Philosophy of Psychiatry Meets Experimental Philosophy: Expertise Naturalized

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Introduction

Recent methodological debates on the value of traditional conceptual analysis in philosophy (Strevens 2019; Machery 2017) have implications for both philosophy of psychiatry and scientific psychiatry. For example, the idea that concepts are universal in nature has been criticized, with experimental philosophers showing how different social groups have differing intuitions about the application of certain concepts. This has led to the development of new approaches in philosophical inquiry, such as naturalized conceptual analysis and conceptual engineering (Machery 2017). Taking cues from this debate, this chapter calls for a naturalized conceptual analysis of the concept of "expertise" in psychiatry. I propose using the methods of both empirically informed research and experimental philosophy to clarify and perhaps modify the definition of "expertise" operative in psychiatry. A definition of expertise modified in this fashion could include not only those who are formally trained in psychopathology and hold academic degrees, e.g., MD, PhD, but also those with direct experience of mental disorders. In fact, interdiciplinary fields as critical disability studies and mad studies have already articulated such ideas about expertise, generating important body of work authored by experts by experience, yet traditional scientific psychiatry has not directly engaged with this literature nor critically examined their own assumptions about expertise (See, for example, Carlson 2010). A modified notion of expertise, I believe, through naturalized conceptual analysis and experimental

philosophy would help psychiatry better align with its fundamental goals as a branch of medicine, enhancing the understanding of mental disorders and facilitating effective and ethical treatments and care.

I start with an overview of the main tenets of naturalized conceptual analysis and illustrate how its insights might be helpful for scientific psychiatry and philosophy of psychiatry. I then turn to the existing notions of "expertise" in scientific psychiatry and philosophy of psychiatry, with a focus on the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the Research Domain Criteria (RDoC), conceptions of expertise in some patient/consumer/survivor/ex-patient groups, and the understanding of some clinicians and philosophers. This examination will illustrate that first, there is no consistent and unified notion of expertise in psychiatry, and second, naturalized conceptual analysis could benefit psychiatric epistemology. Using insights from the DSM, RDoC, and patient movement frameworks, I conclude the chapter with a sketch of what experimental studies about the concept of expertise might demonstrate. My hope is to suggest to philosophers of psychiatry and clinicians (if not to convince them) that experimental philosophy has the potential to expand our knowledge of what it means to be an expert on mental disorders.

Naturalized Conceptual Analysis and Philosophy of Psychiatry

Broadly defined, traditional conceptual analysis in philosophy is the method of answering a philosophical question, such as "What is disease?" by analyzing one's grasp of relevant concepts, such as "being treated by medical professionals" or "experiencing distress." The relevant concept, i.e., "being treated by medical professionals," is then analyzed using thought experiments or counter-examples. The result of this process is the determination of the necessary

and sufficient conditions for a phenomenon to be called "disease." For example, we may realize that defining "disease" as "a condition treated by medical professionals," is wrong, as conditions such as pregnancy are treated by medical professionals but fail to fall under the category of "disease."[1] In this sense, a counter-example or a thought experiment might provide suggestive evidence showing the insufficiency of some of the properties.

Traditional conceptual analysis has been called into question for a variety of reasons by feminist philosophers, empirically-informed philosophers, and experimental philosophers. Feminist scholars criticized traditional concepts such as knowledge as justified true belief, arguing instead, for embodied and situated knowledge (e.g., Code 1991, Longino 1992) Some empirically informed philosophers of mind also have expressed concerns about the over-reliance on thought experiments or counter-examples in conceptual analysis, at the expense of engaging with actual, real-world phenomena. For example, in *Real People*, Kathleen Wilkes challenges the use of thought experiments to study the self or personal identity instead of considering the actual experiences of those affected by mental disorders. Through what I have previously called the Real People Challenge (RPC) (Tekin 2021a), Wilkes argues that 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). Experimental philosophers have joined these criticisms of traditional conceptual analyses by arguing that concepts don't have a definitional structure, and that there is variation in the intuitions that are used to test proposed analyses and counterexamples. They thus called for a model of conceptual analysis that engages with and is responsive to empirical research and real-world frameworks (Machery 2017). This has led to the development of new approaches in

[1] This example comes from Christopher Boorse's seminal work on disease (Boorse 1977).

philosophical inquiry, notably, naturalized conceptual analysis and conceptual engineering, the topic of this chapter (Machery 2017).

