ROYAL COLLEGE OF PSYCHIATRY

Philosophy Special Interest Group (PhilSIG) Newsletter

Issue LVI
February 2026

'Everything is vague to a degree you do not realize till you have tried to make it precise, and everything precise is so remote from everything that we normally think, that you cannot for a moment suppose that is what we really mean when we say what we think'

-Bertrand Russell, *The Philosophy of Logical Atomism*

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Notes from the Editor: *A Meal with Socrates*

It was great pleasure to attend the most recent bi-monthly PhilSIG drop in session as a last minute panelist and wonderful to see such a great turn out. The topic centered on the 'philosophy of biology' with presentations from Dr Temi Metseagharun, Chair of RCPsych Philosophy SIG, FRANZCP, Dr Riadh Abed, Chair of RCPsych Evolutionary Psychiatry SIG and Professor Samir Okasha, Professor and philosopher of Biology, University of Bristol – and was followed up by an enthusiastic and thought-provoking Q&A with the audience. The recording will be made accessible to all those who signed up in due course (see 'Updates & Announcements' below for info on the next Drop in session).

Metseagharun began by setting the context, drawing on both the historical and contemporary landscape. Okasha outlined four ways in which evolutionary theory may have important implications for psychiatry. Abed highlighted conceptual advances in 'causal explanation' and the limits of 'traditional biological reductionism' from the perspective of evolutionary psychiatry. It is impossible to do justice to the depth and breadth of content covered, so I will limit myself to two themes that were notable for me (there were many others!)

One argument put forward by Professor Okasha was that the concept of biological function/dysfunction (as understood in evolutionary terms) may provide a means to 'naturalize' the notion of 'psychiatric disorder'. For those familiar, the most famous version of this argument is Jerome Wakefield's 'Harm-Dysfunction' Model, but for the unfamiliar, lets 'zoom-out' a little to get a sense of the lay of the conceptual land. What do we mean by 'naturalizing' the notion of psychiatric disorder, and why would we want to do so?

At the heart of this debate is a set of related questions – how do we define mental disorder? How do we distinguish between mental disorder and say 'social deviance', typical 'problems in living' or simply 'differentmodes of being' in the world? This is sometimes termed 'The Boundary Problem' and is not to be confused with the separate question of how best to classify different types of mental disorders (think DSM, ICD, HiTOP). By analogy, we are not are asking "what kind of art is Duchamp's 1917 'Fountain?" but rather "does it belong in the category of art at all?"

Traditionally there have been two main approaches to answering the boundary problem – Normative and Naturalistic. The former argues that disorder status is at least in part value-laden, whilst the latter argues that it is a matter of fact alone. The appeal of naturalistic approaches is that we can avoid the messy issue of norms (who's values count and why?) as well as sidestepping a related concern that if value judgements are at play, the phenomena in question may be in some sense less 'real and out the in the world' and more a 'social construct'.

As a quick(ish) aside, this argument is often set up (implicitly or explicitly) in terms given to us by Thomas Szasz's 'The Myth of Mental Illness', which sharply contrasts mental and physical illness, arguing(admittedly with a few steps missing) that physical disorders are value free and therefore real, with mental disorders being normative and therefore myth. Whilst there have been various attempts (e.g. see Kendall, Borse) to demonstrate mental disorders are 'real' by way of aligning them with physical disorders (the latter presumed to be defined in naturalistic and value-free terms). It would be remiss not to now highlight our own PhilSIG member Bill Fulford's response which turns the debate on its head, arguing that both mental and physical disorders (conceptualised at the level of 'illnesses') are in fact value-laden, with values pertaining to the latter, generally being

more widely shared and hence largely going unnoticed – after all, 'where values are shared, we can trade in facts'.

Back to evolutionary theory then – can it help naturalize the concept of mental disorder? Wakefield's hybrid 'Harm-Dysfunction Model' has been highly influential but also widely criticized. At the heart of the model is the notion that disease/disorder consists of a) some biological dysfunction (naturalistic) and b) there is associated subjective harm or subsequent impairment (normative). Hence, although 'hybrid' in accounting for the normative harm aspect of disorder, the (presumed naturalistic) notion of biological dysfunction does a lot of the heavy lifting.

"where values are shared we can trade in facts"

Dysfunction is defined in terms of there being a observed breakdown in the evolved biological function of a particular system or systems (bodily, cognitive or psychological etc). Setting aside the huge philosophical debates about the notion of 'evolved biological functions Vs causal-systemic biological functions', it is not at all clear that (even if ontologically accurate), epistemically we could ever have the means to ascertain what the evolved functions of sub-systems X were? This is sometimes called the problem of 'just-so' stories – there is no fossil record of the mind.

But let's assume we can – how would this actually inform the debate? One issue is the relevance (or lack-there-of) of some evolved functions, given the radically different environment we now live in. We could have a particular cognitive-arousal system working perfectly well based on its evolved function(s) (See RM Nesse's Smoke Alarm Detector example) but causing significant problems for individuals due to an environmental mismatch (in this case anxiety) - presumably Wakefield's model would be forced to conclude this is not mental disorder, given the evolved function is working perfectly well, despite the harm and impairment. See here for a wider critique and rebuttals.

These are arguments Prof Okasha will be well familiar with and his presentation was nuanced, highlighted other issues such as limited 'one-one mapping between traits and functions' and did not draw specifically on Wakefield's model. Indeed, it is plausible (likely?) that evolutionary psychiatry can helpfully set out a number of different ways in which traits and (dys)functions associated with particular mental disorders may have evolved and may interact in interesting ways with our current environment to produce or maintain disorders (there's already a nice flow diagram to this effect, which for the life of me I cannot find). For me, evolutionary psychiatry has lots to contribute to psychiatric research, practice and conceptual analysis (I would highly recommend Adam Hunt's podcast on evolutionary psychiatry and this special issue in World Psychiatry). Prof Okasha's other points (the distinction between ultimate and proximal causes, within-organism evolution and cultural evolution) were fascinating and again well made but 'naturalizing the concept of mental disorder' seems to be a conceptual overstep. I would agree with Stein et al 2024 when they argue "...both naturalist and normativist considerations are now viewed as important – psychiatric constructs necessitate a consideration of both facts and values".

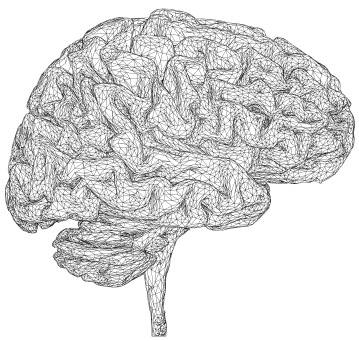
Dr Abed's emphasis on the limits of biological reductionism, the notion of multiple levels of explanation, top down causation and complex systems (see Unsimple Truths by Sandra Mitchell and, if enthused, Wimsatt's Re-Engineering Philosophy for Limited Beings) was music to my ears and was a nice demonstration of the multitude of ways that evolutionary psychiatry can inform both wider practical and conceptual debates in philosophy of psychiatry.

To that end I will finish with a brief point that is related to the limits of biological reductionism but that is often overlooked. There is an assumption I hear amongst colleagues (and in the literature) that goes something like this:- "until we discover the underlying brain circuit for mental disorder X, its validity as a 'real' phenomena out there in the world will remain unclear". This assumption rests on a premisepertaining to the question of 'essences' & 'natural kinds' and it mirrors a model of disorder that is ubiquitous throughout physical medicine, in which the signs and symptoms of disorder emerge from a central underlying pathophysiological 'essence'. It can be hard as psychiatrists to conceptualise what might 'hold it all together' unless there is a (as-yet-undiscovered) central underlying pathophysiology at the level of the brain that maintains a mental disorder, with the alternative often being assumed that if there isn't some biological essence it must instead be a 'social construct' or in some sense 'less real'.

