "inner citadel" of private thought as a reaction to the decline of Greek society and the rise of the Roman empire, a situation in which juridical rule, global expansion, and growing anxiety undermined any sense of a shared social ethos. While proponents of CBT have taken its empirically measurable outcomes to be proof of the framework's success, I argue that the historical situatedness of Hegel's critique offers resources for thinking about why therapeutic interventions that privilege a self-sufficient, rational subject might emerge under specific cultural conditions.

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Belief revision in psychotherapy

J.P. Grodniewicz

What we think and believe often contributes to our mental suffering. If a person believes that they are unlikeable, they may withdraw from social life and experience a depressed mood as a result of their way of thinking and behaving (Beck, 1967). Patients diagnosed with a borderline personality disorder often hold such beliefs as: "People will take advantage of me if I give them the chance," "I can't cope as other people can," or "People will pay attention only if I act in extreme ways." (Bhar et al., 2008). The list goes on.

Available therapeutic approaches vary significantly when it comes to the strategies of working with clients' maladaptive beliefs. In this paper, I compare two such strategies: cognitive **restructuring** (characteristic of the Cognitive Therapy (CT) or the so-called "second wave" of Cognitive Behavioral Therapy (CBT)), and **defusion** (characteristic especially of Acceptance and Commitment Therapy (ACT), but present also in other therapies of the so-called "third wave" of CBT, e.g., Compassion Focused Therapy (CFT) and Dialectical Behavioral Therapy (DBT)).

Cognitive restructuring is the process of "modifying beliefs through the review or production of evidence that contradicts negative or maladaptive conclusions drawn by a client" (Padesky, 1994, 268). According to the "third wave" approaches, attempts of such a modification are largely ineffective. Instead, the "third wave" therapies rely on the process of defusion, which aims to "minimize the influence of verbal relations, such as thoughts [and beliefs], on behavior" (Assaz et al., 2018, 1) without changing the contents of particular beliefs held by a client.I argue that the most important differences between these two approaches originate from the underlying philosophical assumptions regarding the nature and organization of our beliefs.

Proponents of cognitive restructuring tacitly accept the unificationist model of belief-organization, according to which all beliefs of a given subject are: (1) consistent, (2) equally accessible at any given time and in any given context, and (3) equally brought to bear in production of any belief-governed behavior. Only under these assumptions can they expect clients to be "forced to revise their belief system"(Hofmannand Asmundson, 2008, 12) when confronted with contradictory evidence generated or brought to the fore in the interaction with the therapist. Proponents of defusion, on the other hand, tacitly accept the fragmentationist model of belief-organization (cf. Egan, 2021), which rejects (1)-(3).

Even though more empirical evidence is needed to decide which of these therapeutic approaches is more effective, their comparison provides us with fresh insights into some long-standing puzzles in the philosophy of mind. Moreover, it gives us tools to better scrutinize newly emerging therapeutic approaches, such as psychedelic-assisted psychotherapy (cf. Carhart-Harris and Friston, 2019), which also make assumptions about the processes of belief revision in psychotherapy

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Edwin R. Wallace Memorial Lecture

Ethics of Distributing Psychotherapy Chatbots to Refugees: Stuff WEIRD People Do

Serife Tekin

The gulf between the needs of individuals with mental disorders and available mental health care services disproportionately affects vulnerable populations with a high risk of developing mental health problems, such as refugees. Advances in applications of artificial intelligence and the use of data analytics technology in biomedicine create some optimism, with some researchers and developers proposing that psychotherapy chatbots, i.e., artificially intelligent bots that offer cognitive behavior therapy to their users, may fill the need-availability gap by increasing mental health care resources for refugees. Proponents often list their low cost, wide accessibility through cell phones, and availability in different languages as advantages and argue that these make them an ideal medical tool, especially in areas with a shortage of therapists who speak the native language of refugees requiring care.

In this talk, taking cues from Joseph Heinrich's examination of the characteristics of WEIRD (Western, Educated, Industrialized, Rich, and Democratic) people, as individualistic, self-obsessed, control-oriented, nonconformist, and analytical (Heinrich 2020), I raise epistemic and ethical concerns about addressing refugees' mental health problems with psychotherapy chatbots. I focus on the specific features of smartphone psychotherapy chatbots designed to address Syrian refugees' mental health (such as an Arabic speaking bot Karim). For example, the very proposal that a psychotherapy chatbot can address mental health problems hinges on the assumption that WEIRD people's mental health and well-being needs are universally applicable to people from different cultures and backgrounds. In addition to epistemic and ethical constraints of bots in addressing mental health challenges, I worry that motivating the development of this technology to address the growing needs of refugee populations medicalizes social and political problems. It encourages masking these instead of offering solutions.

Session 3 - Saturday

When is Enough Enough? Treatment Refusal and Psychiatric Euthanasia

Brent Kious

In Belgium and the Netherlands, and as will soon be true in Canada, persons with psychiatric conditions can request medical aid in dying (MAID, which generally involves voluntary euthanasia but may involve physician-assisted suicide) with few formal constraints on how much treatment they must have tried before receiving it. Existing criteria only require that there is no additional treatment that is likely to be effective and which is *also* acceptable to the patient. At first blush, this seems problematic, as it suggests that there are people who receive psychiatric MAID whose conditions could have been ameliorated. While the requirement that physicians must judge the MAID requestor's suffering as irremediable may provide some additional protection against this outcome, data published by Kim *et al.* (2016)[1] indicate that this protection may be insufficient.

