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Rethinking Insight: What Does It Mean to Be Aware of Illness When Awareness Doesn't Map to Concept of Illness?

Kathleen Lowenstein

Once considered paradigmatic of a schizophrenia diagnosis, poor insight is a common clinical problem in individuals diagnosed with schizophrenia or other psychotic spectrum disorders. Denying that they are ill and consequently refusing treatment, individuals suffering from poor insight often end up mired in protracted and contentious engagement with frustrated family members and treatment providers. As such, individuals presenting with poor insight constitute one of the most challenging patient populations among those with a schizophrenia diagnosis.

The dilemma posed by individuals presenting with poor insight is generally considered to result from lack of treatment, rather than failure of an epistemological framework. However, the work of psychiatric service users highlights the way in which the concept of poor insight is itself indicative of competing epistemological frameworks.

Critical psychiatry has challenged the role of master narratives and the way in which traditional framing of mental illness frequently excludes or diminishes the perspectives of psychiatric service users. Central to this conversation has been a focus on the role of meaning in both interpretation of and recovery from extreme states of consciousness. A central tenet of the Hearing Voices Network is that voices demand interpretation. As much work by and with psychiatric service users suggests, the ability of an individual to find meaning in and make meaning of their experiences is often central to their identity and, more broadly, to recovery from states that, in standard medical narratives of psychosis, are frequently presented as arising from neurological dysfunction and thus constituted as essentially meaningless.

The dilemmas posed by lack of insight epitomize an area in which competing epistemological frameworks determine what experiences, if any, should be given uptake in a clinical encounter. Accordingly, poor insight serves as a means of determining which experiences, or interpretations of experiences, should be accorded epistemic weight. Though the subject of multiple definitions and measured across a range of metrics, poor insight is generally understood to function as lack of awareness or denial of illness. In the most strident of conceptualizations, poor insight in psychosis is considered to be a literal neurological deficit akin to (if not the same as) anosognosia.

A largely unexamined tension inherent in the concept of lack of insight is the way in which it structures the epistemological frame of both pathology and treatment. As a result of this structure, the possibility of acknowledging alternative forms of meaning in the clinical encounter is drastically limited. Given that poor insight is associated with many of the core ethical tensions in psychiatry- poor insight often serves as an impetus for involuntary treatment and is associated with greatly increased morbidity- the lack of interrogation regarding its theoretical underpinnings is striking. Given this lack of interrogation, analyses of poor insight and its role in treatment rarely if ever consider insight itself as a site of contested epistemological frameworks.

Within standard framing of insight in psychosis, ways of finding meaning that differ from standard medical narratives are considered proof of illness. Standard medical narratives of psychosis consider symptoms to be essentially meaningless and best controlled with medication. However, the importance of meaning to recovery illustrates the need for a frame that is at least hospitable to the possibility of contesting epistemological frameworks. Current ways of conceptualizing poor insight only reinforce the problem of contesting epistemological frameworks inherent to the concept. At heart, poor insight represents a sight of contested meanings. An individual's attempts to make meaning out of extreme states of consciousness are often taken as proof of illness. Critical psychiatry and the input of

psychiatric service users asks whether attempts to find meaning in and make meaning out of extreme states of consciousness might instead be indicative of health.

Self, Subjectivity, and Science: The Weight of First-Person Experiences in Psychiatric Practice

Brent Kious and Ben Lewis

A central claim of many of psychiatry's critics is that first-person experiences of mental illness carry a special priority. This oft-repeated observation is supposed to cast doubt on psychiatrists' judgments about symptoms, diagnoses, and management, and plays a central role in claims that psychiatry systematically marginalizes, oppresses, or controls the mentally ill. The nature of the special subjective priority of the mentally ill, however, is unclear. Here, we attempt to disentangle several related views, and then to argue that given this disambiguation, there is no important sense in which psychiatry, as it is typically practiced by conscientious clinicians, fails to attend appropriately to first-person experiences.

We regard claims that psychiatry should prioritize or pay greater attention to first-person experiences as meaning any of five different things: (1) that patients' subjective experiences have significant evidentiary weight for psychiatry, in that they are often the basis for diagnoses and treatment recommendations; (2) that patients have special insight about the *nature* (i.e., correct classification) of their experiences that supersedes the knowledge of skilled clinicians; (3) that patients have special insight about the *origins* or *causes* of their experiences that supersedes the knowledge of skilled clinicians; (4) that patients have special knowledge about which interventions that are most likely to alter (beneficially or harmfully) their experiences; (5) that patients, in virtue of their intimate knowledge of their own values and the apparent truth of value pluralism, have special insight about what is good for themselves.

We argue that psychiatry already accepts claim (1). Claims (2), (3), and (4) are, we contend false, although related and more plausible claims are already accepted by psychiatry. Regarding claim (2), although patients clearly have privileged access to the phenomenology of their experiences, there is no particular reason to think that they are highly accurate judges about the correct classification of those experiences. A patient may, for instance, be aware that she has some intense negative emotion or complex of emotions and classify these as "depression," but in fact her subjective experiences may be more similar to anxiety or agitation; there can be wide differences in persons' use of psychiatric and psychological terms, and the accuracy of each use should not be taken for granted. Similarly, with respect to claim (3), patients' privileged access to phenomenology does not translate into their being highly reliable judges of the causal factors that lead to their symptoms; indeed, an important focus of psychotherapeutic treatment is often helping patients develop better insight regarding the precipitants of their symptoms, thereby helping them alleviate self-defeating patterns of behavior. Admittedly, however, conscientious psychiatrists are attentive to patients' reports about these relationships, as they can have important evidentiary weight when added to other considerations. Claim (4) is doubtful, as well, since although patients may generally be reliable judges of the valence of their experiences and even the changes in their experiences after exposure to a treatment (usually, a medication), this privileged access does not necessarily yield good predictions of treatment response and remission—often, quite the opposite is true. Still, conscientious psychiatrists typically consider patient reports of the side-effects they attribute to medications and their perceptions of the harmful and beneficial effects with great care, as these data affect treatment planning and medication adherence.

Claim (5) remains ambiguous. On one interpretation, (5) reduces to the idea that people are frequently most knowledgeable about their own interests because of their extensive knowledge of their own circumstances and their own values. But on this interpretation, (5) is already respected by

conscientious psychiatrists, given constraints imposed by the presence or absence of decision making capacity. On a second interpretation, however, (5) reduces to relativism about values, i.e., the idea that patients (and persons more generally) are the sole arbiters of what constitutes their own best interest, so that there are no independent or objective standards of reasonableness in this domain. This interpretation, we think, is often exemplified by the so-called “mad pride” and “neurodiversity” movements. We concede that psychiatry, even when conscientiously practiced, is committed to rejecting this claim and to asserting that certain ways of being are better, for humans, than others. In particular, we suspect that the characterization of mental illness is impossible without reference to standards of normality or human flourishing. We contend, however, that value relativism is at least as contentious as such standards; to the extent that criticisms of psychiatry are anchored in value relativism, they should not substantially modify psychiatric practice.

Standpoint Theory and Psychiatry: The Epistemic Advantage of Lived Experience

Phoebe Friesen

This paper offers an exploration of how feminist standpoint theory might apply to the field of psychiatry. A case is made for the claim that individuals who have lived experience of the mental health system from the perspective of being a consumer, and who have thought critically about knowledge production within the field, have attained a standpoint that provides them with an epistemic advantage within psychiatry. The first section lays out the basic claim of standpoint theory, which is that a standpoint is arrived at as a result of two necessary components, a marginalized social location and critical reflection, and once arrived at, a standpoint offers an epistemic advantage over other positions with regards to relevant scientific pursuits (1-4). While the epistemic advantage that arises from a standpoint has been described in different ways by different theorists, usually an ability to uncover problematic assumptions or maintain an objective stance is emphasized (4, 5). Evidence for standpoint theory has primarily been given through accounts of shifts that have taken place in epistemic landscapes after oppressed individuals (often women) joined the ranks of the discipline (6-12). These accounts explore the way in which the standpoints of individual from particular social locations give them a unique ability them to uncover biases, assumptions, and faulty reasoning within a scientific domain. The second section explores the question of who might be considered to have a standpoint in psychiatric research. It is suggested that the two conditions of having a marginalized social location and engaging in critical reflection are both necessary and sufficient for having a standpoint related to psychiatric science. A marginalized social location in most cases will arise from having lived experience of being diagnosed with a mental illness and experiencing the mental health system as a consumer. Critical reflection can be thought of as a form of consciousness raising, in which an individual reflects on the way in which knowledge is produced within the field of psychiatry in relation to power. This can be done on one’s own through research or can be done within a community. While there is little doubt that many individuals in the c/s/x, mad pride, or recovery movement have achieved a standpoint through critical reflection and lived experience, the claim of standpoint theory is that these individuals have an epistemic advantage over others when it comes to psychiatric research. The third section explores what evidence we have for this claim. In particular, three examples are given of problematic assumptions within the field that have been identified by individuals who have achieved a standpoint. The first assumption is that wellbeing is equivalent to symptom reduction. Individuals with lived experience have long been pointing towards the vast distance between the goal of simply reducing symptoms and the goal of living an engaging, meaningful life as defined by the individual living it. The recovery movement has pushed towards closing this gap and developing both mental health services and supports that help individuals to attain more than an asymptomatic state, as well as research that focuses on measuring wellbeing in its more expansive forms (13-17). The second assumption is that the biomedical model can

