

# THE ASSOCIATION FOR THE ADVANCEMENT OF PHILOSOPHY & PSYCHIATRY



ANNUAL MEETING 2023 - MAY 20-21 - HILTON UNION SQUARE - SAN FRANCISCO

KNOWLEDGE, EXPERTISE, & VALUES

KEYNOTE SPEAKERS: NANCY POTTER PHD & BRENT KIOUS MD PHD

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## PROGRAM SCHEDULE SUMMARY

San Francisco Hilton Union Square

Program Committee: Douglas Heinrichs, Jennifer Radden, John Z. Sadler

### Saturday, May 20, 2023

8:30 a.m. Welcome - Christian Perring, AAPP President

8:45 - 9:45 a.m. **Claims to knowledge** Moderator: Jeff Bedrick

#### Lecture 1

How can expertise by experience remedy epistemic injustice? The case of concretism  
Pascal Markus Lemmer, Charité Berlin, Jana Tabea Stern

#### Lecture 2

Critiquing values in psychiatry  
Natalia Washington

#### Lecture 3

Utility of perspectivism and epistemic humility in medical student psychiatric education  
Zohaib Haque

9:45 - 10:00 a.m. Discussion

10:00 - 11:00 a.m. **Epistemic injustice** Moderator: Brent Kious

#### Lecture 4

Why should we include people with lived experience in the DSM revision process?  
Ethical and epistemological arguments in tension  
Anne-Marie Gagne-Julien

#### Lecture 5

Who knows? Psychogenic illness and epistemic injustice  
Zach Schwartz

#### Lecture 6

Epistemically compromised? Treatment, justice, and emancipation  
Harriet Fagerberg

11:00 - 11:15 a.m. Discussion

BREAK

11:25 - 12:25 p.m. **Particular psychopathologies** Moderator: Eisuke Sakakibara

Lecture 7

Philosophy and the 2-process model of sleep regulation

Douglas Moul

Lecture 8

Treatment for whom?

Towards a phenomenological resolution of controversy in autism treatment

Themis Pantazakos

Lecture 9

First-person perspectives and scientific inquiry of autism:

Towards an integrative approach

Sarah Arnaud

12:25 - 12:40 p.m. Discussion

12:40 - 2:00 p.m. LUNCH

2:00 - 3:00 p.m. **Perspective epistemology and humility** Moderator: Şerife Tekin

Lecture 10

Patients as experts, participatory sense-making, and relational autonomy

Michelle Maiese

Lecture 11

Hybrid objects, hybrid tensions:

The translatability of explanatory thresholds in early psychosis intervention care

Katherine Lynch

Lecture 12

Towards hermeneutical pluralism in psychiatry

Bennett Knox

3:00 - 3:15 Discussion

BREAK

3:30 - 4:50 p.m. **Keynote Address** Moderator: Doug Heinrichs

Lecture 13

Manic behavior and the place of uptake and other ethico-epistemic practices

Nancy Nyquist Potter

## **Sunday, May 21, 2023**

8:30 a.m. Welcome - Christian Perring, AAPP President

8:45- 9:45 a.m. **Diagnosis and treatment** Moderator: Christian Perring

Lecture 14

Jonathan Fuller

Overdiagnosis in psychiatry: Rethinking 'the loss of sadness'

Lecture 15

Value coordination and patient inclusion for a democratic psychiatry

Aaron Chavez

Lecture 16

Neoliberal subject formation through psychiatric and state management of phenomenologies

Marcus J. Byrd

9:45 - 10:00 a.m. Discussion

10:00 - 11:20 a.m. **Treater expertise** Moderator: Paul Lieberman

Lecture 17

Expertise by empathy

Riana Betzler

Lecture 18

Scoping expertise in psychiatry (An apologist's account)

Katherine Rickus

Lecture 19

Epistemic injustice and the value of distrust

Keyao Yang

Lecture 20

Impact of methodologies of clinical reasoning on epistemic injustice in the clinical encounter

Douglas Heinrichs

11:20 - 11:40 a.m. Discussion

11:40 - 12:40 p.m. LUNCH

12:40 - 2:00 p.m. **Keynote Address** Moderator: John Z. Sadler

Lecture 21

Is it helpful for psychiatrists to worry about epistemic injustice?

Brent Kious

2:00 - 2:45 p.m. **Jaspers Prize Lecture** Moderator: Scott Waterman

Lecture 22

Institution or individuality?

Some reflections on the lessons from personal accounts of recovery from schizophrenia

Rosanna Wannberg

3:00 p.m. Adjournment

## PROGRAM TITLES, AUTHORS, & ABSTRACTS

**Saturday, May 20, 2023**

8:45 - 9:45 a.m. **Claims to knowledge** Moderator: Jeff Bedrick

### Lecture 1

How can expertise by experience remedy epistemic injustice? The case of concretism  
Pascal Markus Lemmer, Charité Berlin, Jana Tabea Stern

The mentally ill suffer many injustices. Some of them have been analysed as epistemic injustice since the term's introduction by Fricker (2007). Particularly vulnerable to being harmed in this way are mentally ill people, also in the domain meant to care for them, psychiatry. Patients diagnosed as psychotic or delusional, for example, are seen as a less credible source of knowledge, even about themselves, and/or unintelligible by psychiatric health care providers (e.g. Ritunnano 2022). This unfair credibility deflation due to negative identity stereotypes refrains psychiatric patients from participating on equal foot in practices of meaning-making and knowledge-production which are integral to psychiatry and patients' well-being (Sanati & Kyratsous 2015). Our talk aims to shed new light on the interdependence of epistemic injustice and the scientific concepts upon which psychiatry draws.

Epistemic injustice in psychiatry is currently mostly sought in clinical encounters, where psychiatric patients' testimony may be deemed less credible than would be justified (Crichton et al. 2017), considered unintelligible unjustly (Ritunnano 2022), or not taken seriously as a means to understand and express themselves (Miller Tate 2019). However, the scientific conceptions underlying clinical tools which may perpetrate such testimonial, hermeneutic, or contributory injustice are scarcely investigated for their epistemic harm. A notable exception is the notion of "user-led research", i.e., research being conducted by people with expertise by experience as emphasized by recent work regarding contributory injustice in psychiatry.

Involving people with expertise by experience, however, is not enough to rectify epistemic injustice in psychiatry. Our analysis shows how epistemic injustice is perpetuated at the level of the scientific reasoning which ostensibly awards psychiatry its epistemic authority. Though epistemic injustices on this level may not be as obvious and hide behind a veil of scientific objectivity, the lack of adequate scientific concepts is a straight-forward case of hermeneutical injustice, which may, for example, mislead psychiatric attempts to make sense of patients' experience and actively cause other forms of epistemic harm (Crichton et al. 2017). Hence, patients' expertise by experience must be taken seriously not only as an expertise about their own condition, but also form the bedrock of scientific concept formation.

This talk aims to demonstrate this for the case of concretism. Concretism is defined as "a general proneness to neglect the figurative meaning" (Rossetti et al., 2018, p. 670) of an utterance in favor of a more literal interpretation and usually associated with psychosis. Assuming that the distinction between figurative and literal speech is already highly problematic and self-undermining on the conceptual level (Lemmer 2022), calling an utterance concretistic is arguably a textbook case of testimonial injustice: patients are not deemed credible epistemic agents because they are considered concretistic. However, such a concept of concretism may not adequately reflect the meaning-making underlying concretism and other forms of psychosis. The resulting hermeneutical injustice makes it possible to erase the epistemic injustice of calling concretism "intrinsic" to patients' impaired cognitive functioning rather than a scientific limitation. Currently discussed remedies for such injustices emphasize the patient's perspective (Crichton et al. 2017), giving a proper uptake to patient organizations and their collectively developed self-understandings (Miller Tate 2019), and developing more collaborative doctor-patient relationships (Ritunnano 2022).

These proposals are certainly not wrong. But they evade the crucial question of how exactly such expertise by experience is incorporated. Since we hold that scientific concepts like concretism can be the perpetrators of epistemic injustice, oftentimes, they themselves have to be adjusted. Only then can expertise by experience not be undermined by epistemic injustice and be awarded the status of scientific experience.

