Self and Mental Disorder:

Lessons for Psychiatry from Naturalistic Philosophy

1. Introduction

The question "What is the relationship between the self and mental disorder?" is especially important for mental health professionals interested in understanding and treating patients, as most mental disorders are intimately tied to self-related concerns, such as loss of self-esteem and self-control, or diminished agency and autonomy. Philosophy, along with the cognitive and behavioral sciences, offers a wealth of conceptual and empirical resources to answer this question, as the concepts of the self and psychopathology have occupied a central place in these fields since their inception. Interestingly, and unfortunately, however, scientific psychiatry, in its approach to mental disorder as primarily a cluster of signs and symptoms has been slow in acknowledging the advances in conceptualizing and investigating mental disorders in relation to the self.

The article addresses this problem and offers solutions for better cross-fertilization between empirical and philosophical inquiry into the self and psychiatric research on mental disorders. The first part evaluates what empirically informed philosophical inquiry and philosophically informed empirical inquiry offer to the examination of the relationship between the self and mental disorders. The second part argues that scientific psychiatry has missed opportunities to find effective treatments for mental disorders because of its insularity from debates in naturalistic philosophy and cognitive and behavioral sciences. Psychiatry has much to gain from the conceptual, scientific, and clinical resourcefulness of philosophy's collaboration with the cognitive and behavioral sciences.

2. The Self and Mental Disorder in Philosophy and the Cognitive and Behavioral Sciences

Consider the question "What is the relationship between the self and mental disorder?" in detail. A crucial first step is to clarify what it asks. One interpretation focuses on whether selfhood can be attributed to those who experience mental disorders. The answer to this question has been mostly a "no". The history of Western philosophy is full of examples showing the possession of a phenomenologically typical cognitive state is a prerequisite for selfhood. In these examples, the phenomenologically standard self is the norm, and the possibility of developing selfhood is completely ruled out for those with a mental disorder. Mental disorders, to the extent they are featured in these arguments, are used as thought experiments to support or undermine the theses developed to explain the fundamental nature or properties of the self.

Now, consider the Cartesian notion of the self as a metaphysical substance, a notion emerging from Descartes's methodological search for indubitable knowledge. To arrive at such knowledge, Descartes doubts the veridicality of his own senses and the existence of the external world by positing that he may be (i) dreaming, (ii) tricked by an evil demon, or (iii) mad. While he engages in detail with the possibilities inherent in (i) and (ii), he takes less time to assess (iii), i.e., the possibility that he is a "madman," "whose brains are so impaired by the strong vapor of black bile that they confidently claim to be kings when they are paupers, that they are dressed up in purple when they are naked, that they have an earthenware head, or that they are a totally hollowed-out shell or are made of glass" (Descartes, 1641/1968). He quickly dismisses – instead of examining – this possibility by arguing, "But those people are insane, and I would seem to be equally insane if I followed their example in any way" (Descartes, 1641/1968). At the end of this process, the only thing Descartes can say for certain is that he is thinking (i.e., doubting), and this

serves as evidence of his own existence as a thinking substance, the "self" (Descartes, 1641/1968). The self is a thinking substance, metaphysically simple, unified, bounded, permanent, independent, and self-transparent.[1] The possibility that the self in question may be a self-with-mental-disorder is not envisaged; nor is the nature of the relationship between the self and mental disorder examined.

Philosophers responding to the Cartesian notion of the self as a mental substance followed Descartes' example, not really considering the possibility of selfhood being attributable to a person with a mental disorder, leading, in effect, to the separation of questions about selfhood from questions about mental disorders in Western philosophy. Debates of this nature continued in the analytic philosophy of mind up to the mid-20th century without a robust engagement with the question of how the experiences of people with mental disorders are related to the self.[2] In so far as the topic of mental disorders and the self was examined, it was merely through thought experiments laying out fantastic scenarios involving mental disorders and endorsing or challenging certain assumptions about personal identity (e.g., Locke, 1690/1975;