Naturalized conceptual analysis requires empirical methods to be pursued successfully for philosophers to arrive at knowledge that is "within their epistemic reach" (Machery 2017). These empirical methods include (i) generating actual empirical knowledge in the domains where these concepts do epistemic work and (ii) conducting studies in experimental philosophy. Let me give an example. Following (i), for example, a philosopher might look at work in psychology on the split-brain syndrome in order to arrive at a definition of the concept of consciousness (e.g., Bayne 2008; Schechter 2018). Following (ii), philosophers may conduct studies using the methods of experimental philosophy to test folk intuitions about whether consciousness poses a hard problem (see, for instance, Díaz 2021). Naturalized conceptual analysis is epistemically beneficial because it helps philosophers identify concepts that are invalid, obscure, or ambiguous. What follows conceptual analysis is conceptual engineering, defined as the modification of an existing concept in light of naturalized conceptual analysis. The goal of conceptual engineering is to remedy the epistemic flaws in our concepts such as obscurity, imprecision, etc.

The methods of experimental philosophy are widespread and accepted in philosophy of science (e.g., Griffiths and Stotz 2008; Stotz 2009; Machery 2017). In addition, important work has been done recently in philosophy of medicine about the concepts of health and disease using the tools of experimental philosophy (e.g., Veit 2020; Lemoine 2013; Machery, this volume; Beghin and Faucher, this volume). For example, Walter Veit advocates for the use of the tools of experimental philosophy to inform and advance debates within philosophy of medicine, including the long-standing disputes between "naturalists" and "normativists" about the concepts

of health and disease. Unfortunately, these conversations within the larger world of philosophy, philosophy of science, and philosophy of medicine have not made their way into philosophy of psychiatry even though these themes also matter for philosophy of psychiatry since 'health' and 'disease' usually also pertain to the mental. While some studies address topics of interest to philosophers of psychiatry, such as delusions, these have largely been in the context of debates on the nature of beliefs in philosophy of mind (e.g., Rose, Buckwalter, and Turri 2014).

Debates on the important concepts in philosophy of psychiatry, ranging from defining the concepts of mental disorder to demarcating what patient autonomy entails, have generally followed the method of traditional conceptual analysis. Some have expressed worries about the applicability of traditional conceptual analysis in philosophy of psychiatry to actual scientific, clinical, and social phenomena in psychiatry and its responsiveness to "real people" (Wilkes 1988, Tekin 2019a, 2019b; Powell and Scarfe 2019). For example, in the context of the US healthcare system, it matters whether an individual's condition fulfills the criteria for a mental disorder for the individual to receive disability benefits from an employer.[2] Similarly, whether a patient's testimony about their experience at a mental hospital is taken seriously in the context of the law is contingent upon whether patients[3] are considered reliable and autonomous agents who have knowledge about their condition.

[2] For an opposing view, see Hesslow, G. Do we need a concept of disease?. *Theoretical Medicine* **14,** 1–14 (1993). https://doi.org/10.1007/BF00993984

[3] I use the word "patient" to refer to the individual who is in a position of need due to the distress she is experiencing, seeks help from a professional to address her condition, and receives a formal diagnosis through the diagnostic criteria of the DSM manual. The term is not used in a degrading manner. For my present purposes, I use the terms "person," "subject," and "patient" interchangeably. I could equally say "the diagnosed subject" but for simplicity, have chosen "the patient."