offer us a complete explanation of what mental disorder consists of. Many argue that capturing the complex phenomenological experiences of individuals is incompatible with thinking of mental illness as primarily a neuroscientific phenomenon, especially given the involvement of pharmaceutical companies (18-20). The third assumption is that mental illness is always a bad thing. Individuals with lived experience have pointed to the links between madness and creativity, and suggested that rather than seeing symptoms as purely pathological, they might be better thought of as 'dangerous gifts' (21, 22). The important role of individuals with lived experience in identifying these assumptions substantiates the claim that arriving at a standpoint gives one an epistemic advantage within the field of psychiatry. In the fourth section, the implications of this claim are unpacked. First of all, if it is in fact the case that individuals who have attained a standpoint have an epistemic advantage within the field of psychiatry, it is argued that psychiatric researchers have an obligation to include such individuals in all stages of the research process. Secondly, the question of whether the epistemic advantage extends to the realm of clinical practice is raised. It is argued that there is good reason to think that individuals who have achieved a standpoint may also have an epistemic advantage within the realm of clinical practice, based on the many effective clinical tools that have been developed by individuals with lived experience (21, 23, 24), as well as growing evidence concerning the effectiveness of peer support, peer run centers, and the inclusion of peers on clinical teams (25-29). Finally, in the last section, two objections that might be raised in response to this argument are considered. The first is that these assumptions are visible to many without lived experience and so are not necessarily linked to a standpoint. The response given is that a standpoint makes it more likely that an individual will identify problematic assumptions within the field, but does not exclude others from seeing the assumptions as well. The second objection holds that there is no sense in asking who has an epistemic advantage within psychiatry, since those working within the medical model and those in the recovery movement are engaged in two distinct knowledge projects within two meta-epistemological frameworks. In response, it is argued that the question of which meta-epistemological framework is superior collapses into a question of what constitutes well-being, a question which needs to be answered empirically and with reference to the subjectivity of individuals with lived experience.

The Stigma Paradox and the Ghost of Thomas Szasz

Zachary Schwartz

The effort to destigmatize mental disorder seems poised for an identity crisis. Despite decades of public campaigns and documented increases in "mental health literacy," numerous studies suggest that little progress has been made in overcoming stigmatizing attitudes themselves [1]. The fundamental problem (as previously described by Nick Haslam and colleagues) may have to do with the rhetoric of biological psychiatry: although portraying mental disorder as a "disease like any other" helps alleviate blame and guilt, it tends to provoke other modes of stigmatization, such as the perception of dangerousness and prognostic pessimism [2, 3]. Yet biological models are still favored by many service users and their families, and the flip side of Haslam's work has also been empirically demonstrated: normalizing mental disorder is good for inclusivity but allows moralizing attitudes to flourish [4, 5]. At least one philosopher has gone so far as to call this situation an irresolvable paradox for destigmatization [6].

In this talk, I plan to lay out the "stigma paradox" in relation to the historical-philosophical legacy of Thomas Szasz, whose critique of mental disorder still seems to haunt the minds of many service users and psychiatrists. Mainstream psychiatry has (from a charitable point of view) been locked in a long struggle with the ghost of Szasz over the best way to diffuse negative social attitudes toward mental disorder. Indeed, from the perspective of mainstream psychiatry, the Szaszian critique of mental disorder serves as fertile ground for reactive moralizing and blame. Yet Szasz obviously never intended to cause more suffering, and he almost certainly saw himself as the protector of those who would be

labeled as mentally ill and controlled. This historical-philosophical debate, I argue, has much to do with the now very practical problem of the stigma paradox.

In trying to make some headway, I suggest we look to contemporary philosophy of psychiatry, which has made significant progress in moving beyond the simplistic divide between biological psychiatry and Szaszian anti-psychiatry. The recent explosion of work on natural kinds, with its careful elaboration of “kinds of kinds,” is particularly helpful here. This is because much of the trouble with stigma seems to arise from vague, unexamined conceptions of what it means for something to be a “real disorder.” Popular psychology tends to assume that for a condition to support induction and causal reasoning (and therefore mitigate moral blame), it should also be uniform, immutable, possess inherent underlying features, and so on [7, 8]. And so the biomedical model, in the process of trying to legitimize mental disorder, unwittingly defines mental disorder in insidious, essentialist ways. But by making a distinction between different “kinds of kinds,” we can preserve mental disorder as causally efficacious without it needing to be homogeneous, unchangeable, etc. Thus it may be possible to shed some of the stigmatizing features of a biomedical model without discarding what is truly important in that model to service users. If such an application of philosophy is legitimate here, in dealing with this very practical problem of decreasing stigma, it argues for a more central role for philosophy in mainstream psychiatric education.

Nevertheless, I conclude with the possibility that the stigma paradox is complicated by more profound philosophical problems, which offer no ready-made solutions in contemporary philosophy of psychiatry literature. These problems pertain to free will, determinism, and moral responsibility, and they have existed in some form for as long as the written history of mental disorder. For even if we can shed all the essentialist features of the biomedical model, there still seems to be some paradox concerning the causal power *per se* of mental disorders, i.e. to what extent mental disorders impinge on autonomy. On the one hand, accepting that mental disorders significantly impinge on autonomy vindicates from moral blame; on the other hand, taking the impaired autonomy claim seriously seems to encourage the feeling that those with mental disorders are fundamentally more dangerous, more primitive, more hopeless. If the stigma paradox is indeed tied up with this conceptual difficulty, it could certainly benefit from the attention of skilled philosophers. In any case, I hope to demonstrate in this talk how psychiatric stigma is not a mere technical problem—of simply acquiring the means to make the public more “aware” of mental illness—but is inherently tied up with the kinds of philosophical problems that have long concerned mainstream psychiatry as well as its most vocal critics.

Toward an American critical psychiatry: Leveraging theory for real change

Nev Jones

Taking Derrida's essay "deconstruction as the possibility of justice" as its point of departure, this talk explores what 'critical' discourse on the objects of psychiatry might look like in the United States in 2017, and where and how such a discourse might unfold. The presentation also seeks to unpack some of the converging forces that have shaped contemporary psychiatry and that pose ongoing barriers to its deeper disruption or transformation, including the clinical and academic professionalization of the Psy disciplines, the role of extramural and industry-controlled funding, and ideological polarization between and across critical and mainstream academic actors, political decision-makers and user/survivor groups.

Failure to Flourish Framework for Mental Disorders

Benjamin Young

Contemporary theories of mental disorders suffer from an anchoring effect that generates too narrow of a conception by contrastively defining mental disorders relative to mean psychological or biological function. This paper widens the conception of mental disorder by re-anchoring our conception to the

notion of Eudemonia. The theory on offer is Aristotelian in spirit and builds upon past models of mental disorders as a failure to flourish. What will be argued is that mental disorders are a form of mental dysfunction that are a multidimensional continuum phenomena relative to the human and their society. The paper develops a new framework for thinking about mental disorders in three sections. The first section surveys past Aristotelian accounts as a starting point for the framework. The second section develops the new framework using contemporary theories in philosophy of mind and philosophy of biology. The third section displays the strengths of the new framework and suggests future directions for testing out this new framework. Both Foot (2001) and Megone (1998, 2000) have argued for conceiving of the notion of biological and psychological disorders using an Aristotelean teleological model of function. My theory will borrow from Megone's neo-Aristotelian model for mental disorders. He reconceived the notion of a mental illness in terms of a person's breakdown of Aristotelean teleo-function. While the current framework borrows the notion of flourishing as its primary anchoring concept of mental health, it is Aristotelian in spirit only. Nonetheless I would like to borrow the idea that the concept of mental health that anchors our contrastive definition of mental disorders is the notion of flourishing and not merely the notion of a biological function. Furthermore, I will adapt the notion of a function of a subsystem of the organism only relative to the function of the whole teleos in developing the new multidimensional framework. Additionally, I agree with Wakefield (2000) that the notion on offer is not fully coherent as it requires the further notion of social role i.e. that the function of the human organism must be widened to include our societal roles. Moreover, I agree with Cooper's argument that the current Aristotelian model is too inconclusive. The over inclusivity is such that Megone's model will not respect the precision condition that Oulis (2012) argues is a necessary condition for any adequate theory of mental disorders. We should re-conceiving the notion of a mental disorder as a mental dysfunction along a continuum between illness and thriving. In keeping with the strategy of defining a mental disorder in light of its mental dysfunction (Schramme 2010), mental disorders are conceived of as an inability for humans as social entities to achieve a flourishing lifestyle. Mental disorders are a phenomena along the continuum of dysfunction anchored by both biological notions of functions and mental descriptors assessing psychological flourishing. Maintaining physical monism, while endorsing epistemic nonreductionism (Papineau, 1994) the theory separates the biological function from psychological functioning in conceiving of health generally. Accordingly the conception requires two separate anchoring concepts. The first, a biological function conceived not in terms of biological notions of fit or survival, but instead in terms of the system function allowing us to further define sub-dysfunctions within the human (Green, 2015; MacLeod, 2016). The second dimensional along which we must measure mental disorders is psychological function. Mental function will be defined in terms of teleological function in a similar fashion to Aristotle as an individual's ability to achieve a psychological flourishing state across their lives. What is innovative about the framework is not just the multi-dimensional framework, but also sub-functions of psychological teleos determined in accordance with homuncular functionalism (Lycan, 1996). The multidimensional framework on offer can both explain the complexity of determining if a mental and biological dysfunction yields a mental disorder both at a given point of development, as well across the persons life. The approach can handle the over inclusivity problem of Megone's theory, generate a precise account, as well as address our practical concerns for treatment. Previous neo-Aristotelian theories suffered from an over inclusivity problem (Wakefield, 2000, and Cooper 2007a and 2008b). The paper will reconsider how to handle these issues using examples such as attractiveness or ugliness, lack of intelligence, and deafness. Furthermore, the precision of the account can explain how deafness, as a prime example, might be considered a biological dysfunction but not a disorder as deaf people may still maintain a flourishing lifestyle. Additionally, it will deal with the practical concerns of the notion of a mental disorder by allowing us to chart the degree of illness of any given mental dysfunction and the resultant lack of flourishing. Moreover, the framework yields a means of deciding treatment priority both in terms of

who should be getting treatments, how they should be treated, and how public funds should be dispersed for the treatment of mental disorders. Lastly in keeping with the Aristotelian spirit of the framework the prerequisites for Eudomonia generate further tools for considering preconditions that are causally responsible for the development of mental disorders though they are not constitutive of the concept itself nor of the biological and psychological dysfunctions that generate the failure to flourish.