[1] I don't argue that Descartes's metaphysics cannot accommodate individuals with mental disorders. We may argue, for instance, that when Descartes is talking about the self, he means what a Kantian might call the "transcendental ego," not the "empirical ego." With the self, Descartes has in mind the thing whose existence cannot be doubted, something that is not part of the complex and changing empirical world. Rather, the self is something that endures through change. In that sense, we may further argue that Descartes cannot deny that a mentally disordered person also has a self; it is, in fact, *a priori* true that each person, whatever the order or disorder of their mental state, is identical to some mental substance in the sense that the persistence of this mental substance—and not the connectedness of mental states or the connectedness of bodily states—accounts for persistence through time. My point is that Descartes's own inquiry does not take seriously the experience of individuals with mental disorders in the sense that he immediately dismisses the possibility that the self may be mad. (I am grateful to Mike Almeida for drawing my attention to this point.)

[2] No doubt the history is much more complex than can be delineated in this short article; my aim is to offer a reading in broad strokes that streamline the debates on the relationship between the self and mental disorder.

Hume, 1896; Parfit, 1984; Wiggins, 1967; Tabb, 2017). For example, to support his psychological continuity thesis, Locke argues we do not punish "the mad man for the sober man's actions, nor the sober man for what the mad man did" (Locke, 1690/1975). However, he does not examine precisely how to think about the personal identity of the person with a mental disorder or what kinds of responsibility – if any – must be attributed to that person.

The philosophical landscape of the debates on the self and mental disorder relationship started to change with the rise of psychoanalysis at the beginning of the 20th century through the work of Sigmund Freud and Jean-Martin Charcot. Psychoanalysis is a theory of personality development according to which the mind has conscious and unconscious layers. Unrecalled traumatic childhood events (stored in the unconscious) and adaptations to environmental influences shape the mental functioning of adults (Freud, 1917). Psychoanalysis promotes treating mental disorders by investigating the interaction between conscious and unconscious elements in the patient's mind, using techniques such as dream interpretation, hypnosis, and free association. Freud's most important contribution, for the purposes of this article, was his examination of the properties of the self and mental disorders through his case studies. These help to contextualize mental illness in the historical and social dimensions of a real person's life.

A number of philosophers challenged the use of thought experiments to study the self or personal identity instead of considering the actual experiences of those affected by mental disorders. For example, with what might be called Real People Challenge (RPC), Kathleen Wilkes argues philosophers of mind in the analytic tradition have much to gain from contemplating the experiences of "real people," including those experiencing what was then called multiple personality disorders (Wilkes, 1988). RPC is a point of concern in the phenomenological tradition of philosophy as well, for those referring to mental disorders to

merely endorse their views about the self, as opposed to examining the nature of the relationship between the self and mental disorders. Founded by Edmund Husserl at the turn of the 20th century, phenomenology offers a study of human experience and existence by investigating the essential structures of consciousness – i.e., those structures that hold for any experiencing human subject – including selfhood and intersubjectivity. Some phenomenologists evaluated psychopathology in their examination of the human experience in the world, using it as a thought experiment to support their own views of the nature of human perception. For instance, Merleau-Ponty's *Phenomenology of Perception* examines how some aspects of perceptual experience are disrupted in psychopathologies such as schizophrenia; however, he uses this analysis pragmatically to develop an account of typical consciousness/perception (Merleau-Ponty, 1945/2012; Fernandez, 2019). He does not give a detailed analysis of mental disorder in relation to the concept of the self, using actual cases. Others engaged more directly with individuals' experience of mental disorders in their analysis of the relationship between the self and mental disorders (Jaspers 1913/1997; Sartre 1981). For example, Karl Jaspers, in *General Psychopathology: A Guide for Students, Physicians and Psychologists*, aims to provide a scientific framework for psychopathology. He examines the inner mental experiences of people diagnosed with schizophrenia and regards them as reflective of the general properties of human consciousness, such as delusions, modes of self-consciousness, and modes of emotions (Jaspers 1913/1997).