One answer is epistemic – mental disorders or the features that maintain them, may be so multiply realizable, to the extent that the brain simply represents an untenable/unhelpful 'level of explanation' (think loads and loads of different brain configurations across individuals, that despite their differences nevertheless maintain a state, disorder or symptom that manifests consistently at a higher scale e.g. psychological symptoms of depression) - this is plausible, especially given the brain's known plasticity and adaptability, but probably unlikely.

The second answer, I find more compelling and is highlighted in different ways including in Borsboom's Network Theory of Psychopathology, Kendler's Mechanistic Property Clusters and Cooper's (more filled out) adaption of Dupree's Promiscuous Realism (Chap 4). An oversimplified version goes like this. It's at least plausible that at least some mental disorders represent 'real, consistent phenomena that exist out there in the world' without being maintained by a central underlying 'pathophysiological essence' (e.g. at the level of the brain). Instead, they could conceivably be maintained by many dappled and distributed interdependent causal mechanisms that occur across and between various different explanatory scales (bio, psycho, social) and timelines (ultimate, proximate) that interact to mutually reinforce one another and therefore 'hang-together' in meaningful and (at least somewhat) predictable ways.

In other words, psychiatric disorders might be complex 'fuzzy-kinds'. Of course it still represents an empirical question as to whether or not this is the case, but conceptually, mental disorder as a 'complex, non-decomposable, dynamic system' seems a promising notion.



The Philosophy SIG annual Conference: Autonomy and Responsibility in Psychiatry and Mental Health/Health Care

James Adams

The Annual Conference of the Special Interest Group took place on the 7th of November at the Royal College, with a broad range of speakers and a similarly broad range of attendees, including psychiatrists of all stages and ages as well as non-specialists. It struck this author pretty rapidly how debates about autonomy and responsibility are still fundamental to the discipline of psychiatry and are still, fundamentally, unsettled.

The day began with a broad-minded and generous introduction from the Chair of the Special Interest Group, Dr Temi Metseagharun, and continued with the keynote lecture, 'Mental disorder, self-disclosure, and responsibility' from Dr Anneli Jefferson. Dr Jefferson distinguished between two broad ways of thinking about moral responsibility present in the literature – capacitarian and self-disclosure approaches. Taking the former approach, one holds that to have moral responsibility is to have the appropriate kind of capacity to reason morally. This capacity is formed of two elements: knowledge, so the ability to be receptive to moral reasons, and control, the ability to act on this knowledge.

Taking the latter, self-disclosure approach, one holds that taking moral responsibility is a matter of the desires that one acts on are indeed the desires that reflect your real or actual concerns, the concerns of your deep self. The first and perhaps best-known example is that of Harry Frankfurt, who argues that responsibility is exercised when the first order desire on which you act is endorsed by your second order desire – your desire to have the desire.

The substance of the paper lecture was an argument – although a nuanced one – against the self-disclosure view. Jefferson pointed out that on the self-disclosure view, responsibility is a matter of how you relate to your own desires. It is purely relational. And this has consequences which are both, she suggested, good and bad. On the positive side, the self-disclosure approach takes very seriously the extent to which we can be alienated from our own desires. Frankfurt's example of the unwilling addict is one such case, and they can be multiplied: self-disclosure accounts provide a vivid picture of what has gone wrong in some cases of mental illness, and gets at the pain of being possessed by feelings which they do not recognise and which cannot be controlled.

What Jefferson suggested is a problem for the account also stems from its purely relational character. As she observed, two people can have the same condition, but whether they are responsible shall depend on whether they endorse the condition, or not. The particular example used was that of the person with an eating disorder. That person may or may not find it useful to endorse anorexic desires, but if they do, then that person ends up being morally responsible for them – and therefore for the hurt that those desires produce, which Jefferson takes to be an unhappy conclusion on its face. A modification of the position was considered, in that many who experience treatment for their mental health condition subsequently are happy and grateful to have done so, and this could be used as a criterion for whether decision making has in fact been autonomous and reflective. But this will not always be the case, preferences of this kind are inconstant, and are themselves often post hoc rationalisations. Thus: 'self-disclosure views are unable to categorise endorsed desires as external to the real self, even when they are clearly symptomatic of a mental health condition and go away after recovery'.

Dr Jefferson's argument seems to pose some real problems for anyone who endorses something like a self-disclosure view. I shall make just a few defensive suggestions that occurred to me on its behalf. Firstly, it does seem to me to be open to the proponent of a self-disclosure view to assert that in fact whatever the endorsement consists in for an individual person with a mental illness is faulty, so long as this endorsement is caused by their illness, which we already recognise as clearly pathological. This might or might not end up causing an uncomfortable regress – but might not, for it seems open to the proponent of self-disclosure to

assert that we are in fact made up of complicated complexes of desires, that relate to each other in complicated (many-to-one; nested; variably hierarchical) ways. So, a patient with anorexia might have a second-order desire that endorses her first-order anorexic desires. But we might maintain that this second-order desire is clearly pathological, for reasons independent of itself, and might also observe that the patient is likely to have other desires – to love and care for their family, or to thrive, or to be happy – that are strongly discongruent with their anorexic desires, and on that basis to insist that the patient is not really expressing their true self, and is not responsible for their actions.

But what about a patient who doesn't have any of these positive desires left? This would be a patient who completely endorses their anorexia, with no modulating or discongruent desires. I think the deeper objection to Dr Jefferson must be that in some cases of profound illness, part of the tragedy consists in precisely the fact that disease attacks patient to the extent that it generates a kind of moral deformation. But it does not seem to me to be problematic to maintain that someone with mental illness is morally responsible for their actions, but nonetheless that they are unwell and need care. This might be an uncomfortable conclusion but is not obviously inconsistent, and strikes at what seems to me to be a deep truth about the challenge of looking after people psychiatrically. It also approaches deep waters, regarding the normative basis of what we do and do not count as mental illness (involving for instance, whether simply being a bad person ought to count as disease, and if not, why exactly; whether suicide ought to be taken as *prima facie* evidence that somebody is mentally ill) which I won't approach here. But Dr Jefferson delivered a keynote lecture that was striking in the care that it took to hew to the rough ground of the actual and complex human experience of mental illness, and the question-and-answer session following the lecture was similarly careful.

This was followed by a morning refreshment break and, subsequently, a lecture from Professor Drozdstoj St. Stoyanov and Dr Kristina Stoyanova, from the Medical University Plovdiv: 'A journey into neurolaw: can neuroscience provide normative borders between mental health and disorder?'. Their lecture began with the observation that norms of behaviour vary across different cultures, to try to motivate the problem of relativity and situate the role of forensic psychiatry in assessing what is and is not an indicator of mental illness. This was then highlighted by an extensive clinical vignette from a criminal case for which they were both called as expert witnesses. The medical and psychiatric paradigms were distinguished, the former defining illness as deviation from objective criteria of health, and the psychiatric defining the norm as rather an absence of disorder, which is in turn defined in subjective and culturally variant terms.

This is something that troubled Drs. Stoyanov and Stoyanova, because the inherently subjective nature of psychiatric practice, construed in these terms, makes obvious problems for making consistent expert statements in court proceedings. It is important, therefore, to try to establish biophysical correlates for psychiatric categories, and their recent paper is aimed at doing exactly that, by correlating fMRI imaging with psychometric testing, using neural networks to assess network activity between different brain areas. The psychometric test used was Alexander Lowen's bioenergetics scale, which uses the personality categories 'schizoid', 'oral', 'rigid', 'psychopathic' and 'masochistic'. This recent paper was then correlated with other, similar fMRI studies that have shown correlations between fMRI brain activity and psychological categories.