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## Lecture 2

### Critiquing values in psychiatry

Natalia Washington

In this paper I will present a commonly held view about mental health—indeed, one I am disposed to endorse—and then present an apparent dilemma it affords. The view on offer, briefly, is *contextualism* according to which mental health should be understood as *values based psychological flourishing*. Contextualism is consilient with a popular framework in clinical psychiatry known as *values-based practice* (Fulford & Van Staden, 2013). It also, as I have argued previously [redacted], makes sense of the philosopher's notion that prudential goods are *relational goods*. If I enjoy a strong cup of coffee, but the same would hurt your stomach, then we would say of coffee that it is *good for me* but *bad for you*. Similarly, because different people value different things, we might say that a successful academic career makes my life go well (or it contributes to my mental health) but plays a different role in yours. Endorsing a contextualist claim like this is to deny *objectivism* about mental health, according to which a set list of goods plays the same role for everyone (as for example with Aristotelian *eudaimonia*). Of course, it is common practice in therapeutic settings (not to mention in everyday conversations with friends and loved ones) to critique each other's values. Values critique, in the sense I'm interested in, is the practice of making counterfactual claims about how a person would be 'doing better' with a different set of values from the ones that they currently have. For example, consider the medical student who values her career in medicine, but also wants quality time with loved ones, and wants to avoid anxiety or other negative mental states. Because medical school is directly contributing to her tight schedule and lack of sleep, we might be disposed to say something like "I know you care about this, but it's making you miserable. You would be *better off* if you changed careers."

Here, then, is the dilemma. If values based psychological flourishing is *constitutive* of mental health, then a counterfactual claim like the one above seems incoherent. The options on offer: (A) give up contextualism, or (B) give up values critique. Ultimately, I argue that B is the preferable option, but making this argument requires clearing the conceptual territory around cases like these. I short, I believe that the critical intuitions we have about each other's mental health and wellbeing (the proverbial baby in the bathwater) can be saved despite rejecting values critique itself. Nearby counterfactual dependencies that highlight external features of a situation (for example the relationship between hours of sleep and hours in one's shift during residency) serve just as well to underwrite these intuitions. And this is all to the good, since rejecting values critique should encourage epistemic humility in thinking about human being's

diverse ways of valuing and flourishing.

### Lecture 3

#### Utility of perspectivism and epistemic humility in medical student psychiatric education Zohaib Haque

With social media commanding a growing importance in the lives of adolescents and young adults, the benchmarks of healthy and normative social interactions can no longer be taken for granted. The epicenter of friendships are no longer physical, and updating our information of the tectonic shifts in the norms of social communication are demanding that providers acknowledge and address our inadequate understanding of the shifting landscape. It is, therefore, more important than ever to acknowledge perspectivism and epistemic humility as it pertains to our understanding of our patients with further responsibility to acquire this missing information. Accessing, understanding, and harnessing these new digital phenomena takes active collaboration with the students of today whose lived experience reflects the ongoing mental health metamorphosis being influenced by social media, regardless of sphere of positive or negative influence.

Our presentation will focus on the various philosophical utilities of medical students in psychiatric clinical practice. Starting with their inherent ability in helping us acknowledge our perspectives of diagnosis and treatment while illuminating their ability to acknowledge their own perspectives; subsequently, communicating our epistemic humility and providing a space to develop theirs so as to help them grow as future clinicians while strengthening our own skills in the face of novel challenges. Medical students in their clinical clerkship are at the ideal crossroads to dismantle their own patriarchal views while acknowledging the importance of perspectivism in an increasingly divisive and intolerant world. Integrating these discussions into didactic time and fostering ongoing, healthy discourse can positively influence and impact both professor and student, with the ultimate goal being a confluence of both past and present helping guide the mindset of the future mental health practitioner.

Empowering medical students by acknowledging their expertise is integral in displaying the accessibility of our field and taking steps to help provide the most updated care possible. Discussing the power of epistemic humility is not a commonly broached subject during clerkships when more rote academic bullet points are stressed. We will highlight how bilateral cognizance in educational settings can help all parties involved in understanding social media nuances and its effects on trends in the mental health industry, while still adhering to effective tenets of the past.

10:00 - 11:00 a.m. **Epistemic injustice** Moderator: Brent Kious

### Lecture 4

#### Why should we include people with lived experience in the DSM revision process? Ethical and epistemological arguments in tension Anne-Marie Gagne-Julien

In recent years, an increasing number of philosophers of psychiatry have developed arguments for including patients/service users/survivors in psychiatry. This participatory turn has been advocated for (and observed in) care practices, research, and professional institutions (e.g., the DSM revision process and the APA) and have been based on many types of arguments. Recently however, Friesen and colleagues (2019) have argued that at least in participatory research, the epistemological reasons for including people with lived experience may obscure the ethical reasons for this participatory turn. In this paper, I want to generalize this insight by reflecting on how this type of tension between epistemic and ethical benefits of inclusiveness arises within the DSM revision process. I will argue that depending on the arguments philosophers use to defend inclusiveness, different types of inclusiveness follow. This is



important given the growing dissatisfaction expressed by people with lived experience when they are included in different psychiatric structures. To raise philosophers' awareness toward this potential problem, my argument will be threefold.

First, I will look at the DSM revision process and at how people with lived experience have been included. This analysis will yield a first result: the DSM's position on the inclusiveness of "patients" is unclear and merges the epistemic and ethical benefits of including people with lived experience. Moreover, the DSM is not sensitive to the difference between people with lived experience and what they call "the public" (e.g., APA 2013, p. 6).

Second, I will review the different types of arguments that have been offered to justify a more inclusive review process. I will propose a non-exhaustive taxonomy of three types of arguments: 1) The objectivity arguments (e.g., Gagné-Julien 2021a, b; Tekin 2022) 2) the social justice/democratic arguments (e.g., Sadler and Fulford 2004; Sisti and Johnson 2015) and 3) the epistemic justice arguments (e.g., Bueter 2019; Knox 2022). The social objectivity argument states that maximizing the diversity of perspectives is the best way to uncover possible biases in our categories, and thus to improve knowledge about these categories. People with lived experience having different perspectives, their viewpoints should be actively looked for. The social justice argument says that since diagnostic categories impact public policies, these categories should reflect the values of those affected. Inclusivity of people with lived experience is the best way to have access to their needs and interests. The epistemic justice argument holds that since there are good epistemic reasons to consider patients' testimony during the revision of the DSM, but that this testimony is not actively sought, the DSM commits an epistemic injustice. For better epistemic justice, the DSM should include people with lived experience's perspectives.

Finally, I will argue that while these different arguments all ask for better inclusiveness in the DSM revision process, depending on the type of argument one adheres to, different practices of inclusion should be put in place (e.g., representativity in work groups vs. external consultation) and different types of lived experience should be looked for (e.g., experience of oppression vs. phenomenological experience of distress). So far however, we do not have overarching principles to prioritize one argument for inclusivity over another, and therefore no uncontroversial prescription over what the appropriate form of inclusiveness in this context should be. In the end, what this discussion will show is that ethical and epistemological reasons for participation are important to disentangle. This is so because, building on Friesen and colleagues, confusion about the form of inclusiveness that we are looking for can result in role confusion, tokenism, and experience of not being heard/not feeling useful for individuals with lived experience included in the process.

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## Lecture 5

### Who knows? Psychogenic illness and epistemic injustice

Zach Schwartz

There has been growing interest in epistemic injustice (EI) as this concept relates to medicine and psychiatry. Many purported cases of EI in medicine concern instances in which somatic symptoms have been wrongly attributed to psychological causes. (Kidd & Carel, 2017). Yet, curiously, little attention has been paid to EI specifically as it relates to psychogenic illness. To put the question directly: when are healthcare providers epistemically justified in attributing the symptoms of patients to psychological causes, even where this goes against the beliefs of patients themselves?

Any answer to this question must begin with an examination of the relevant concepts. EI and subtypes of EI like testimonial injustice (TI) have been adequately defined and elaborated elsewhere (Fricker, 2007). The concept of psychogenic illness, on the other hand, could likely benefit from greater philosophical scrutiny. While psychogenic illness can be generally defined as any illness in which mental states (“psycho-”) play an etiological role (“-genic”) in the development or perpetuation of symptoms, the boundaries of this category are fuzzier than they may first appear. There have been various attempts over the past century to revise the terminology of psychogenic illness—from “hysteria” to “conversion disorder” to “functional neurological disorder” and “psychogenic non-epileptic seizures”—but these changes have done little to bring the underlying concept into focus.

