Philosophy of Mind

A six-session workshop series based on project PERFECT themes

Facilitator Pack

Contents

Introduction

Philosophy of mind is that bit of philosophy where we aim to understand the nature of experience, thoughts and reasoning. Our inquiry will fare better if we draw upon as wide a diversity of perspectives as we can.

This 6-session, discussion-driven workshop series is for everyone with an interest in mental health: e.g. for people with lived experience of unusual beliefs and experiences; those involved in mental health advocacy; and for mental health service providers and clinical practitioners, and beyond.

The workshop series looks critically at:

- Unusual experiences and beliefs which do not reflect shared reality, and ways of thinking which seem irrational, and how these cognitions can very often arise in *absence* of any mental health crisis or any psychiatric diagnosis, as well as alongside these.
- Why some unusual beliefs and experiences have been pathologised, while others have not; and why some instances of irrationality have been identified with 'madness', and others have not.
- The claim that unusual experiences and beliefs are predominantly negative: we look at how these cognitions can contribute to knowledge, and explore their role in supporting a unified and coherent sense of agency.

The workshops are best run with small groups (of 6-10). There is a slide deck for each session, containing the guiding questions, outlines of relevant philosophical models, examples, and other material to help guide and anchor the discussion. Ideally, the facilitator will spend some time becoming familiar with the material, and will be able to introduce the guiding questions, talk through the different models and viewpoints presented on the slide deck, and encourage discussion and participation from all group members. These facilitator notes are chiefly to guide you how to present the material and how to set up group discussion and participation. There are a few pointers on facilitator practice, but in general, the facilitator will benefit from undergoing specific peer support group facilitation training, e.g.:
http://www.mindincamden.org.uk/services/training

This facilitator pack includes extended guidance to accompany the powerpoint slides, and also includes a "core questions and ideas" section for each session, if you want to run a more stripped-down group, without the slides.

This workshop series has been developed by Dr. Sophie Stammers, research fellow at Project PERFECT, in the philosophy department of the University of Birmingham, based on the project's themes (see next page). It was conceived of in partnership with Mind in Camden (see page 4), and first run with people with lived experience of unusual beliefs and experiences, as well as people working in mental health services and advocacy, in 2017.

About project PERFECT

We are a team of philosophers and psychologists based at the University of Birmingham and Aston University, exploring the Pragmatic and Epistemic Role of Factually Erroneous Cognitions and Thoughts (PERFECT). PERFECT is funded by the European Research Council, and will run from 2014–2019.

PERFECT aims to establish whether cognitions that are unusual or which do not reflect shared reality can help us practically, psychologically or epistemically (contributing to knowledge). Can cognitions sometimes classified as delusions, distorted memories, and confabulatory explanations, (which are frequent in the non-clinical population and also listed as symptoms of psychiatric conditions such as schizophrenia and dementia) have redeeming features?

Aims

- Show that cognitions can contribute to knowledge and self-knowledge without reflecting shared reality
- Recognise the role of unusual and unshared cognitions in supporting a unified and coherent sense of agency.
- Propose that clinical interventions should be compatible with the development of a self-narrative that supports agency.
- Provide strong theoretical reasons to regard the so-called 'normal' and 'abnormal' cognition as continuous, and challenge the stigma associated with mental health issues.


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About Mind in Camden

Mind in Camden provides high quality support and capacity building services to benefit people who are struggling with mental distress, including: hearing voices, extremes of mood, anxiety, unusual beliefs and post-traumatic reactions.

Values and Vision

Mind in Camden sees mental health as a continuum we are all at different points on at different times in our lives – there is no 'us' (= well) and 'them' (= ill). The organization sees experiences such as hearing voices, seeing visions, having unusual beliefs and experiencing anxiety, hopelessness or extremes of mood as responses to real events, feelings and cultural influences that people can identify in their own lives – rather than as delusions, hallucinations or symptoms of a bio-medical 'disorder'. Mind in Camden recognizes that many people who experience voices, visions and other unusual experiences and/or beliefs lead happy and fulfilled lives, and that, in some cultures, these experiences do not result in stigma.

Working alongside people of all ages who are experiencing distress through voices, visions, unusual beliefs, anxiety, hopelessness and extremes of mood, Mind in Camden will stimulate change and development in mental health services by providing, promoting and partnering in services in diverse settings that:

- enable self defined recovery, increase self esteem and promote hope
- involve guided and unguided self help, co-production and peer support
- challenge stereotyping, stigma, isolation and social exclusion

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Session 1: Introduction and philosophical techniques
Extended facilitator notes

Supporting material: print outs of thought experiments for small group discussion (see p28-31)

In this session, we introduce some key philosophical techniques and notions that will be helpful for our discussions throughout the following workshops.