Partially motivated by these kinds of worries, the last few decades have seen an expansion of more empirically informed work in philosophy of psychiatry (e.g., Radden 1998; Poland and Graham 2011; Poland and Tekin 2019; Tekin and Bluhm 2019; Faucher and Forest 2021). Such work primarily embodies the first kind of naturalized conceptual analysis, i.e., engaging with actual empirical work pertaining to the concept of mental disorder. Briefly stated, these include work on melancholy and depression (Browne, 2018; Radden, 2009, 2016), schizophrenia and the brain's default network system (Gerrans, 2014; Tekin, 2017), bipolar disorder (Radden, 2013; Tekin, 2014), substance use disorders (Flanagan, 2013; Pickard, & Ahmed, 2019; Tekin, 2019a, 2019b, 2019c; Tekin, Flanagan, & Graham, 2017; Tekin and Steel 2021), and delusions and religious beliefs (Graham, 2015). A number of novel approaches have also been developed in which the concept of 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; Tekin, 2019a, 2019b, 2019c; Thagard, 2014). 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). Most of this research engages with clinical and scientific work on mental disorders, as well as the first-person encounter with mental disorder.[4] I argue that the second kind, i.e., experimental philosophy, also has a lot to offer to philosophy of psychiatry.

To illustrate these benefits, in the remainder of this chapter, I will focus on the concept of "expertise" in psychiatry and show how naturalized conceptual analysis can benefit psychiatric epistemology. My hope is that philosophers will engage in similar analyses of other themes and

[4] For a detailed overview of these see Tekin, 2021a.

topics in philosophy of psychiatry. Note that my discussion only focuses on how the concept of expertise can benefit from naturalized conceptual analysis. It opens the door for possible studies in experimental philosophy by sketching examples that test the public's intuitions about the notion of expertise in psychiatry, but it does not develop an experimental study.

Conceptual Clarification: Existing Approaches to "Expertise" in Psychiatry

In this section, I examine the existing approaches to "expertise" in psychiatry in the DSM, RDoC, and some patient/consumer/survivor/ex-patient groups and evaluate their merit. The DSM and the RDoC represent the dominant perspectives in scientific psychiatry and are the primary schemas currently used to expand scientific knowledge on mental disorders. In addition, the DSM is used to facilitate the diagnosis and treatment of mental disorders and is used in a variety of educational and administrative contexts (APA 1980, 1994, 2013). As I explain below, the DSM and RDoC have shared commitments to the concept of expertise, in that they both take experts to be those with recognized training in psychopathology and consider them as the primary knowledge generators on mental disorders. In contrast, individuals with a diagnosis of mental disorder and patient/consumer/survivor/ex-patient groups are not a homogeneous group with shared ideas and commitments. Yet at least some individuals in these communities implicitly or explicitly consider themselves experts on their condition. Consider, for example, the growing number of first-person memoirs of mental illness or the explicit articulations of some individuals diagnosed with mental disorders explaining why they are experts by experience (e.g., Saks 2007, Frank 1995, Goidsenhoven and Masschelein 2018). As I discuss below, some patient/consumer/survivor/ex-patient groups requested a seat at the table during the DSM-5

revision process, while others have written about their disappointment at not being considered "experts." Now, let's look at each of these in turn.

In 1950, an American Psychiatric Association (APA) committee consulted its members and the Veterans Administration (VA) and created the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I), published in 1952. Since then, it has gone through a series of revisions. It is perhaps best to think of the DSM as a "work-in-progress," as the knowledge on mental disorders is incomplete, complex, and dynamic, making it open to updates and changes in light of the most recent scientific work. Currently in its 5th edition, the DSM has multiple designated uses; it is a research guide and a diagnostic tool. It is used to educate medical professionals, and it serves a variety of administrative purposes, from handling insurance claims to making decisions on medical leave.