Nevertheless, in the practice of medicine, the diagnosis of psychogenic illness is common and can lead to significant conflicts between patients and healthcare providers. Healthcare providers have been accused of EI/TI where, for example, “psychogenic diagnosis challenges the veracity of a patient’s assessments of her own psychosocial well-being” (O’Leary, 2018). Though I agree there is cause for concern here, I think the case for EI/TI, as it is typically framed, is misleading. Patients certainly have epistemic authority over their own first-person experience of symptoms, but this authority does not necessarily extend to the *causes* of those symptoms. About such causes a patient may simply be wrong, where the doctor is right. The proposition that EI/TI has occurred whenever healthcare providers do not concur with patients’ beliefs about the causes of their symptoms or assessments of their own well-being is clearly untenable.

At the same time, we ought to acknowledge that there is something peculiar, epistemically speaking, about psychogenic diagnosis. Psychogenic illnesses appear similar to many common psychiatric disorders in that the diagnosis cannot be confirmed by laboratory or imaging studies; the skilled clinician must, instead, gradually increase the certainty of their hypothesis by eliciting symptom patterns. However, unlike with other symptom-based psychiatric diagnoses—which since DSM-III have been intended as merely descriptive, etiologically agnostic categories—psychogenic diagnosis entails a non-trivial supposition about mental causation. It is not clear that healthcare providers have any special expertise regarding these supposed mental causes, even though they may be quite skilled in recognizing associated symptoms patterns.

I suspect this issue is at the root of many conflicts involving psychogenic diagnosis. It is not clear that either patients or healthcare providers have the epistemic authority to settle disputes about the role of specifically mental causes in generating physical symptoms. Rather than a case of EI/TI, where one party who “knows better” overlooks the testimony of another party who actually knows better, this may be a situation where, simply, nobody knows. Because I don’t think this epistemological quandary is likely to be resolved anytime soon, I will conclude with some practical recommendations to minimize patient-provider conflicts around psychogenic diagnosis.

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## Lecture 6

### Epistemically compromised? Treatment, justice, and emancipation

Harriet Fagerberg

It is often argued that mental health service users stand in a privileged epistemic relation to their conditions. This paper considers the opposite phenomenon: when mental health service users stand (to some extent or in some respects) in a compromised or impoverished epistemic relation to their own conditions. I call this being ‘epistemically compromised’. This paper explored this phenomenon, and considers three implications for treatment, epistemic justice and the scope for emancipation. I first present the puzzle (1). We rightly want to recognise the special epistemic insights which service users have. This is necessary in order to avoid epistemic injustice, and in ensuring that we adequately respect the person as an agent and full participant in their own treatment trajectory. On the other hand, there are also cases in which the nature of the condition itself is such that those experiencing it lack ‘insight’, experience disorder-specific epistemic blind spots, or otherwise are prevented from forming relevant true beliefs. Recognising the latter phenomenon does not negate the former, but it does raise some *prima facie* issues as to how the two truths may be adequately and appropriately reconciled.

In section 2, I present a case study of this phenomenon. Body dysmorphic disorder (BDD) is a mental health condition characterised by a “preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others” (American Psychiatric Association, 2013). In other words, BDD involves false beliefs about the state of affairs – in particular, the person’s own physical traits and, often, the reactions and beliefs of others. People with BDD are often strongly committed to their false beliefs, and find it very difficult, even impossible, to accept that what they perceive is not there in reality or is not perceivable by others (Khalidi & McKinnon, forthcoming). There are as such facts of crucial importance to the person experiencing BDD that *others* can readily come to know on the basis of the available evidence, but that the person with BDD is (almost by definition) unable to grasp. In this sense, those with BDD stand in a uniquely epistemically compromised position in relation to their own mental health condition.

In section 3, I explore three possible implications of being epistemically compromised. First, I make the case that being epistemically compromised often reverberates through the person’s life in far-reaching, complex ways, and may as such have impacts well beyond the specific blind spots entailed by the disorder. On this basis, I suggest that disorders characterised by epistemic anomalies of this kind make unlikely bases for positive and emancipatory group identifications, and thus are often left out of this discourse. Finally, I consider the implications for treatment. When the condition involves severe epistemic errors or blind spots, correcting these often becomes a focus of therapy. I argue that the epistemically compromised as still subjected to an epistemic *harm* when their narratives, self-perceptions and testimony are undermined, questioned and discounted in the course of psychotherapy – even if it does not qualify as an epistemic *injustice* (see Carel & Kidd, 2017). This epistemic harm should be named and acknowledged in the course of treatment.

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American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

11:25 - 12:25 p.m. **Particular psychopathologies** Moderator: Eisuke Sakakibara

## Lecture 7

### Philosophy and the 2-process model of sleep regulation for patients

Douglas Moul

Psychiatric clinicians treat sleep problems, and psychiatry is a part of sleep medicine. In sleep medicine, the two-process model of sleep regulation initially proposed by Borbély is the long-established, empirically-validated functional theoretical construct, and now has been securely linked to the neurophysiologies of particular anterior hypothalamic nuclei. Process S (for "Sleep") describes the gradual build-up of sleep pressure from the time of wakeup, which is progressively diminished from later sleep onset forward through the sleep bout. Caffeine is an antagonist of this process. Process C (for "Circadian") describes the pattern of sleepiness that is separately governed by the circadian system. Ocular light exposure mainly regulates Process C timing. Clinical competency as a sleep clinician is strongly determined by how a practitioner uses it in the conceptualization of a patient's sleep complaints. As examples, the advice for patients with insomnia to avoid taking afternoon naps is based on an understanding of Process S, and advice about managing jet lag is based on an understanding of Process C.

The 2-process model is usually conceptualized quantitatively, which may be rendered graphically as though the processes are instead "static" subjunctive structures. Considering this graphically subjunctive treatment then suggests that a clinician's conceptual task in treating individual patients in the clinic is to consider these process structures dynamically alongside the other processes (e.g. medical, psychological) at play for individual patients' or clients' sleep. Hence, in the clinical encounter, the clinician is asked to reason quickly about many fluid supposals based on the alethic weights of various causal considerations in the context of the 2-process model.

As an additional part of the dialectical clinical complexity, these two processes are latent, implicating the notion that "sleep" as commonly referred to by laymen is, ironically, logically a meta-language reference to biological sleep. The correlative Non-REM and REM sleeps are the object-language sleeps to which the 2 processes correspond. So there is also a dialectics in the level of discussion about "sleep"! The mention of these two processes and kinds of sleep may conflict with some patients' notions that general sleep instead be theorized as unitary: Patients often take the Hegelian view of "quality." Many patients care more about their sense of sleep quality, irrespective of sleep length, timing, or other contingencies, and they may not be adept at comprehending latent constructs of their own functioning. In the clinical encounter, the clinician is then tasked with finding a way to explain sleep as part of the advice-giving, but in a way that the patient or client can understand and accept, while addressing the biological complexities in an honest way.

Since sleep processes are parts of consciousness and an appropriate concern of psychiatric clinicians, the 2-process model of sleep regulation is of theoretical and practical relevance to the philosophy of psychiatric practice, but also to the philosophy of mind to which it is related. The mind and the self can be influenced by temporal contingencies and interventions. Medications and psychotherapies to improve or inhibit general sleep relate to the two-process model, but their mutual philosophical integration remains underdeveloped. Sleep medicine trainees currently benefit from considerations of how the 2-process model relates to archetypal clinical scenarios, but without much formal philosophical education. Perhaps in the future more formal philosophical analysis of the 2-process model may improve ways to translate clinical intervention theories into rationales for patients that will be more accurate, understandable, and safe.