You may want to spend some time at the start setting up the values and principles of the group in accordance with any facilitator training you have undertaken. The group principles can be jointly created and jointly agreed upon, and returned to whenever necessary during the ensuing sessions.

You can go around the group, asking participants what philosophy means to them, and what they are hoping to get from the sessions to open the discussion

Guiding questions:

1) *What sense of 'argument' is relevant to philosophy?*
2) *What is a thought experiment, and what are they used for?*
3) *What's the difference between normative and descriptive claims, and why does it matter?*

1) What sense of 'argument' is relevant to philosophy?

SLIDES: "Argument"

It could be said that philosophy proceeds through arguments. But what sense of argument is relevant? This term can evoke the notion of combat and aggression – those are not the senses we're interested in. As it happens, looking at the etymology of the term "argue" is revealing for our purposes, as you can see on the accompanying slides. There is a sense of the term "to make clear, make known" that we are more interested in. Philosophy is about articulating your position clearly, reflecting on what you think, or feel, or how things seem to you, and articulating that position, giving reasons and supporting statements when appropriate. Actually, it is from the same root (to make clear, to make known, to *shine,* in fact!) that we get the word for *silver*. You can ask if there are any chemists in the room who are familiar with the periodic table (if not, you can say briefly what that is) and move to the slide with the symbol for silver…***Ag***!

So, the sense of argument that is relevant for us is the sense in which we are striving to articulating our position clearly, and listening for our peers to do the same. We can do away with the notions of combat and aggression in this space, they'll not be relevant for what we want to do.

2) What is a thought experiment, and what are they used for?

RESOURCES: thought experiment hand-outs, attached to the bottom of this document
SLIDES: thought experiments

You can ask whether anyone in the group has heard of, or ever done, a thought experiment, and get people's ideas on what they might be for. In philosophy, we sometimes want to put our ideas to the test, reflect on them, look at them from different angles, because sometimes, doing this produces new intuitions about the ideas in question. This is what thought experiments allow us to do.

Split participants into groups of 2-3 and give them each a print out of one of the thought experiments (scroll to the bottom of this document to find them) to read and discuss, answering the following questions, answers to which are presented when the whole group comes back together.

Ask the group to nominate someone to summarise their thought experiment to the rest of the participants. What is the philosophical issue that the thought experiment is encouraging us to think about? What are your intuitions, what do you think it shows?

3) What's the difference between normative and descriptive claims, and why does it matter?

SLIDES: normative vs. descriptive claims

It is important to distinguish between normative and descriptive claims, and this will be relevant to a lot of material that we later discuss.

Normative claims:
Normative claims make value judgements, such as being good, or worthwhile, or not good. Sometimes they prescribe what ***should*** be done *(relative to some set of values or standards)*

Descriptive claims:
Descriptive claims do not make value judgements, they just make a claim about how something ***is***.

Answers: normative claims are underlined, descriptive claims are italicized:

•*Sarah went to the gym near her house and played squash with Sayeed for 45 minutes.*
• We should try to get 7-8hrs sleep a night.
• *Game of Thrones is watched by millions of people.*
• Game of Thrones is a great TV series.
• *John believes that cats are great.* <- bit of a trick one this, the *content* of John's belief on its own is normative, but the entire sentence about John's belief is a descriptive claim.
•John's belief is weird.
• *Sarah bought the coat for £30*, but it is a very high-quality coat, and she should have paid more for it.

• The bus should have picked them up at 08:13*, but they waited until 08:43 before a bus arrived.*

Discussion:

Why might it be important to know if a claim is normative or descriptive?
You can prompt the group here, saying that if we want to evaluate a claim, then there are different ways of doing this depending on whether it is normative or descriptive. If the latter, then we look at the world to see if the claim matches. Of course, it may be that we may have different perspectives on how the world is, so there is this to contend with. If the claim is normative, then we have to refer to the relevant set of norms. It may well be that we disagree with these norms!

When you have a normative claim, who decides what the relevant norms are?
This will be different for different claims. Always worth thinking about when you come across a normative claim, it may help you work out whether the claim is a good one or not.

In general, being able to distinguish between normative and descriptive claims will improve our philosophical enquiry , because it will help us determine whether or not we need to look just at the way the world is to evaluate a claim, or whether we also need to think about whether we agree with the set of norms or values that a claim defers to.

Further questions and exercises (if there is time, or to take away):

- Can participants come up with their own thought experiments to illuminate an idea about the mind, thinking, or another aspect of philosophy?
- Are there any normative claims that have you come across in everyday life where you have called into question the norms that they assume? Why?