Evaluating the moral implications of this state of affairs is complex. On one hand, most of us would resist the

idea that patients must have tried *all* available treatments prior to receiving MAID (assuming we regard MAID as ever permissible). Generally, capacitated persons should be entitled to refuse whatever treatments they wish when MAID is not a consideration. And in somatic (i.e., non-psychiatric) illnesses, even if MAID is a consideration, refusing some treatments can still be reasonable: if I have metastatic melanoma, it could be reasonable for me to refuse some novel chemotherapy that promises to make me horribly sick, extend my life by only 2 months (all while I'm still in pain), and cost over $250,000. In such a case, MAID might be a morally acceptable alternative to continued treatment.

On the other hand, treatment refusal in advance of MAID for somatic illness is not always reasonable. If I have ALS, and a cure is discovered which is both inexpensive and without serious side-effects, it would not be reasonable for me to refuse treatment and request MAID instead. Likewise, I argue, it *might* be reasonable for a person with depression that has failed to respond to *all* available evidence-based treatments to request MAID, assuming their suffering is severe, but it would not be reasonable for them to request MAID when there was a very high likelihood that their depression would respond to a treatment they have not yet tried. Consider, for example, a person who has tried multiple medications and psychotherapeutic interventions but who declines to utilize electroconvulsive therapy, which he refuses because he is afraid of the risk of memory loss. Such a patient, I argue, should not be regarded as eligible to receive MAID, barring a special story that makes sense of the idea that mild memory loss would be much worse for him than dying (and, thereby, losing all memories).

Generally, I contend, the extension of MAID, initially reserved for persons with terminal illness, to persons with non-terminal illnesses inadvertently removed an implicit requirement that the illness in question could not reasonably be expected to respond to available treatments. This requirement was built into the concept of *terminal illness* itself. To correct this lapse, MAID laws should stipulate that MAID should not be provided to persons with psychiatric illness—nor, indeed, to persons with non-terminal somatic illness—if available treatments could substantially ameliorate those persons' symptoms *and* the patient's illness-specific quality of life after treatment cannot reasonably be viewed as worse than death, where this quality of life encompasses the adverse effects of the treatment plus residual suffering due to the illness itself.

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Madness and Idiocy: Rethinking the problem of defining mental illness

Justin Garson

In the Late Modern period (roughly, from the end of the 18th century through the 19th), physicians and philosophers were preoccupied with defining madness in a rigorous way, just as we are today. However, for *them*, the problem of defining madness was framed and elaborated quite differently than it is for us. For *us* – that is, us philosophers of psychiatry, along with the occasional mental health practitioner who busies herself with philosophical issues – the project of defining mental illness (mental disorder, madness, insanity) is equivalent to the problem of distinguishing madness from sanity, and more generally, distinguishing disease from health. For the late moderns, in contrast, the problem of defining madness was one of *distinguishing madness from idiocy* – or better, to mark a three-fold distinction between sanity, madness, and idiocy. Resurrecting this earlier debate can illuminate both our folk notion of madness and the more technical concept of "mental illness" from which it emerges.

What, for the late moderns, is the distinction between sanity, madness, and idiocy? In short, the distinction comes down to the *manner of functioning of the reasoning faculty or faculties*. While sanity marks the *proper functioning* of those faculties, and idiocy their *abolished (or diminished)* functioning, madness marks their *perverse* functioning. The project of distinguishing, in a philosophically rigorous manner, madness and idiocy was probably initiated by Locke and his famous dictum, from the *Essay*, that while the madman reasons correctly from false premises, the idiot reasons "scarce at all." (II.11.12) Though Locke falls outside of the time period at issue here, this distinction is observed among thinkers of madness such as Kant, Wigan, and Heinroth.

Madness, then, is not the absence of reason – instead, it carries reason inside of it, albeit in a perverse form. But

for the presence of reason, madness would not be madness but idiocy. Any theorist during this time period who wishes to think through the nature of madness, then, must confront, squarely, a simple problem: what is the relation between reason and madness such that the mad person can "have" reason but still be mad?

Here, I examine three thinkers who offered ingenious solutions to the problem: Kant, Wigan, and Heinroth. For Kant, reason discloses itself in madness insofar as madness inherits from reason its systematizing quality. Even a person with outlandish delusions seeks to codify those delusions into a system of thought. For Wigan, in turn, the mad person can still possess reason by virtue of the mind itself being *dual*: each of us has two minds, and madness happens when one mind is reasonable and the other sick. For Heinroth, the mad person possesses reason in the sense that her disconnection from the world is itself a reasonable mechanism for buffering herself from the pain of reality; put differently, Heinroth demonstrates that a reasonable person could prefer madness to sanity.

This exploration of madness in the Late Modern period raises a host of questions, both historical and philosophical, that I can only sketch here: Why was this distinction lost in current philosophical discussion about mental illness? Put differently, how, historically and empirically,

did the philosophical problem of defining madness come to be identified with the problem of distinguishing sanity from its opposite? And how might a comparable distinction, one between madness and severe intellectual disability, be valuable for recovering a "positive" characterization of madness – not "positive" in the sense of good or noble, but positive in the sense of not being defined primarily in terms of the lack or absence of reason?