Materialism and the goals of psychiatry or What is the role of human flourishing in psychological treatment?

Robert Kruger

In a recent Op-Ed piece in the New York Times, John Markowitz (New York Times, 2016-10-14) bemoaned the policy initiated by Thomas Insel at NIMH of requiring "neurosignatures" (i.e., bona fide neurobiological theoretical underpinnings and/or findings) to receive funding. Markowitz goes on to opine that this policy will be carried on by Joshua Gordon who is taking over the helm from Insel. Markowitz notes that during Insel's tenure, the NIMH has increasingly shifted the focus of the research it will support to neuroscience at the cost of marginalizing clinical research which might have more direct application to treating patients. What Dr. Markowitz does not say is that, in its rush to the barricades of science, the NIMH has neglected an all important aspect of all types of clinical work: human experience and its description. These form the phenomenological foundation of psychiatry and clinical psychology. Moreover, they are at odds with a different type of conceptual framework fundamentally entrenched in science: materialism.

This paper argues for psychiatry as a socially situated body of knowledge and set of practices designed to understand and ameliorate particular kinds of human suffering (Fetterolf, 2016). While the conceptualization of it as such need not be strictly incompatible with an understanding acquired through neurobiological investigation, the position elaborated here is an endorsement of phenomenological descriptions of human experience as legitimate characterizations of mental illness and its treatment by psychosocial interventions such as psychotherapy. It further argues that understanding the "phenomena" and the behavioral manifestations to which they give rise is an old tradition in science going back to Aristotle. From such descriptions of experience and human actions (e.g., "symptoms") arise hypotheses which can be tested through various interventions. These hypotheses and their testing can be thoroughly grounded in rational argument (and, thus, be scientific). Indeed, materialistic explanations and, by extension, interventions based on them have legitimacy in psychiatry by their impact on the domains of social and emotional phenomena where operative queries are founded on phenomenological descriptions (e.g., "How do you feel?")

In utilizing descriptions of experience and human action, psychological interventions employ the mental language of motives, intentions, desires, wishes, and choices. It will be argued that the neglect and/or deprecation of a phenomenological approach to experience in favor of a "more scientific" one runs the risk of neglecting key dimensions which shape our experiences as human beings such as political movements, social actions and institutions, cultural practices, and ethical choices. This socio-cultural axis helps to define the type of social world in which we exist and, therefore, the quality of the lives we lead with one another. In short, phenomenological descriptions of experience and social action place a high value on human flourishing in our lives with others as the sine qua non of our humanness. Such flourishing is undermined by psychological symptoms and behaviors which are maladaptive with regard to our social functioning.

Accordingly, the role of a Critical Psychiatry is to draw our attention as clinical practitioners and philosophers to the dangerous effort to ease the broader social dimension out of the conversation in psychiatry and clinical psychology. As a result, topics like race and gender prejudice, social acceptance, and values become unimportant in clinical practice. Indeed, ethical and epistemic choices become secondary as there is, as yet, no neurobiological description of them. Nonetheless, they are fundamentally what make us human and deviations from how such decisions are made (e.g., by psychopaths, sociopaths, and those with autism) define some types of failed human flourishing which clinicians attempt to remedy. Similarly, Markowitz's own expertise in treating PTSD would become unimportant as a topic for funded research unless the focus is on the changes in brain function brought on by the trauma (which itself is essentially an "experience"). However, equally important as a subject to be addressed by clinicians are the social situations and environments which result in such trauma: violent crime, social unrest, war, prejudice, and all types of human hatred. A discussion restricted to the brain changes in humans subjected to violence and torture without an examination of the epistemological frameworks, motives, values, and ethics surrounding those who inflict such trauma does not go very far in ending our oppression of one another nor does it assist us in understanding how to create more humane societies.

Finally, this paper will examine a few clinical examples and demonstrate how a phenomenological psychosocial approach to thinking about and studying psychological treatments can enhance them without a loss in the rigor in our conceptual framework.

Proud to be Different, Proud to be Crazy, Proud to be Ill?: Defending the Conceptual Coherence of Mad Pride

Ginger Hoffman

One movement closely aligned with the critical psychiatry movement (and, indeed, often considered to be an important part of it) is the Mad Pride movement. The Mad Pride movement promotes the idea that so-called "mental illnesses" (for example, the behaviors, experiences, and mental states falling under the labels of schizophrenia, bipolar disorder, depression, autism, obsessive compulsive disorder, etc. – what I will henceforth call "mental conditions") are forms of mental and neural diversity of which one can justifiably be proud. Its name is intentionally structured as analogous to "gay pride" and "black pride," reclaiming the word "mad." (Glaser, Lewis, Newsweek Staff, Robinson & Rodrigues). My main purpose in this presentation is to argue that mad pride is justifiable; specifically, that it is conceptually coherent to be prideful of mental conditions. My ultimate, broader hope is that such an argument can be leveraged to decrease sanism and stigma, and to empower those individuals who have been, or will be, psychiatrically diagnosed. One of the biggest objections to the conceptual coherence of mad pride is that mental conditions are bona fide diseases ("just like diabetes"), and that pride in a disease is not conceptually coherent (see Glaser). One obvious way to respond to this objection is to argue that mental conditions aren't, in fact, diseases. Indeed, much of the existing Mad Pride rhetoric seems to support this strategy by assuming that a rejection of the so-called "disease model" – the model promoted by contemporary biopsychiatry – is actually one of the central tenets of Mad Pride (The Icarus Project, Lewis). Here, however, I pursue a dramatically different and perhaps counterintuitive option: I assume, for the sake of argument, that mental conditions are bona fide diseases, and then explore whether it is conceptually coherent to be proud of a disease. To do this, I assume Wakefield's influential definition of "disease," which states that a disease is a biological dysfunction that is harmful (Wakefield). [However, my strategy is also compatible with definitions of disease that require only biological dysfunction, and do not require harm (e.g. Boorse)]. My "counterintuitive" strategy has the advantage of sidestepping the long and sometimes seemingly intractable debate over whether mental conditions are bona fide

diseases. My strategy may also be more convincing to biopsychiatry itself, since it adopts biopsychiatry's preferred conceptualization of mental conditions as diseases. I pursue my "counterintuitive" strategy by adopting Elizabeth Barnes' trenchant analysis of physical disability (Barnes). Barnes argues that physical disabilities are "neutral simpliciter" – which roughly means that they are neither intrinsically good nor intrinsically bad. They may, however, be instrumentally good and/or instrumentally bad. Her paradigm example of something that is neutral simpliciter is being gay (or being straight).² One of the remarkable aspects of Barnes' work is that her argument that physical disabilities are neutral simpliciter is presumably compatible with their being biological dysfunctions (a classic example is blindness). Moreover, such physical disabilities are also likely harmful, at least on many definitions of "harm." Thus, this can be used to support the possibility that even if certain things are diseases (on Wakefield's definition) they may nevertheless also be neutral simpliciter. Thus, one possible way to employ Barnes' work to defend the coherence of mad pride, even assuming that the mental conditions in question are bona fide diseases, entails showing that: (1) It is possible for mental conditions to be both (a) bona fide diseases (and therefore biological dysfunctions), and (b) neutral simpliciter. And: (2) Pride in things that are neutral simpliciter is justifiable. And one way to support (1) is to rebut the following objection: Objection: A biological dysfunction is necessarily an intrinsic bad – and therefore not neutral simpliciter – because it is limiting. That is, it restricts or closes off certain valuable experiences and skills. In other words, the objection goes, if a part of an organ (including a part of the brain) has a biological dysfunction, then presumably the individual possessing this organ "misses out" on life in some important way. For example, blindness – a dysfunction of the visual system – precludes one from seeing paintings, or seeing the faces of their loved ones (Barnes). However, one way to respond to this objection is to maintain that functioning might also be limiting – it might also cause people to "miss out on life" too. For example, Kay Jamison, referring to her bipolar disorder (which she, herself, assumes is a bona fide disease) says: I honestly believe that as a result of it I have felt more things, more deeply; had more experiences, more intensely; loved more, and been more loved; laughed more often for having cried more often... I have run faster, thought faster, and loved faster than most I know. And I think much of this is related to my illness. (Jamison, 218) In comparison, those who do not have bipolar disorder – whose minds presumably function in the exact way in which Jamison's presumably dysfunctions – ostensibly miss out on these depths of experiences, feelings, and love. As such, one could argue that functioning in this way is limiting. And if being limiting is sufficient to render a state intrinsically bad, then this would mean that this type of functioning (as well as many³ others) is intrinsically bad. Thus, many (or even all!) types of both dysfunctioning and functioning would be intrinsically bad, and this certainly seems to be a reductio. Another possible response to the above objection questions the claim that dysfunctions are necessarily limiting in the first place – at least in any truly damaging sense. This response rests on the recognition that there are more goods in the world than any person has time to pursue, such that being unable to pursue some of them doesn't end up imposing any greater limits or restrictions than those that are already in place. In sum, I think there are ways to defend the appropriateness of pride in one's mental condition, even if this mental condition is a disease. If this is indeed the case, the idea that it is rational to cultivate pride in one's "defect" can have, I believe, potentially radical and transformative effects on how mental difference is treated: opening up opportunities for valuation, dignity, and even celebration.