Reading in preparation for the next session:

"Hearing voices? Don't assume that means schizophrenia"
https://theconversation.com/hearing-voices-dont-assume-that-means-schizophrenia-38616

"Perception and Perceptual Illusions"
https://www.psychologytoday.com/blog/theory-knowledge/201305/perception-and-perceptual-illusions

General resources for browsing or own research:

Imperfect Cognitions blog: **imperfectcognitions.blogspot.co.uk**

The Stanford Encylopedia of Philosophy: **plato.stanford.edu**

Session 1: Introduction and philosophical techniques

Core questions and ideas

1) What does ‘philosophy’ mean to you?
2) What does it mean to make an argument? Is making an argument always aggressive? Or can it sometimes be helpful?
3) Are there good and bad ways to make an argument? How can we tell?
4) Do you think our different beliefs and values affect our statements and arguments? Is this good or bad? And how can we tell?
5) Can we learn new anything by sitting back and reflecting on our own experience of the world? If you think yes, can you think of an example?

Session 2: Experiences
Extended facilitator notes

Guiding questions:

1) What is the "naïve model" of unusual and unshared experiences?
2) How do we perceive the world? Passively or actively?
3) What do the different models of perception mean for the naïve model?

The aim of this session is to think about how different theories of perceptual processing (particularly, active processing) may undermine the naïve model of unusual experiences and beliefs.

1. The naïve model of unusual and unshared experiences

SLIDES: Naïve model

Be mindful that some participations will have had distressing clinical encounters where the naïve model is assumed. Some participants may want to question this model straight away, so the facilitator can make it clear that the intention of this session is not to assume the naïve model, but to invite criticism of it – but it is necessary to ensure everyone in the room understands what is being said first, and that, as a group, we should discuss the key concepts involved (i.e. what is an experience? How do we perceive?) because this will better equip us to level an effective philosophical challenge against the naïve model later on.

2. Group discussion

SLIDES: Group discussion… "What is an experience…" etc

As above, this is where the group can come together to think about the notions in the naïve model, this can be an open discussion session, but it includes prompts (i.e. the dress – people are generally in disagreement about whether this picture shows a white and gold dress, or a blue and black dress). Part of the facilitator's aim is to bring out the idea that it appears that not everyone has the same experience when presented with one and the same object. With the dress, you can ask who is team white-gold and who is team black-blue, for instance.

Some people in the room will want to talk about objective facts of the matter, and how experiences are either accurate or inaccurate at representing reality. Others will prefer to talk about experiences that are shared and those that are unshared. As a facilitator, you probably want to make space for the merits of both models, whilst being mindful that fact and objective reality talk, when used carelessly by people in positions of power, can contribute to stigma and being made to feel unwelcome.

Models of perceptual processing

SLIDES: Two models of perceptual processing

You can introduce the two models of perceptual processing, without too much group discussion. Then you can move to the cream soda example, and pose the question "Which model, passive or active processing, better explains this example?" to the group. There are slides considering how each model tackles the question.

You can also mention that in general it might not be an either-or situation for all perceptual experience, sometimes perceptual processing may be passive, other times active.

Illusions

SLIDES: Illusion 1 and Illusion 2

The illusions are further examples to help demonstrate when active processing may be occurring. You may want to load the links in a browser prior to the session in case you don't have internet where you are facilitating. With the dalmation illusion, you can ask whether people can see what it is (asking those who already know the picture to keep it to themselves). Then you can move to using the "Help 1" and "Help 2" hints if you have internet connectivity, or you can trace the outline of the dog with your finger to help people pick it up. Now the idea that there is a dog there is planted, many people will be able to see the dog. You can invite the group to think about why this might show that active processing is going on.

With the upside-down faces, you can use the first example (Ricky Gervais) and ask participants whether they think anything is strange about the image on the right, before moving to the next image with the slider, which reveals quite how strange the second picture looks - because the mouth and lips have been flipped! Those of us for whom the illusion works only notice something is amiss when the face is the right side up because we expect faces to be the right side up when we encounter them – out internal model of what faces look like shows them in this orientation – we are therefore much better at comparing them to our internal model, and noticing when something is odd when the face is right side up! (Be aware that this illusion doesn't work for everyone – that just adds to the idea that we don't all perceive the same thing when presented with the same object).

You can invite anyone who did the reading to share ideas they might have had from that (e.g. hallucination and other unshared perceptual experiences occur regularly outside diagnosis, and not in conjunction with any experience of mental distress).

You could also share this gif if you have internet connectivity:
https://media.giphy.com/media/5xtDarJY0nvM4bjntHa/giphy.gif
(many people, regardless of diagnosis, hear a "thud" in this silent gif)

Participants may also want to talk about their own unshared experiences with the group, which will be valuable for the discussion we're having.