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Session 4 - Saturday

Reasons and Compulsions

Jared Smth

Moral philosophers consider compulsions prototypical examples of unfree action and this

conception is frequently invoked regarding obsessive-compulsive disorder. For example, Michael McKenna presents 'Handy the compulsive handwasher' as a counterexample to reason-responsive views of responsibility. Similarly, Walter Glannon applies semicompatibilism to demonstrate the ways in which persons with OCD lack the control required to be considered free and responsible agents. Yet, the details regarding how persons with OCD deliberate and act in the context of their obsessions and compulsive rituals, paired with their strong subjective judgments that they are effective agents who would be blameworthy for acts or omissions, should give us pause. I argue that once we are attentive to an accurate account of OCD, as well as a faithful understanding of semicompatibilism, a novel issue for the moral responsibility debate emerges. Rather than being insufficiently reactive, such agents are *overly receptive* to reasons, 'seeing' reasons where there are none, or granting them more deliberative weight

than is warranted. This new view of compulsion presses on whether and how blameworthiness can be mitigated or obviated by over-receptivity to reasons, and places pressure on the conception of compulsion as being a lack of control.

I begin by outlining the semicompatibilist theory of moral responsibility, which emphasizes the need for guidance control. Having guidance control requires that the agent is properly *receptive* and *reactive* to the relevant reasons for action and displays a pattern of reason-recognition that is intelligible to a third party. This sets

up McKenna's critique of semicompatibilism's reactivity requirement which is couched in the example of 'Handy the compulsive handwasher.' Problematically, Handy is a caricature of OCD which distorts the nature of psychological compulsions by omitting their cognitive features. This leaves the question of how to properly understand OCD in the context of a reason-responsive theory unanswered. Next, I establish that OCD has often been miscast in moral philosophy, eliding how compulsive rituals are goal-directed, voluntary, and deliberate. Due to this, many with OCD *do* appear to meet the weak reactivity requirement. So, while McKenna is correct that persons with OCD possess sufficient reactivity to be considered morally responsible, he does not present the complete picture. Following this, I turn to the receptivity aspect of semicompatibilism to show how the dysfunctional beliefs at work in OCD lead these agents to recognize an odd but intelligible pattern of reasons for action. When we consider the remaining aspect of semicompatibilism, 'taking responsibility,' we see that those with OCD experience a subjective perception of being responsible (and blameworthy) for real or imagined harms. This demonstrates that persons with OCD meet the requirement of 'taking responsibility' for their compulsive behavior.

The foregoing raises a new question: How does semicompatibilism conceive of agents who are receptive to reasons to such a degree that it negatively impacts their agency? Two distinct issues arise when considering this question. The first concerns the relationship between compulsion and freedom. For, it is a problem for our conceptual tidiness and coherency if compulsive action and free action overlap. The second issue arises in the context of the relationship between compulsion, responsibility, and blameworthiness. What partly motivates our intuitions about the incompatibility of compulsion and freedom is that compelled actions, all things being equal, make us ineligible for blame. If being psychologically compelled does *not* explain why we might excuse or exempt someone, then we must either cite some other reason for exemption or we must accept that they are as blameworthy as anyone else. I conclude with a discussion of how a nuanced conception of 'difficulty' regarding resisting compulsions should focus on the role of dysfunctional beliefs.

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Moral Responsibility: A Spectrum and Where Drug Addiction Fits In

Christina Weinbaum

There have been two troubling categorizations of individuals with a drug addiction that have only perpetuated harmful stigma. The brain disease model of addiction paints a picture of addicts as fundamentally irrational slaves to a disease. On the other hand, the moral model of addiction takes addicts to be willing agents who consistently make the choice to seek and use drugs despite negative consequences and thus their character is subject to condemnation. Both categorizations have negative implications for moral responsibility that are harmful to addicts and fail to capture the nuances of choice and responsibility in cases of addiction. I am especially troubled by the moral model because of its role in criminal law. In order to address this problem, I begin with a discussion of Hannah Pickard's approach where she suggests that we can holdindividuals suffering from addiction responsible for their actions without blaming them for the harm they have done to themselves or to others. This approach removes the moral aspect from responsibility which I can appreciate because it is compassionate and encourages an interest in care for those suffering from a grave mental illness. However,

for the purposes of criminal justice I do not believe it is entirely realistic to remove the moral aspect from responsibility. Rather, what I believe is that we should reframe our understanding of moral responsibility such that blame does not have to be a source of shame or guilt. For these reasons I champion Gideon Yaffe's burden-based excuse approach to addiction in which an individual's control is not completely diminished yet they face a terrible burden as a result of their condition that undermines control. Additionally, I argue that moral responsibility should be treated as a spectrum rather than a dichotomy. Individuals with a drug addiction can and should be held morally responsible for their actions to a degree that is dependent on the psychological and physiological effects of addiction that limit control and impede on one's capacity to reason. I believe that if criminal law were to hold individuals morally responsible through a burden-based excuse approach that takes moral responsibility to be a spectrum we would see people suffering from an illness treated more compassionately, and their character would not be slandered.

Additionally, this approach can help move us toward stronger advocacy for rehabilitation and treatment options for those suffering from addiction. No due diligence can be done by putting millions of people in prison and failing to treat the mental health issues of most of them.

