

The Institutional Definition of Psychiatric Condition and the Role of Well-Being in Psychiatry

[Draft accepted for publication in PSA2022 Proceedings Special Issue of *Philosophy of Science*.
Please cite published version when available.]

Bennett Knox

This paper draws on Quill Kukla’s “Institutional Definition of Health” to provide a definition of “psychiatric condition” that delineates the proper bounds of psychiatry. I argue that this definition must include requirements that psychiatrization of a condition benefit the well-being of 1) the society as a collective, and 2) the individual whose condition is in question. I then suggest that psychiatry understand individual well-being in terms of the subjective values of individuals. Finally, I propose that psychiatry’s understanding of collective well-being should be the result of a “socially objective” process, and give certain desiderata for this understanding.

1. Introduction. In “Medicalization, ‘Normal Function,’ and the Definition of Health,” Quill Kukla (writing as Rebecca Kukla) provides a definition of health meant to underwrite social justice projects related to health, while avoiding the pitfalls of overly scientific approaches on the one hand, and purely social constructivist approaches on the other (2015). As an alternative approach, Kukla proposes a definition of health as an *institutional* concept:

The Institutional Definition of Health: A condition or state counts as a *health condition* if and only if, given our resources and situation, it *would be best for our collective wellbeing* if it were medicalized—that is, if health professionals and institutions played a substantial role in understanding, identifying, managing and/or mitigating it. In turn, *health* is a relative absence of health conditions (and concomitantly a relative lack of dependence upon the institutions of medicine). (2015, 526)

This definition is explicitly and intentionally value-laden, and so it avoids objections to scientific views that seek to define health in a value-free manner. At the same time, whether or not something is a health condition is not simply a matter of whether or not our society in fact medicalizes that condition, as it would be on a simplistic social constructivist view. Importantly, on this definition we can still be *wrong* about whether or not something *really is* a medical condition—if, in fact, treating it as such does not benefit our collective well-being. However, the answer to this question will be partly dependent on facts about things like our social institutions, the state of medical knowledge, and our collective values.

I believe this definition of health deserves much greater attention. It strikes me as both intuitively plausible, and a fruitful framework under which to continue work on the concept of health and the proper bounds of medicalization. It also seems especially compelling in the field of psychiatry, where debates about over- and under-medicalization loom particularly large. In this paper, I present a version of Kukla’s definition specific to the realm of psychiatry, and build on their framework in order to sketch an account of the proper bounds of psychiatric medicine. I argue that an adequate definition of psychiatric condition must include requirements that psychiatrization of a condition be to the benefit of the well-being of 1) the society as a collective, and 2) the individual whose condition is in question. I then draw on the work of Daniel M. Haybron and Valerie Tiberius (2015) to argue that psychiatry should take an attitude of “pragmatic subjectivism” towards individual well-being, and aim to promote the well-being of individuals according to their own subjective definitions of well-being arising from their “personal welfare values.” Finally, I suggest how psychiatry should understand well-being at a collective level, arguing that it must decide how to understand collective well-being through a process that conforms to the standards of “social objectivity,” and suggesting a few desiderata for any understanding which emerges from such a process.

2. The Institutional Definition of Psychiatric Condition. I focus on the concept of a psychiatric condition, rather than the more often discussed concept of mental disorder or illness. As such, my first gloss on a definition for psychiatric condition follows Kukla almost exactly:

(Preliminary) Institutional Definition of Psychiatric Condition: A condition or state counts as a *psychiatric condition* if and only if, given our resources and situation, it *would be best for our collective well-being* if it were psychiatrized—that is, if psychiatric professionals and institutions played a substantial role in understanding, identifying, managing and/or mitigating it.

One could build up a definition of mental disorder or illness from this definition of psychiatric condition. Kukla makes this move with regard to disease in general, which they roughly define as “a repeatable, relatively stable bodily state or process that systematically causally contributes to one or more health condition” (2015, 527). I leave this question aside, however, because I am interested in the full set of phenomena that psychiatry rightly plays a substantial role in, which may include more than conditions which are the result of mental disorders or illnesses.¹ As I have defined things, the domain of psychiatric conditions and the domain in which psychiatry legitimately operates are coextensive. The insight gained from Kukla is that on this definition, whether or not a given condition rightly falls within the psychiatric domain is contingent on whether or not treating that condition as psychiatric is to the benefit of our collective well-being.

However, concerns about unjustified psychiatric paternalism lead me to think that this definition is missing an essential element: a requirement that psychiatrization be to the benefit of the individual whose condition is in question. Kukla is right that medicalization cannot be contingent *only* on benefiting the well-being of the individual in question; otherwise we would be forced to admit any case where an individual could benefit from intervention using the tools of medicine (even if these would be interventions we intuitively see as enhancements rather than treatment of medical conditions). I agree that medicalization/psychiatrization must be to the benefit of collective well-being. But medicalization is a blunt tool, and psychiatrization in particular can often cause a person more harm than good. Therefore, to protect individuals from unjust psychiatric paternalism, we must add a requirement that psychiatrization contribute to the well-being of the person whose condition is psychiatrized.