There was a sense in the room that some of the technicalities of the approach might be pitched at a level above the listeners. Dr Stoyanov was robust in his insistence that the work was part of a project to finally validate psychiatric categories by looping them into a nomothetic network of bridging laws, asserting that it would be a way for psychiatry to finally move beyond the asking of subjective questionnaires towards real objectivity.

One question that this listener did have was how this was achieved by the project of this paper. As far as I could determine, the method was to assess subjects' bioenergetic 'traits' (oral, etc) before putting them in an fMRI, to see whether there were commonalities across subjects. But the fact that there are some commonalities is not surprising – there are, I think, relatively few psychiatrists who would maintain that mental states or traits exist without corresponding brain states, and it might be surprising if one were to ask systematic questions of any group of subjects and find wildly diverging brain activity. As Dr Stoyanov asserted in response to a question from the floor, questioning the validity of mind-brain identity theory, we are most of us now committed to some form of supervenience.

While the use of neural networks to understand brain network effects, as opposed to the static states of older fMRI studies, is exciting, conceptually this effort relies on the prior validity of the psychometric testing that is used. From a forensic point of view, the 'traits' that are assessed would need to be robustly predictive of behaviour for an fMRI of a suspect in a crime to tell you anything about responsibility– and again, this is something that is dependent on the quality of the categories elicited by the questionnaire, rather than the other way around.

Certainly if the concern were the apparent cross-cultural relativity in cultural norms, this will do nothing to allay that concern, for presumably, the traits which are found to be more or less desirable in different cultures will themselves vary and therefore the relativity worry simply re-emerges. This will not be done away with by the establishment of some neurological correlate of those traits. It will simply give us another human feature to be relativists about. And the exercise raises the prospect, instead of providing assessments of the mental states of suspects in a crime by interview with a human being, of simply shoving them in a scanner and sending them down on the basis of their masochistic tendencies – a prospect which one may find exciting or not, depending on one's views on criminal justice.

"give us another human feature to be relativists about"

The plenary lecture, 'Why philosophy?', from Dr Sam Wilkinson of the University of Exeter followed at 12:00. Dr Wilkinson's presentation of the reasons for caring about philosophy in psychiatry was admirable – sane, forthright, and committed. This author is always delighted to see Wilfred Sellars come up in any context, and a lecture that begins with that thinker's definition of philosophy is, in my book, always likely to be an excellent one. Dr Wilkinson focussed on the thorny issue of diagnosis, once more raising the difficulty of delineating categories of mental illness and health. Diagnosis and purported *over*diagnosis are of course very much in the news at present, and the body of the lecture was made up of a suggested deflationary approach the difficulties of coming up with a clean account of what's going on when we make psychiatric diagnoses.

Dr Wilkinson began with J.L. Austin, and speech-acts. Performative speech-acts are utterances that do something by virtue of their being uttered, and one category of performative speech-act is a 'verdictive'. This is a type of utterance best exemplified by the handing down of a judicial verdict – 'I find the accused guilty' – and is an utterance that delivers a judgement, whose force in the world is backed up by the institutional authority of the speaker. Wilkinson made the case that medical diagnosis ought to be thought of as a verdictive, whose ground comes from consensus between practitioners. He suggested that it fails in the same way that other verdictives fail – if performed without legitimate authority, or delivered outside the recognised institutional framework.

This consensus-oriented approach brings together somatic and psychiatric diagnosis in a way that would, if successful,

sidestep any purported problem with diagnosis (and overdiagnosis). As Wilkinson put it, diagnosis is on this account not subject to accuracy conditions but rather to appropriateness conditions. The account is neat, and is valuable in that it pays a close attention to the undeniably social aspects of diagnosis, and the elements of justice and injustice that accrue to attributions of mental disorder in virtue of this social element to the institution of psychiatry. But I worry whether the account can do the work that it needs to satisfy someone already dissatisfied with the grounds underlying the practice of psychiatric diagnosis.

Presumably, the worry that someone might have about specifically psychiatric (as opposed to somatic) categories is exactly that there is nothing that grounds the former in the way that observable biophysical properties ground the latter. Wilkinson observed, correctly, that the ground that makes the verdictive of a medical diagnosis succeed is the diagnoser's role as representative of scientific medical knowledge. This practice has authority precisely in virtue of the fact that it is truth-seeking in a particular way – but someone who is already concerned by psychiatry's special status (in all the usual ways – the inherently syndromic nature of categories of disorder; the normativity inherent in our judgements of what is and is not normal) is *precisely* concerned that psychiatric practice does *not* conform to the general truth-seeking practice of medical science more generally, and therefore the assurance that there exists consensus among psychiatrists will not comfort them as to the validity of the judgements that those psychiatrists make.

It then is no good to assert, as Wilkinson did, that what science 'really' (actually, secretly, *contra* the general opinion) confers to a medical diagnosis is the backing only of consensus, rather than that there is a factual ontological grounding of disorder. Because in general, that consensus is only valuable, only confers authority, in virtue of the presumed ontological stability and truth-seeking character of medical science, which is *exactly* what is in question in the problematic case. One may take of pragmatist approach to science in general, and insist from the other end of the practice – the metaphysical end, rather than the end that's manifest in speech acts - that indeed somatic and psychiatric medicine are not differentiable by being to do with a factual ontological grounding of disorder, because in fact *all* science is just a matter of consensus and there is *no* factual ontological grounding to be had – ever. But that is not a deflationary account at all, requiring a lot of heavy-duty metaphysical reasoning, and I fear will not be reached just by a consideration of our linguistic practices.

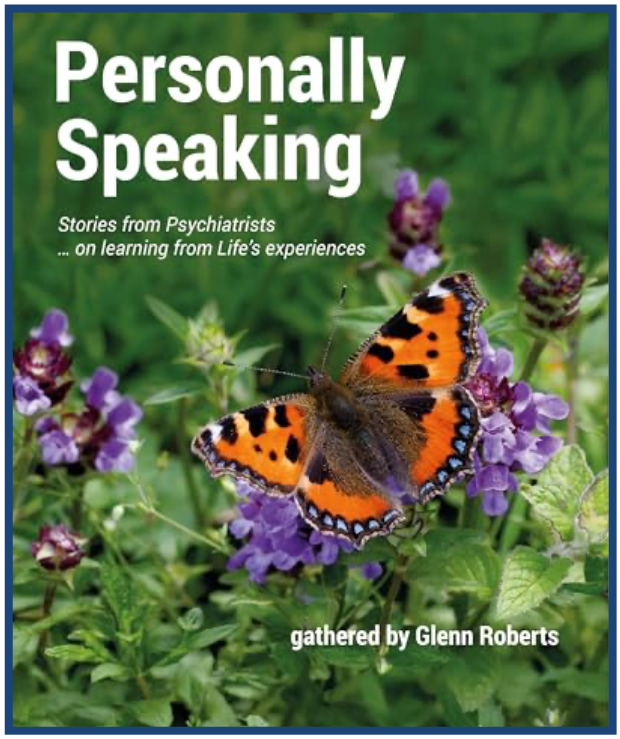
Though I do not think that the account can stand on its own, Dr Wilkinson's presentation of it, as well as his clear excitement by and commitment to the role of philosophy for psychiatry were envigorating, and engagement and interest from the floor sufficient that the second (briefer) part of his plenary lecture had to be abandoned for reasons of time which gives some indication of the engagement that he fostered in the conference attendees.