## Lecture 8

### Treatment for whom?

#### Towards a phenomenological resolution of controversy in autism treatment

Themis Pantazakos

Autism spectrum disorder (ASD) now records a prevalence rate of 1:68 in North America, with similar figures for the rest of the western world (Xu et al. 2019). Applied behaviour analysis (ABA) is by far the most dominant method of treatment, professing to decrease the frequency of harmful behaviour (e.g., tantrums) and increase the frequency of pro-social behaviour (e.g., hygienic habits, communication skills) in diagnosed individuals. ABA has become sovereign among ASD treatment approaches for, as I argue in this paper, several reasons. First, it deals in rigorously defined programs of intervention and outcomes that are easy to measure, which fits very well with the contemporary evidence-based turn in medicine. Second, ABA entertains the demands of health insurance agencies for treatments that are composed of a preordained number of sessions, on which a cost estimation can be easily attached. Third, it came about during the 1960s-70s, in an era when individuals diagnosed with autism were condemned to a life of institutionalization, often involving 24h restraint and overall abandonment. Breaking away from this state of affairs, ABA was the first organized endeavour to actually engage with such individuals and offer some way of social re-integration. Fourth, it indeed delivers well-evidenced results, albeit often in purely behavioural terms.

ABA is known to be at the heart of one of the most heated controversies surrounding ASD communities (Pantazakos 2019; Chapman and Bovell 2022). Numerous neurodiversity activists, diagnosed with ASD and not, have maintained that ABA frequently violates patients' self-determination, autonomous pursuit of a desired life, and even their basic human rights. They also uphold that ABA's results are mostly or exclusively useful to those who benefit from the behavioural normalization of individuals diagnosed with ASD, or their neurologically typical peers and society at large.

In this paper, I fuse testimony of individuals diagnosed with ASD and discourse of neurodiversity political movements with recent cognitive neuroscientific research on ASD to argue that, first and foremost, treating ASD plainly as a 'package' of behaviours different to the typical is, to say the least, extremely superficial. Individuals diagnosed with ASD experience the world in a way that can be dramatically different to its neurologically typical equivalent, these differences cutting much deeper than the behavioural level. For such individuals, the world is often individuated and made sense of, perceived and felt, in a fashion so alternate as to be almost unimaginable for most of the rest of us. This, I argue, is consequential as regards what constitutes a happy life worth living. The assumption that the things that make a neurologically typical person, by and large, happy (e.g., a vibrant social life) are the same things that will make an individual diagnosed with ASD happy, is erroneous, the related divergence deeply rooted in first-person experience. Therefore, ABA materializations that commit this mistake indeed violate the patient's pursuit of their own conception of happiness, and ABA in general is a treatment method that leaves unaddressed the part of ASD that does not relate to behaviour but is constitutive of a structurally varied life experience.

I employ Edmund Husserl's phenomenological concept of the life-world (*lebenswelt*) and use it as an analytical tool to capture differences between the autistic and neurologically typical lived experience. Bearing in mind that all autistic life-worlds are in all likelihood not the same, this endeavour is a pluralist, outlining a manifold autistic life-worlds. I attempt to delineate autistic phenomenological differences across five axes: ontological (what there is); metaphysical (how it relates); semiotic (what it means); emotional (how it feels); self-referential (how the embodied self as being-in-the-world navigates reality). Besides utilizing conceptual resources from phenomenology, I also utilize testimony from individuals diagnosed with ASD in the form of interviews, works of art, and political discourse. Invaluable in delineating the autistic life-worlds are also qualitative studies within ASD research, which are gaining prominence within the field, using foremostly interpretative phenomenological analysis to gain insights into the first-person autistic lived experience

(Atherton et al. 2019; Howard, Katsos, and Gibson 2019). Moreover, I refer to cognitive scientific work that aims to provide neuro-phenomenological perspectives on ASD (Narzisi and Muccio 2021).

My ambition for this work is not purely academic, as I aim to connect it with ways of improving ASD treatment, specifically making for practices that are more phenomenologically informed. I investigate approaches alternative to the behavioural that began with a phenomenological imperative (most often cashed out in terms of “making sense from the subject’s own point of view”) and that appeared to be, at least partly, successful (e.g., Sacks 1995). Reading the reports on these cases closely and cross-referencing them with the findings pertinent to the autistic life-worlds, I seek to find out what it was that these endeavours got right about the autistic life-worlds, and how they navigated them in a treatment context. In so doing, I hope to be able to generalize conceptual and methodological principles of therapist-patient communication and treatment orientation, which will serve to make for ASD mental health practice that is both more humanistic and effective.

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## Lecture 9

First-person perspectives and scientific inquiry of autism:

Towards an integrative approach

Sarah Arnaud

There has been increasing interest on the role and importance of first-person perspectives in advances in psychiatry, notably in terms of epistemic authority and privileged epistemic access. The legitimacy of patient voices in scientific research regarding their psychiatric label has been the topic of numerous recent reflections in philosophy and on the ethics of psychiatry. Many facets of this topic can be considered to evaluate the scope of this perspective and assess its repercussions.

One concerns the inclusion of psychiatrized people in the scientific reflections surrounding their diagnoses. This leads to the following question: what are the roles of people with a psychiatric diagnosis in the understanding and descriptions of psychiatric categories? Another important facet—that is related to the first—concerns the role of activism in psychiatry, notably the role of movements that aim at fostering the inclusion and recognition of patients and contest the acts of "pathologizing". This leads to the following questioning: how do these movements contribute to the understanding of psychiatric categories? Is this contribution social or scientific? These two lines of questionings are related to the more general question of epistemic authority, namely whether activism and science are in competition for the understanding of psychiatric categories. I propose to consider these questions here through the

example of autism. Applied to autism, they correspond to the following: (I) what are the roles of autistics' perspectives in the characterization of autism?, (II) how do activism, notably the Neurodiversity movement and Critical Autism Studies, contribute to that characterization? (III) How do they interact with scientific inquiry about autism?

In this presentation, I wish to underline the importance of first-person perspectives in advancing scientific research on autism. I show how it has already considerably increased the validity of the category of autism. I argue that the inclusion of first-person perspectives in research on autism represents a necessary step towards more accurate and scientific knowledge on autism.

To do so, I first question the role that has been attributed to autistic's perspectives on the characterization of autism by considering a debate between Ian Hacking and Kenneth Kendler about the idea that the concept of autism would have been "shaped" by people "personally connected to an autistic person (p-c-a)", rather than science. I consider inherent problems in the debate by pointing a confusion in the term "p-c-a" that reflects an example of epistemic injustice; and an ambiguity in the term "shaping".

I then show how activist movements have been contributing to the current understanding of autism. I consider three influential activist movements –the anti-psychiatry movement, the Neurodiversity movement, and Critical Autism Studies, and I evaluate their epistemic impacts on autism research. I argue that activism and science have been intrinsically related in the shaping of our understanding of autism. Rather than viewing activism and science as incompatible paths that correspond to two distinct conceptualizations of autism, I propose to evaluate their interactions.

Finally, I apply Haslam's conceptualization of validity in psychiatry on the case of autism. I argue that the inclusion of first-person perspectives on autism, one of the main demands of activist movements, constitutes an epistemic gain for the understanding of autism. I show this by giving examples of advancement in autism research that are directly the results of such perspectives. Each of these cases have improved validity in one of its dimensions as identified by Haslam. (1) Content validity, (2) criterion-related validity, and (3) construct validity of the category of autism have been increased through first-person perspectives.

2:00 - 3:00 p.m. **Perspective epistemology and humility** Moderator: Şerife Tekin

## Lecture 10

Patients as experts, participatory sense-making, and relational autonomy

Michelle Maiese

Although practitioners traditionally have been viewed as sole experts and decision-makers, there is increasing awareness that people with mental illnesses have in-depth, intimate knowledge of how their condition impacts their life, which treatments are effective, and what kind of life they want to lead. Arguably, viewing patients' experiential knowledge as a source of expertise in treatment settings allows for a deeper understanding of their unique circumstances and needs. I argue that in addition to these epistemic benefits, regarding patients as experts has important agential benefits insofar as it allows for participatory sense-making to unfold during the therapeutic encounter; this helps patients to be "seen" as epistemic agents and thereby strengthens their ability to exercise autonomy.