‘Coming Out Proud’: A Critical Analysis of the Long-term Effects of Identifying as Mentally Ill

Nicholas Slothouber

Vanessa Slothouber

Empirical evidence suggests that both public stigma and self-stigma have deleterious effects on people suffering from mental illness. Corrigan, Kerr and Knudsen (2005) review evidence of the impact of stigma on mental illness, concluding that public stigma (public prejudice and discrimination directed at those suffering from mental illness) is associated with negative outcomes such as an inability to maintain competitive employment, increased criminalization, as well as reduced access to health care. In addition, self-stigma (the internalization of public prejudice and discrimination) has been associated with a decrease in self-efficacy and self-esteem (Corrigan, Kerr & Knudsen, 2005; Corrigan et al., 2015) and an exacerbation of symptoms of mental disorder (Schrank et al., 2014). Recent evidence also suggests that many individuals engage in label avoidance (Ben-Zeev et al., 2010). That is, they do not seek out mental health services for fear of stigmatization (Corrigan, 2004; Corrigan, 2007; Link, Castille & Stuber, 2008; Quinn & Chaudoir, 2009; Corrigan, Druss & Perlick, 2014).

This may explain epidemiological findings indicating that up to two-thirds of individuals suffering from mental illness either drop out of treatment early or do not seek treatment at all (Barrett, Chua, Crits-Christoph, Gibbons & Thompson, 2008). The reduction of self-stigma is thought to follow from the reduction of public stigma; however, because reducing public stigma is a long-term enterprise, Corrigan and Fong (2014) point to a need to reduce self-stigma for individuals struggling with mental illness in the interim. In this paper, we focus on efforts to counter self-stigma, particularly through the strategy of identifying as mentally ill. Specifically, we examine Corrigan et al.’s (2015) ‘Coming Out Proud’ (COP) model, adapted from the LGBTQ community, where ‘coming out’ as gay or lesbian is thought to be empowering and successful in fostering pride around one’s identity and reducing self-stigma. Recent research has revealed that coming out as mentally ill may be empowering for those struggling with mental illness (Corrigan, Kosyluk & Rüsck, 2013). In fact, studies that have reviewed the effects of identifying as mentally ill have found that hope, self-efficacy, and self-esteem increase with identification (Yanos, Roe & Lysaker, 2010; Corrigan, Kosyluk & Rüsck, 2013; Corrigan et al., 2015). Yet, these authors also acknowledge that in some cases embracing a mental illness identity may not be beneficial. Specifically, these authors suggest that the benefits of identification are mediated by perceived legitimacy of stigma. In other words, individuals who identify with mental illness and perceive stigma to be legitimate do not benefit from identification, while the opposite is true for those who perceive stigma as illegitimate. Cruwys and Gunaseelan (2016) specifically analyzed the implications of mental illness identity in relation to the diagnosis of depression. They suggest that identifying with depression may not be beneficial insofar as depression is linked with decreased well-being, suggesting that identifying with depression may automatically result in identifying with poorer well-being. However, they conclude that identity content mediates the effects of identification, whereby one’s perception of the legitimacy of stigma is associated with either reduced or enhanced wellbeing. In light of this, Cruwys and Gunaseelan (2016) suggest that “when a mental illness diagnosis is disclosed to a patient, it ought to be accompanied by information that . . . challenges the legitimacy of stigma towards people with mental illness” (p. 41). Thus, it may be reasonable to conclude that identifying with one’s mental illness is beneficial as long as such identification is accompanied by a resistance to the stigma associated with mental illness.

Nevertheless, in our review of this literature we found that different uses of the term ‘identification’ are often conflated. For example, identification is written about in some cases as identifying as mentally ill (e.g., “Depression is who I am”), in others as identifying with a social group, and in other instances it is used to refer to one’s acknowledgement of having a mental illness (Yanos,

Roe & Lysaker, 2010; Corrigan, Kosyluk & Rüsck, 2013; Thoits, 2016). We contend that these three ways of talking about identification are not equivalent. For instance, identifying with a social group or acknowledging that one has (or has been diagnosed with) a mental illness are not the same as identifying as mentally ill. To identify as mentally ill is to make mental illness central to one's identity, to "take on" the social category of a particular mental illness and its associated meaning in both the relevant clinical and cultural context. While we agree that acknowledging that one has a mental illness is integral to recovery, and that identifying with a social group may provide a buffer against stigma, we question the impact of identifying as mentally ill on long-term recovery, specifically in relation to anti-stigma programs aimed at disclosure, or 'coming out.' Queer theorists have long problematized the strategy of 'coming out' in relation to homosexual identities. Butler (1993), for instance, suggests that coming out is not only an act of claiming an identity, but of producing this identity. We extend this analysis to the case of mental illness. In particular, we argue that the the COP paradigm, and other anti-stigma identification strategies, are in danger of producing identities that only serve to obstruct recovery by stabilizing (and in some cases exacerbating) symptoms of mental illness. In this paper we explore the following questions: How might identifying as mentally ill hinder long-term recovery? In what ways does identifying as mentally ill work to reinforce essentialist assumptions about the nature of mental illness? How might identifying as mentally ill artificially construct boundaries between health and illness?

CRITICAL PSYCHIATRY AND THE NARROW PATH: FROM AUTHORITY SKEPTICISM TO POPULISM BUT NOT BEYOND?

Peter Zachar

A hallmark of the modern era is the abandonment of dogmatic faith in epistemological authority in favor of various degrees of authority skepticism. In this respect, Critical Psychiatry is very modern. Particularly important are its skepticism about the disease model of psychiatric disorder, of the influence of the pharmaceutical industry on psychiatric science and practice, and of the reification of DSM diagnostic categories. One thing that unifies these various criticisms is an attempt to see the patient as a person and not just a case of illness.

In the sociopolitical realm, modern skepticism can occasionally precipitate populist uprisings against the establishment. Such uprisings may be framed as a conflict between the common people and the elites, with the Reign of Terror after the French Revolution being a consensus example of taking it too far. Taking it too far often occurs when recognizing various forms of corruption in the establishment system evolves into perceiving most establishment figures as personally corrupt.

Anti-establishment appeals to populism often have to walk a narrow path between reform and various degrees of revolution. The same is true of the Critical Psychiatry movement and some of its siblings such as Allen Frances' opposition to the medicalization of normality the Postpsychiatry perspective. Like the moderate Jacobins in the French revolution, the critical psychiatrists and their siblings risk being the target of the passions that they help stir – which requires them to walk a narrow path.

Some examples of being on a narrow path are Critical Psychiatry's preference for broad, even vague concepts such as madness and psychosis rather than what they refer to as the "scientifically invalid" categories of schizophrenia and bipolar disorder (Moncrieff & Middleton, 2015). Critical Psychiatry's use of "paternalism" and "manipulation" to describe the psychiatric practice is another. Frances' (2011b, 2013b) narrow path includes his claim that the experts on DSM committees are inbred research types who do not understand the clinical world and his assertion that the development of DSM should no longer be entrusted to the American Psychiatric Association. For Postpsychiatry examples include the rejection of the modernist technological framework (including the logic of randomized

clinical trials) and a spirited advocacy of the psychiatric survivors movement (Bracken & Thomas, 2001; Lewis, 2012; Thomas, Bracken, & Timini, 2012).

What would be a populism too far? Some possible candidates include claims about mental illness not existing, about the psychiatric profession being an exercise in coercion, of being corrupt and in collusion with the pharmaceutical industry, and being fundamentally flawed and rotten. In my presentation I will describe actual instances of such assertions.

Interestingly, Allen Frances (2011a, 2013a) has consistently argued that those who adopt perspectives aligned with the Critical Psychiatry movement have taken it too far, even calling them silly and lacking a real world foundation. Frances himself has a specific cluster of positions that he believes keep him from going too far. But in fact the same is true for the leaders of the Critical Psychiatry network and of Postpsychiatry.

In the final part of my presentation I will systematically compare and contrast these perspectives with respect to what they believe keeps them from going too far, and make some comments about the strengths and weaknesses of each.

critical psychiatry: Its definition and differences

Duncan Double

Critical psychiatry may not be well defined. It critiques the biomedical view that mental illness is due to brain disease. Since the 1990s, there have been parallel developments of other critical subdisciplines, such as 'critical psychology' and 'critical social work'. These new movements have been associated with 'post-modernism' and postpsychiatry is one recognized version of critical psychiatry.

However, one problem with the post-modernist narrative is that it suggests an orderly transition from modernism to post-modernism. This may not be the best way to define critical psychiatry, as there has always been a conceptual split in the understanding of mental illness since the origins of modern psychiatry. For example, Southard (1914) differentiated between the 'mind-twist' and 'brain-spot' hypotheses of mental illness. What he was indicating is the importance of distinguishing between those that identify a psychogenic cause of mental illness and those that emphasize brain aetiology.

The development of the anatomoclinical method in medicine in the 19th century, linking clinical signs with physical pathology, led to the acceptance later in the century that mental illness was functional without structural lesion. There has nonetheless always been speculation that an underlying physical cause will still be found. In the origins of modern psychiatry, a few authors, such as Philippe Pinel and Ernst von Feuchtersleben, took a more integrated perspective about the relationship between mind and brain before the new pathology completely abandoned its vitalistic principles. In a sense, then, there has always been a minority psychosocial perspective in psychiatry, such as critical psychiatry. The majority view has been biomedical and DSM-IV in fact abolished the distinction between functional and organic psychosis. The tendency within psychiatry has always been to marginalize the psychosocial perspective, which may be why it needs to be defined critically.