After lunch, Professor Subodh Dave, Dean of the Royal College spoke about what philosophy can offer to psychiatric education and practice in the UK. His talk was bracing, and fostered some lively debate. In some ways the prospects of enacting the kind of psychiatric care that any practitioner would prefer seem more and more distant given the current challenges to the service. Professor Dave engaged with these specific challenges that face the profession at the same time as insisting on philosophy's relevance, with practical suggestions for the inclusion of philosophy in psychiatry training pathways. His insistence that many of the fundamental conceptual challenges to modern psychiatry still stand, and remain challenges to anyone who wishes to see the discipline and their role in it clearly, was salutary; trainee attendees confirmed that they felt that they were lacking a conceptual underpinning to their training pathway.

Following afternoon refreshments, Professor Jonathan Hill, Professor of Child and Adolescent Psychiatry and Dr Anna Bergqvist, Reader in Philosophy at Manchester Metropolitan University gave a joint lecture: 'Agency, Responsibility and Recover: Domain-Specific Approaches to Personality'. The lecture was characterised by an interactive dynamic, with each intervening freely in those sections the other was delivering, an approach which modelled the kind of interface between philosophy and psychiatry which the Special Interest Group is trying to foster. Using an Aristotelean framework, the presentation paid close attention to the ways in which responsible action is keyed to the domain specific rules that govern practice – so behaviour that counts as responsible action and, further, that might count as expressive of psychological recovery needs to be characterised within its specific social domain. Once again, the attention paid by the speakers to the contours of life within which the treatment of mental illness occurs felt particularly valuable to this author.

The final talk of the day was a group panel, including Dr Hasanen Al Taiar, a consultant forensic psychiatrist, Dr Annelli Jefferson, who had delivered the keynote lecture at the beginning of the day, and two judges – His Honour Judge Jonathan Cooper, Resident Judge at Aylesbury and Amersham Crown Courts, and Judge Teresa Munby, First Tier Tribunal Judge, Mental Health. Again, the cross-disciplinary character of the panel led to fascinating insights, both regarding the challenges and realities of the intersection between justice and psychiatric care in the current context, as well as the more theoretical issues that Judge Cooper raised. His presentation explored the nature of UK sentencing guidelines in the context of crimes with elements of psychiatric disorder, and the different priorities given to culpability and likelihood of reoffending for, on the one hand, offenders with mental illness and, on the other hand, other offenders for whom such factors are not relevant. The viewpoint into the workings of these systems in the UK which the combination of expertise on the panel was able to provide was deeply compelling.

The conference ended late – indicative of the interest and engagement sparked in the attendees – with a brief summing up by Dr Metseagharun, and certainty on the part of this author that every attendee would have been given something substantial to take away with them.



Q&A with Dr Glenn Roberts; *Personally Speaking*

Earlier this month Dr. Christopher Meechan sat down to speak with Dr. Glenn Roberts, the creator of *Personally Speaking: Stories from Psychiatrists...on learning from Life's experiences,* a new book collating eighteen stories by clinicians working in psychiatry, to discuss the book and how his career has shaped its creation.

For more information and ordering see www.personally-speaking.com

Chris: Many thanks for agreeing to speak with the Phil SIG on your new book, *Personally Speaking*. Before we delve into the book itself, given its focus on personal narratives, it seems fitting to start by asking you to tell us a bit about your own story.

Glenn: Thank you for asking, I think the two are quite closely related, but like many, it has taken me many years to sympathetically understand the influence of my personal history upon my life and work:

My parents grew up in the aftermath of the second world war, both came from poor, uneducated, working-class backgrounds, both lost their fathers in childhood. With few resources, they worked very hard to make a secure and outwardly successful home. I'm sure they loved their two boys, but my memory is mostly of an anxious and argumentative household from which I wanted to escape, albeit with a longing for belonging.

I look back on a rather lost, lonely and troubled childhood. I was bullied and anxious around others. I struggled with learning to read and write but nonetheless found great comfort in books and stories, but was most at home wandering in Epping Forest, with nature for companionship.

School was bit of a nightmare, but I was saved by being curious, intelligent and creative and able to rise to challenges when I needed. So, it was an improbable and rather bumpy path that led me to medical school in Bristol where I struggled to cope with the social challenges more than the academic, but really started to find my feet, for the first time, when I was introduced to psychiatry.

Chris: Could you say more about your clinical work, and how narrative and meaning-making influenced your practice?

Glenn: It's nearly 50 years since I was on my student psychiatry placement, but I can still remember the enduring impact of two books. The team social worker gave me an anthology of carers stories from the National Schizophrenia Fellowship (NSF – now 'Rethink') and our teacher, who became a friend and mentor, introduce us to Anthony Clare's 'Psychiatry in Dissent'. The first vividly opened my awareness to the complex experience of living with psychosis as a family, and the second to how just about every aspect of psychiatric practice was contested – particularly by those on the receiving end.

These were stimulating and confusing, in equal measure, but from the outset it seemed to me that psychiatry was all about engagement with life experience and personal meaning and there were no simple or universally applicable 'answers'.

On completing my training, I was drawn to work alongside Jeremy Holmes in North Devon and learned a great deal from his emphasis on psychotherapeutic psychiatry. I was later able to move to Exeter and develop the county-wide rehabilitation service, which focused on taking a positive long-term perspective and supporting people in their recovery through enabling relationships. It took me six years, alongside my NHS work, to complete my MD thesis, 'On meaning and purpose in delusional belief systems' but this prolonged biographically based study into the meaning of symptoms became a 'royal road' for me to develop a narrative approach to rehabilitation practice. It didn't answer why people became psychotic, but it did make the content more intelligible and therapeutically approachable, as we became more able to understand and empathise with the life predicament of the people who became our patients.

Chris: Is there anything else you'd like to share about your own story?

Glenn: Well, life continues to have its complexity and shadows but I'm very pleased to be entering my 71st year, in a warm and secure relationship, as a father and grandfather, and with a dear doggie companion. And, having taken the 'step-up' into retirement, I'm mindful of Oliver Sacks' final essay, 'On gratitude', and, overall, share his sense of deep appreciation for what has been possible to experience and achieve.

I have known times of significant mental distress but I'm pretty sure that finding a way to survive and sit with those anguishing experiences, gave me confidence to sit alongside others in their darkness, without being frightened of despair, and hopelessness, and confusion.

Learning from the 'Recovery Movement' was the most hopeful and helpful discovery in my personal / professional life and I had the good fortune to become the RCPsych's lead on Recovery (2006-11) and many other opportunities. In later years I feel I've come home to a more secure and grounded way of being through meditation and contemplative studies. It has been a time of (re) integration and healing for much of what has gone before, which has led directly to the purpose and process of our book.

Chris: For those unfamiliar, could you explain what the book is about?

Glenn: In a simple sense it is richly illustrated anthology of intimate autobiographical stories, from well-known and well-respected colleagues, reflecting on what they have learned from their life experiences that has informed, influenced and inspired their work. It underlines how the interconnections between our personal and professional lives can be mutually supportive, on the life-long road to maturity. It is a rich resource that invites the reader to reflect on their lives and value their experience, but what it is 'about' is likely to be different for different readers as they engage in their own personal contemplations.

In trying to summarise the book, various metaphors have come to mind … it is somewhat like **a welcoming campfire**: offering warmth and light, somewhere to gather in the dark and listen to stories that connect with the story you're living. Or **a buffet table**: with a spread of narrative nourishment to which you can bring your plate and choose what you value or need. And I joke that it's also **'a bit of a mess'**: in the old style of the doctors' mess, a safe place where you could sit with colleagues, including elders, and hear them talk about life and work, what was going wrong, what mattered. In a way this is a 'mess' in a book.