Beginning with psychology's recognition as a scientific discipline in the late 19th century, more interdisciplinary work started to emerge by way of collaborations between philosophers and psychologists on the nature of the relationship between the self and mental disorder. Thus, the focus shifted to a second interpretation of the question I asked above: "What is the

relationship between the self and mental disorder?" This new interpretation involved thinking about the changes the self goes through in the presence of a mental disorder. For example, William James made major contributions to a picture of the self that can plausibly be interrupted by the presence of a mental disorder. In his understanding, the self is constituted by four different but complementary selves: (i) the material self, (ii) the social self, (iii) the spiritual self, and (iv) the pure ego. Psychopathology, such as multiple personality disorder, emerges when there are disruptions in these dimensions of the self (James, 1890/1983). James's approach to the self is one of the first formulations of the naturalistic position in the philosophy of mind; he examines the nature of the mind in reference not only to metaphysics but also to the empirical sciences (Flanagan, 1991).

A naturalistic approach to the question of the self and mental disorder relationship in philosophy accelerated with the Cognitive Revolution in the second half of the 20th century. Theories of mind and human cognition in both the analytic and the phenomenological traditions were challenged by philosophers whose work was informed by data supplied by the cognitive and behavioral sciences, such as psychology, anthropology, linguistics, neuroscience, etc. (Bechtel, Abrahamsen, & Graham 1998). Taking seriously the empirical work on the relationship between the self and mental disorder, these philosophers embraced the experience of mental disorder as a contingent property of selfhood. They examined such topics as childhood amnesia, the role of memory in the development of the self, the interactions between linguistic and memory development, and the disruption of self-experience and personal identity by memory problems (Luria, 1982; Neisser, 1982; Schachtel, 1982). Others asked how mental disorders affect an individual's rationality and decision-making capacity or her self-related capacities such as self-conceptualization and self-control (e.g., Koenig, 1997; Neisser and Jopling, 1997; Jopling

2000; Lakoff, 1997; Nuckolls, 1997). At the same time, philosophical analysis enriched the empirical investigation of the self by encouraging scientists to be more rigorous in making conceptual distinctions among various self-related phenomena (Jopling, 1997, 2000; Schechter, 2018).

In what follows, I loosely organize the work emerging from collaborations between philosophers and cognitive and behavioral sciences into "empirically informed philosophical analysis" and "philosophically informed empirical analysis."

2.1. The Self and Mental Disorder: Empirically Informed Philosophical Analysis

An important philosophical approach to the relationship between the self and mental disorder is the work focusing on what was previously labelled multiple personality disorder (MPD), currently called dissociative identity disorder (DID). MPD is characterized by the presence of at least two distinct and relatively enduring personality states which are sometimes amnesic to one another. MPD became popular among philosophers in the second half of the 20th century because it posed significant challenges to the widely accepted Cartesian conception of the self as a unity. Significant debates occurred on topics ranging from the metaphysical reality of MPD to the properties of the self with the potential to give rise to it (Radden, 1996; Hacking, 1996; Flanagan, 1991; Dennett and Humphrey, 1989; Tekin, 2014). For example, Jennifer Radden brought together the philosophical debates on personal identity over time and the research in cognitive and behavioral sciences to examine how people radically transform as a result of a mental disorder. For Radden, mental disturbances such as MPD and delusions allow us to reconceptualize the traditional approaches to personal identity and abandon the notion of a bounded and unified self in favor of a view that posits a "succession of selves." This work aligns

with the feminist approaches to the self, according to which the self is not a disembodied, unified, bounded, and metaphysical substance, as the Cartesians claim it to be, but an embodied, dynamic, and relational entity responsive to the social and cultural layers of the community it is placed in (Willett, Anderson, and Meyers 2016; Radden 2019). Radden suggests the normal or the typical self is heterogeneous and subject to variations and perturbations, and the psychopathological self must be understood in reference to it. Radden's work offers a rich framework to make sense of psychopathology in the context of typical human cognition, personal identity, and the self. It challenges the traditional conceptions of the self in philosophy and offers clinicians a framework for their treatment of individuals with mental disorders.