Session 5: Sunday

Taxonomy is Taxidermy. Thinking Clearly About Diagnostic Kinds

Natalia Washington

Scientific clinical psychiatry has multiple, overlapping explanatory goals, just one of which is to classify individuals according to diagnostic categories. Unfortunately, diagnostic discrimination—the process of grouping patients together in epistemically helpful ways—has been a source of consternation in recent history, as we learn more about the degree to which salient psychiatric phenomena are dependent on contingent elements of our physical and social environments (Tabb, 2014). Most agree that culture has some influence on mental illness—the disagreement concerns how much impact there is and what to make of it. Meanwhile, new diagnostic labels are emerging to cover newly salient ways of suffering in the 21st century. Take for example, hikkikomori, sometimes translated as 'shut-in syndrome' or 'acute social withdrawal' (lit. "pulling inward, being confined"), a condition in which individuals seek 'extreme' degrees of social isolation and confinement, in some cases remaining isolated in their bedrooms for years at a time (Saito, 2012). While hikkikomori has been a clinical diagnosis in Japan since at least 2015 (Teo et al., 2015), the label has functioned as a social identity taken on by individuals for much longer (Conti, 2019). Both the timescale and the locality of this phenomenon raise old questions about the universality of psychiatric diagnoses and whether the underlying disease entities qualify as natural kinds (not to mention whether such entities exist).

In this paper, I attempt to clear some territory by addressing two interrelated questions: What kinds of things are diagnostic kinds? and, Which labels belong in a psychiatric nosology and what inferences can we legitimately draw from their inclusion? Answering these two questions involves both addressing the long-running conceptual debate about the nature of mental disorders, as well as clear-headed, pragmatic thinking about what we want from a diagnostic document like the DSM. In answer to the first question, I will argue that diagnostic kinds are extended kinds—that they are real, and that their unique characters are partially and differentially determined by the cultural practices surrounding them. Making this argument requires, first, understanding how and why the recent quest to validate DSM diagnoses has failed. After covering this history, I next follow the work of Ron Mallon on the social construction of extended kinds and argue that diagnostic categories are kinds of this sort, albeit ones that change more quickly than some of his archetypal examples.

Of course, dependence on contingent social circumstance invites a worry about the stability of diagnostic categories, and our ability to latch onto them for the purpose of objective, empirical research—I call this the shifting sands problem. In answer to this problem, I argue that the radicality of the extended kinds thesis is only apparent, and that the variable nature of diagnostic categories is actually beneficial when we consider the multiple goals we need our nosology to serve. In fact, pluralism about diagnostic kinds—allowing different diagnostic categories to have different metaphysical grounds—can alleviate an age-old pressure to provide a taxonomy of mental disorders as a homogeneous kind. Thus, in answer to the second question, I argue that we should be prudential pluralists about diagnostic kinds. Further, it will turn out that this makes clinical psychiatry more similar to, and not distant from or inferior to the rest of medical practice. Just as influenza, breast cancer, and metatarsalgia

(inflammation and pain the ball of the foot) all have different etiologies but are equally fine diagnoses in the domain of physical medicine, so too can Autism Spectrum Disorder, schizophrenia, and Major Depressive Disorder peaceably co-exist.

Reactivity in Psychiatric Classification: Resolving Tensions between Incomparability, Instability, and Legitimacy

Rosa Runhardt

In cases of reactivity, psychiatric classification affects individuals' attitudes and behaviour to such an extent that measurement results are also affected. In severe cases, reactivity consists of the individual's reinterpreting of some of the terms involved in the classification or of recalibrating their own position relative to others. For example, a research subject may gain self-knowledge about their mental health during an initial take-in interview, and therefore report a different level of e.g. some depressive symptom in a second interview. Such reactivity can interfere with the study of psychiatric interventions: to what extent can we blame the decrease in depressive symptoms on some intervention of interest, and to what extent ought we to blame it on reactivity? Moreover, reactivity problematizes comparing different measurement results and is a potential threat to the stability of objects of classification in psychiatry (cf. Hacking 1999; Tsou 2019).

While reactivity is thus often seen as an effect to control for, in this paper I will argue that for certain types of mental disorders, reactivity is nevertheless *legitimate*, by which I mean that it does not undermine the accuracy of the measure. Specifically, research subjects' reinterpreting and recalibrating is legitimate for those disorders which are not constituted or caused by simple biological regularities, but which instead combine social and biological aspects. Unlike in the measurement of concepts that have a clear one-on-one correspondence with a biological phenomenon, there is no single correct way to conceptualize such 'mixed' mental disorders, and so a reinterpretation or recalibration may be no less accurate, as long as it respects the biological constraints that do exist.

In the first part of the paper, I briefly recap the key arguments for asserting that mental disorders such as depression are indeed not reducible to simple biological regularities (cf. Horwitz 2014; Kendler, Zachar & Craver 2011). I then show that for such disorders, there is room for a research subject to reinterpret or recalibrate accompanying concepts, and provide a framework for classifying types of reactivity. I illustrate this framework with a recent study of reactivity (Marsay et al. 2018). While reactivity may be legitimate, this does not mean its threats to comparability and stability are defused. Researchers can only make strong inferences, e.g. about what happened under an intervention, if they discover whether reactivity has occurred. Therefore, in the second part of the paper I start an inventory of how researchers may break apart legitimate reactive effects on the one hand and biological changes under intervention on the other. I end the paper by discussing the stability of mental disorders, arguing (following Jonathan Tsou) that mental disorder concepts allow for prediction and intervention even under legitimate reactivity exactly because of the biological mechanisms that underly them (cf. Tsou 2019).

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Doctor Knows Me Best? A Philosophical Examination Of Epistemic Privilege In Psychiatry

Katherine Rickus

There is a question of particular interest to clinicians seeking to understand the emotions of their clients: is there a philosophical justification for, say, a psychiatrist to reasonably question a client's first-person ascription

of their own emotional states?