"we are people before we are practitioners"

Chris: You describe the "heart, art, and soul" of psychiatry as fundamentally relational. What do you mean?

Glenn: I have struggled to summarise the book in a single sentence, but landed on: 'Through intimate *autobiographical stories, leading psychiatrists illustrate how the heart, the art, and the soul of psychiatric medical practice are fundamentally relational, starting with themselves.'*

That "starting with themselves" matters. The stories repeatedly show that how we relate to our own experience informs how we relate to patients, and our colleagues and teams too. This doesn't mean collapsing boundaries or assuming equivalence. It means recognising that psychiatry is dependant not only on technical competence but on personal connection and capability. Relationship-building is not "extra"; it is intrinsic and essential. The book is, in a sense, about re-visioning our professional identity as a relational identity: we are people before we are practitioners and our work is essentially that of seeking to form trusting and helpful relationships with those in great distress … we can call on many technical skills and resources too … but I'm with Irv Yalom in thinking that it's the relationship that heals.

Chris: Was there a story that stood out for you personally?

Glenn: I've learned something important from all the stories but have a particular connection with Mike Shooter's. I read an earlier version many years ago in a BMJ interview. He described his depression, suicidal thoughts, despair, and the sense of wasted years. When he stood for the presidency of the Royal College of Psychiatrists, he included his experience of depression as a qualification for high office. I read it while I was going through a very difficult patch myself, feeling depressed and fraudulent, struggling to reconcile being a patient and being a doctor. His story embodied the possibility that these are not two different species of human being. They are two aspects of one human life, and each can inform and support the other. It was a vision for how professional and personal maturity can be helpfully interconnected.

And having been personally helped by his personal story, Mike was the first person I approached to contribute to this project, and I was delighted he accepted …

Chris: What is the importance of narrative in psychiatric theory, practice, and research?

Glenn: Valuing narrative is valuing meaning: meaning attached to experience, and experience as arising from trouble in life. A narrative perspective inherently humanises our understanding of distress. It situates difficulties within a life trajectory: one thing happens after another. It offers a different perspective on psychopathology and on formulation.

Narrative also offers insight into painful or corrosive stories—stories people are told about themselves, or attach themselves to, which become toxic and destructive. People can live by painful meanings that shape identity: who they are, what they've been through, how they got here.

Therapeutically, narrative work can involve story-making and story-breaking. Many people are confused about their life: what happened, what it means, where it came from. Sometimes we work to help them create a story to live in and live by. At other times, people are stuck in a story; constrained by it; fed indigestible meanings. Then we may help them to open meanings, let go of some of them, and see from another perspective, a more hopeful and healthy way of understanding that stands them in better service as a map to live by.

The journey of personal recovery is often marked by a transition and transformation of the story people are living in as they come to understand what they've been through, where they are now, and where they'd like to be. This reauthoring of our lives and finding satisfactory meanings-to-live-by is personal work, but something that can be enabled by practitioners and peers.

Chris: Do you feel the culture of psychiatry values narrative more now?

Glenn: I can only offer a personal perspective, and it feels to me as though the 'culture' of psychiatry is significantly and unhelpfully divided, such that, depending on viewpoint, the answer could be both 'yes' and 'no'.

One division is between the psychotherapeutic and bio-medical camps, what Luc Ciompi referred to as 'the disastrous split', and which broadly mirrors our endemic cultural divide between science and the arts. Many forms of psychotherapeutic training and practice are deeply attentive to narrative awareness, but these are seldom the leading approach in our services. In my view, our therapeutic approaches need creative integration if we are to really to develop person-centred care.

But a deeper and more disturbing division may be between the aspiration and culture of our training as Psychiatric professionals and the often conflicted and compromised reality of our employed roles in practice. It's hard, very hard, to value and sensitively engage with personal meaning and intimate therapeutic relationships, if you are overworked, under supported, stressed and struggling yourselves.

The stories in our book are set against the tensions of these uncomfortable realities, and I feel one of our overarching messages is of the need to find a practical way to reclaim, inhabit and embody the guiding narrative of our own profession as based on 'holistic and person-centred care' – including that for ourselves.

Chris: Although the book isn't principally philosophical, there are philosophical implications. Did anything come out for you?

Glenn: I have no specialist training but have always been drawn to philosophical perspectives. I really appreciate how the etymology of 'Philosophy' unpacks as, 'the love of wisdom', and that our

college motto is, 'Let wisdom guide' ... I've sometimes thought our work could be reframed as 'clinical philosophy'.

But, what is 'wisdom'? For me it is about knowledge, understanding and skill in learning how to be well and live well … it's about life and living. Over a lifetime I've dabbled with many perspectives and have come to see what is of value as arising from many convergent streams of culture and contribution.

For some years now I've been learning from secular Buddhist teachings which are psychological and philosophical, rather than religious, in nature, and observe many overlaps with early Greek philosophy. The Buddhists call their teaching 'Dharma' which is substantially focused on meditation and ethics and seeking to realise the fundamental nature of things … but with a clear focus on practicality, learning how to be well and live well, here and now.

But I take this Buddhist dharma to be part of a much broader accumulation of human wisdom - what Jon Kabat Zinn refers to as 'universal dharma' ... and from that viewpoint I consider our book of stories to be 'dharma tales' - whose guiding purpose lies in fulfilment of our College motto to, 'Let Wisdom Guide' ... our stories being focused on the experiential wisdom of learning about life through open and honest contemplation of experience. And I think it's important to emphasise that the 'guidance' here … is not something offered by the storytellers so much as something the reader is invited to discover for themselves in the context of reflecting upon their own lives.

Chris: One philosophical debate that comes to mind when thinking about narratives, concerns Karl Jaspers' idea of the experiential aspects of schizophrenia as being inherently "*un-understandable*". Is there a need to be mindful of the potential limits to the 'understandability' of some people's personal stories?

Glenn: This is an important question. I think Jaspers' views on 'un-understandability' has been substantially misunderstood to suggest that *everything* about psychosis is beyond the grasp of understanding – and therefore people experiencing psychosis are nonsense speakers – which, historically, has led to tragically depersonalised treatment, stigma and othering, the shadows of which affect us still.

Wisdom is also defined in relation to 'truth seeking', but I believe 'truth' can be apprehended symbolically or metaphorically as well as through verifiable facts. I've explored this in some detail in my writing on, 'Narrative approaches to psychosis' in Healing Stories (1999) and that on 'Understanding madness' in Enabling Recovery (2006). In short, I really value the distinction Jaspers made between 'understanding' and 'causal explanation' and particularly his assertion that, 'understanding proceeds by way of empathy', which I see as enabled by narrative perspectives. (Note: I needed to look this up after our conversation but I was pleased to remember that Jaspers also said, 'extreme psychotic states offer a human parable … patients see into depths that do not belong so much to their illness as themselves as individuals with their historical truth … in psychotic reality we find an abundance of content representing fundamental problems of philosophy' (1963, p309))

And if I understand the spirit of your question correctly … there is a need to be careful and cautious in how we relate to the 'truth' of any particular story … stories are meaningful and motivated constructions of meaning, not read-outs from reality … but similarly there are also truths revealed and evoked by stories that can never be accessed through facts alone. This is very important in our therapeutic work as well as in living our lives.

Chris: Any specific advice, and any changes you hope to see in training and practice?

Glenn: There is work involved in turning experience into expertise, sometimes hard work. Our book suggests this (self) work could be a key aspect of both training and practice in support of our personal and professional maturation.