Another example of a philosophical inquiry into the relationship between the self and mental disorder illuminated by the cognitive and behavioral sciences is the narrative approach. Philosophers and psychologists posit various kinds of connections between the self and the narratives about the self, i.e., the stories individuals tell themselves about themselves (autobiographical narratives) and the stories others tell individuals about themselves (social narratives). Psychologists mostly use empirical studies of memory, joint reminiscence of the past, and parent-child narratives to examine how the self develops in response to autobiographical and social narratives (Fivush and Nelson, 2006; Hoerl and McCormack, 2005). Philosophers, however, often think of narrativity as having a temporal nature, whereby people remember the past and envision a future. They use both thought experiments and real cases to cite experiences of mental disorders and connect them to the narrative nature of the self (Flanagan, 1996; Dennett, 1992). Some philosophers and psychologists take narratives or narrativity as merely *one* basis of personal identity and one cognitive tool used by the individual to construct self-concepts (Flanagan, 1991; Fivush, 1994; Tekin, 2010, 2011, 2013). Others

disagree, seeing narrative as *the* basis for self-constitution (Dennett, 1991; MacIntyre, 1981; Schechtman, 1996). Robyn Fivush's work on parent-child narratives illustrates, for example, how social narratives shape children's perceptions and responses to reality, serving as a fundamental building block in their emotional development (Fivush, 1998).

Such work has been used by philosophers to make sense of psychopathology (Flanagan, 1994; Tekin, 2010, 2011). For example, using the narrative approach to the self, Owen Flanagan argues the self is multiplex – i.e. various self-representations are collected into a single autobiographical narrative by the individual, who performs "active authorial work" to integrate her memories about the past and plans for the future (Flanagan, 1991, 1996). In typical cases, a robust selfhood remains even in the face of transformation, change, and conflicts in its relationship to itself and the world. In effect, a narrative thread connects the multiplex dimensions of the self. If this unifying authorship fails, however, we are confronted with multiple selves, as opposed to multiplex selves. This is how Flanagan explains MPD.

Similarly, according to Dennett, the "normal" individual of the species *Homo sapiens* creates a self by spinning stories about herself in the process of presenting herself to others through language. For humans, the tendency to create selves by way of creating stories is akin to how spiders weave webs to protect themselves; it is both intrinsic and unconscious (Dennett, 1991). Because it is constructed and abstracted from narratives, the self is permeable and flexible. Dennett also uses MPD to illustrate the idea of the self as constructed and abstracted from narratives and as permeable and flexible (Dennett & Humphrey, 1989). The multiple personalities said to be possessed by the same body cannot be reliably individuated, either by the individual or others, precisely because the self is not a real thing that is easily identifiable.

As empirical research in philosophy of cognitive and behavioral sciences has evolved, the number of mental disorders examined in relation to the self has proliferated (Radden, 2019); including melancholy and depression (Radden, 2009, 2016; Browne, 2018), schizophrenia (Tekin, 2017; Gerrans, 2014), bipolar disorder (Tekin, 2014; Radden, 2013), substance abuse disorders (Flanagan, 2013a, 2013b; Pickard &Ahmed, 2019; Tekin, 2019; Tekin, Flanagan, and Graham 2017), and delusions and religious beliefs (Graham, 2015). A number of novel approaches have been developed in which the self is construed as a multilevel and multi-dimensional mechanism that interacts with the social and physical environment and with the culture in which it is embedded (Bechtel 2008; Thagard 2014; Tekin 2019). Finally, important philosophical work has challenged the traditional accounts of agency by taking into account the experiences of "disorderly psychologies" and called for an empirically informed and pluralistic reflection on how persons develop agency and ethically order "the lives they live together" (Doris 2015). Taken together, they offer ample conceptual and empirical resources for an examination of the relationship between the self and mental disorders.