Although the essence of critical psychiatry may be the belief that what is identified as mental illness is not caused by brain disease, there are differences in views expressed within critical psychiatry. For example, these include (1) whether psychiatry should be seen as a medical discipline, (2) whether the Mental Health Act should be abolished and (3) the suitability of seeing mental disorders as illness and disease.

These issues may not be totally distinct and they do lead to views being expressed which are critiqued from within critical psychiatry. For example, Kirk et al (2013) have argued that professionals should only offer voluntary treatment and that physicians' prescription privileges should be abolished. They come to this view from the essential critical psychiatry position of challenging the claim that mental disorders have been established to be brain diseases. However, the loss of mental capacity in mental illness can justify psychiatric detention. Psychiatry inevitably has a social role. Non-medical prescribing can be developed with proper training, but this does not mean that medical training is not of value for psychiatry, if only because many physical complaints have a psychogenic origin.

Similarly, Moncrieff and Middleton (2013), the chairs of the UK Critical Psychiatry Network, have produced a critical perspective on schizophrenia. They argue that the concept of 'schizophrenia' is neither valid, nor useful, and suggest replacing it with more generic concepts such as 'psychosis' or 'madness'. From their point of view, it is not appropriate to regard mental disorders as illness and disease. They come to this conclusion from the essential critical psychiatry position that mental illness, such as schizophrenia, is not brain disease. However, abnormalities of mental function can be understood as 'illnesses' in the same way as bodily dysfunctions. There will inevitably be limitations in the application of psychiatric diagnosis, whatever way symptoms and signs are grouped and conceptualized. Psychiatric practice needs to acknowledge this state of uncertainty. The concepts of mental illness do not necessarily need to be abandoned for this reason. They merely need to be recognised for what they are - attempts to describe psychological states. The problem is the reification of psychiatric diagnosis and not necessarily psychiatric diagnosis in itself.

This paper will analyze the different views within critical psychiatry. In philosophical terms, this means clarifying the ontological, epistemological and moral bases of critical psychiatry. The intention of the paper is to work towards critical psychiatry providing a more rigorous account of its foundations.

Does the Organisation of Mental Health Services and its Underlying Power Dynamics act as a “Total Institution” in a Community Setting? A Contemporary Update of Goffman’s *Asylum*.

Katharine Larose-Hébert

In this talk, we will discuss the findings of our doctoral research which investigated the subjective experience and care trajectories of mental health service users in the French speaking province of Quebec, Canada. As a self-declared “psychiatric survivor”, our research project was developed in order to offer a contrasting and critical portrait of the organisation of mental health services. Our position is inevitably engaged, seeking to denounce the systemic exclusion of psychiatric patients’ voice in regards to their care, which leads to a loss of power and discredits emic knowledge. In order to discover the ways in which a patient’s identity is transformed throughout their care trajectory, we developed a conceptual framework linking two complementary perspectives, namely 1) a microsocial analysis of the direct interactions between psychiatric patients and structures (constraints, employee, policies...), using Goffman’s concept of “career”, and b) a macrosocial analysis of the forming of the subject through Foucault’s analysis of power. Methodologically, we drew inspiration from the principles of institutional ethnography to guide our 16 months of ethnographic fieldwork; which took place mainly in three mental health community service agencies, but also in many health and social services used by our participants. We collected our data through participant observation as well as semi-structured interviews. We gathered information on 95 participants. Our target population was composed of adults receiving services in the three agencies where we conducted most of our fieldwork.

Our results show that the organization of mental health services fosters the development of new identity traits in the individuals having to “live” through it. These transformations, which affect a patient’s relation to themselves, to others and to society, stem from structural constraints within the organisation of mental health services. These constraints result from power dynamics latent to the organisation of these services and therefore external to service users’ everyday lives. We were able to form a portrait of the power relations underlying (and thus often invisible) the patient’ experiences. These power relations seep into the narratives, penetrate intimacy and interactions, resulting in an undesired identity transformation in which the individual becomes a “subject” able to receive the services in the way they have been designed. This analysis shows that mental health services are effectively focussed on “a” person but that this person doesn’t exist until it’s identity has been remodelled. Throughout the care trajectory an identity continuum is formed which culminates in the identity of the “docile self”. This identity corresponds to the functional needs of the structure of services and contributes to perpetuate asymmetrical power relations, which serve to maintain the service user in a marginalised state. As social work, a social scientist and a psychiatric survivor, we advocate using the critical consciousness approach with mental health service users to counter this modulation of the self and allow them to regain power over their own lives.

When the Institution Collides With the Self. The Social Success of “Self-Management” as a Contemporary Keystone for Critical Psychiatry

Mélissa Roy

Self-management in the mental health field, which is often a key element in the scientific and professional definitions of “recovery”, is usually considered to be a form of “empowerment”. It is often placed in opposition to professional and formal psychiatric interventions: whereas the institutional setting, usually resituated in its historical context, tends to be seen as oppressive and authoritative, self-management is considered to be a way to redefine and reaffirm one’s self, outside of this coercive context. Self-management is therefore somewhat untouchable on a moral scheme.

This communication aims to nuance this perception of self-management. More precisely, we consider that, if self-management can be an efficient tool to resist psychiatric power (as seen within the various social movements in the 1960’s – the mad movement, the antipsychiatry movement and the consumer/survivor movement), it can also act as a form of “government of the self” and as a control mechanism anchored in a liberal context. Indeed, liberal government is characterized by a “letting go” of State government strategies, by their decentralisation and by a softening of the control exerted directly on individuals, to the benefit of self-regulation. Indeed, self-management calls to the rationality of “free” individuals, asking them to take part in a government strategy, to be somewhat autonomous and self-sustaining by relying mostly on themselves to regulate their mental health. The current social context, rather than imposing normative regulations on the individual through professional interventions, promotes self-management, encouraging a self-regulation of symptoms and a self-normalisation.

Therein lies our interest: **the philosophical implications related to the analysis of self-management as a form of government and empowerment, at the crossroads of liberation and oppression, and between emancipation and an articulation of the psychiatric apparatus.** This communication will argue that the “finer” and “subtler” power relations in the psychiatric field should be taken into account, as much as the formal, official and institutional psycho-medical interventions. We will suggest, more precisely, that the mobilization of individuals’ expertise should be an object of reflection within critical psychiatry, as it can be seen as a contemporary articulation of psychiatric oppression. Thus, our research question is: How, and to what extent, have the assumptions of conventional psychiatry infiltrated the self-management paradigm? How is individual expertise solicited

and mobilised, in order to sometimes be at the service of the psychiatric practice? In short, this communication aims to **analyze the role of the “self” in the psychiatric apparatus, and to question the analytical implications of the taking into account of the “self” in critical psychiatry.**

This communication will be based on my original master's research, in the social work field. A qualitative analysis of 10 semi-structured interviews, conducted with Canadian men and women diagnosed with a “severe and persistent” mental health problem, will reveal some of the ways in which self-management in the mental health field is a regulatory vector in different spheres (social, economic, normative, etc.) Indeed, from a Foucauldian perspective, we will focus on the ways in which conventional psychiatry contributes to the construction of the goals that participants aspire to, when they self-manage. Participants' stories show that, when they apply self-management practices, they construct an “ideal self” (influenced by social, normative, medical and neoliberal standards), a form of “ideal identity”, that they seek to attain. This socially constructed model tends to be holistic (developing healthy and rewarding social relations, living in a nice apartment and, especially, acquiring a job) and ambitious (the complete absence of symptoms, no longer relying on medication, etc.) In other words, when participants self-manage, they not only wish to manage their symptoms or to “go back” to an anterior “pre-mental health problem” self: they seek to normalize themselves in many social spheres by conforming to a model. This model, which is idealized and rarely accessible to participants, leads to a perpetual quest to conform to an ideal is associated with a dissatisfaction regarding the “actual self”, seen as “lesser” than the norm. This weighs on participants', reinforcing the idea that they differ from the norm, that they are living a “pathological condition”, that they are “not as they should be”. The identity model to which participants' wish to conform is certainly influenced by the psychiatric apparatus (for example, the goal to no longer have “symptoms”, as labeled by the DSM). However, our interviews also demonstrate the importance of employment in self-management: acquiring a paid job was the most important goal for participants. In this respect, self-management in the mental health field can sometimes be used as a self-regulating tool benefitting the current neoliberal and capitalist context. Moreover, when participants self-manage and try to conform to this idealized model, they act within the limits of conventional psychiatric perspectives. They support, for example, the practices that they have learned by psychiatric professionals (medication, mindfulness) and never question them, all the while devaluing those which are sometimes helpful to them but not recommended by professionals (self-mutilation, playing with the medication posology).

In sum, from a microscopic, but macrologic perspective, this communication will analyze the social function of self-management in the mental health field, by problematizing it as a technology of government in the psychological, psychiatric, social and economic spheres. Through self-management, conventional psychiatry does not necessarily lose its powers: it is re-articulated, modified and liberalized, infiltrating the “self”. Besides, these changes may actually render psychiatric powers more efficient: being less repressive and more discrete, it is a formula which is adapted to the contemporary liberal social context. It may therefore be more difficult to resist. Thus, in conclusion, we will reflect on some possibilities for resistance: this resistance will not be “outside” of the psychiatric oppression through the self, but within the oppression.