3. Returning to the naïve model

SLIDES: "3) What do the different models of perception mean for the naïve model?"

Now we have discussed what an experience is, whether we all have the same experiences in the same situation, and different models of perceptual processing, we can return to a critique of the naïve model. Criticism will likely come organically from the group, but here are some ideas to help prompt discussion:

Claim 1) seems wrong. If at least sometimes we use active processing, then our perceptions will be in part shaped by our existing ideas – and not everyone has the same existing ideas: so everyone *regardless of whether they have experienced mental health crisis or have been given a psychiatric diagnosis* will have experiences that others will not share.

Claim 2) also seems wrong. We may shape our experiences with our existing ideas, but this doesn't seem to show that doing so is bad for us, or restricts our knowledge. It might be that relying on existing ideas in this way sometimes helps us to make better sense of our environments (remember the Dalmatian example).

You can invite discussion of how the naïve model might be replaced with a model that pays more attention to the philosophical discussions we've been having, and to lived experience.

Further questions and exercises (if there is time, or to take away):

- Sometimes in both psychiatry and popular culture, when someone is experiencing something that others cannot see, or that isn't part of shared reality, this it thought to be a sign of illness. What is problematic about this assumption? And what should we, as philosophers, tell people to enable them to see why the assumption is unwarranted?
- How else does active perceptual processing help us? Can you think of any examples further to those discussed?

Reading and listening in preparation for the next session:

1. Could Being Unrealistic Actually Be Good For Your Mental Health?
http://www.redonline.co.uk/health-self/could-being-unrealistic-actually-be-good-for-your-mental-health

2. Why False Beliefs Are Not Always Bad
https://philosophynow.org/issues/124/Why_False_Beliefs_Are_Not_Always_Bad

Session 2: Experiences

Core questions and ideas

1) What is an experience?
2) What causes our experiences?
3) If 2 people are in exactly the same situation, do they have exactly the same experience?
4) Do our existing ideas ever influence the way we experience the world?
5) Can experiences be usual or unusual? What is the difference?
6) Has anyone in the group ever seen an *optical illusion*? What are they and what do they tell us about how we see the world?
7) Are there some experiences that only people with mental distress or illness have?
8) Do you think that people without mental distress or illness sometimes have unusual experiences?
9) How does what we've discussed change or add to your thinking about experiences and mental health?

Session 3: Beliefs
Extended facilitator notes

Guiding questions:

1) What is the "naïve model" of unusual and unshared beliefs?
2) How do we form beliefs? And what are they for?
3) What does our discussion about 2, as above, mean for the naïve model?

1. The naïve model of unusual and unshared beliefs

SLIDES: The naïve model…

You can acknowledge that this model echoes that we looked at last week regarding experiences. You can also be mindful that some participants may have had distressing clinical encounters where something like the naïve model was assumed. As before, the idea is to acknowledge that the naïve model is out there, and that it is assumed by many clinicians (and academics!) and that the purpose of this session is to create shared philosophical resources for critiquing the naïve model.

2. Group discussion on beliefs, presentation of the possible sources of beliefs

SLIDES: Group discussion, starting with "What is a belief?"

This section of the slides begins with two open ended questions, and you can open it up for discussion. (The dress is a prompt for the idea that if not everyone has the same experiences, then not everyone will have the same beliefs).

SLIDES: The sources of beliefs

You can present the 3 models (outer world as source, outer and inner world, and inner world only) and then invite more discussion, or invite discussion as you go. Think of an example to demonstrate that one's inner world sometimes mediates or illuminates how information from the outer world is interpreted and processed to form a new belief. For instance, I might look at a passenger areoplane in the sky, and form the belief that "there is a plane" but my friend, who is an aeroplane fanatic, and so has much more knowledge to draw on, might form the belief "that is a British Airways plane, taking off from Bristol airport, likely heading to America". You can also ask participants to contribute examples of when someone draws on existing information they already believe in order to interpret new incoming information.

SLIDES: When the world doesn't match beliefs: unrealistic optimism

After some more open-ended questions for the whole group, move to discussion of "unrealistic optimism" that came up in the readings. These are cases where, either because of mathematical impossibility, or other features of the study in question, it is objectively the

case that the beliefs involved are false/do not reflect shared reality. You can link these cases to the discussions just had – the people involved are likely using existing (optimistic!) ideas to interpret their own situations, as well as the evidence available to them from shared reality. And yet, is there no value at all in these beliefs? How might they be helpful to the people in question? Perhaps they make us feel good, and in the case of the professors, perhaps they even help them to keep working, and to keep discovering new things in their research, thus playing a role in contributing to knowledge – even though the optimistic belief itself is inaccurate.