2.2. The Self and Mental Disorder: Philosophically Informed Empirical Analysis

Now consider the philosophically informed empirical work in psychopathology that includes an examination of the relationship between the self and mental disorder. The work of philosophers and psychiatrists trained in phenomenology has, at times, directly shaped clinical work on mental disorders (e.g., Gallagher, 2004; Sass, 2010; Sass and Parnas, 2003; Parnas et al, 2005; Parnas and Bovet, 2014; Parnas, Bovet and Zahavi, 2002; Parnas et al, 1998; Maiese, 2015), but as I explain in detail below, this line of research suffers from many conceptual and empirical problems.

One example is the characterization of schizophrenia as a “self-disorder” in the work of Louis Sass, Joseph Parnas, and Dan Zahavi. Note that "schizophrenia" is a contentious phenomenon because it is heterogeneous when examined from etiological and phenomenological perspectives. Some philosophers and psychiatrists have vehemently argued that what is often referred to as schizophrenia is not a tidy and clean phenomenon, and it is not appropriate to call it a single disorder, or even claim that it exists at all (Bentall 2017). Philosophers and psychiatrists in the phenomenology tradition who refer to schizophrenia as a self-disorder remain silent about these concerns. They take it for granted that there is such a thing as schizophrenia, and it can best be described as a self-disorder. Their conceptualization of schizophrenia does not align with the definition of schizophrenia in the Diagnostic and Statistical Manual of Mental Disorders, but they see this discrepancy as emerging from the problems of the DSM. These philosophers and psychiatrists understand the loss of “inner unity of consciousness,” “splitting of the self,” and the “loss of the ability to direct thoughts” as core features of schizophrenia. More specifically, they argue schizophrenia is “an ipseity disturbance in which one finds certain characteristic distortions of the act of awareness” (Sass and Parnas, 2003). The concept of “ipseity,” from the Latin for “self” or “itself,” refers to the experiential sense of being a vital subject of experience with a first-person perspective on the world. Also called self-experience[subjecthood](Tekin, 2017), this phenomenon can be defined as an individual’s experience of herself as the *subject* of cognition and emotion, *through* which she acquires a *first-person perspective* on the world. For example, when I take a sip of my coffee, I taste the coffee, while, simultaneously, I am aware that I am the subject of my experience of tasting the coffee. Phenomenologists call this the “mineness” of first-person experience (Parnas and Sass, 2011). In

other words, self-experience[subjecthood] is directed at the world around the self; it is the unarticulated constituent of subjective experience (Perry, 1998).

Self-experience[subjecthood] is pathological in individuals with schizophrenia, phenomenologists argue, because these individuals fail to consider themselves to be the vital *subjects* of awareness, emotion, and cognition. The vitality of their own subjective self-presence is diminished; they do *not* perceive themselves as the active agents of their own cognitive states. Phenomenologists' analysis rest on these clinicians' observations of these individuals and the individuals' self-reports about the diminishment of the sense of "mineness" of their actions, thoughts, feelings, impulses, etc., to the point of feeling they are possessed by an alien being (Parnas and Sass, 2011). Typical utterances include the following: "I don't feel myself," "I am not myself," "I am losing contact with myself," "Something inside me turned inhuman," "I am feeling like a spectator to my own life" (Parnas and Handest, 2003), "I am half-awake," "My I-feeling is diminished," and "My I is disappearing for me" (Parnas and Sass, 2011).