What De Jaegher and Di Paolo (2007) term 'participatory sense-making' is a process of collaborative meaning-making in which new understandings can be generated that were not available to each individual on their own. While the participants involved do remain autonomous, separate agents, the relationship that arises between them has its own properties that constrain and modulate their behavior. Through the coordination of intentional activity, the way that each agent understands a situation is mediated and modified via the meaning-making activities of the other participant(s). During this process

of participatory sense-making, preservation of each participant's autonomy involves a mutual recognition of the subjecthood and agency of the other individual (Brancazio 2020); rather than being unidirectional, regulating processes are reciprocal and flow back and forth between the agents.

Effective talk therapy sometimes counts as a striking example of participatory sense-making: by way of bodily resonance and interactive engagement, patient and therapist have an opportunity to develop shared understandings. This can occur, for example, when therapist and patient take "dialogic turns": one person's comment regulates the sense-making and orients the attention of the other participant, and this verbal utterance or gesture "creates and projects a space of meaningful responses, reactions, and rejoinders" for the other agent to take up (Di Paolo et al., 2018, p. 223). By way of multiply authored dialogic fragments, therapist and client jointly regulate their interaction and engage in a collaborative interpretation of the patient's experiences, struggles, and achievements. A myriad of shared, complicit, disputed, and rebutted significances and meanings can emerge in a constantly shifting way over the course of the interpersonal encounter.

I argue that treating a patient's experiential insights as a form of expertise, and as valuable inputs to the process of participatory sense-making in therapeutic settings, is one powerful way to strengthen their epistemic agency (i.e., their capacity to produce and share knowledge) and moral agency (i.e., their capacity to act and make choices). Specifically, it has potential to strengthen (i) a client's confidence in their beliefs; (ii) their sense of themselves as an epistemic agent and a full human person; and (iii) their ability to engage in trustful conversation. When a patient's experiential knowledge is regarded as a source of expertise, this counts as "a valuation of [their] contributions to that shared domain of sense-making" (Brancazio 2020, p. 8) and allows them to build a sense of self-efficacy and self-trust. My proposed account highlights the important sense in which autonomy is socially embedded and fundamentally *relational*: agents can develop and sustain their capacity for autonomy only insofar as they are embedded in a network of social relationships that scaffold and support their agency (Barclay, 2000). In cases where a therapist discounts patient testimony or imposes pre-established categories without taking their experiential knowledge into account, genuine participatory sense-making is not possible and associated social supports for autonomous agency are lacking.

## Lecture 11

Hybrid objects, hybrid tensions:

The translatability of explanatory thresholds in early psychosis intervention care

Katherine Lynch

A goal for psychiatry can be said to lie in expanding or building upon the scope of healing persons with lived experience of mental illness: such expansion might involve aligning treatment efforts more closely with the lifeworlds of service users and with their expectations and desires regarding their quality of life (Friesen, 2019). One way to accomplish this lies in questioning and re-visioning the knowledge structures which enforce perspectives on healing in the clinical realm as it unfolds under the larger umbrella of the discipline of psychiatry, the latter which must be regarded as made up of a system of specific institutions, actors, and beliefs that need to be analyzed and critiqued in the context within which they have come to operate (D'Arcy, 2019).

Berrios and Marková propose an epistemology specific to psychiatry which is capable of recognizing the "hybrid" nature of its "objects", namely that of mental symptoms and disorders; such recognition involves the conceptualization of said objects as falling from a lineage drawn from the natural and human sciences (2015, p. 43). In this frame, mental disorders and symptoms are moreover acknowledged as "hybrid" in that they are understood as arising from a combination of biological, social and cultural factors. This vision of the epistemology of psychiatry (EP) in particular considers "knowledge as socially and historically determined and accept[s] that there are many (complementary) ways of capturing reality" (Berrios and Marková, 2015, p. 44). Such a "hybrid" epistemology allows for reckoning with subjective



experience in the research and clinical realm: where space created for the narratives of individuals living with experience such as psychosis, becomes an integral part to building upon knowledge of mental disorders which takes full account of mental affliction, in terms of what it means and how it can be understood. Critical to this is the importance of treating “psychotic subjectivity [...] as a form and structure of knowledge in its own right” (D’Arcy, 2019, p. 93).

The “hybrid” nature of the symptoms constituting a first episode psychosis diagnosis will be explored in this talk, from the point-of-view of service users enrolled in an early psychosis intervention program. Through the collection of their testimonies, the talk will consider the concept of thresholds as discussed in Frederic Will’s book *Thresholds and Testimonies*; namely, how might the thresholds which make up a person’s understanding of their illness experience help inform the ways that different explanatory models hang together, or don’t, in the clinical sphere? Among the different explanatory elements that might constitute a person’s illness narrative, from the spiritual, to the biological, to the psychological, what can the space where these different explanations meet (in discord or in concord), tell us about how to account for them in clinical practice? Through investigating the thresholds whereby these explanatory models are joined, which at once reveal the gaps between them and yet through them the areas where they can be more closely linked, can we pinpoint the extent to which they are (un)translatable.

## Lecture 12

### Towards hermeneutical pluralism in psychiatry

Bennett Knox

Recent work in the philosophy of psychiatry has renewed calls for meaningful inclusion of those diagnosed with mental disorders in scientific processes including psychiatric research and the revision of the DSM. At the same time, social movements emerging from some of these same communities (such as the Neurodiversity, Mad Pride, and Psychiatric Survivor Movements) have developed interpretations of their experiences which explicitly resist or reject psychiatric interpretations. The question naturally arises: how should psychiatric science relate to the interpretations of purportedly psychiatric phenomena from these social movements?

In this presentation, I will begin to answer this question by developing an account of what I call *hermeneutical pluralism* in psychiatry, focusing primarily on the relationship between psychiatric science and the Neurodiversity Movement. On this view, though psychiatric and alternative interpretations ought to have some forms of productive engagement, the alternative hermeneutical framework of the Neurodiversity Movement also ought to be able to continue to exist somewhat independently of psychiatric science. That is, we should aim to avoid psychiatric science assimilating or fully integrating Neurodiversity interpretations, even as we insist that psychiatry respond productively to input from this community. First, I will give a short overview of the kind of pluralism I aim to argue for, by contrast with some other forms. Then, I will explain why we should aim to avoid assimilation of Neurodiversity frameworks by psychiatry. Finally, I will outline some ways that psychiatric science can productively interact with the Neurodiversity movement, without fully assimilating or integrating it into psychiatric science.

I will begin by surveying some views of pluralism about psychiatric science, and specifying what kind of pluralism I mean to advocate for. The pluralism I endorse is both *descriptive* and *prescriptive*: it argues both that there are multiple interpretations of the domain that psychiatry concerns itself with, and that this plurality of interpretations is a good thing—it is a “healthy pluralism.” Further, my pluralism is not merely *temporary*, but rather is *thoroughgoing*: I assert that this pluralism of interpretations is not just a valuable state of affairs right now, but ought to be maintained indefinitely into the future. Having specified my version of pluralism, I will explain why I think Neurodiversity (and other similar) interpretations should be preserved externally to psychiatric science. I will focus on two major concerns: 1) the political and sociocultural value of the extra- scientific aspects of the Neurodiversity movement, and 2) the danger of

shallow uptake of Neurodiversity critiques by psychiatric science.

Finally, I will provide a few methods by which psychiatry can engage productively with Neurodiversity critiques, without problematically assimilating the Movement. First, I will discuss the role of neurodivergent scientists, and how their insider-outsider status can contribute to psychiatric science. Next, I will argue that Neurodiversity advocates have an essential role to play in evaluating and critiquing the role of values in psychiatric research. Given their first-hand experience of the impact of various psychiatric research programs on their lives, autistic people themselves (including, though not limited to, Neurodiversity advocates) have special authority to determine what research programs on autism are “pursuit-worthy” and which are not. Further, these same considerations mean that autistic Neurodiversity advocates should have a role to play in other aspects of scientific processes which involve value judgments, such as choices between competing theories that rely on normative background assumptions, as well as considerations of inductive risk.

I hope that my vision for *hermeneutical pluralism* can begin to provide guidance on how psychiatric science can respond substantively to input from the Neurodiversity movement, without subsuming it or stifling its radical political potential.