Our book opens with an invitation to spend time with these authors, listening to their stories and reflecting on how that connects with the stories we are living in. I advise readers to read slowly, one story at a time. Don't try to squeeze the juice out of it as you would a paper, looking for facts. Sit with an awareness of the author's presence, really listen. And rather than ask, 'what are they saying?', ask yourself, "what does this have to say to me?" This is a book with a job to do, and putting the book to work offers opportunities for coaching, mentoring, supportive contemplation and personal reflection.

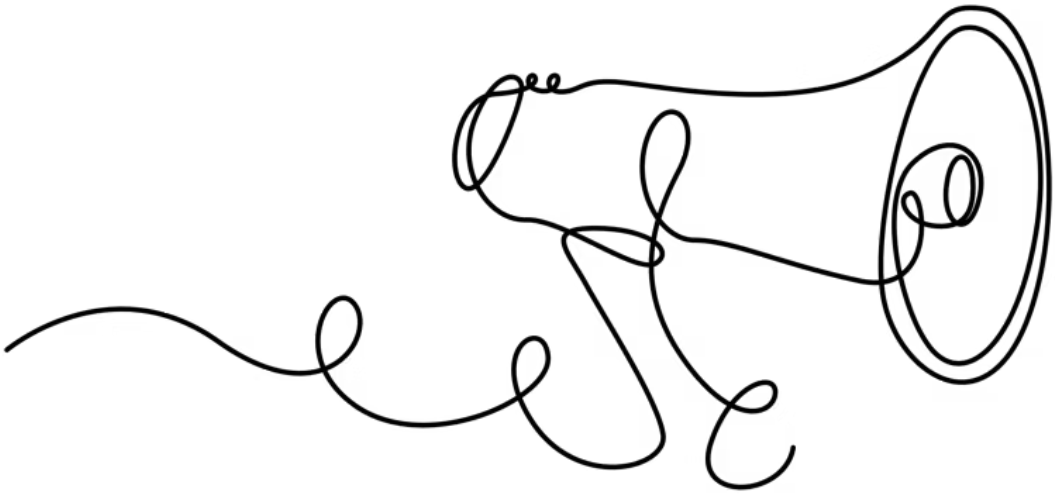
I hope that groups of colleagues may like to read and discuss these stories together and perhaps be encouraged to find and offer one another stories of their own.

My hope, our hope, is that our 'gift of stories' will be a supportive contribute to re-visioning psychiatry, based on person-centred and relational training and practice … but just how, is a question for our profession as a whole to consider.

Interview by Dr. Christopher Meechan
Edited by Dr. Conor McAvoy

Many thanks to Dr Glenn Roberts for sharing his time and wisdom

'Personally Speaking' is available **HERE**



Updates and Announcements

4.1. Webinar in association with RCPsych HoPSIG and PhilSIG - 'Emil Kraepelin (1856-1926) and Jacques Lacan (1901-1981): Two important and contrasting figures in Mental Health and Beyond'

Date: Wednesday 18 March 2026
Time: 8:00pm - 9:30pm CET (7:00pm - 8:30pm GMT; 21:00-22:30 EET)
Location: Online

In 2026, anniversaries of Emil Kraepelin (100 years since his death) and Jacques Lacan (125 years since his birth) invite renewed reflection on two contrasting legacies in psychiatry. This event brings their traditions into dialogue, exploring diagnosis, biology, language and subjectivity in mental illness. It addresses contemporary challenges in psychiatry and will interest psychiatrists and academics concerned with mental health and culture.

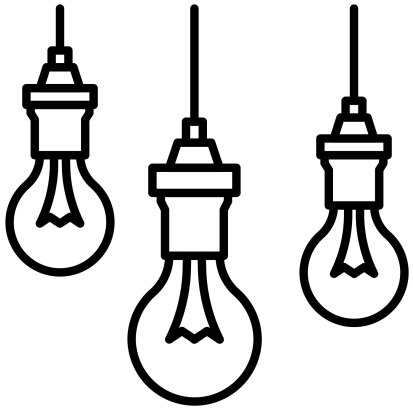
Learning Objectives:

- Review the legacy of Emil Kraepelin for psychiatry
- Reflect on the contemporary status of psychiatry as a medical specialty
- Review the legacy of Jacques Lacan for psychiatry
- Reflect on the significance of Jacques Lacan's theories of subjectivity, the unconscious and desire in the contemporary predicament of psychiatry
- Explore issues relating to research, training and clinical practice in relation to the biopsychosocial model of psychiatry in the 21st century

You can **register here** and the programme and speakers **available here**

4.2 A meal with Socrates: The PhilSIG drop-in sessions: Phenomenology, psychoanalysis, and clinical practice

Date: Wednesday 29 April 2026
Time: 12:00pm - 1:30pm BST
Location: Online



The PhilSIG drop-in sessions are intended as a regular semi-informal forum for mutually rewarding discourse between philosophers and psychiatrists. They reflect essentially what this SIG was set up for.

There is no end to the number of subject matters on which we could philosophise. Life throws phenomena and experience at us, and we must make sense and meaning out of them. This is the task of the philosopher psychiatrist. Amateurs are most welcome! We hope you will be satisfied both in conceptual and clinical terms. Our next session is an exciting one!

Panel members:

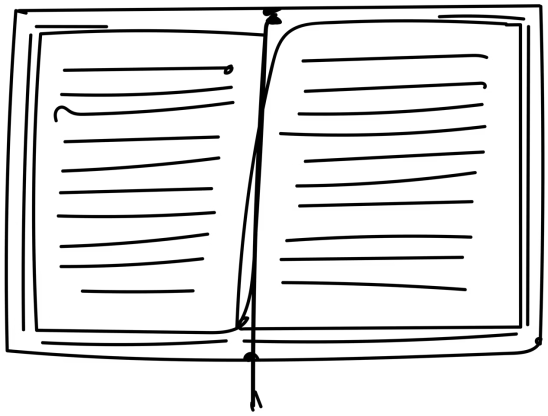
- Professor Femi Oyebode is a MBBS, MD, PhD, FRCPsych (honorary – Lifetime Achievement Award recipient), and former chief examining officer at the Royal College of Psychiatrists.
- Dr Francesca Brencio is a PhD, Teaching Fellow at the University of Birmingham Institute for Mental Health, School of Psychology.
- Dr Andrew Hodgkiss is a BA MBBS MD DCP FRCPsych, Retired Consultant Liaison Psychiatrist and Lacanian Analyst.
- Dr Temi Metseagharun is a MBBS, MRCPsych, MA (Philosophy), FRANZCP, and Chair of RCPsych Philosophy SIG.

The session will (in Socratic fashion) attempt to define phenomenology and provide a brief history. The session would then focus on two key aims: translating phenomenological concepts into practical clinical applications, and bridging the gap between academic approaches to phenomenology/psychoanalysis and the real-world needs of mental health professionals.
As an interactive session, the audience and attendees would include not just psychiatrists, RCPsych members and/or medical trainees, but also (external/university) philosophy students who may be interested.

You can **REGISTER HERE**

4.3 PhilSIG Reading Group

Date: Wednesday 14 April 2026
Time: 7:00pm - 8:00pm BST
Location: Online



We are very excited to announce the re-launch of the PhilSIG Reading Group, which we hope will run Bi-Monthly online

The provisional format (subject to change!) is to pick one or two key or landmark papers related to philosophy of psychiatry, which will be sent round and read in advance. The paper will be briefly summarised informally by one of the chairs, drawing out key themes and questions, leaving the majority of the time for what will hopefully be a fruitful and enlightening discussion.