Consider the following two set of intuitions from folk psychology: firstly, the assumed transparency of emotional states to the first person. For example "If I think I am happy, then I'm happy!" We might call this the "Infallibility Hypothesis", which says that I don't misrecognize my emotional states, they present themselves to me as they are, and I recognize them as being what they are. I can't be happy and fail to recognize it, nor can I be happy and be wrong about my happiness. I have privileged access to the best evidence on which assertions about emotions are based – my feelings, my bodily experiences, say. It assumes that introspection is direct, self-intimating, and epistemically privileged in the first-person.

The second intuition is about the assumed authority of the first person perspective over the third. For example – if I think I happy, who are you to tell me otherwise? This is the "Incorrigibility Hypothesis": you can misrecognize my emotional states, but I can't. So you can think I am happy, but I can assert, sincerely and on authority, that I am not what I seem. And you are in no position to tell me otherwise. This is because you don't have the right evidence for making a judgement about my emotions, because my internal experiences are the best evidence. You aren't in the privileged position when it comes to reporting them, but I am.

Can a clinically-trained third party have an epistemically privileged perspective on my emotional states? Perhaps in a therapeutic counselling relationship we would like to preserve this privilege, although on reflection, we might also want to have robust justifications for doing so, given the intuitive appeal of the "Incorrigibility Hypothesis". I propose that we can argue for such epistemic privilege for clinicians, by way of arguments against the Infallibility and Incorrigibility hypotheses. This paper takes up the matter of how disparate subjective and objective perspectives on a client's experiences can be reconciled in a clinical setting or in a counseling relationship. The experiences under discussion are emotional experiences, although there are many aspects of introspection and symptomatology to which the framework suggested here can be applied.

I argue against the two intuitions about self-knowledge, in particular, against incorrigibility, of knowledge of one's own emotional states. I argue that there are certain epistemic liabilities that we suffer with respect to knowing emotions in the first person, and that there are asymmetries between the knowledge of emotion that we can acquire in the first person and from the third person perspective. I apply the understanding of these epistemic asymmetries to the clinical therapeutic relationship and give a philosophical rationale for facilitating and developing emotional self-understanding and self-ascription in a clinical context, whilst examining the nature of professional expertise in psychiatry.

Session 6: Sunday

Obsessive-Compulsive Disorder and Recalcitrant Emotion: Relocating the Seat of Irrationality

Somogy Varga

Obsessive–compulsive disorder (OCD) is a relatively common and in many cases debilitating condition characterized by recurrent, anxiety-evoking thoughts (obsessions) and compulsive behaviors (Markarian et al., 2020; DSM-5, 2013). It is widely agreed that OCD involves irrationality. Indeed, in most cases, OCD patients themselves recognize that there is something irrational about their state of mind. However, rather than protecting patients from the substantial emotional distress and impairment caused by their irrational state, this insight into their own irrationality often contributes to the disturbing and bewildering experience of the condition.

But where in the complex of states and processes that constitutes OCD is this irrationality be located? A pervasive assumption in both the psychiatric and philosophical literature is that the seat of irrationality is located in the *obsessive thoughts* characteristic of OCD. For example, according to this assumption, an OCD sufferer might be considered irrational in thinking that her hands are contaminated, or in thinking that her house might burn down unless she flicks the light switch some particular number of times.

We challenge this common assumption and propose an alternative. Our challenge builds on a recent puzzle posed by Evan Taylor (2020), arising from the common phenomenon of *insight* into one's own OCD. Insight can take two forms: "world-directed insight" in the form of knowledge that one's own obsessive thoughts are *false*; and "self-directed insight" in the form of knowledge that one's own obsessive thoughts are *irrational*. However, as Taylor shows, none of the candidate theories about the nature of obsessive thoughts allow these thoughts to be the object of both kinds of insight. In light of this, we argue that it is a mistake to assume that both kinds of insight take the same object. While world-directed insight

is indeed a matter of knowing that one's obsessive thoughts are false, we argue that self-directed insight into one's own irrationality does not take obsessive thoughts as its object. In other words, the irrationality associated with OCD should not be located in obsessive thoughts, but elsewhere.

Where, then? We propose to locate the irrationality of OCD in the *emotions* that are characteristic of OCD, such as anxiety or fear. In particular, we propose to understand the irrationality of OCD as a matter of harboring *recalcitrant emotions*, i.e. emotions that endure in spite of standing in a tension or conflict with one's own considered judgments. For example, an OCD sufferer who is obsessed with the cleanliness of her hands is not irrational in virtue of having thoughts about her hands being contaminated, but rather in virtue of experiencing anxiety about her hands being contaminated in spite of her considered judgment that they are not. We argue that this account not only solves Taylor's puzzle about insight, but also makes better sense of how OCD sufferers experience and describe their condition, as well as helps explain some otherwise puzzling cognitive processes and patterns of behavior associated with OCD.

Here is how we will proceed. First, we describe the diagnostic criteria for OCD and an illustrative case. We introduce the phenomenon of insight and discuss Taylor's puzzle, leading us to the conclusion that we should abandon the assumption that self-directed insight takes obsessive thoughts as its object. Then, we describe our main proposal, namely, that the irrationality associated with OCD should be located in recalcitrant emotions. In the final part of the talk, we explore some further theoretical and therapeutic implications of this proposal for our understanding of OCD.