In the first edition of the DSM, the primary "experts" on mental disorders were psychiatrists and the military. The following paragraph describes *who* was involved in the development of DSM-I:

> In April, 1950, the Committee distributed mimeographed copies of a proposed revision of the psychiatric nomenclature to approximately 10% of the membership of the American Psychiatric Association. Addressees were picked from the geographical listing of members, 10% of the members in each State and Canada being selected. In addition, addressees were selected by position held, in order to give complete coverage to all areas of psychiatry. Attention was paid to membership in other organizations (American Neurological Association, American Psychoanalytic Association, Academy of Neurology, American Psychopathological Association, etc.), so that a fair sampling of those groups was included. Members of the staffs of State Departments of Mental Health

were included in order to obtain an expression of opinion from such departments concerning the statistical and clinical impact of the proposed revision. (APA 1952: viii-ix)

The emphasis was on bringing together psychiatrists with different specialties to include representatives of all areas in mental disorder research, as well as various interest groups of specialists in mental health. The foreword to the DSM-I also states that the US Navy made some revisions to the work (APA 1952). The military was involved because the DSM-I was intended to be a statistical guide to determine fitness to serve in the Korean War (Grinker 2010). In addition, after World War II many American soldiers were returning back and their illnesses such as combat fatigue and shell shock produced relatively mild mental disorders, and yet the existing conceptions of mental disorders were not responsive to them. In order to address these pressing needs, the APA has decided to expand its categories of mental disorders (Grob 1991).

In the further iterations of the DSM (DSM-II to DSM-5), the status of expert has been limited to those with clinical training in psychopathology, mostly psychiatrists and psychologists who are members of the American Psychiatric Association (APA).[5] The introductions to the DSM manuals list the groups consulted in their creation; these include psychiatrists, psychologists, and medical doctors, as well as representatives of psychiatry networks, e.g., the members of the Association for Women Psychiatrists. Patients e have never been included.

During the DSM-5 revision process, the APA was invited to include patients and other stakeholders. For example, some philosophers and clinicians pushed for the need for the process to be democratic; in their view, participants should include members of the public with a stake in

[5] For a more detailed discussion of how the concept of expertise used in the DSM, see Tekin (2020).

the diagnostic criteria, such as patients, individuals with disabilities and their families (Sadler and Fulford 2004). Some clinicians approached the subject from the perspective of patient advocacy and emphasized the need "for scientific experts to review their nosological recommendations in the light of rigorous consideration of consumer experience and feedback" (Stein and Phillips 2013). This would, for example, mean that patients would give feedback on a proposed criteria for a mental disorder category that is developed by the psychiatrists in the DSM Task Force. Meanwhile, some psychiatrists argued for the value of patients' subjective experiences; this, they said, would help the DSM criteria for mental disorders to be finer-grained and more responsive to the real experiences of patients (Flanagan, Davidson, and Strauss 2010). Finally, some philosophers noted that the DSM was facing a crisis of public trust, and the inclusion of patients and individuals with a disability into the DSM revision process would address the issue (Bueter 2018). These calls show at least some reception among philosophers and psychiatrists of the possibility of considering patients as having some kind of expertise in understanding mental disorders and thus able to help develop the diagnostic criteria. Yet the DSM-5 Task Force did not invite patients to join in. Their worries were epistemic: they raised concerns about the subjectivity of the data in patients' reports and the apparent conflict with psychiatry's desire to establish itself as an objective form of inquiry (Regier, Kuhl, Kupfer, and McNulty 2010; Tekin 2020).[6]

The conception of expertise in the Research Domain Criteria (RDoC) framework is similar to the DSM conception. The RDoC is a research framework developed by the National Institute of Mental Health (NIMH), the largest funding agency in the US (and around the world)

[6] I won't develop it here, but, from the patients' perspectives these attitudes of psychiatrists have important implications for thinking about epistemic injustice in the context of psychiatry.

providing support for mental disorder research. As it was partially a response to criticism of the DSM's fitness for research purposes, the RDoC offers a framework to investigate mental disorders by integrating different levels of information, including genomics, neural circuits and behavior. Its goal is to explore basic dimensions of human functioning, such as fear circuitry or working memory, as opposed to disorder or diagnostic discrimination (Tabb 2015), the focus of the DSM. The dimensions span the full range of human cognition and behavior from normal to abnormal. These dimensions cut across mental disorder categories of the DSM; psychiatric investigators present their experiments as targeting fundamental components of mental functioning (or "research domains") based on research from allied sciences, instead of using DSM constructs.