All are welcome and no prior philosophical knowledge is required. We hope to use this as a forum to introduce those interested to key concepts in philosophy of psychiatry and to provide a space for discussion. The group will be chaired by the PhilSIG Trainee Sub-committee and we hope in future to involve wider membership in paper selection and presentation (though this is not a requirement!)

If you would like to be added to the mailing list please email **chrisfmeechan@gmail.com**

4.4 (Via INPP) The Self in the Social World Conference

Date: Thursday 24 September - Saturday 26 September 2026
Location: Heidelberg (Germany)

The Heidelberg University Hospital, Section for Phenomenological Psychopathology and Psychotherapy, is pleased to announce an international conference - in Heidelberg, September 24 - 26 - on *'The Self in the Social World'*

This conference explores how the self is shaped, experienced, and transformed within the social worlds we inhabit. Human selfhood does not arise in isolation; it unfolds within networks of interpersonal relations, cultural and institutional settings, technological infrastructures, and shifting ecological and political conditions. As these worlds evolve, so too do the experiential dynamics through which individuals make sense of themselves, others, and their place in a shared reality. A more specific yet central form of social sense-making consists in individuals' striving to find a place in the social world that bestows a sense of belonging, meaning, and fulfilment.

However, finding such a place is not something we can simply take for granted. Social environments must have certain features for individuals to be able to make them their home, just as bodily, affective, and cognitive aspects of individuals precondition whether they may benefit from the interactions within the communities they navigate. The fit between various features of environments and individuals is notoriously precarious. A central aim of the conference is to investigate the lived experience of the self in its dynamic embeddedness in the social world. This topic provides a fitting opportunity for us to come together and celebrate Thomas Fuchs's dedicated years of service, now coming to an end, as the Karl Jaspers Professor at Heidelberg University.

For full details please **CLICK HERE**

4.5 3rd Phenolab Summer School

Date: Monday 8 June - 12 June 2026
Location: Spoleto, Umbria (Italy)

Registrations for the 3rd PhenoLab Summer School in Umbria are now open until June 1st . The theme of this edition is *Phenomenology and Medicine. Exploring the Lived Experience of Illness and Care.*

Keynote Speakers (in alphabetic order):

- Dr. Roxana Baiasu, University of Birmingham (UK)
- Dr. Francesca Brencio, University of Birmingham (UK)
- Prof. Dr. Matthew Broome, University of Birmingham (UK)
- Prof. Dr. Havi Carel, University of Bristol (UK)
- Dr. Lorna Collins, Expert by experience (UK)
- Dr. David Crepaz-Keay, FRSPH, The Mental Health Foundation, London (UK)
- Prof. Dr. Magnus Englander, Malmö University (Sweden)
- Prof. Dr. Susi Ferrarello, California State University (East Bay) (USA)
- Prof. Dr. Dr. Thomas Fuchs, Heidelberg University Hospital (Germany)
- Prof. Dr. Ashok Handa, St Catherine's College, University of Oxford (UK)
- Prof. Dr. Guilherme Messas, Santa Casa de São Paulo Hospital (Brasil)
- Prof. Dr. René Rosfort, University of Copenhagen (Denmark)

To register **CLICK HERE**

4.6 (Via INPP) Call for Abstracts - 27TH INTERNATIONAL NETWORK OF PHILOSOPHY AND PSYCHIATRY CONFERENCE

Date: Thursday 8 October - Friday 9 October 2026
Location: Nijemegen (Netherlands)

The next INPP annual conference will be held in Nijmegen, the Netherlands. The conference theme is “What can Philosophy do for Mental Health Care?”. We invite submissions for abstracts on a wide range of topics at the intersection of psychiatry and philosophy. We prioritise submissions which actively seek to bridge the gap between theory (e.g. philosophical, ethical or phenomenological) and practice (e.g. mental health care design, treatment or organisation).

Abstract submission is possible until March 27, via the website https://inpp2026.com/

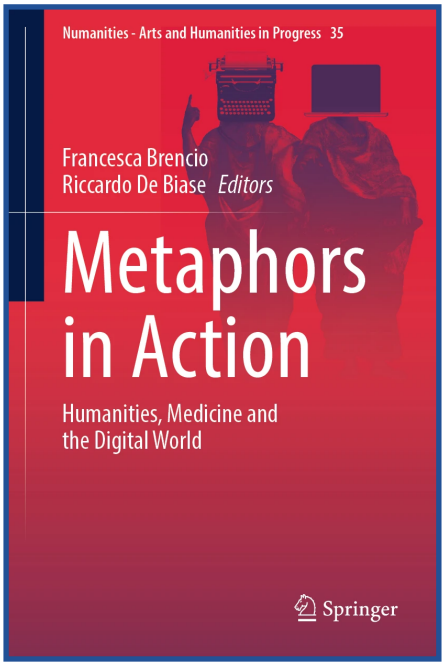
4.7 Royal Australian and New Zealand College of Psychiatrists Updates and Future Conferences

The RANZCP hosted a recent webinar that took place on 18 February 2026. This webinar had Bill, Anna and our char Temi in addition to two members of RANZCP's Section on Philosophy and Humanities - Dr Andrew Howie and Dr Susan Lutton, This webinar was well attended - over 600 registrations and 431 actual participants. It was that well received, such that there is already a plan for an Australia and New Zealand Conference on Philosophy and Psychiatry within the next 12 months!

We (our SIG) hope to work with the RANZCP and look to facilitate an International Conference in Perth Australia in 2028 - watch this space!

Notable Publications

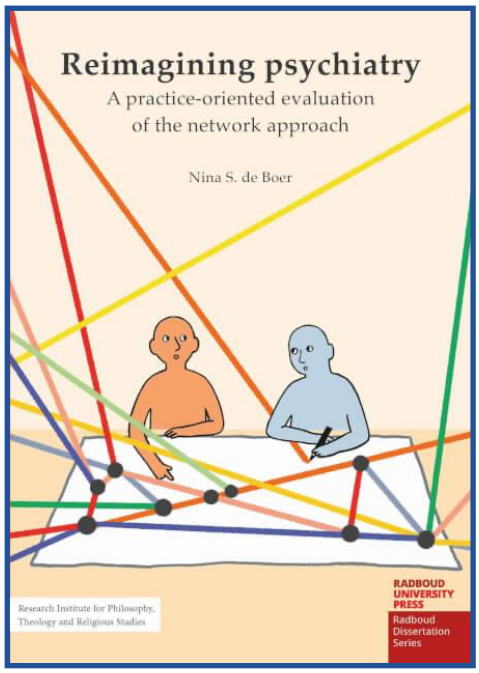
Metaphors in Action: Humanities, Medicine edited by Francesca Brencio & Riccardo De Biase (Springer Press 2026) ”



Through a transdisciplinary lens, this book offers a unique description of how metaphors inform our conceptual system and shape our world accordingly. *Metaphors* in action means marking a break from conventional methodologies: observing metaphors as they operate reveals how conceptual mappings serve as interpretive tools, directing perception, limiting reasoning patterns, and either enabling or hindering comprehension in practical situations. This collection guides through an exploration of how metaphors exhibit consistency with the cultural contexts and value systems from which they emerge. We examine metaphor as a "semantic network", a framework that immediately suggests new pathways for generating alternative ontological possibilities.

This book explores the role and significance of metaphors and the landscapes they shape in five disparate fields: philosophy, linguistics, law, health and digital technologies. This volume is an invaluable resource for students and researchers in philosophy, health sciences, psychology, and the digital humanities.”