Less Than Whole: Implications of Reduced Agency of Individuals with Psychiatric Disorders

Kathryn Petrozzo

Individuals with psychiatric diagnoses are typically characterized as "less than full agents," which in turn, mitigates their responsibility for their actions. Consider the hypothetical case of Fred, who is suffering from severe bipolar disorder and borderline personality disorder which affects his ability to thoughtfully reason through his decision-making process, and, the subsequent consequences of his actions. During a bout of mania, Fred is experiencing hallucinations from days of sleep deprivation and sees a 6-foot orange rolling around his kitchen. In a panic, he pulls out his gun and shoots the orange to stop it from rolling. In fact, the orange was his neighbor who was concerned about Fred and came over to check on him. It is clear in this case that Fred was not fully responsible for his actions due to his condition. But, his actions produced harmful consequences and in the scope of the legal system, he still must be held legally accountable. There is no useful term in the literature that captures how to best discuss this kind of deficit other than referring to individuals as less than fully agential, having 'reduced' agency, or as often happens, equating persons with psychiatric disorders to young children or even non-human animals.

This has problematic implications in how these individuals are treated in the clinic, courtroom, and beyond. Chiefly, how these conceptualizations lead to stigmatization and improper treatment in the legal system. Certain prominent accounts push for psychiatric diagnosis to be a special marker of reduced agential status, and thus, reduced responsibility. Yet, these accounts do not take into consideration what is often the practical outcome: while there is a particular intuition amongst laypeople, scholars, and legal counsel that reduced responsibility should be a mitigating factor, it is often the case that reduced agency is an aggravating factor. This has been demonstrated in many studies examining the effect of psychiatric diagnosis when it comes to sentencing (cf: Berkman, (1989); Fluent & Guyer, (2006); Hall et al. (2019); Miley, L. et. al, (2020)). Unlike the rigorous standards in place for those who we consider "full agents," or in other words, individuals who are capable of fully understanding their actions, it is evident there are no comparable set practices for "punishing" those we consider not culpable due to a mental disorder. The threshold of "committing an individual until they're deemed safe to return to the public" is an arbitrary, vague standard. Moreover, this justifies potentially unwarranted paternalistic intervention by characterizing individuals with psychiatric diagnoses as violent, unstable, and unable to make proper decisions regarding their care.

In this paper, I argue that perpetuating the notion that those with psychiatric diagnoses are lesser agents leads to harmful practical consequences that reach beyond the realm of academia. When theorists put forth the notion that an individual is less than an agent due to their psychiatric diagnosis, they are making an evaluative claim. This suggests that theorists take on special responsibilities when making such evaluative claims. I aim to demonstrate that philosophers should take greater care in labeling practices for these groups, as characterizations of psychiatric disorders have

pragmatic, often detrimental, effects in legal, clinical, and social settings. I will conclude with a positive account on how to best reconceptualize agency and suggestions for moving towards punishment reform when it comes to individuals with psychiatric disorders.

Karl Jaspers Awards: 2021 and 2022

The Standpoint of the Psychopathologized and the Threat of Hermeneutical Ignorance in Psychiatry

Bennett Knox

This project brings together considerations from philosophical work on standpoint epistemology, feminist philosophy of science, and epistemic injustice to examine a particular problem facing contemporary psychiatry: the conflict between the conceptual resources of psychiatric medicine and alternative conceptualizations like those of the neurodiversity movement and psychiatric abolitionism. I argue that resistance to fully considering such alternative conceptualizations in processes such as the revision of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* emerges in part from a particular form of epistemic injustice (hermeneutical ignorance) leveled against a particular social group (which I call the "psychopathologized"). Further, insofar as the objectivity which psychiatry should aspire to is a kind of "social objectivity" which requires incorporation of various normative perspectives, this particular form of epistemic injustice threatens to undermine its scientific objectivity. Though I can provide only a limited argument for embracing the social objectivity model in psychiatry in this context, my main goal is to show fellow proponents of social objectivity that the particular kind of hermeneutical ignorance I describe presents an important obstacle to achieving it in psychiatry.

My argument proceeds as follows: First I give some reasons why I believe social objectivity is a proper desideratum for psychiatry and the DSM. Next I introduce my term "psychopathologized," and argue that this community fulfills criteria to qualify as having the kind of marginalized standpoint discussed in standpoint epistemology. Then I explain how this relates to epistemic injustice, and particularly how exclusion of this community from psychiatric science can stem from hermeneutical ignorance. Bringing the pieces together, I argue that exclusion of the psychopathologized stemming from hermeneutical injustice threatens to undermine social objectivity, and explore some implications of this view.

Though my analysis draws from seemingly disparate areas of philosophy of science and social epistemology, part of my goal is to show how these concepts are interrelated in this particular case. The psychopathologized, conceived of as a marginalized social group with a particular epistemic standpoint, have unique experiences which may cause them to develop alternative conceptualizations of the psychiatric domain. These alternative conceptualizations sometimes go directly against mainstream psychiatric conceptualizations, and as a result of hermeneutical ignorance there may be powerful resistance to taking these alternatives seriously by psychiatrists, including those with power over the DSM revision process. If this hermeneutical ignorance results in the psychopathologized (or just the most radical among them) not having their criticism seriously considered in the DSM revision process, then that process will fail to achieve the kind of social objectivity that it must aspire to if it is to be objective at all.