Phenomenological approaches to the self and schizophrenia relationship have influenced clinical practice through a psychometric instrument called EASE (Examination of Anomalous Self-Experience). Created by Joseph Parnas and colleagues to diagnose schizophrenia (Parnas et al, 2005; Parnas and Handest, 2003), EASE is a "symptom checklist for semi-structured, phenomenological exploration of experiential or subjective anomalies that may be considered as disorders of basic or 'minimal' self-awareness" (Parnas et al., 2005; McGorry, 2009). First developed as an outcome of clinicians' impressions of patients' experiences, EASE was later supported by empirical research, with significant reliability and validity, making it an important tool to diagnose and treat schizophrenia (Parnas et al., 2005). Its proponents take EASE to be a better alternative than the DSM, even though it seems conceptually problematic to label EASE a

tool to diagnose schizophrenia, as the category is currently defined (for better or worse) by the DSM criteria.[3]

The phenomenological work on the self-disorder relationship in the context of schizophrenia has been reinforced by neuroscientists working on the brain's default network system (DNS) – the anatomically defined brain system that is active when individuals are not focused on the external environment. Findings of correlations between atypical activity in the brain and the symptoms of schizophrenia have increased optimism that a Phenomenology-Neuroscience Partnership (PNP) research paradigm (Tekin, 2017) will shed light on the neurological underpinnings of the disorder. Neuroscientific studies of the DNS have problems, however, and these cause further problems in the work looking at schizophrenia from the perspective of the DNS paradigm (Tekin, 2017; McCaffrey and Danks 2017). Those sympathetic to a neuroscience-phenomenology partnership (PNP) attribute the symptoms of schizophrenia, such as the ambiguation between the boundaries of the self (subject) and other, or the imagined and real world, to an over-active and over-connective DNS (Whitfield, Gabrieli et al., 2009; Buckner et al., 2008; Nelson et al., 2008). This has led some scientists to call for using DNS activity as a diagnostic tool to identify the at-risk population and facilitate early interventions. The goal is to detect the DNS anomalies in individuals who are in the prodromal phase of schizophrenia, i.e., those who do not experience all typical symptoms of schizophrenia but show some of its early signs and "treat" them before the disorder is fully developed (Nelson et al., 2008). This, proponents argue, would increase the likelihood of long-term recovery or even prevent the illness onset (Yung et al., 1996; Yung et al., 2003; Yung et al., 2004). Early intervention strategies for the prodromal population include, for example,

[3] I am grateful to an anonymous referee for bringing this point to my attention.

psychopharmacological treatment. This, of course, raises ethical problems about whether to treat an individual *before* she fully develops the illness (Broome, Fusar-Poli, Wuyts 2013). Arguably, the benefits of such early diagnosis using prodromal presentations may outweigh the harms, but the burden to justify this stance is on those who advocate the practice.

More importantly, for the purposes of understanding the relationship between the self and mental disorder, the PNP paradigm poses serious epistemic concerns that philosophers are uniquely poised to examine. A core assumption of these proposals is that self-experience can be individuated by the DNS activity in the brain. Anomalies in the DNS activity are believed to reveal the neurological underpinnings of the disturbance of self-experience in schizophrenia – a core phenotypic marker of the illness, as phenomenologists see it. Evidence of the traction of self-experience in DNS activity comes from a number of fMRI studies (Northoff, 2015; Qin and Northoff, 2011; Northoff et al., 2006).

However, there are major conceptual problems with the different characterizations of the concept of self-experience in the neuroscientific research on DNS and the phenomenological work on schizophrenia. DNS researchers take self-experience to be an individual's experience of herself as the *object* of perception, cognition, and emotion, i.e., self-experience^{objecthood}. For instance, my recognition that the hands holding a cup are *my* hands, or that a personality trait such as gregariousness characterizes *my* personality, are examples of me experiencing myself as the object of my cognitive states. DNS activity is measured when subjects are engaged in cognitive tasks that individuate self-experience^{objecthood} , involving representing some mental or physical feature as a feature of themselves. In a frequently cited study, tasks that purportedly tracked self-experience^{objecthood} included "trait adjective judgment" where subjects were asked if a particular adjective defined their personality trait, and "face and body recognition" where

subjects were asked to pick themselves out in photographs (Qin and Northoff 2011). However, the concept of self-experience that characterizes schizophrenia, according to phenomenologists, involves atypicality in the individual's experience of herself as a *subject* of experience through which she attains a first-person perspective on the world, i.e., self-experience^{subjecthood}. As noted above, individuals with schizophrenia report a loss of the sense of ownership in inhabiting their own cognition to the point of feeling they are actually in the possession of some alien being.