Reimagining Psychiatry: A Practice-Oriented Evaluation of the Network Approach by Nina de Boer (Radboud University Press, 2025) “

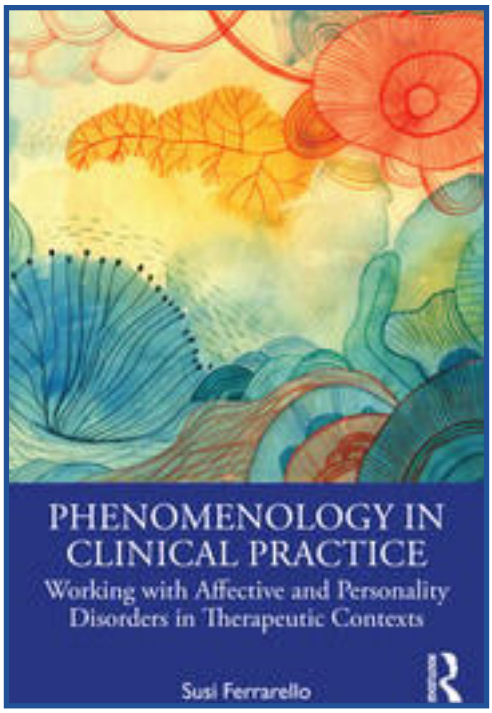


As the biomedical approach to mental disorders has fallen short of its promised breakthroughs in our knowledge of mental suffering, systemic alternatives – like the network approach – are gaining traction. But given psychiatry's history of promoting reinventions with big promises and unrealistic expectations, how should we evaluate the “epistemic potential” of the network approach?

In this thesis, Nina de Boer formulates a practice-oriented response to this question, focusing not just on how well the network approach reflects the reality of mental suffering but also on how it represents mental suffering, who uses it, and for what purpose.

By examining the use of the network approach in scientific practice, clinical practice, and daily life, De Boer offers a new perspective on the value of the network approach and contributes to broader debates about the epistemic potential of psychiatric reinventions.”

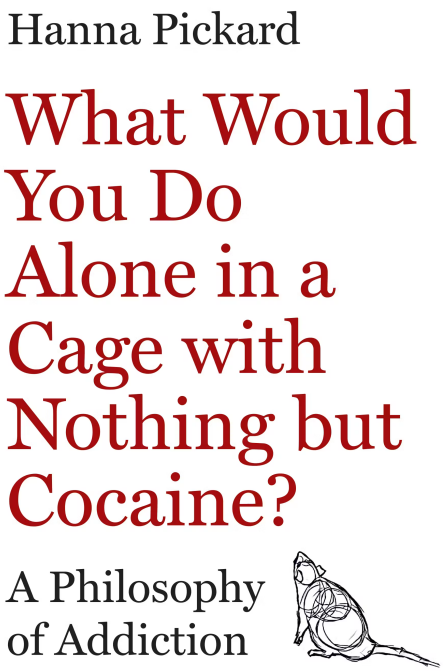
Phenomenology in Clinical Practice: Working with Affective and Personality Disorders in Therapeutic Contexts by Susi Farrarello (Routledge Press 2026) “



Phenomenology in Clinical Practice introduces core concepts of Husserlian phenomenology and applies them to the understanding and treatment of affective and personality disorders in clinical settings. Dr. Susi Ferrarello illuminates the source of emotional cycles and instability and offers mental health practitioners guided approaches to addressing affective disorders, alleviating disturbances, and promoting integration. Designed for mental health professionals and students in psychology, psychiatry, and medical humanities, this book bridges theory and practice through case-based applications and accessible explanations of philosophical concepts. It offers a non-reductionist, lived-experience approach to mental health and aims to expand both academic and therapeutic perspectives on conditions such as C-PTSD, alexithymia, BPD, narcissism, and schizophrenia. Asserting that philosophical investigation can deepen an understanding of mental illness and care, the author invites readers to develop transformative approaches to address mental suffering with greater compassion and holistic awareness.

This book is an indispensable tool for those working in mental health care, especially for those looking for new lived experience-based solutions for clinical and psychopathological problems. It is also an invaluable resource for graduate students and researchers, as well as people who are not philosophers but seek support in reflecting on the ethical, psychological, and social challenges that are present in clinical practice.”

What Would You Do Alone in a Cage with Nothing but Cocaine? A philosophy of addiction by Hanna Pickard (Princeton University Press, 2026) “



Why do people with addiction use drugs self-destructively? Why don’t they quit out of self-concern? Why does the rat in the experiment, alone in a cage, press the lever again and again for cocaine—to the point of death? In this pathbreaking book, Hanna Pickard proposes a new paradigm for understanding the puzzle of addiction. For too long, our thinking has been hostage to a false dichotomy: either addiction is a brain disease, or it is a moral failing. Pickard argues that it is neither, and that both models stifle addiction research and fail people who need help.

Drawing on her expertise as an academic philosopher and her clinical work in a therapeutic community, Pickard explores the meaning of drugs for people with addiction and the diverse factors that keep them using despite the costs. People use drugs to cope with suffering—but also to self-harm, or even to die. Some identify as “addicts,” while others are in denial or struggle with cravings and self-control. Social, cultural, and economic circumstances are crucial to explaining addiction—but brain pathology may also matter. By integrating addiction science with philosophy, clinical practice, and the psychology and voices of people with addiction themselves, Pickard shows why there is no one-size-fits-all theory or ethics of addiction. The result is a heterogeneous and humanistic paradigm for understanding and treating addiction, and a fresh way of thinking about responsibility, blame, and relationships with people who use drugs.”

By examining the use of the network approach in scientific practice, clinical practice, and daily life, De Boer offers a new perspective on the value of the network approach and contributes to broader debates about the epistemic potential of psychiatric reinventions.”

Articles and Book Chapters

Clark, O. (2025). Modes of Delusionality: The Doxasticism Debate in Deadlock. *Philosophy, Psychiatry, & Psychology*, Advance online publication on *Project MUSE*. https://dx.doi.org/10.1353/ppp.0.a978321.

Fellowes, S. (2025). The Epistemology of Psychiatric Diagnoses in Lived Experience Research. *Philosophy, Psychiatry, & Psychology 32*(4), 467-481. https://dx.doi.org/10.1353/ppp.2025.a978091.

Fulford, K.W.M., Moskalewicz, M., Stanghellini, G. (2025) A new role for phenomenology in empowering patients based on quantitative evidence-based research. *World Psychiatry* 24(1), pp. 139–140.

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Ikkos, G., Becker, T., Stanghellini, G., ... Morgan, A., Hoff, P.(2025). An Emil Kraepelin centenary: psychiatry's long 20th century, 1899–2026 and after. *British Journal of Psychiatry*. Online.

Jerotić, S., Nešić, J., Vuković, V., & Madeira, L. (2025). The Embodied Mind as Pharmacological Target: Towards a Phenomenology of Psychopharmacological Interventions. *Psychopathology*, 58(6), 366-378.

Nielsen, K. (2025). Enactive approaches to conceptualising psychopathology. *New Ideas in Psychology,* 79, 101189.

Plutynski, A. (2026). The meaning of a measure: p as a general measure of psychopathology. *Philosophical Psychology,* 1–33. https://doi.org/10.1080/09515089.2025.2611430

Spencer, L., Broome, M.R., Stanghellini, G. (2025). The future of phenomenological psychopathology *Philosophical Psychology* 38(1), pp. 1–16

Stanghellini, G.(2025). How to improve psychiatric nosography in the XXI century: A phenomenologists viewpoint. *European Psychiatry* p68(1), e2

"Ask yourself at every moment - Is this necessary?"

-Marcus Aurelius, *Meditations*

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Thank you to all those who have helped make this newsletter possible!

If you have any suggestions for future newsletters or would like to contribute a guest article please contact the editor at chrisfmeechan@gmail.com