3:30 - 4:50 p.m. **Keynote Address** Moderator: Doug Heinrichs

Lecture 13

Manic behavior and the place of uptake and other ethico-epistemic practices

Nancy Nyquist Potter

I have been theorizing the virtue of giving uptake as it applies to persons diagnosed with borderline personality disorder and other cases in clinics and hospitals. This paper asks whether giving uptake might apply to people who seem to be manic. Specifically, I argue that some service users would receive better health care if clinicians were open to hearing their perspective on proposed treatments. To begin, I set out a framework for understanding epistemic issues in psychiatry, paying particular attention to testimony and credibility. By situating social epistemology within the larger domain of domain of epistemology, I argue that clinicians may benefit from listening to the needs and experiences of the service users they diagnose and treat. I present a case and discussion of a person who seems to others to be escalating into a full manic episode. The second half of the paper addresses some virtues and skills that promote broader knowledge production and move toward epistemic justice and ethical practices.

**Sunday, May 21, 2023**

8:45- 9:45 a.m. **Diagnosis and treatment** Moderator: Christian Perring

Lecture 14

Jonathan Fuller

Overdiagnosis in psychiatry: Rethinking ‘the loss of sadness’

Psychiatry stands accused of ‘overdiagnosing’ disorders from autism to Alzheimer’s and depression. A common way of understanding overdiagnosis in philosophy of medicine is as pathologizing: the labeling

of conditions as disordered that aren't disordered or that we ought not label as disordered. This position is the one taken by Horwitz and Wakefield in the *Loss of Sadness* in response to the overdiagnosis of depression. They argue that many cases of grief are being improperly diagnosed as major depression because those cases are not mental disorders (on Wakefield's harmful dysfunction analysis (HDA), they are not dysfunctional). Grief is being pathologized.

However, pathologizing is not the only or even the main problem with the 'loss of sadness'. While both overdiagnosis and pathologizing may be occurring, we ought to distinguish these two phenomena, which have different harms. I propose that 'overdiagnosis' is the making of accurate and legitimate diagnoses that do not in the cases in question beneficially inform medical management. (In contrast, in 'misdiagnosis', the diagnosis is inaccurate; and in the diagnosis of homosexuality by psychiatrists (and potentially the diagnosis of other controversial psychiatric categories), the psychiatric diagnosis is illegitimate). This phenomenon, rather than pathologizing, better explains many of the harms with the 'loss of sadness' discussed by Horwitz and Wakefield, as well as the harms of other examples of overinclusive DSM diagnoses.

A glance at non-psychiatric examples of overdiagnosis shows that is a mistake to conflate overdiagnosis with pathologizing. Good prognosis tumors found on screening are often said to be overdiagnosed, yet are genuine cases of medical disorder on at least some concepts of disorder. Meanwhile, risk factors and pre-disease states like pre-hypertension can be overdiagnosed even when they are *not* considered cases of medical disorder. Moreover, a major problem with overdiagnosis – what makes overdiagnosis bad diagnosis – is that it often leads to overtreatment; that is, non-beneficial treatment. This is the main criticism of aggressive cancer screening: it leads to overdiagnosis of tumors in the sense that they may be medically managed in a way that does not benefit the overdiagnosed individuals. However, overtreatment is not an inevitable consequence of pathologizing because not all presumed cases of medical disorder are treated (while non-disorders can also be treated and overtreated). We should not blame pathologizing for overtreatment.

Distinguishing overdiagnosis from pathologizing has two benefits for psychiatry, and in particular for the 'loss of sadness'. First, it allows us to sidestep the thorny issue of whether a particular case of grief that meets the criteria for major depression is a genuine disorder, which remains muddled by disagreement over the concept of mental disorder in general (and muddled in particular on Wakefield's HDA by the difficulty of evaluating the dysfunction requirement in the absence of a good understanding of the relevant evolutionary psychology).

Second, distinguishing overdiagnosis from pathologizing helps us properly attribute distinct harms to distinct problems. The harms of overdiagnosis are mainly its downstream effects on medical management such as overtreating with antidepressants, for example. When someone with grief is overdiagnosed with depression it means that psychiatrists ought not manage them as a patient with depression – *even if* they meet the criteria for major depression, and *even if* they have a genuine mental disorder. In contrast, the harms of pathologizing might include stigmatization and the harms associated with adopting the medical model of psychological distress.

Thus, while Horwitz and Wakefield may (or may not) have been correct about the pathologizing of grief, their claim that the 'loss of sadness' is a matter of pathologizing grief misdiagnoses much of the problem with overinclusive psychiatric categories.

## Lecture 15

Value coordination and patient inclusion for a democratic psychiatry

Aaron Chavez

(abstract next page)

In contexts where an individual lacks the facts to properly assess the situation at hand, it can be said that the individual is ignorant, given a deficiency of some relevant piece of knowledge. Expertise is then supposed to fill in those knowledge gaps by providing crucial or highly relevant information which will figure into decision making. In medicine, patients defer to physician expertise for treatment and so it is the case for psychiatry as well. In a clinical encounter, patients seek an explanation for experienced symptoms and clinicians are meant to provide such explanations. Weinstein (1993) provides an account of expertise in medical practice where different domains and subdomains require different experts but where the physician has final say on the explanation—given that they know the theoretical basis of a domain of medical practice. In psychiatry, there has been much discussion regarding the value of diagnostic categories and the epistemic injustice that might result from an uncritical adoption of these (Crichton, Kidd, and Carel 2017, Tekin 2022, Gagné-Julién 2021). The current project aims to examine the relation between practitioner qua expert and patient qua nonexpert in terms of value-coordination. In coordinating values, there is recognition that each participant in a shared endeavor (e.g. settling on a long-term treatment, determining categories, etc.) is a stakeholder and contributes relevant information that is necessary for a more robust picture of a given context. In psychiatric practice, the object under study is often nebulous, vague, and its boundaries indeterminate. Indeed, it is quite difficult to referentially map a conceptual category onto some physical system in a straightforward manner and attempts to accomplish this by psychiatric nosology often fail to capture socially relevant aspects which may invariably figure in medical explanation.

If psychiatry is to be as fair and democratic as a socially embedded science—then patient values must be seriously taken into consideration on behalf of the psychiatrist across multiple and diverse settings in the construction of diagnostic categories. This effectively means treating patients as experts in their own right. While it seems that in medicine more broadly, physicians are widely regarded as the definitive source of expertise due to their knowledge of biological facts which explain observed signs, it is not at all clear that this is how psychiatry should operate. The construction of diagnostic categories requires the phenomenological reports of patients in order to establish a symptomology to which formal classification systems (e.g. DSM) can refer. As such the data that is constitutive of these categories is necessary for the advancement of psychiatric inquiry. Expertise by experience is expertise all the same. Psychiatric conditions can often be persistent/chronic and so it is not the case that patient input can only serve as simple, static data. In terms of applicability, this amounts to patient inclusion in the research process such as roles in the DSM task force. In the clinical setting, practitioners need to be transparent about the process of diagnosis in order to allow the patient to be as informed as possible. It is only in this manner that problems of value coordination can be resolved while minimizing the risk of epistemic injustice.

## Lecture 16

### Neoliberal subject formation through psychiatric and state management of phenomenologies

Marcus J. Byrd

The institutions of psychiatry and psychology have long been theorized as mechanisms, complementary to broader state apparatuses, by which individual psyches are made subject to state-sanctioned surveillance and curated for optimized productivity toward a neoliberal economic and political order. Psychiatry and psychology work alongside other political and economic structures—including those, as Byunn Chul Han notes, of Big Data and information technology—to keep people, constructed discursively as “patients,” psychologically well enough to maintain social and occupational functioning. In line with the Power Threat Meaning Framework, a non-pathologic, non-diagnostic explanatory model of psychic distress published by the British Psychological Society, when multi-disciplinary critique of the institution of psychiatry and the mental disorders it espouses is adequately considered, psychic distress and many forms of socially deviant behavior may best be reconceptualized as typical or expected responses to the threat waged by various forms of power deficiency.