3. Reassessing the naïve model

SLIDES: 3. Reassessing the naïve model of unusual and unshared beliefs

As in session 2, now we have discussed what a belief is, and thought about how we sometimes use existing ideas to form beliefs, resulting in positive outcomes, even though sometimes these beliefs do not reflect shared reality. Again, criticism of the naïve model will likely come organically from the group, but here are some ideas to help prompt discussion:

Claim 1) seems false. For instance, *we* don't share the professors' beliefs that they are all above average – we know that can't be the case! But these unshared beliefs appear to be unrelated to any experience of mental distress or potential diagnosis.

Claim 2) also seems false. Both the optimistic beliefs we looked at seem to play an important psychological role in making the person in question feel better. And, at least in the example of the professors, it might help them keep working, discovering new things about the world, thus contributing to their knowledge. We typically think about professors as contributing to knowledge, but might other unshared or unusual beliefs also help us to keep going, to keep seeking things out in our environment, and to stay in touch with our worlds? You can ask the group!

Further questions and exercises (if there is time, or to take away):

- What other overly optimistic beliefs might we have that, whilst inaccurate, can make us feel good, or which help us keep seeking things out in our environment, and learning new information?
- What about other inaccurate or unshared beliefs (not just the optimistic ones)? Can you think of any examples that might have beneficial functions?
- Sometimes in both psychiatry and popular culture, when someone believes something that others do not, or that isn't part of shared reality, this it thought to be a sign of illness. What is problematic about this assumption? And what should we, as philosophers, tell people to enable them to see why the assumption is unwarranted?

<u>Reading in preparation for the next session:</u>

1. "The Irrationality Within Us" https://blogs.scientificamerican.com/mind-guest-blog/the-irrationality-within-us/

2. Philosophy Bites podcast: "Irrationality"
http://traffic.libsyn.com/philosophybites/Lisa_Bortolotti_on_Irrationality.mp3

3. Cognitive bias codex (not really "reading", but have a look at this, and feel free to do an internet search for some of these biases if they interest you)
http://www.visualcapitalist.com/wp-content/uploads/2017/09/cognitive-bias-infographic.html

Session 3: Beliefs

Core questions and ideas

1) What is a belief?
2) What is the relation between beliefs and experiences?
3) Do our existing ideas and beliefs influence the new beliefs we acquire, or not? Why?
4) Can a belief be usual or unusual? What makes this so?
5) Does anyone know what “wishful thinking” is? In what ways is it good? In what ways is it bad?
6) Are there some beliefs that only people with mental distress or illness have?
7) Do you think that people without mental distress or illness sometimes have unusual beliefs?
8) How does what we’ve discussed change or add to your thinking about beliefs and mental health?

Session 4: Rationality
Extended facilitator notes

Guiding questions:
1) What are rationality and irrationality, and where are these concepts employed?
2) Should irrationality be identified with illness, or mental health crisis?

1) What are rationality and irrationality?

SLIDE: "Popular view in psychiatry: irrationality is a significant symptom of "mental disorders""

As in previous sessions, the idea is to present this view, and to have it in the background as we move to discussions of what rationality is, knowing that we will come back to look critically at it more extensively later on in the session.

Then follows some open questions for the group to discuss.

SLIDE: Different senses of rationality

There are many, many different senses of 'rationality' in the philosophy literature (as well as those of related disciplines). There are also different ways to taxonomise these different senses – and different names in different disciplines for similar distinctions. Here we look at a few distinctions that are of particular relevance to our discussion. (This is by no means the only way of laying out the distinctions, and you may want to mention this. But there is no need to go into *all* of the possible distinction to still be able to have a useful and meaningful discussion.)

The believing/doing distinctions links to some of our discussions from last session: beliefs can be said to be rational or irrational, but so can decisions and actions – we're looking at the whole set of possibly (ir)rational things this session.

In particular, it will be worth highlighting the distinction between instrumental rationality and value rationality, and linking back to session 1 where we discussed the descriptive/normative distinction. Rationality is a normative concept (it prescribes what you *should* do) but value rationality is normative in the notable sense in that there are some set of values or principles that one is supposed to act in accordance with. What might these be? Or is instrumental rationality all that matters? Open this discussion up to the group!

SLIDE(s): Cognitive biases

You can talk through the 2 examples on the slides: confirmation bias in forensic experts, and social biases.