In short, phenomenologists track anomalies in self-experience^{subjecthood} in schizophrenia whereas DNS researchers track self-experience^{objecthood} (Tekin, 2017; Legrand, 2007; Legrand and Ruby, 2009). The misalignment between the phenomenological concept of self-experience^{subjecthood} and the neuroscientific concept of self-experience^{objecthood} leads to serious empirical problems, making it challenging, if not impossible, to draw reliable conclusions about the correlation between DNS anomalies and schizophrenia (Tekin, 2017). It would be misguided to infer that because schizophrenia is a self-experience disorder and self-experience is individuated by DNS activity, schizophrenia etiology can be traced in anomalous DNS activity.

3. Psychiatry on the Self-Mental Disorder Relationship

Creating a system of classification for mental disorders with the goal of advancing research on the understanding and treatment of these disorders has been a central project for psychiatry since the late 1800s. Efforts to develop a robust classification system for mental disorders accelerated in the 1950s, both in Europe, through the World Health Organization's International Classification of Diseases (ICD), and in the United States, through the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Interestingly, however, the psychiatrists spearheading these movements have largely remained silent in the

debates on the relationship between the self and mental disorder in philosophy and cognitive and behavioral sciences. I shall focus exclusively on the DSM here, the classification manual of mental disorders created and regularly revised by the APA in an effort to respond to new scientific developments in understanding mental disorders.

Creators of the DSM have neither systematically engaged nor incorporated the insights of philosophers and cognitive scientists who conceptualize mental disorders in relation to the self. This is puzzling, because the APA, especially starting with the third edition of the DSM (DSM-III), has made a serious commitment to making the DSM a scientifically rigorous manual that will advance psychiatry's scientific and clinical goals, yet it has neglected to acknowledge the advances in philosophy and the cognitive and behavioral sciences on the relationship between the self and mental disorder (APA, 1980; Tekin, 2019; Parnas and Bovet, 2014).

The historical context of the APA's debates on psychiatric taxonomy makes the oversight especially puzzling. The initial motivation to develop a classification of mental disorders in the United States in the late 1940s was to collect statistical information on the "mental fitness" of soldiers prior to deployment. The US Army and the Veterans Administration collaborated with psychiatrists to incorporate the outpatient presentations of World War II service members and veterans into the DSM system. The DSM-I (APA, 1952) was created for this purpose; its psychoanalytic framework reflected the dominant approach to understanding psychopathology at the time. As briefly discussed above, psychoanalysis attributes mental disorders to unrecalled childhood traumas stored in the unconscious (Freud, 1917). Mental disorders are treated by investigating the purported relationship between conscious and unconscious elements in the mind, using tools such as dream interpretation, hypnosis, and free association. The DSM-I and the DSM-II (APA, 1968), following the psychoanalytic framework, referred to mental disorders

as “reactions” and represented them in relation to causal factors such as dysfunctions in the brain or general adaptational difficulties to environmental stressors. Starting in the 1960s, the DSM framework was criticized for lacking scientific validity and reliability (Hempel 1994/1961; Schwartz and Wiggins 1987a; 1987b). Critics argued that a scientifically valid category of mental disorder needs *external validators* such as signs (observed by others) and symptoms (experienced by the patient), not simply *theories* such as psychoanalysis (Robins and Guze, 1970; First et al., 2004). In addition, critics raised concerns about the reliability of the DSM categories (Cooper et al., 1969). Because the classification of mental disorders was not based on observable and measurable evidence, but on the psychoanalytic theory about the relationship between the unconscious and the conscious mind, they argued it was difficult to individuate a set of behaviors expressing the same mental disorder across settings. For example, there were significant variations between the diagnoses made in the USA and England primarily because they used different frameworks to classify mental disorders. As a result, scientific psychiatrists promoted grounding the descriptions of mental disorders in scientific data derived from studies in the natural sciences (Robins and Guze, 1970; First et al., 2004).