Research domains represent one axis of the proposed matrix, and these are subdivided into more specific "constructs," for example, "reward valuation" or "attachment formation and maintenance." The other axis is "units of analysis," ranging from "genes" to "behavior." The RDoC's self-designated purpose is to translate rapid progress in basic neurobiological and behavioral research to an improved integrative understanding of psychopathology and the development of new and/or optimally matched treatments for mental disorders (Cuthbert, 2014). Committed to providing a rigorous framework for research on mental disorders, and critical of the DSM-5 framework, NIMH Director Thomas Insel announced it was time to "re-orient" away from the DSM's symptom-based categories in psychiatric research and said the NIMH would fund research that used the RDoC framework (Insel 2013).

While there is no explicit discussion of who was consulted to create the RDoC framework, the notion of expertise seems to be reserved for those with technical training in psychopathology. The framework was officially developed by the scientists working for the

NIMH, and researchers are required to use the RDoC's units of analysis in their applications for NIMH funding. Units of analysis include the following: "circuits," i.e., measurements of brain circuits as studied by neuroimaging techniques and/or other measures validated by animal models or functional neuroimaging; "physiology," i.e., measures such as heart rate and cortisol; "behavior," i.e., behavioral tasks (e.g., a working memory task) or systematic behavioral observations (e.g., a toddler behavioral assessment); "self-reports," i.e., interview-based scales, self-report questionnaires, or other instruments that may encompass normal-range and/or abnormal aspects of the dimension of the function that is of interest. All these reveal the assumption that the primary knowledge generators in the investigation of mental functioning are those with research expertise in psychopathology and patients' perspectives/experiences are only objects to be studied or synthesized. The problem here is that if patients' reports are not considered valid, or relevant, the researchers may not engage with them or make these insights a part of the systemic knowledge even though those perspectives may be essential in grasping the phenomena. In addition, most mental disorders affect the meaning making system of the individual subject and understanding their perception of their experiences is essential to addressing their medical needs and caring for them.

While it is promising that unlike the DSM, the RDoC includes an explicit unit of analysis to engage with the self-reports of individuals or patients, thereby highlighting the value of individuals' lived experiences, they are considered the *objects* of inquiry, rather than the *subjects* generating knowledge. An unanalyzed assumption in both the DSM and the RDoC is that patients lack the expertise required for the scientific investigation of mental disorders.

When we turn from scientific psychiatry to the reports of individuals diagnosed with mental disorders, we see another perspective, one that challenges the status quo of the DSM and

the RDoC and is more aligned with the views of the clinicians and philosophers who advocated for patient inclusion in the DSM-5 process. Some individuals diagnosed with a mental disorder consider themselves experts on a variety of dimensions of their condition, yet their expertise is rarely recognized as such. I cite at length here from a memoir, *Musings of a Mad Activist,* written under the pseudonym "the Borderline Academic":[7]

> Every so often, I am told that I am "harping on my trauma" or "wallowing in self-pity" for speaking at length about the times I've been victimized. Much more often, and more benevolently, I am told that I am so "brave," or "bold" or "strong" for my willingness to be vulnerable and share personal details about my life. But it is very rarely, if ever, that I am treated as an expert. If I am treated as an expert, it is not because of my victimhood. It is because I am a PhD student, or an editor at a critical psychiatry web magazine, or a founder of a grassroots group that raises awareness about human rights violations. It is because of some position of title I have that is equated with productivity or empirical knowledge, with serving a population or doing work within the capitalist framework that is viewed as respectable, valuable, or most commonly, monetizable. The reality is that while all of the above experiences have contributed to knowledge about mental health, human rights, and cognitive liberty, it is deeply personal experiences of human right violations and victimizations that gave me the bulk of my expertise. It is not study, readership, or editing that enables me to viscerally feel the impact of psychiatric coercion and paternalism in every bone of my body; it is not intellectual or empirical knowledge that drives me to speak out. It is only my subjective experience of victimization – which I

[7] Thanks to Ginger Hoffman for drawing my attention to this book.