SLIDE: cognitive bias codex

The idea of including the codex is to demonstrate how many biases / deviations from rationality have been identified, which are not related to mental health crisis or diagnosis. But try not to tell this to the group, it should come through organically. There are some slides to walk through this. You might want to save a version of the cognitive bias codex (creative commons licence) onto your own computer so that you can zoom in to see the different sections.

SLIDE: cognitive biases affect everyone
You can move to this slide, and subsequent ones, to guide the discussion after talking about the codex.

SLIDE: But if multiple cases of irrationality which are not related to mental health crisis
You can leave this slide up whilst inviting open discussion on the topic.

Further questions and exercises (if there is time, or to take away):

- What are the costs and benefits of the cognitive biases we discussed, and any you might have come across in your own reading?
- Are there any relevant differences between the irrationality identified in the examples of cognitive bias and the irrationality that some mental health practitioners see as pathological?
- What should we, as philosophers, tell people to dispel the idea that irrationality only occurs in mental health crisis?

Reading in preparation for the next session:

"'Them and Us' no longer: mental health concerns us all'
https://www.birmingham.ac.uk/research/impact/thebirminghambrief/items/2015/11/them-and-us-no-longer.aspx

"Models of Mental Health: A Critique and Prospectus"
http://serendip.brynmawr.edu/exchange/mentalhealth/modelsofmentalhealth

Session 4: Rationality

Core questions and ideas

1) What is rationality, and what does it mean to be rational?
2) What is irrationality, and what does it mean to be irrational?
3) Do you think there are lots of different meanings of ‘rationality’ and ‘irrationality’ or just the one?
4) If you think there are different meanings, do they apply in different situations? Is one meaning better than the rest?
5) What sort of ideas and behaviours are rational, and how should we decide?
6) What sort of ideas and behaviours are irrational, and how should we decide?
7) Are there some ways of being irrational that only people with mental distress or illness have?
8) Do you think that people without mental distress or illness are sometimes irrational?
9) How does what we’ve discussed change or add to your thinking about rationality and mental health?

Session 5: Models of mental health
Extended facilitator notes

Guiding questions
1) How are mental health crisis or illness and mental wellbeing related?
2) What shapes mental health, and where is illness? Biology, psychology or society?

1) How are illness and wellbeing related?

SLIDES: categorical vs continuum model

The first half of this session gives an opportunity to sum up what we have discussed so far, and see how it feeds into broader questions about mental health, i.e. whether the categorical or continuum model is right.

Start with the categorical model. This holds that there is a clear distinction between mental illness/crisis and mental health/wellbeing. We can draw a line so that all cognitions and symptoms that arise in instances of mental ill-health fall on one side of that line (e.g. unusual experiences and beliefs, and irrationality), and all cognitions and symptoms of good mental health and wellbeing fall on the other (e.g. usual experiences and beliefs, and rationality). You can begin to see how what we discussed in the last 3 sessions challenges this model.

SLIDES(s): Summary of sessions 2-4.

This table makes the challenge explicit. Note that what is expressed here is a **conditional claim**. It does not say unusual experiences and beliefs DO occur alongside crisis and psychiatric diagnosis, and that they DO occur in absence of these things. This is important, because some participants may not be on board with the characterization of experience as usual/unusual at all. What we're doing here is not asking you to get on board with this characterization. We're saying *even if one assumes the usual/unusual characterization is a good one, it does not cleanly cut across the categories of illness or crisis / health or wellbeing.* The conditional is true, even if you don't buy into the usual/unusual characterization. This is a powerful philosophical move. What we're doing is saying, "let's grant the dominant psychiatric model of mental health its assumption that usual-unusual and rational-irrational are meaningful categorical distinctions, and then show that, even granting that assumption, that we do not have a clean-cut distinction that characterises those deemed as mentally ill from those deemed as mentally well.

This pushes us towards something like a continuum model. The slides showing the dots are to invite a discussion of whether the correct model is that (i) any one individual sits just at one point on the continuum, or (ii) maybe we can rate each of our cognitions in terms of where they lie on the continuum. This could mean that for any one person, they have some cognitions closer to the illness end, and others closer to the wellness end. It's then not the case that the whole person is ill, or that the whole person is well. Which interpretation

makes sense to you? Perhaps people think there are alternative models beyond the categorical or continuum ones? This can all be part of the discussion.