Starting with the DSM-III, published in 1980, the emphasis shifted from a psychoanalytic explanation of the causes of mental disorders to the criterion of a necessary and sufficient number of observable and measurable behaviors, such as symptoms (reported by the patients) and signs (reported by others.) APA considered symptoms and signs observable and measurable because they are reported by the patients themselves and can be plausibly confirmed by others observing their behavior. Thus, symptoms and signs are considered to be better parameters to diagnose and measure mental disorders than theories about unconscious conflicts. For instance, if Jane is suffering from insomnia (symptom), her self-report will plausibly align with Jane’s

partner's observations (sign) of Jane's behavior indicating inability to sleep. The last three editions of the DSM (i.e., DSM-III, DSM-IV, and DSM-5; hereinafter DSM-III+) adopted this approach, and mental disorders were individuated by a list of signs and symptoms (APA, 1980; APA, 1994; APA, 2013). This new framework was considered a necessary step to make psychiatry more scientific, allowing researchers to identify and investigate its measurable targets, e.g., the clusters of signs and symptoms serving as observable correlates of disease and bases for genetic and neural research.

DSM-III+'s approach has been a target of significant criticism, however, with many doubting its efficacy in meeting psychiatry's scientific and clinical goals (Poland and Tekin, 2017; Sadler, 2005; Tekin, 2014; Parnas and Bovet, 2014; Schaffner and Tabb, 2014; Tekin 2019). For example, the DSM creators' refusal to consider the work in philosophy and cognitive sciences on the relationship between the self and mental disorders is puzzling, and it has direct negative consequences for both psychiatric research and clinical treatment. Neglecting this relationship and the related research has led to four suppositions about mental disorders. In the DSM-III+ mental disorders are characterized as (i) atemporal events (without a gradual development over time), (ii) emergent phenomena (divorced from underlying causal factors), and (iii) things that happen to solitary individuals (independent from the social and cultural world). This feature of the DSM categories, also called "hyponarrativity," or "the abstraction of the illness category from the particular experiences and contingencies of the individual patient" (Sadler, 2005; Tekin, 2015; Tekin and Mosko, 2015), yields an incomplete picture of a complex phenomenon and puts epistemic and ethical obstacles in the way of psychiatric research and clinical care.

4. Conclusion

This article calls for the direct examination of the relationship between the self and mental disorder in psychiatric research using insights from the philosophy of cognitive and behavioral sciences. This call is grounded on two arguments. First, the examination of mental disorders in relation to the concept of the self has valuable implications for better understanding and treating individuals with mental disorders, and philosophy and the cognitive behavioral sciences have made important strides in explaining this relationship. Their contributions are visible in both the empirically informed philosophical inquiry and the philosophically informed empirical inquiry on the relationship between the self and mental disorder. Second, I draw attention to scientific psychiatry's surprising neglect of the conceptual, empirical, and clinical resources offered by the philosophy of cognitive and behavioral sciences, despite its self-declared commitment to develop a taxonomy of mental disorders based on rigorous scientific analysis. The cross-fertilization between philosophy and the cognitive and behavioral sciences has practical implications not only for how mental disorders are defined, understood, and clinically treated, but also for the self-understanding and moral possibilities of those diagnosed with mental disorders and, as such, it must be taken more seriously by psychiatrists. An individual with mental disorder can learn how to manage her condition and develop effective responses by drawing on the conceptual, linguistic, and practical resources offered by philosophy and cognitive science frameworks. Philosophically informed empirical work, in conjunction with empirically informed philosophical work, has much to offer scientific research in psychiatry.

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