Postcolonialism and (anti)psychiatry: On hearing voices and ghostwriting

Sarah Kamens

This paper will demonstrate the relevance of postcolonial theories for understanding contemporary psychiatric discourse and praxis. More specifically, I will outline the ways in which postcolonial theories expose, problematize, and challenge implicitly subjugating discourses in the 'psy' or mental health disciplines. Drawing on Foucault's theory of subjugated knowledges, I will focus on recursive epistemologies that privilege specific clinico-communicative modalities over marginalized

discourses. My focal examples will be two discursive phenomena in which an addressee experiences the originator of communication as ethereal or absent: hearing voices and ghostwriting.

The presentation will open with a brief introduction to postcolonial theories and their significance for the humanities and social sciences. I will argue that postcolonial theories are directly relevant for addressing not only the historical role of psychiatry in colonial and postcolonial movements (e.g., in prewar Germany, apartheid-era South Africa, and present-day Haiti), but also for understanding the microcolonizing aspects of psychiatric practice in the Western world. Particular attention will be given to writings on the lived experiences of oppression and resistance in the works of Edward Saïd, Franz Fanon, Gayatri Spivak, and Homi Bhabha, whose works have detailed ways in which imperialistic practices and ideologies are resisted, transformed, and/or internalized by the peoples on whom they are forced. These authors have also delineated the ways in which colonial discourse distorts and misrepresents the experiences of those whom it colonizes, such that power and the means of social control are maintained through discursive violence. Epistemic production, in other words, becomes a tool for recursive oppression. Spivak's writings on epistemic violence and Saïd's explication of orientalism demonstrate the range of colonial discourses from overtly aggressive speech acts (e.g., military commands) to popularized genres or documents with deceptively benign facades (e.g., objectifying travel narratives by Western writers).

With their focus on the (im)possibilities of elevating marginalized narratives, postcolonial theories might seem mostly irrelevant to contemporary psychiatry, *ipso facto* a project of translating suffering into universal clinical terms. However, viewed from the lens of postcolonial history, universalizing discourses are often anachronistic and oppressive—even when promoted as benevolent enterprises. I will argue that psychiatric theory contains hierarchical, universalist assumptions about communication that subjugate content (messages) to the media (or mediums) by which they arrive. On the nominally lower end of this hierarchy are communications or narratives that are distrusted, ignored, and silenced by virtue of their modality. Voice hearing is one example; from a traditional biopsychiatric perspective, the form of auditory hallucinations renders their content irrelevant or meaningless, such that voices act as empty signifiers for their own lack of discursive power as symptoms. On the upper end of the hierarchy are elite communications in which the medium has the privilege of dematerializing or, alternatively, transferring the message for dissemination through a more powerful modality. Examples include academic texts generated through ghostwriting, which are rendered relevant or meaningful by the pure fact of their transfer to a privileged medium. Both ends of this discursive hierarchy represent an extreme version of McLuhanism in which the modality of communication signifies its own relative privilege or disadvantage—the medium is the message, which is the existence of the discursive hierarchy itself.

In addressing the applications postcolonial theories to twentieth-century and present-day psychiatry, I will also touch upon the thematic interrelationships between mourning, haunting, authorship, and voicelessness. In doing so, I will suggest that the implicit discursive hierarchies in psychiatry preclude the possibility of genuine interdisciplinarity. For example, comparisons between the experiential phenomena typically claimed by psychiatry (e.g., psychological suffering) and other interdisciplinary agenda (philosophical, political, artistic, etc.) are typically dismissed as either unduly romanticizing the former or unfairly pathologizing the latter. Yet postcolonial theories might offer a third, alternative option for comparisons between the subaltern and subpsychiatric as sites of oppression and potential resistance. Finally, I will suggest that the writings of postcolonial scholars offer a means for understanding the hierarchical—and often haunted—interrelationships between contemporary psychiatry, its 'antipsychiatric' critics, and its survivor movement.

Critical Psychiatry and the Treatment of Psychosis: Clinical and Ethical Dilemmas and a Framework for their Resolution

Sandy Steingard

Two core principles of clinical practice are informed consent and standard of care. Informed consent refers to the process of explaining the nature of a clinical condition (typically framed in the context of diagnosis), discussing recommended treatments, and outlining risks and potential benefits of accepting or rejecting those recommendations. Standard of care refers to what an average physician might recommend under similar circumstances. Although standard of care is a legal construct, it exerts significant influence over physicians' actions because of its application in medical malpractice cases. Psychiatry considers itself a part of modern medicine, which is informed by empirically validated standards of care.

While diagnostic uncertainty is a fundamental problem addressed by critical psychiatry, objections to current treatment standards remain an equally relevant focus of critique. A dilemma arises for a psychiatrist who evaluates the scientific literature and arrives at different conclusions from those generally held by her peers. Should one follow one's own carefully derived conclusions about diagnosis and optimal care, or should one adhere to accepted community standards that are at odds with one's own assessment of the available database? This paper will elaborate on this clinical and ethical challenge in the context of treatment of people who experience psychosis.

Antipsychotic drugs are an accepted first-line treatment for schizophrenia. They are, in fact, considered by most psychiatrists to be essential to recovery. Many psychiatrists consider it unethical to withhold these drugs and humane to force some individuals who refuse to take them to have them administered against their wishes. Yet, there is a parallel narrative. There are many people who have recovered without having taken these drugs. Studies challenge the concept that prescribing them as soon as possible after psychosis develops improves outcomes. Others challenge the benefits of prescribing antipsychotic drugs over the course of many years.

Because of the dominance of a drug-focused treatment model, our system of care relies heavily on the use of antipsychotic drugs to quell psychosis rapidly. A psychiatrist who believes that it is reasonable to avoid the use of antipsychotic drugs faces a dilemma: While the drugs pose risks, psychosis itself carries risks. Judgement can be impaired and a person acting under the influence of hallucinations or delusional beliefs might put himself or others in harm's way. Without a treatment venue that can provide safety while avoiding antipsychotic medications, adherence to standards of care may leave a psychiatrist no choice but to refer patients to settings in which drugs are used as first-line treatments.

Open Dialogue (OD), a treatment model developed in northern Finland, offers an alternative approach. In OD, neither the assignment of a diagnosis nor rapid administration of antipsychotic drugs is considered essential to good care. Rather than position the psychiatrist as the expert who confers a diagnosis and treatment recommendations, the patient along with her social network come together with the treatment team with the initial goal of creating a dialogue in which everyone's perspective and voice is valued. Tolerance of uncertainty is a basic principle of OD. Researchers report much better outcomes than are found in other geographical regions where treatment proceeds in the standard manner.

This paper will conclude with a discussion of the author's experience working in a community mental health center where she uses principles of Open Dialogue to convey an alternative narrative regarding

optimal use of antipsychotic drugs in an effort to provide safe, effective, and ethical care to people experiencing psychosis.

Neuroleptosis: Confrontation with the Ethic of Nonindifference and Ecstatic Naturalism

Steven Epperson

A principal effect of the administration of first and second generation neuroleptics is “psychomotor slowing, emotional quieting and affective indifference”—a concise description of the condition of *neuroleptosis*. Many “service users” describe this drug induced state more colloquially as “feeling like a zombie”—that is, impervious to caring, lacking in creative thought and agency, oblivious and indifferent to the needs of self and others. Psychiatrically induced states of neuroleptosis, as well as the systems of power and “plausibility structures” (Peter L. Berger) which rationalize neuroleptic states as “therapeutic,” present individuals, religious communities and their clergy with profound challenges to the religious life, where the latter is understood as both obligating individuals and communities to achieving “the just and the good” through active service and care, and enabling the “opening of one’s soul to the infinite.” (Donniel Hartman)

This paper will explore the intersection of Critical Psychiatry with the prophetic, ethical imperative of “nonindifference” (Hartman) and “ecstatic naturalism.” (Robert S. Corrington)

From the perspective of Critical Psychiatry, and the author’s pastoral experience in professional ministry, this paper will critique the disempowerment and marginalization that occur when those experiencing extreme states and emotional and mental distress are reductively pathologized as suffering from organic brain disorders and made subject to conventional psychiatric treatment.

Through the lens of the ethic of nonindifference—the cornerstone of the religious ethics of the major Western religious traditions—this paper will critique the so-called “therapeutic benefits” of neuroleptic induced states which disarm and relieve persons and systems of “creative maladjustment” (Martin Luther King Jr.), from the disciplined responsibility of “confronting powers and structures of evil with justice, compassion and the transforming power of love.”

Furthermore, from the perspective of “ecstatic naturalism” (Robert Corrington), this paper will critique drug induced neuroleptosis for its effect on dampening creative thought and the meaning bestowing encounter with the transcending mystery and wonder at the root of all things. Though the experience of extreme states occasions suffering, at its best, it draws upon an “evolutionary surplus of energy conducive to forge products that probe into the complexes of nature that have an uncanny depth and provenance that collectively constitute some of the treasures of human thought and creativity.” (Corrington)

This paper will conclude with some thoughts on consequences when clergy surrender epistemic authority to the practitioners of conventional psychiatry.

This is not an exercise in religious apologetics. Rather, it arises from lived experience as a parent of a “service user,” as a religious professional working in a parish setting of a post-Christian, pluralistic religious community (Unitarian), and as an ally for those whose distress has been pathologized and their lives negatively impacted by conventional psychiatry. Critical Psychiatry, along with a professional/existential engagement within my religious tradition and community, has been useful in interpreting and helping to make sense of these various, challenging and inspiring experiences.