This paper analyzes how assemblages of the state, including politico-legislative drug scheduling and privatized psychiatric care craft subjects for neoliberal exploitation by two, non-mutually exclusive, mechanisms of alteration in phenomenologic experience. The first is through alteration in how subjects “think” about their distress and behavior by way of a now-universal neo-Kraepelinian psychiatric ideology which privileges some states of consciousness and pathologizes others. The second mechanism involves direct and indirect alteration in how subjects “feel”—in every phenomenologic sense of the word, including considerations of perception and inter-subjectivity—in their everyday waking state; such alterations in feeling are induced directly by psychiatric drugs, many of which constrict emotion or arousal, and indirectly through social and political restriction of various kinds of so-called recreational drugs (eg, tobacco, cannabis, entheogens), many of which have been used for millennia as sacraments, particularly for indigenous peoples, and which some argue provide more knowledge about the true nature of experience. If one takes seriously the possibility of phenomenology—that first-hand experience only through which anything can be known—as first philosophy, it stands that restriction of thinking and feeling create a subjective experience which makes subjects more susceptible to state extraction and pacification to more radical alternatives of liberation.

10:00 - 11:20 a.m. **Treater expertise** Moderator: Paul Lieberman

## Lecture 17

### Expertise by empathy

Riana Betzler

Empathy is often considered to be a core component of mental health care. It enables clinicians to communicate care and to facilitate a warm environment. It also stands at the heart of the therapeutic alliance, which is perhaps the main driver of therapeutic effectiveness (Luborsky et al., 2002). Carl Rogers, the founder of person-centered psychotherapy, identifies empathy as a necessary condition of psychotherapeutic change. He defines empathy as follows: “To sense the client’s private world as if it were your own, but without ever losing the ‘as if’ quality” (Rogers, 1957, 99). Empathy, on this view, involves engaging in a form of perception or sensing that allows one to step into another’s world, but without becoming fully immersed in it. It enables the empathizer to occupy a unique position—both inside and outside of the other’s perspective. This form of empathy is powerful:

“When the client’s world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meaning in the client’s experience of which the client is scarcely aware” (Rogers, 1957, 99). In other words, by engaging empathically with the client or patient, the clinician facilitates a process of discovery in which the client comes to know things about herself she might not have known before. Clinician and client engage in a reciprocal and iterative exchange that ultimately yields deep knowledge and understanding.

Despite the widespread recognition of the importance and power of empathy within the therapeutic alliance, several questions remain unanswered. How does one develop the ability to occupy this dual position—both inside and outside the other’s perspective? Is it possible to engage in this deep and complex empathic process even with those who are different from us? How accurate is the knowledge obtained through empathy? These are pressing questions, especially as clinicians encounter increasingly diverse populations in their practices. Psychological and neuroscientific research on the limits of our abilities to empathize furthermore contributes to a growing skepticism about the possibility and power of empathic understanding (e.g., Bloom, 2016).

In this paper, I address the empathy skeptics’ concerns by proposing an account of empathy that takes seriously its status as a skill. Empathy is, on this view, is an ability to feel and understand what others are thinking and feeling. This ability involves multiple components, both emotional and cognitive. This ability

can be developed through practice and experience; the skilled empathizer becomes increasingly adept at resonating with the other's feelings and placing those feelings into their wider context. Skilled empathizers furthermore engage in an ongoing process of refinement and discovery with their interlocutors. Empathy on this view yields a form of tacit knowledge or understanding. I draw on the literature on skilled action and its relationship to knowledge to develop this view (e.g., Ryle, 1945-6; de Regt, 2017). Empathy thereby yields a form of expertise that integrates the perspectives of clinician and that of the client into a coherent and dynamic whole.

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## Lecture 18

### Scoping expertise in psychiatry (An apologist's account)

Katherine Rickus

I can treat, and perhaps even cure, psychosis; but I don't really know, in a robust sense of knowing, exactly how I do it. At the levels of explanation that might count towards demonstrating an understanding of how psychosis is treated, I rely on incomplete neuroscientific, biochemical, genomic, and proteomic explanations that are more protoscientific than scientific. By the standards of medical practitioners, I'm still an expert in treating psychosis, but even my best informed account of what happens when I treat psychosis misses out the sort of propositional, explanatory, and objectual elements that count towards the kind of understanding of psychopathology that could satisfy even the most forgiving epistemologist. Psychiatry, of course, doesn't set out to placate epistemologists, but, as a medical specialty, it has public and personal accountability, and it should state on what evidential basis it succeeds and fails, and be transparent about the origins of its epistemic and other domains of authority. This paper, as a sort of social epistemology project, argues that psychiatrists, as practitioners whose clinical work is founded on translated protoscientific disciplines, should thus clarify the foundations and scope the domains of their epistemic expertise. To do this, the paper examines what is distinctive and characteristic of clinical expertise in psychiatry by way of comparison to other medical disciplines. In doing so, it attempts to resolve some criticisms of psychiatry that arise from these distinguishing features by noting that the scope of knowledge in psychiatry should be clarified as comparatively protoscientific, and that such scoping should shape the basis of what we reasonably consider to be psychiatric expertise. In short, psychiatrists should be clearer about the limitations of their knowledge and scope of practice in view of the maturity of the science on which clinical psychiatry is founded. I will focus on two unusual features of psychiatry as a clinical discipline: its deficiency of biomarkers; and its unusual diagnostic classification system, as ways to scope its domain of expertise in a manner which acknowledges (and even celebrates) its protoscientific foundations.

1. Whilst the putative distinction between mental and physical health might be seen as, at best, practically useful and, at worst, dangerously deceptive, diagnostic approaches to mental and physical disorders are, by scientific and clinical necessity, distinct. Clinicians apply the findings of clinical and translational research, and are, in psychiatry, particularly constrained by epistemic limits on the current (proto)scientific understandings of psychopathology and of psychotherapeutics. One salient difference between current psychiatry compared to other medical specialties is the (forced) lack of reliance on

biomarkers for diagnosis, creating epistemic constraints in psychiatry, which leave it vulnerable to criticism as lacking in scientific evidence relative to the more abundant measurements relied upon in physical medicine.

2. Psychiatric illness classification is based on categories of symptoms and symptom clusters, most of which are observed or reported, and few of which are imaged or measured. The epistemic authority of a diagnostic expert in psychiatry is therefore premised, not on an understanding of biological properties, but on acute observation, pattern recognition, and assimilation of reported information of symptoms and signs which can rarely be supported by scientific investigation and are frequently non-factive. There is often considerable clinical acumen and experiential knowledge involved. Until the promises of precision psychiatry are realized, expertise in psychiatry is scoped by the ways in which the specialty has adapted to its scientifically elusive epistemic substrate.

Finally, anecdotal skepticism depicts psychiatry, as, amongst many other undesirable things, ineffective. But clinical practice is informed by translational work in the sciences. Expertise in psychiatry is therefore scoped by scientific progress. The paper concludes by considering the practical importance for publicly scoping expertise in psychiatry, not only as a professional obligation, but as a contributor to the prominent public discourse on “mental health”, and to define the role of psychiatry in sub-clinical difficulties.

## Lecture 19

### Epistemic injustice and the value of distrust

Keyao Yang

In her book *How Can I Be Trusted* (2002), Nancy Potter discusses a case of untrustworthiness:

A young female client called the crisis counseling agency after taking an overdose of pills. She did not want to provide any identifying information. Nancy, the crisis counselor, assessed that her life was in danger. During their phone call, the client asked, “Are you tracing the call? Because, if you are, I’m going to hang up right now.” Nancy assured her that she was not. However, Nancy traced the call and sent an ambulance. When the ambulance arrived, the client learned that Nancy had lied to her.

It is likely that the client would feel betrayed to some extent. After the incident, she might experience difficulty trusting crisis counselors despite knowing Nancy was helping her. Since the purpose of Nancy lying is for saving life, which is obviously and fundamentally for the client’s good, most health care practitioners (including emergency counselors) would not think Nancy’s decision is a betrayal to the client’s trust. However, Potter argues that, despite the justifiability of the lie, it is still a violation of the client’s trust, and it still damages the counselor’s trustworthiness of her words. Potter’s key point here is that the lie’s justification and the broken trust are separate issues, and the former does not make the latter not a betrayal.