The upshot of my analysis is that meaningful inclusion of those I call the "psychopathologized" in the revision process of the DSM is essential in order for psychiatry to achieve scientific objectivity. And this must include consideration of viewpoints which radically differ from those of mainstream psychiatrists—such as those of neurodiversity activists and psychiatric abolitionists. Furthermore, my argument implies that inclusion of the psychopathologized cannot be limited to extrascientific" aspects of the DSM revision process, and that the psychopathologized must be deeply integrated into the process, in a manner that reflects real power to shape its outcomes. Though many questions regarding implementation remain, I hold that psychiatry must grapple substantively with radical reconceptualizations of its domain if it is to achieve legitimate scientific objectivity.

Specific Phobia is an Ideal Psychiatric Kind

Alexander Pereira

Philosophers and clinicians often ask whether mental disorders are, or can be, natural kinds. I want to focus on a different question: which kinds of mental disorder (if any) are natural? This "which" question is important partly because it is concerned with solving practical

problems: asking which mental disorders are natural kinds helps clarify which of our current diagnoses are trustworthy, and which might need radical revision. It also switches focus from abstract theorising about a philosophical term-of-art to some interesting questions at the intersect of philosophy and psychiatry. For example, how can stable kinds of mental disorder crystallise out of complex interactions between biology, psychology, and society? and, what would a natural kind of mental disorder actually look like?

In this talk I argue that specific phobia is psychiatry's best bet at a natural kind of mental disorder. I claim that specific phobia springs from a broad type of fear dysregulation and I put forward a general account of phobia that employs a mixture of biological, psychological, and social causal factors. If phobia is a natural kind, it is one pitched at a higher explanatory level than genes and brain circuits. By sketching specific phobia as a natural kind I aim to address the questions above, and to demonstrate how natural kind concepts can help us make sense of mental illness.

Finally, I think specific phobia shows how a scientific program of psychiatry – an attempt to understand, investigate, and treat mental distress using the techniques of science and medicine – can go right. Whether it will go right in general is unclear. Perhaps specific phobia is a special case.

Session 7: Sunday

Mental Disorders are Dispositions:

Jonathan Fuller

What are mental disorders? Are they causal networks? Pathophysiological processes? Or, because they are diagnosed through behavioral and symptomatic criteria, are they syndromes: constellations of observable clinical features? A syndromic account would sharply distinguish mental disorders from diseases outside of psychiatry because diseases, as specific pathological entities, are syndromes. In fact, the identification of a syndrome is often an early stage in the discovery of disease. Thus, a syndromic view could reinforce the idea that psychiatry is an immature science.

Against the syndromic view – and drawing from recent work on the metaphysics of disease – I'll argue that mental disorders are dispositions, just like many chronic diseases are. Dispositions are realizable properties that are characterized by their characteristic manifestations, or the manifest effects towards which the disposition is disposed. Two paradigm dispositional properties are fragility and malleability. Fragility is the disposition of an object to break under stress/force, while malleability is the disposition of an object to become disformed under stress/force. Dispositions depend for their existence on an enduring 'causal base'. In the case of fragility and malleability, the causal base is whatever atomic microstructure is responsible for the disposition in a given instance.

Chronic diseases are typically dispositions towards physiological manifestations; for instance, diabetes mellitus is a disposition towards hyperglycemia, while asthma is a disposition towards airflow limitation in the small airways. In contrast, mental disorders are dispositions towards the symptoms and behaviors that comprise their diagnostic criteria; for instance, major depressive disorder (MDD) is a disposition towards the symptoms/behaviors that comprise a major depressive episode, while substance use disorder is a disposition towards certain addiction behaviors. By tethering diagnosis to observable manifestations, dispositions allow us to identify a disorder even when we lack good understanding of its causal pathological basis.

The dispositional theory makes better sense of the stickiness of mental disorder diagnoses than does the syndromic view. Mental disorder diagnoses often stick indefinitely to the individual diagnosed. An individual meeting the criteria for MDD or substance use disorder often retains that diagnosis even when symptoms/behaviors relinquish through natural remission or intervention. During a prolonged – sometimes permanent – asymptomatic period, the disorder is said to be 'in remission', 'treated', or 'managed'. Such talk makes less sense if mental disorders are syndromes; it rather suggests that the diagnosis points to a property underlying the syndrome that can persist in an unmanifested state – in other words, to a disposition. Just as an object remains fragile even when it is not broken, an individual still has MDD even when they are not manifesting symptoms.

The assumption that mental disorder diagnoses point towards a stable disposition may not always be true. An object that isn't fragile may still break under unusual stress; and one that is not malleable may still bend under extreme conditions (namely, extreme heat). Analogously, some individuals meeting the diagnostic criteria for a mental disorder may not have a stable disposition. They may instead be under unusual stress or facing extreme conditions. Some of these conditions (general medical conditions, drugs) are excluded by diagnostic criteria. However, it remains possible that some individuals diagnosed with a mental disorder may

not have a disposition grounded in an enduring causal base (such as an irreversible anatomical lesion or stable network of neuronal connectivity).

Finally, the dispositional theory has implications for several important problems in philosophy of psychiatry (to which I'll only gesture here), including psychiatric comorbidity and the distinctness of mental disorders, natural kinds and the projectability of psychiatric categories, nonspecific pathology and the multiple realizability of mental disorders, and the role of psychiatric diagnosis in explaining symptoms/behaviors.

Chronic Disease or Chronic Condition? The Status of Mental Illness

Jack W. Kent Jr.