feel and relive over and over each day – that leaves me with no choice but take action. (2019:36)

Let me highlight a few elements the author emphasizes about her encounter with a mental disorder, its diagnosis, and the ensuing medical and social treatment she received that makes her believe she is an expert. To start with, she has experiential knowledge on the orientational challenges of her mental disorder, such as the feelings of psychic pain. She also offers an evaluation of how she responded to different treatments, e.g. hospitalization, and what may or may not have worked. In addition, she has a grasp of how her experience with mental disorder affects other dimensions of her life, such as her work and relationships. Finally, she is able to situate her experiences with the psychiatric/medical system in the larger context of human rights violations. Yet as she points out, she is never considered an expert on these issues by virtue of her direct experiences; rather, when she is considered as an expert it is often because of her professional training. One might argue that the author's argument fits within a more traditional view of expertise, in the sense that the contextualization of her experiences within a human rights framework is possible given her (admittedly, informal) training as the founder of a grassroot organization.[8] However, what the author seems to be getting at here is not being considered an expert on the basis of her experience/encounter with mental disorder but because of her being recognized as an individual who *knows* about mental disorders, not because she is an individual who *experiences* the phenomena.

This author is not alone in highlighting the legitimacy of her claim to be an expert on her condition, nor is she alone in expressing disappointment that she, as the subject of the experience of mental disorder is not considered an expert by mainstream science. (for some examples, see

[8] Thanks to Andreas De Block for drawing my attention to this point.

Saks 2007, Tekin 2014, 2020; Tekin and Simon 2018; Boevink 2015; Lehmann 2015) There is an increase in the number and quality of first-person memoirs of mental disorders wherein individuals report on their experiences with mental disorders and the medical and social treatment they have received. While some of the individuals who write about their first-person encounter with mental illness are activists – they have become activists about mental health usually following their negative experiences in the medical system – not all of them are. Some individuals have written about their experience for the sake of writing about them; some to better make sense of their experience, some to share it with others who may be experiencing similar things. For example, William Styron's account of depression seeks to make sense of the change he encountered as a person without depression to a person with depression, and the quality of depressive states of mind. Similarly, Elyn Saks's memoir details how her encounter with schizophrenia evolved over time and how she benefited from or harmed by different forms of treatment, such as psychoanalysis or DSM-oriented treatments. On the other hand, there is also an expanding Mad Studies Movement, psychiatric survivors' movement, sometimes called a consumer/survivor/ex-patient/service user movement that is grounded in activism. Growing out of the civil rights movement of the 1960s and the 1970s, the early intellectual development of the movement is grounded on Judi Chamberlin's influential 1979 book, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*. The distinction between memoirs written by activists vs by those individuals who are not activists is an important one, however it is beyond the scope of this chapter to delve into it. A relevant point made be made, for example, how activism may conflict with particular scientific standards (see Van der Vossen, B. (2015). It'd be valuable to take these points in consideration as we develop an experimental philosophy of psychiatry.

The survivors' movement is not a homogenous group with clearly defined shared goals and orientations, yet the movement continues to push for justice, equitable rights, fair treatment, and de-stigmatization. It challenges the psychiatric system to stop authoritarian approaches and work with service users to end systemic abuse. Among other things, it seeks to influence policy and change existing laws that subject people to involuntary treatment (Chamberlin 1990; Oaks 2006). The ex-patients' movement exists to advocate for and give a voice to those individuals who have been marginalized based on their mental health condition and is quite unlike other organizations that also claim this mission, such the National Alliance for the Mentally Ill (NAMI). These others are primarily composed of non-psychiatric service users, that is, psychiatric professionals and relatives of service users who "enthusiastically embrace the medical model" (Chamberlin 1990).