In the Shadows of the Model Psychosis Theory: Emerging Entanglements Between Psychedelic Science and (Post-)Psychiatry

Tehseen Noorani

Psychedelic drugs are capable of unearthing deeply-buried memories from the subconscious, producing powerful, life-altering 'mystical experiences', and sparking creative inspiration. But they have also been described as mimicking psychosis, and are capable of producing terrifying experiences in what are often called 'bad trips'. Indeed, since the 1920s the 'model psychosis theory' has offered a key framework for understanding the effects of psychedelic drugs. By positing that psychedelics induce states of psychosis, the theory has staged an enduring encounter between the disciplines of psychedelics research and experimental psychiatry. Since the 1950s the implications of the model psychosis theory have largely been mobilized in two opposite ways: either to emphasize the need for restraint in psychedelic drug use because of their psychosis-mimicking properties, or to dismiss psychiatry's claims that psychoses are brain disorders lacking in revelatory content. The former has contributed to discourses of regulation and prohibition; the latter, to discourses animating anti-psychiatry and anti-medicalization movements.

This presentation moves beyond this impasse by drawing upon feminist, postcolonial and Marxist philosophies in order to deploy and extend Moncrieff's (2008) 'drug-centered model' of drug action. Instead of focusing on mainstream psychiatry and the re-emergent psychedelic sciences, I focus on the 'shadow sciences' of each, comparing underground cultures of experimentation into psychedelic drugs on the East coast of the US with the practices of the Hearing Voices Network (HVN), a transnational mental health grass-roots network that has emerged in the interstices of the psychiatric treatment of psychosis. Far from withering away, underground psychedelic drug experimentation has flourished since psychedelic drugs were outlawed at the end of the 1960s, today most visible through online repositories of hundreds of thousands of 'trip reports'. This underground research exists in an uneasy yet symbiotic relationship with the resurgence of overground human trials research, furnishing the overground research with research questions, methodologies and indicative results. Meanwhile, the HVN is comprised of an expanding number of local self-help and peer support groups across the world that offer safe spaces for experimenting with a 'post-psychiatric' approach to hearing voices, posing challenges to mainstream psychiatric service delivery. While these two shadow sciences are studied separately through overlapping disciplines such as medical anthropology or social movement analyses, they are rarely brought together, despite the model psychosis theory making a clear case for doing so.

In comparing the formation of knowledge, expertise and authority across underground psychedelics science and the HVN, I identify three themes: the labor involved in making enduring commitments to an experience or experiences, the careful construction of safe spaces in order to ground the exploration of 'inner space', and learning to learn differently through what I term 'trickster pedagogies'. Bolstered by the bridge provided by the model psychosis theory, these three themes offer an architecture for reinvigorating the phenomenological study of psychedelics and psychosis, at a time when funding streams for interdisciplinarity and co-production are enabling pharmacological research to emerge from its long behaviorist slumbers. In particular, the themes draw attention away from the fetishized and romanticized 'mystical experience', towards the hard work of making meaning out of difficult or inexplicable experiences. They also suggest conceptual and methodological opportunities for building alliances between the overground research into psychedelic drugs, which is successfully legitimating the pharmacological study of 'limit experiences' (Foucault 1984) once again, and the expertise-by-experience of psychiatric consumers and survivors.

Many ways of being human: challenging the medical view of mental disorders and the implications for psychiatry

Joanna Moncrieff

Critical psychiatry is a broad movement that questions the accepted medical basis of psychiatry, yet accepts that what we refer to as mental disorders represent significant social and personal problems that society needs to respond to. The present talk will set out the reasons why psychiatry is not another branch of medicine. Extending Szasz's critique of the concept of 'mental illness,' the differentiation of psychiatric and medical, particularly neurological, conditions will be examined. It is proposed that medical and psychiatric conditions have a different relationship to agency, responsibility and self-hood and that mental disorders are best understood as variations on familiar ways of being human. The social consequences of different views will be illustrated by looking at the history of medical involvement in the management of madness, and at the social functions of modern psychiatric practice. This will help to illuminate the nature of an alternative response to mental disturbance that resolves conflicts in a fair and transparent manner without recourse to medicalisation. The role that 'medical' knowledge and interventions might play within such an alternative model will be considered and the talk will conclude by considering the sort of training that such an endeavour would require, including elements of medicine, social science and the humanities.

An Enactivist Reconceptualization of the Medical Model

Michelle Maiese

In the West, mental disorder is understood as a form of illness, parallel to bodily illness, which can be diagnosed by a doctor on the basis of symptoms and administered treatments that have been designed to "cure" it. According to the standard medical model, one organ above all is the source or cause of mental disorder: the brain. One problem with the medical model, according to Matthews (2007), is that it asks us to view mental disorder in objective terms, as comparable to bodily disease. In the case of bodily illness, what is disordered is something objective, namely altered bodily functioning. However, it is doubtful whether disorders such as schizophrenia and depression are caused by anything neurological in the straightforward way that heart attacks are caused by arterial blockage. Many mental, affective, and behavioral problems do not have clear-cut genetic or physiochemical causes, but instead count as "difficult human experiences brought on by faulty learning, inadequate coping skills, stressful events, or other problems in the personal and interpersonal arenas of life" (Elkins, 2009, p. 71). Because mental disorders seem to be "existential" (i.e., subjectively experiential, situated, and agential) in a way that bodily disorder is not (Matthews, 2007, p. 17), they are best understood not as brain diseases but rather as *problems in living*. When minds "go wrong" in this way, it is not simply a matter of mechanical breakdown, and pointing to brain chemistry or anatomy will be insufficient to explain why someone suffers from these disorders.

Moreover, it seems clear that how we understand "disorder" is influenced by cultural norms and values. A subject exhibits a way of behaving, thinking, or feeling that diverges from certain standards of her society, and what counts as disordered is determined in part by those standards. This has led numerous theorists to conclude that 'mental illness' simply is the accepted term for numerous behaviors and subjective experiences that are problematic or that do not fit the cultural norm. Foucault (1961) and Laing (1960), for example, maintain that 'mental illness' is a label that society gives to behaviors it deems deviant, while Szasz (1961) has gone so far as to say that mental illness is a "myth."

In my view, however, this social-constructionist view downplays and obscures the very real difficulties and suffering endured by subjects with mental illness. Schizophrenia and depression, for

example, do truly pose obstacles to adapting and living well, given the way in which they involve distortions in perception, self-awareness, and social interaction. Now, of course it is true that the ways in which people pursue desires, express emotions, or navigate conflict are conditioned by the human and social context in which they pursue them. A fragmented society of individualism may make it difficult for subjects to meet their basic needs, which is to say that some cultural and political environments are toxic and that they may actually foster mental illness. However, claiming that cultural and political factors can contribute to psychopathology is different from saying that mental illness simply is a deviation from cultural or social norms.

Rather than adopting a typical “anti-psychiatry” stance, rejecting the medical model altogether, or viewing mental illness as a myth or a mere social construction, we should *revise* the medical model and think more carefully about what it means for minds to be healthy. I propose that understanding the mind as *fully embodied and enactive* allows us to navigate a middle way between a) the medical model and b) an anti-psychiatry stance. Mental illnesses do not signify simply a “broken brain” or impaired neural functioning, but instead involve one’s living and lived body *as a whole*. Thus, they are not illnesses merely in a metaphorical or analogical sense, but rather in the sense that they involve disruptions to bodily dynamics that make it difficult for subjects to adapt and live well. Like bodily illnesses, they impact the *quality* of the subject’s biological life: these conditions are “likely to reduce the chances of survival and/or of a reasonable quality of life, and/or to increase the level of pain or discomfort of the human being in question” (Matthews, 2007, p. 103). Although the socio-cultural environment does influence the way in which subjects understand and navigate their condition, disorders such as schizophrenia and depression impact some basic aptitudes that (arguably) all humans need, whatever their social environment. This means that there is some objective basis to the term ‘disorder’ though of course our sense of what counts as disordered is not free of cultural influences.

My proposed enactive, embodied approach is neither reductive nor deterministic, and follows in the footsteps of Phenomenological psychopathology in the sense that it takes seriously the lived bodily experience of mental illness. This approach says that we cannot conceptualize mental disorders in *mechanistic* terms or treat the human person as nothing but bits of living machinery. From the enactivist perspective, living animals have “natural purposes,” and they function not as machines, but rather as complex dynamic systems that are self-organizing, self-regulating, and adaptive. This approach says that human subjects enact a meaningful world *in-and-through* their bodies, and that mental illness involves both distortions to one’s mode of being-in-the-world (i.e. changes in lived bodily experience) and also disruptions in the dynamics of the living body. Thus, “disorders” do warrant some sort of causal explanation (in terms of neurobiological dynamics) as well as some sort of phenomenological explanation (in terms of lived bodily experience, thoughts, feelings, and desires). This more holistic approach to psychopathology suggests that we need more holistic approaches to therapy and mental health, ones that simultaneously involve both transforming subjective meanings as well as altering bodily dynamics. In addition, my proposed approach emphasizes that mindedness is not only fully embodied and enactive, but also interactive and socially embedded. Thus, it paves the way for an account of how societal conditions can contribute to various forms of mental illness.

Title: Madness as Dysfunction and as Strategy

Justin Garson

Since the 1970s, professional American psychiatry has been largely – though not exclusively – dominated by a certain intellectual framework I call *madness as dysfunction*. This can be thought of as a paradigm, as in Kuhn, or an episteme, as in Foucault. This framework views psychiatric problems as stemming from the breakdown or failure of a mechanism to perform its natural function. This framework was canonized in the DSM-III and later editions, which holds psychiatric symptoms to result

from various sorts of “behavioral, psychological, or biological dysfunction[s]” (APA 1980, 6). This framework is also implicit in the RDoC system of classification, whose main proponents view mental disorders as the result of inner dysfunctions (Insel et al. 2010, 748). Any attempt at a critical psychiatry must seek to identify, and potentially replace, some of the core ontological commitments on which contemporary American psychiatry is built, and I believe that this is one of them.