What sorts of entities are mental illnesses? Many if not most mental illnesses seem to be persistent, so do they qualify as chronic diseases? For that matter, is 'illness' the right name for them, or should we call them diseases, disorders, or conditions? Does our naming have an impact on how we manage mental illness, whether as affected individuals or caregivers? In attempting to answer these questions I follow an approach provided by Jonathan Fuller in his 2018 paper "What are chronic diseases?," although Fuller specifically excludes mental illness from his work. (He does this, he says, to avoid both ontological and terminological issues that would muddy his project – the realist/antirealist debate is far more prominent in the philosophy of mental illness than that of somatic disorders, and, for reasons I discuss below, we are often hesitant to describe mental illness as 'disease'.) In this essay I will review Fuller's approach and then expand his investigation to see how applicable it is to mental disorders. In the process, I will consider whether 'disease' is the most appropriate label for chronic disorders, whether mental or somatic.

Fuller rejects concept analysis (i.e., arguing from definitions of disease) because of the heterogeneity of phenomena doctors wish to describe as disease. Rather, he employs an empirical approach, gathering a set of accepted descriptions of chronic diseases from the medical literature to find what they have in common. From this he defines three common characteristics of chronic diseases: they are intractable properties of a patient that do not remit naturally, that are incurable given current knowledge, and that are either not fatal or else progress slowly, whether by nature or as a result of ameliorative treatment. The chronic diseases that Fuller considers are all somatic, but I will argue that many mental illnesses fit Fuller's profile. To motivate my argument, I will use the example of an individual (call him Holger) who lives with both type 1 diabetes mellitus (T1DM) and major depressive disorder (MDD). I will argue that for Holger MDD resembles T1DM in that both do not remit, are incurable, but can be managed by appropriate therapies; thus, both are chronic conditions by Fuller's definition.

Are they, however, both chronic *diseases*? I will argue that our reluctance to describe mental disorders as diseases – and, to an extent, the controversy over whether mental illnesses even exist – are based on our uncertainty about the role of volition in mental distress. 'Disease' implies lack of volition – thus, given that some infection triggered autoimmune damage to Holger's endocrine pancreas (events beyond his control), his T1DM fits our intuition about disease. His instance of MDD is less clear: we are unsure if the neurotransmitter imbalances addressed by Holger's antidepressant medication are causes or consequences of his depression, and the benefit he has received from cognitive-behavioral psychotherapy suggests that he has some degree of voluntary control over this condition. I will argue, however, that Holger's experience of both MDD and T1DM depend critically on his level of self-care. Either condition could be disabling or fatal, but Holger has considerable agency in determining the outcomes of both.

For this reason, I will endorse describing both MDD and T1DM as chronic conditions rather than diseases, using the more general term to reflect the critical interplay of voluntary and involuntary contributors to the progression of each. I will argue further that highlighting the element of agency in chronic conditions, both mental and somatic, can beneficially reframe approaches to treating these conditions, on the part of affected individuals and caregivers alike.

Policing and the Production of the Mental Health Crisis

Bahar Orang & Suze Berkhout

The past two years has seen a dramatic rise in the visibility of activism surrounding police defunding, particularly in relation to police involvement in situations marked by emotional distress—the so-called "person in crisis" who interfaces with the mental health system. This paper addresses the urgent demands for police abolition that have arisen from a range of scholars, activists, and communities, thinking seriously

about the enmeshments of the police and psychiatry. In particular, we offer an analysis of the "mental health crisis", which police officers and psychiatrists are called upon (by the state) to manage together. In the Toronto context where we work, a mental health crisis frequently leads to incarceration and coercion by police and/or by psychiatrists, as per mental health law. We ask: What happens when we think about a "person in crisis" as a political category, and the invocation of "crisis" as a political process? What kinds of logic make the mental health crisis legible? What, to the police and the ideological apparatuses from which the police extend, does safety mean and to whom is it granted?

We construct a case study of the intersections of policing, psychiatry, and the mental health crisis through a close reading of legal and institutional documents associated with the Toronto police services and the Centre for Addiction and Mental health location in Toronto, and in so doing attempt to disentangle the ideology that underpins and is produced by the state-sanctioned discourse. We begin our analysis by theorizing the "mental health crisis," both by interrogating the concept of crisis itself, and holding this in relation to the social and political philosophy of Sylvia Wynter's "Man-as-Human" framework. In "Unsettling the Coloniality of being/power/truth," Wynter explains that "Man" overrepresents itself "as if it were the human itself" and that this over-representation is the "coloniality of being/power/truth" (2003). In other words, what we understand today to be the human, is just one genre of the human, one descriptive statement of what is meant by the human, which has been and continues to be articulated vis a vis the subordination of those demarcated as Others. We contextualize the "mental health crisis" as a profound threat to Man-as-Human and discuss the essential function of policing in this regard as the policing and preserving of the predominance of Man-as-Human. Alongside Wynter, we think with the mad and Black studies thinker Bruce La Marr Jurelle, who writes about a carceral and colonial modernist "Reason" (2021) that is likewise essential to the construction of the "mental health crisis."

We discuss Jurelle's analysis in relation to critiques of reason from feminist philosophy, demonstrating how Jurelle's work extends these earlier critiques in importantly intersectional ways. Finally, we offer Jurelle's "radical compassion" of his "mad methodology" as a possible alternative to the coercive practices that the mental health crisis understood as such inevitably produces (2021).

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Closing Remarks

Adjourn

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