2) What shapes mental health, and where is illness? Biology, psychology or society?
The remainder of the session is about what shapes mental health. In particular, if we can't get a neat set of symptoms citing irrationality (as we concluded above, contrary to the dominant model in psychiatry) then what are we to say about what shapes and constitutes mental ill-health? Three models are presented (these are not exhaustive, and you may want to ask the group if they have any other ideas). Succinctly, the medical model says that it is genetic and other biological factors that contribute to mental illness. Treatment focuses on medication and the assumption is that the individual themselves is not in control. The psychological model points to factors such as personality and temperament, and there is sometimes an assumption that the person is not only in control, but is blameworthy for their own mental health crisis. The social/societal model suggests that contributory factors are located in personal relationships and society's structures and distribution of resources. These models have distinct implications for recovery/management. In both the medical and psychological models, the locus of recovery/management is the individual, whilst in the social model, it is factors beyond simply the individual, and can lead to big questions about structural injustice and unfairness at the societal level, as well as mistreatment by others in someone's personal life. The bio-psycho-social model cites a mixture of these factors.

There are some final questions in the slides about the implications for diagnosis and stigma.

Further questions and exercises (if there is time, or to take away):

- Mental health stigma is devastating and harmful to individuals on the receiving end. But with the continuum view we've also seen that it is not philosophically warranted. How can we build this idea into the messaging and campaigns around mental health advocacy?
- Are there practical or instrumental or benefits of any of the models of mental health? Are any of them "useful fictions" and if so, why?
- Are there interplays between the different models, and might they explain different aspects of mental health? Should of the any explanations take precedent over any others?

'Watching' in preparation for the next session:

Lisa Bortolotti, TEDx talk: "The three stigmas about mental health we need to deconstruct": https://www.youtube.com/watch?v=ui9ZzlldFs0&feature=youtu.be&app=desktop

Session 5: Models of mental health

Core questions and ideas

1) How is mental distress/illness and mental wellbeing related?
2) How different is someone who experiences mental distress to someone who experiences mental wellbeing?
3) Is it possible to arrange all people into two groups: those with mental distress/illness and those with mental wellbeing?
4) Do you think mental distress/illness and mental wellbeing are on a spectrum? To put it another way, do you think there is no sharp divide between the people who experience mental distress/illness and people who experience mental wellbeing?
5) How do the discussions we've had in other sessions change or add to the way you think about these questions?
6) What shapes mental health? Why do we have the experiences of mental health that we do? Some people think it is because of our **genes**. Some people think it is because of our **personalities**. Some people think it is because of our **relationships and society**. Some people think it is a mix of all three. What do you think?

Session 6: Evaluating experiences and beliefs
Extended facilitator notes

Guiding questions:

1) What do our discussions over the course on experiences (week 2), beliefs (week 3), rationality (week 4) and models of mental health (week 5), tell us about the naïve model?

2) What are the implications? E.g. for philosophical theorising, but also for practice (clinical, mental health advocacy, activism… etc.)

SLIDES: A reminder of the naïve model

You can encourage participants to think back to what has been said about experiences and beliefs, such that claim 1) of the naïve model looks problematic - we saw lots of instances of unusual experiences and beliefs, and irrationality, that arises in absence of mental health crisis or psychiatric diagnosis.

We have talked less about claim 2); that these experiences are bad for us (although counter arguments to this claim may have come up in your discussions. The next part of this session looks to directly challenge claim 2.

SLIDES starting: Lila

Note that the material in this section is taken from last week's "watching" *"The three stigmas about mental health we need to deconstruct"* by Lisa Bortolotti at TEDxBrum, and you can familiarise yourself with it by watching this a few times.

Introduce the cases of Lila and Jamie. Each tells the story as the individual sees it, and then offers information had by people other than that individual. These are cases in which clinicians have diagnosed mental illnesses, and the ensuing treatments have aimed at eliminating/reducing the unshared experiences and beliefs to some extent, on the basis that they are in some way costly to the individual. Whilst it may be that there is a place for these interventions, we should consider the potential benefits these unshared experiences and beliefs bring the individuals in question, as well as their costs – further investigation of these could well shape the intervention for the better.

SLIDE: With some background information, unusual beliefs make sense, appear to some degree rational

We are encouraged to consider the experiences and beliefs in the context of the person's history – something that may or may not happen in a clinical encounter. In these cases, doing so gives us extra information that renders the cognitions more understandable. Is there also a sense in which they are rational? You can ask the group.

SLIDE: Unusual experiences and beliefs can have an important role to play in our mental lives

It seems like there are a number of ways in which Jamie's and Lila's experiences and beliefs are beneficial to them. You may want to refer to what Lisa says on these points in her video to get more of a sense of this. What does the group think?

It is important also not to neglect the fact that Lila and Jamie's beliefs have costly aspects to them, for instance, setting up expectations that cannot be fulfilled, in Lila's case, and putting Jamie at risk of harmful interactions. But this does not detract from the point that there are benefits to each individual that an intervention which aims solely at removing these usual experiences and beliefs will not replicate. What are the implications of this?