I think the madness-as-dysfunction framework can be harmful to people with mental disorders, in at least two ways. First, it can hinder research and treatment options by encouraging researchers to focus exclusively on purely “internal” factors involved in disorder, such as biological or cognitive factors. This can lead to neglecting other options, potentially leading to less effective treatments. More importantly, I think it promotes a certain *kind* of stigma, one that is captured well by Peter Strawson’s distinction between the reactive and objective attitudes (Strawson 1962; I thank OMITTED for making me aware of this connection). I will return to this latter point shortly.

Fortunately, there is a very different intellectual framework that some psychiatrists have relied on throughout the twentieth century. I call this *madness as strategy* (OMITTED). This approach views psychiatric problems as (perhaps unconscious) strategies that the person is deploying to achieve some end. From this stance, psychiatric problems, such as anxiety, depression, or even the delusions and hallucinations associated with schizophrenia, have a goal-directed or teleological dimension. In fact, what are often regarded as symptoms may be necessary steps towards maintaining some degree of health. This perspective is explicit in psychoanalytic psychology; in Freud’s view, various neuroses represented disguised attempts to fulfill repressed desires (e.g., Freud 1966, 327-333). This view was also embedded in the first edition of the DSM. This manual recognized three major kinds of non-organic mental disorders, and it depicted *each type* as representing a different sort of strategy for resolving inner psychological conflicts. For example, the psychotic reactions were those in which, “the personality, in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism, and withdrawal from reality...” (APA 1952, 12). Harry Stack Sullivan (1962, 8) summarized the idea well when he wrote that the chief job of the psychiatrist is to “understand what the patient is trying to do.” In other words, in Sullivan’s view, the goal of the psychiatrist is merely to figure out what the symptom’s “end” or “purpose” is. My point is not that we should return to Freud or to psychodynamic psychology; rather, as I will explain, what I am calling “madness-as-strategy” represents a much more general paradigm for thinking about mental disorder, one that transcends psychoanalysis entirely.

To clarify, I do not maintain that the madness-as-strategy framework entirely gave way to the madness-as-dysfunction framework in the 1970s. *To an extent*, these frameworks have continued to coexist; in fact, researchers and clinicians will often shift from one framework to another depending on the contingencies of the clinical encounter (I thank OMITTED for this important point). Furthermore, the distinction that I wish to identify cannot be reduced to other conventional distinctions, such as that between psychodynamic and biological approaches, or that between non-medical and medical approaches. Rather, the distinction I recommend cuts across these other distinctions in interesting ways. For example, I think there are some research programs today – though still in the minority – that are biologically-oriented and based on the madness-as-strategy framework. Some of these are rooted in evolutionary psychology, e.g., the idea that depression is an adaptation for dealing with interpersonal conflict (e.g., Nesse 2000). Some are rooted in developmental psychology, e.g., that anxiety represents an outcome of developmental plasticity and that it is an adaptive response to a hostile early environment (e.g., Glover 2011). Some are rooted in cognitive neuroscience, e.g., the idea that the delusions of schizophrenia may have some adaptive value in helping an individual adjust to perceptual

abnormalities (see Bortolotti 2016 for discussion). It is useful to see all of these diverse projects as embodying a core vision (madness-as-strategy) and as representing a resurrection of a way of thinking that was common in psychiatry prior to the 1970s.

There are several benefits to recognizing this distinction, for historiography, psychiatric research and treatment, and philosophical analyses of the *concept* of mental disorder. Most importantly, for this context, it has potential benefits for lessening stigma associated with mental illness. I think the madness-as-dysfunction approach creates a distinctive kind of stigma, which is captured well by Strawson's (1962) distinction between objective and reactive attitudes. When I assume a reactive attitude toward you, such as resentment or forgiveness, I am treating you as having some responsibility or authorship over your words and actions. My ability to adopt reactive attitudes toward you is the basis for having an authentic relationship with you: "being involved in normal interpersonal relationships as we normally understand them precisely is being exposed to the range of reactive attitudes and feelings that is in question". In contrast, in the objective attitude, I can no longer see you as having authorship over your words and actions. As a corollary, in Strawson's view, I cannot have a normal relationship with you; I have situated you outside of the circle of people with whom I can normally relate. Suppose, however, I adopt the madness-as-strategy approach. This approach encourages me to assume the way you think and behave is an intelligible response to the circumstances in which your character has been forged. As a consequence, I'll be more inclined to see you as a person, someone like me, who is struggling – perhaps unsuccessfully – to cope with what life has thrown at you.

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Sartrean ethics and critical psychiatry: a novel perspective on the autonomy and mental illness debate

Alexis Thibault

Critical psychiatry argues that mainstream psychiatry is justly undergoing a crisis of confidence. This movement criticizes various aspects of conventional psychiatry; the biomedical perspective on mental distress, the reductive 'technological reasoning' of contemporary psychiatric science, the criticizable state of current psychiatric knowledge, its production often being in the hands of the pharmacological industry and, also, the relation of psychiatry to issues of power, control and coercion. If the targets of critical psychiatry are multiple, the movement appears to have one overarching concern: the moral integrity of the discipline in the face of these challenges. While advocacy for an ethically-relevant psychiatry is constant, this preoccupation has scarcely been tackled from a direct ethical standpoint; the field of psychiatric ethics remains largely untapped by the critical psychiatry movement. Filling a void in

the scholarship, I intend to examine one of the central ethical issues of psychiatry: the autonomy of those considered mentally ill. Autonomy, as a core concept of psychiatric practices, can play an essential part in changing the face of the psychiatric enterprise. I begin by undertaking a dissection of current conceptualizations of autonomy, and their associated concept of capacity which operationalizes autonomy in practices. In most Western jurisdictions, no matter the actual legal definitions of capacity, and regardless of whether autonomy and capacity are conceptualized as a function of rationality or authenticity, I argue that 1 AAPP Meeting 2017 the conceptual role of capacity is that of delimiting autonomy from (severe) mental illness. Thus, there is almost always — in theory and practice — a concealed sine qua non condition where madness and autonomy are considered mutually exclusive. Furthermore, when scrutinized, it appears that determining capacity in practice — in other words, determining the ability for autonomous decision-making — is always a third-person perspective judgment, a normative, subjective and partial judgement. This judgment, which covertly impacts every clinical decision, far from being solely a legal tool and categorization, is the meeting point of competing interests and values; those of society are often competing with those considered to be suffering from mental illness. Looking at the impact of those clinically omnipresent yet surreptitious judgments of capacity and incapacity on the lives of the mentally ill, I wonder whether capacity, as an operationalization of autonomy, really is an ethically sound concept for practice. I contend that the upshot of judgments of capacity and incapacity is problematic because mentally ill patients and their will, human beings and their perspective, are deemed worthy of respect only to the extent that they are judged to have capacity. The mistake of psychiatry there is to obscure the fact that it is possible to have profound ethical justifications, a plurality of reasons, to value and respect the choice of mentally ill persons, regardless of whether it is judged to be exercised with capacity. Capacity is not the only feature of a human being that justifies respect. In turn, the use of capacity-as-autonomy as an ethical standard has downstream negative effects which have been underestimated. It contributes to the legitimization of coercion, both in its formal and informal forms. It conveys the message that mentally ill persons' perspectives, narratives, values, and truth in illness are erroneous; it negates the possibility for individuals experiencing distress and marginalization to legitimately re-organize their values accordingly. It assists in patients' 2 AAPP Meeting 2017 negative visions of themselves, and ultimately in their overall disempowerment. Capacity as a gatekeeper to autonomy, and hence as a gatekeeper to respect, strengthens society's negative vision of madness, contributing to prejudice and stigma, looping back to how the mentally ill experience themselves. Because of this, capacity-as-autonomy needs to be re-evaluated as a gold standard in psychiatric ethics. It appears that to depose capacity, a novel account of autonomy is needed. It is there that Sartre's account of autonomy appears like an ethically sound alternative. Sartre's positions have been largely forgotten in contemporary philosophical debates around psychiatry, including those stemming from a critical psychiatry perspective. His existentialist phenomenological ontology, taken mainly from Transcendence of the Ego, Existentialism and Humanism, and Being and Nothingness, conceptualizes autonomy in a radically different way, so much so that I observe its incompatibility with capacity. Sartre, through a process of phenomenological reduction, argues that existence precedes essence, that freedom is the only superior value, the value that makes possible all other values, and that meaning and values are subjective and elicited only through one's life-project, one's judgment on one's being-in-the-world. It follows that his account of autonomy grants almost absolute respect to the choices of individuals, and thus de-emphasizes the necessity of externally-judged capacity, whether that be based on judged rationality or authenticity, expanding the non-interference sphere of patients. As such, his perspective creates the possibility for a practice that avoids coercion, disempowerment and stigmatization. It allows for meaning-in-illness, guarantying the respect for patients' perspectives, acknowledging the legitimacy of their possibly transformed self-in-illness. Sartre's 3 AAPP Meeting 2017 conception of autonomy attains this whilst avoiding a state of extreme subjectivism and ethical relativism, for every human is understood as

morally responsible for his decisions and actions. While Sartre's account of autonomy does not appear unproblematic, notably in regards to harm prevention, I argue that the possible caveats do not outweigh the benefits for the fate of the mentally ill in our society. Exploring its possible application in psychiatric practice, including its impact on doctor-patient relationship and on the relationship between psychiatry and power, I argue that a Sartrean autonomy can prove a better approach than capacity to psychiatry's cardinal aims: the promotion of autonomy, the search for well-being and the advocacy for empowerment. A Sartrean conception of autonomy in psychiatry, deposing capacity as a key concept in its ethics, is also readily compatible with the recovery and service-user movements. Such a reformed conception of autonomy in psychiatry appears as an interesting alternative for psychiatry's ethical relevance.