In addition to patients and some clinicians, such as those who advocated for patient inclusion in the DSM-5, an increasing number of philosophers and psychiatrists take the first-person perspective seriously and show some support of the claim that some patients could be considered experts on mental disorders. For example, some philosophers advocate for taking the first-person accounts of those who experience or witness mental disorders seriously in philosophical contemplation, especially those accounts available in the form of memoirs (Flanagan 2013; Tekin, Flanagan, and Graham 2017; Tekin 2011, 2014, 2020). For example, George Graham, in "Melancholic Epistemology" (1990) refers to J. S. Mill's experience with depression as a young man, notably how, by delving into his depression, he reached a deeper understanding of himself. Mill recognized the importance of aesthetic enjoyment and renewed his hopes about his ability to change his character. In his case, Graham suggests, depression

worked as a "recognitional epiphany in which he discovered certain truths and used them to shape his life" (Graham 1990, 417).

Flanagan's recent work on addiction showcases the pertinent role played by the first-person perspectives of those with addiction[9] in enhancing our understanding of this condition (Flanagan 2013). He writes that each of the scientific, clinical, and first-person perspectives contributes to the complete truth of alcoholism or alcoholisms. Paying attention to all perspectives is necessary to understand any psychobiosocial phenomenon that has phenomenological, behavioral, social, genetic, and neurophysiological features (Flanagan 2013).

Similarly, some philosophers advocate for the inclusion of patients' perspectives in medical case studies, noting their important contribution to medical epistemology (Ankeny 2017). A clinical case study, as a research methodology, is an empirical inquiry that investigates a medical phenomenon within its real-life context. Clinical case studies are based on in-depth investigations of individuals' illnesses to describe the details of a case, explore its underlying causes, study its unique aspects, create effective interventions, and so on. Ankeny noted that most clinical case studies are only presented from the physician's point of view; accordingly, "the doctor's voice becomes authoritative, even though in a sense his or her version of the events could be seen as a mere interpretation of the 'real' case as narrated by the patient." She argues for the inclusion of patient perspectives in clinical studies not just as a source of added value but also as a source of evidence, because patients provide unique details about their illness that may otherwise be overlooked.

[9] See, also, Clara De Ruysscher, Peter Tomlinson, Stijn Vanheule & Stijn Vandevelde. Questioning the professionalization of recovery: a collaborative exploration of a recovery process, Disability & Society, 2019, 34:5, 797 818, DOI: 10.1080/09687599.2019.1588708

Similar arguments are found in the Medical Humanities literature. In the last few decades, an important topic for proponents of humanistic approaches to medicine has been the nature of the relationship between the health care professional and the patient. There is a push to strengthen humanism in medical practice by encouraging medical professionals to recognize, seek, and engage with patients' narratives. Rita Charon, the founder of narrative medicine, argues the clinician must acquire the skills to listen to, interpret, and reflect on the patient's stories with an "engaged concern" to achieve therapeutic outcomes, because this is the fundamental way in which the patient learns to trust the clinician (Charon 2006). The focus of narrative medicine is on the experiences of patients rather than on the generalizable propositions about them produced by logico-scientific inquiry. Taking up patients' narratives is considered necessary not only to build trust between clinicians and patients but also to give physicians the means to improve the effectiveness of their work with patients, their colleagues, and the public. Active research and clinical programs in various hospitals are testing the fundamental tenets of narrative medicine in medical practice.

The proposal to include patients as experts in the knowledge production process in psychiatry is developed in a similar spirit of humanism: a good way of enhancing psychiatric epistemology and practice is to give a voice to those directly affected by mental illness. In addition, a growing literature takes as its starting point the phenomenology of encounter with mental disorder to develop clinical diagnostic scales prepared in light of patients' direct encounters (Parnas 2012). More recently, some have promoted amateur/citizen/user-led research conducted outside traditional academic settings by the mental health users themselves (Cooper 2017). Some work has tuned into the literature on expertise in Science and Technology scholarship to make a case for distinguishing different kinds of expertise and creating a venue for

different experts to collaborate on generating knowledge on mental disorders. The argument is that patients, as experience-based experts, and clinicians and scientists, as training-based experts, can collaborate in expanding knowledge on mental disorders (Tekin 2020). Finally, important work is also being done from the perspective of feminist philosophy of science that calls for developing objective accounts of mental disorders, their treatment and care by including patients' perspectives into scientific research (e.g., Gagné-Julien 2021, Tekin 2021b). Very recently some philosophers of psychiatry have started connecting the above-mentioned work to debates on epistemic injustice. While there are many common threads between work on the value of first- person perspectives in psychiatric epistemology and the literature on epistemic injustice, philosophers of psychiatry have only very recently started examining the direct connections between these areas of inquiry.[10] It is my hope that the emerging work on epistemic injustice in the context of psychiatry and the anticipated experimental work on philosophy of psychiatry will pursue opportunities for cross-fertilization.