You can relate this back to the naïve model – in particular, how this supports criticism of its second claim that:

> unusual experiences/beliefs are **bad** for us. In particular, there are (supposedly):
>
> **i) Psychological costs:**
> These experiences/beliefs make us *feel* bad. Not always true!
>
> **ii) "Epistemic" (knowledge) costs:**
> These experiences/beliefs do not depict reality. So they harm our *knowledge* of ourselves and the world.

Neither (i) nor (ii) seems wholly true – Lila and Jamie show that.

There are numerous implications of this that you can discuss with the group. Firstly, this changes how many people typically think about mental health. But further, there are implications for how we relate to each other (recall Lisa Bortolotti stressing the importance of listening and taking seriously people who are in mental health crisis, because their experiences and beliefs may be helping them to give structure to their world, and can be deeply meaningful). You can then ask the group to think about how this should feature in how we communicate about mental health in advocacy and activism work, as well as the changes they'd like to see in clinical practice.

Further questions and exercises (if there is time, or to take away):

- Are there any implications for self-understanding when we consider the potential benefits as well as the potential costs of unusual beliefs and experiences?
- What lessons from our critique of the naïve model can we pass on to mental health practitioners, to incorporate into their practice? How should we get the message across?

Session 6: Evaluating experiences and beliefs

Core questions and ideas

1) How should we decide whether our beliefs and experiences are good or bad?
2) Can any one belief or experience have *both* good bits and bad bits?
3) Can you think of an example?
    i. An experience with both good bits and bad bits: what are they?
    ii. A belief with both good bits and bad bits: what are they?
4) Can we decide to stop thinking about a bad experience, or get rid of a distressing belief?
5) If the experience or belief has some good bits as well as bad, what does this mean for how we deal with it?
6) Can reflecting like this, and asking these sorts of questions help our self-understanding?
7) What lessons from our discussions can we pass on to mental health practitioners? What can we do to get the message across?

For thought experiment resources (session 1), scroll down:

The bridge

On holiday, you decide to visit a new attraction – a bridge that spans a wide canyon, with a floor made of glass so that you can see the distant ground below. You learn that the bridge has been guaranteed as structurally sound by several engineers, but as you walk out across it, your heartbeat rises, your legs go weak, and you are soon trembling with fear. What should we call your new attitude towards the bridge? After all, on reading the engineers' guarantee, you *believe* the bridge is safe. Do you also *believe* it's not safe, or is your state of mind something other than a belief?

Adapted from Tamar Szabó Gendler in:
Gendler, T. S. (2008.) 'Alief and Belief,' *Mind and Language* 23 (5): 552-585.

The notebook

You and a friend are invited to a dinner party by another friend. Your friend has an excellent memory for dates and addresses, but you decide to write down the date and address of the party in your notebook. The day of the dinner party comes, and there is your first friend, having retrieved the information on when and where to go from her memory. You consulted your notebook to prompt you where you needed to go. Is it correct to say that you both *remembered* the date and address of the party, or is it only your friend who truly remembered? If we use external objects to help us store and retrieve information does that count as thinking itself? If it doesn't, what's the relevant difference between thinking "inside the head" and thinking "outside the head"?

Adapted from Andy Clark and David Chalmers in:
Clark, A. and D. Chalmers. (1998). 'The Extended Mind,' *Analysis* 58: 10-23.

The city dweller

Imagine a person blind from birth, who used his other senses, such as hearing, touch, proprioception, etc. to learn all about the city he lived in. He knew everyone in the city, he learned about the city's buildings, its side streets, its animals, its markets, and so on. Now imagine that he recovered his sight. True, the names of colours would not be known to him. But in general, he would find that nothing in the city would be different to the idea that he had of it before he recovered his sight, and he would be able to recognise everything in the city as he knew it before. The only significant change would be that he would know his surroundings with greater clarity and fullness. Do you agree this would be the case?

Adapted from Ibn Tufayl in:
Tufayl, I. (1972) *Ibn Tufayl's Hayy ibn Yaqzān: a philosophical tale*. Translated with introduction and notes by Lenn Evan Goodman, New York: Twayne.

The experience machine

Virtual reality technology advances to a point where you can put on a headset and body suit, and enter into an experience that is indistinguishable from reality. The programmers have made it such that you can live any life experience you want – travel the world, live in a mansion, become a famous rockstar – all the while totally believing that it is really happening, having no memory of the machine. But there's a hitch: if you want to use the experience machine, there's no going back. You can either opt into your dream life experience forever, or not get to try it all. So, what would you do?

Adapted from Robert Nozick in:
Nozick, R. (1974). *Anarchy, state, and utopia,* New York: Basic Books, 42–45.