In this paper, I focus on and examine cases of client’s distrust towards mental health care practitioners through the lens of epistemic injustice. According to José Medina (2013), the privileged people have epistemic obstacles and limitations in their social perception. In contrast, the oppressed people have advantages in social perception. They have access to both the privileged people’s perspective and their own perspective. The two perspectives generate tension and friction, which give the oppressed people an epistemic advantage to understand the nature of social events and relationships in more depth. However, the privileged people’s voices are often the mainstream voices, and their perception becomes the mainstream way of seeing and understanding social events and relationships. According to Miranda Fricker (2007), the oppressed people’s insights are often not properly heard and suffer from testimonial and hermeneutic injustice.

The suicidal client and the counselor's relationship is not exactly one of oppression. However, the power imbalance between them shares some features of epistemic injustice. Mental health care practitioners have epistemic authority in theorizing, defining, and judging the behaviors and attitudes of mental illness clients. Their judgments are more acknowledged and respected by the society as the mainstream way to interpret mental illness clients' behaviors. In contrast, clients such as the suicidal person in the example are often more vulnerable and stigmatized, and they lack epistemic authority in affecting the mainstream explanations of their behaviors. Therefore, one way to explain what happens in Potter's case is the following. The suicidal client's experiences and perspectives allow her to perceive the untrustworthiness of the counselor's words. However, her lack of epistemic authority makes it hard for the other people to appreciate her insight about the untrustworthiness element implied in Nancy's choice. Therefore, her last resort is to distrust counselors, which can be a kind of epistemic resistance. However, due to epistemic injustice, her distrust is in danger of being misinterpreted by the mainstream judgments as a symptom of her mental illness. Only when Potter, who is a counselor herself, argues for the untrustworthiness and a need to repair the broken trust implied in this type of cases, can the point behind the client's distrust go into the mainstream understanding.

## Lecture 20

### Impact of methodologies of clinical reasoning on epistemic injustice in the clinical encounter

Douglas Heinrichs

In this paper I argue that a psychiatrist's method of clinical reasoning, and the assumptions about scientific method that lie behind it, strongly impact the likelihood of epistemic injustice emerging in clinical work. I will first maintain that the methods of evidence-based medicine (EBM), the currently dominant explicit theory of clinical reasoning, encourages epistemic injustice because: 1) EBM typically sees the patient as a token instance of a general type, usually defined in terms of a diagnosis. This reflects a view of scientific explanation as subsuming an individual instance under a law or generalization. Thus, the rich uniqueness of the individual patient's experience and perspective tends to be undervalued. 2) EBM assumes that there is, given the current state of knowledge, a best objective answer to the question of how to treat the patient derived from the clinician's expert reading of the literature, largely apart from the patient's perspective. 3) While lip service is paid to incorporating patients' values and preferences, this typically comes into play late in the EBM process and after the clinician has already defined the theoretically optimal course of action.

Developments in the philosophy of science beginning in the last quarter of the 20th century offer a compelling alternative to a view of scientific explanation as subsuming individual instances under general laws. Instead, most of the actual work of science is seen as constructing individualized models of specific, circumscribed systems in the real world that nonetheless yield causal and testable hypotheses related to solving specific problems. Generalizations may later follow from noting recurrent similar patterns of components in individual models, providing useful heuristics for constructing models of novel but similar systems. All models are partial, approximate, perspectival and pragmatically relate to a goal.

I propose such a model-based clinical methodology for psychiatry that sees its primary task to be the shared construction by doctor and patient of a unique model that both hypothesizes causally-relevant, interacting components that led to the patient's specific distress and suggests a range of possible helpful interventions. As any model only partially captures the real system it intends to describe, multiple models could be constructed for any individual case. None of them are complete or literally true about the piece of reality being described. The worth of any model is judged by its effectiveness in achieving the purpose for which it was created. Clinically, this means that appreciating the patient's unique goals based on her understanding of her situation, values and preferences must precede the construction of any model. The clinician must engage in a dialogue with the patient to articulate those goals and together weigh the pros



and cons of any potential intervention. This dialogue is ongoing as goals may change over time and as the model is tested. That there is no *a priori* best answer to how treatment should proceed encourages clinical humility in the doctor and greater openness to the patient's perspective and experience, while maintaining scientific rigor by generating testable hypotheses by which the adequacy of the model is judged. This approach breeds mutual respect by encouraging both patient and doctor to realize that they each contribute a partial and complementary expertise to the process. This method will be illustrated by a case example.

I believe that most experienced clinicians tacitly employ many elements of this approach in their work with patients. Making this method explicit is nonetheless important to epistemically validate this process, curb the excesses of EBM and the resulting epistemic injustice, and aid in the training of young clinicians.

12:40 - 2:00 p.m. **Keynote Address** Moderator: John Z Sadler

## Lecture 21

Is it helpful for psychiatrists to worry about epistemic injustice?

Brent Kious

An increasing number of scholars have argued that psychiatrists (and other mental health providers) are often guilty of epistemic injustice (EI). For instance, it might be suggested that psychiatrists routinely, and *wrongly*, discount the knowledgeable reports of persons with psychotic disorders because of their psychosis. If this is true, and if it is also (as nearly everyone thinks) true that EI is something we should try to avoid, then psychiatrists would have a strong reason to change their approach to patient care. Drawing on recent work with colleagues Benjamin Lewis and Scott Kim, however, I argue, that they do not—or at least not because of EI.

A few framing remarks: It is often assumed that there are two kinds of EI: testimonial injustice and hermeneutic injustice. I focus on testimonial injustice, as it is more likely to be relevant for individual psychiatric practice, while hermeneutic injustice more often pertains to a society's conceptual resources and policies. It is also worth noting that, like any other persons, psychiatrists are potentially guilty of non-psychiatric kinds of EI, which involve wrongly discounting a person's ability to know because of irrelevant factors like their race or gender. Here, however, I focus on specifically *psychiatric* EI, which involves inappropriately discounting a person's testimony because of their diagnosis or psychiatric symptoms.

Psychiatric EI undoubtedly occurs, but our reasons for worrying about as a social ill are undercut in four respects. First, evidence for psychiatric EI usually relies on examples and case studies, which may not reflect what psychiatrists *often* or *routinely* do; thus, these cases do not underwrite any sweeping indictment of the field as a whole, despite their ambitions. Second, many purported examples of epistemic injustice involve short-lived, partial errors that are corrected through ordinary processes of clinical investigation; such examples fail to appreciate that good psychiatrists can and should change their minds about what is happening with their patients as they learn more. Third, psychiatrists might reasonably dispute that many purported cases of EI are really epistemically unjust, by arguing that they were justified in doubting a patient's testimony even if that doubt later proved incorrect. Fourth, allegations of epistemic injustice are often superfluous. They add little (apart from a moralistic tone) to our ability to evaluate or improve psychiatric care, since conventional standards of good care and good clinical reasoning are usually sufficient to capture the errors they identify.

Most importantly, excess concern with epistemic injustice in psychiatric practice carries risks. Gently doubting a patients' testimony is often clinically necessary, because patients often *do* (just like non-patients) have false beliefs, misunderstand or misinterpret their own experiences, and even deliberately misrepresent the facts. But we might fear that if routine psychiatric practice were to be altered by a fear of perpetrating

EI, psychiatrists' ability to doubt their patients' testimony would be threatened. Psychiatrists might become excessively concerned with avoiding the suggestion that they doubt a patient's testimony, where any doubt amounts to presumptive wrong-doing. Such a trend would be inimical to providing good care.

In sum, then, psychiatrists should not worry about avoiding psychiatric epistemic injustice *per se*. They would do just as well, and probably better, to stay focused on practicing good medicine.

2:00 - 2:45 p.m. **Jaspers Prize Lecture** Moderator: Scott Waterman

## Lecture 22

Institution or individuality?

Some reflections on the lessons from personal accounts of recovery from schizophrenia

Rosanna Wannberg

This paper aims at defending a social conception of the self, via a philosophical reading of *Schizophrenia Bulletin's* "first person accounts". The paper posits that these accounts of recovery (in the sense of having restored one's sense of self and personal agency, despite or independently of residual or remitting symptoms) exemplify a more general tension between normative and experiential dimensions of the self. While this might seem to shed doubts on the author's claims about their recovered "self" - at least if one sticks to familiar sociological, phenomenological, or narrativist concepts - I argue on the contrary that a more positive understanding could be found in the idea of a *grammar of recovery*, which does not oppose the individual to the social or the institution, but rather sees the latter as a condition for the former.