Conclusion: A Space for Experimental Philosophy

Recall that naturalized conceptual analysis and modification require (i) generating actual empirical knowledge in the domains the concepts are about, and (ii) conducting studies using the tools of experimental philosophy. The actual empirical knowledge about the concept of expertise in the psychiatric domain and philosophy of psychiatry, as discussed in the previous section, indicates the lack of a unified notion of expertise. While the mainstream scientific frameworks do not recognize patients as experts, some patients, members of the consumer/user/ex-patient

[10] Crichton, Paul et al. "Epistemic injustice in psychiatry." *BJPsych bulletin* vol. 41,2 (2017): 65-70. doi:10.1192/pb.bp.115.050682

movement, and some clinicians and philosophers show an openness to at least consider expanding the concept of expertise to include experience-based experts, even though they do not explicitly state this. Therefore, conducting studies using the tools of experimental philosophy and considering whether the notion of patients as experts aligns with lay intuitions about expertise might illuminate and even expand psychiatric epistemology.

Let me draw a sketch of what these studies might track. First, they may reveal significant differences among the various stakeholders in the world of mental disorder experience, research, and treatment. We might get different responses from psychiatrists, researchers, philosophers, and individuals diagnosed with mental disorders. Such differences in responses may obviate certain power dynamics among these groups. Psychiatrists, for instance, may be unwilling to call patients experts because they do not consider them sufficiently educated on these matters, or may feel that deeming them experts would threaten their own status as experts and thus threaten their power. In addition, the differences may reveal biases within these communities towards individuals with mental disorders, such as the pervasive yet unfounded[11] assumption that individuals with experience of mental disorder are not fully rational; thus, they cannot and should not be considered to have a stable knowledge of mental disorders.

Second, studies using the tools of experimental philosophy may find that some are receptive to the claim that patients' perspectives are valuable in generating knowledge about mental disorders, yet they may be hesitant to grant any patient/diagnosed individual the status of

[11] These assumptions are unfounded; there is no conclusive data support them. In fact, most studies show that patients are capable of rational decision-making (e.g., Appelbaum et al 1999, Cardella 2020). There will of course be situations where the patients may have limited epistemic agency due to their condition but mental disorders do not necessarily nor universally interrupt epistemic agency: not all conditions create impairments. If they do, they may do so in varying degrees of severity and transiency.

expert. Consider, for example, some arguments expressing concerns about the reliability of first-person accounts in memoirs (Radden and Varga 2013). Addressing the challenges involved in autobiographical writing, such as memory errors, the effect of mental disorders on remembering, and the efforts to convince an audience beyond a mere telling of one's experience, Jennifer Radden and Somogy Varga argue that the "true nature of depressive experience… *cannot be discerned*" (2013:100). Following this line of reasoning, we might argue that patients cannot be experts on their experiences.

Whether or not a modification in the concept of expertise in psychiatry and philosophy of psychiatry is warranted is an empirical matter, but I believe that engaging in naturalized conceptual analysis promises an enhancement in psychiatric epistemology. Expanding the concept of "expertise" to include experience-based experts (Collins and Evans 2002) will not only reduce the epistemic flaws pervasive in the notion of "expertise" used in contemporary scientific psychiatry but will also pave the way to a "developing, untidy, methodological pluralism" (Solomon 2015) in psychiatric epistemology. I thus close the chapter by inviting philosophers of psychiatry and scientific psychiatrists to use the tools of naturalized conceptual analysis to open up multiple venues for expanding psychiatric epistemology.

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