¹ I also leave aside the question of defining “mental health.” I am convinced by Sam Wren-Lewis and Anna Alexandrova’s arguments that mental health must be more than just freedom from mental disorder, but less than full achievement of well-being (2021). But extending my account to an institutional definition of mental health goes beyond the scope of this paper.

To make this point, I draw on the work of Natalia Washington in “Contextualism as a Solution to Paternalism in Psychiatric Practice” (2018). Washington is concerned with the “danger of characterizing, and thereby mistreating, individuals as unwell who are not,” presenting this as “the *problem of paternalism* in psychiatry, the frequent occurrence of clinical intervention—including diagnosis itself—on the basis of unjustified standards.” (2018, 236).² In order to address this problem, Washington argues that “to solve the problem of paternalism, psychiatry must ground what it means to be mentally ill or mentally healthy in the concerns of individual patients...” (2018, 236). My addition of an individual requirement to Kukla’s definition is an attempt to do exactly this: to ground the very definition of a psychiatric condition in the concerns of the individuals whose conditions are in question.

To make this concern more concrete, consider an example that Washington uses to motivate her point:

Vincent lives alone on a remote piece of property in the Pacific Northwest. After college he began to remove himself from his social circles, and now spends most of his time in his home, making highly detailed wooden sculptures, based on the suggestions of ‘other voices.’ Vincent has no phone or Internet access, and interacts mostly with the owner of the general store in a nearby town. He makes a modest living by occasionally making a sale of a sculpture. His buyers find him to be distant and abrasive, and are often disturbed by his behavior, and lack of adherence to social norms. (2018, 238)

By hypothesis, Vincent is flourishing according to his own understanding of well-being, and vocally denies that the voices he hears are a psychiatric condition. The question is whether or not we ought to diagnose someone like Vincent with a psychiatric disorder and/or treat the fact that he hears voices as a psychiatric condition. Washington argues that, even if we grant that Vincent may be neuropsychologically atypical in virtue of his experience of hearing voices, this does not

² Though Washington’s focus is on psychiatric diagnosis of mental disorder, I think her concerns apply equally well to my broader notion of psychiatric condition.

suffice to show that he has a mental disorder, since he is flourishing according to his own standards of well-being. I add that it would be equally unjustifiably paternalistic to treat him as having a psychiatric condition. Lest we dismiss this as a contrived and fanciful example, note that this is exactly the way that members of the “Hearing Voices Movement (HVM)” conceive of their own experience of hearing voices: as non-psychiatric experiences which are not only consistent with flourishing, but can in fact actively contribute to an individual voice-hearer’s well-being (Corstens et al. 2014).

Kukla’s emphasis on collective well-being risks giving us the wrong answer when it comes to someone like Vincent, or a member of HVM. It could be entirely true that it would be to the benefit of our *collective* well-being to treat Vincent as having a psychiatric condition. Perhaps paternalistically treating his voice-hearing as pathological (for instance by coercing him into taking antipsychotic medications) would result in him becoming more socially agreeable to the people around him, such that overall well-being would be promoted. But if this increase in overall well-being would be at the cost of Vincent’s individual well-being as he understands it, then this seems to me like an unjustified encroachment on his individual autonomy. In light of this concern, I propose a modified version of my previous definition:

Institutional Definition of Psychiatric Condition: A condition or state counts as a psychiatric condition if and only if, given our resources and situation:

- 1) **Collective well-being requirement:** *it would be best for our collective well-being* if it were psychiatrized, AND
- 2) **Individual well-being requirement:** *it would be best for the well-being of the individual in the condition* if it were psychiatrized

Notice that this definition implies that two people could have a seemingly similar experience and similar underlying neuropsychology, and yet one could have a psychiatric condition while the other does not—because psychiatrization would benefit one of them and not the other. This may seem counterintuitive, but it is a feature of my view, not a bug. For instance, there may be many

people who hear voices who are unlike Vincent, and who would benefit greatly from having their condition be treated as psychiatric. If my definition yields the result that such people have a psychiatric condition and someone like Vincent does not, I consider that to be an advantage of the view.

I foresee another immediate objection: the case of the “successful psychopath.” We might think that psychiatrizing such a person’s condition could undermine their own well-being, but that psychiatrization could nevertheless be warranted to protect others from their behavior. Like Washington, I am willing to bite the bullet here and assert that if psychiatrizing the psychopath’s condition undermines their well-being then it is illegitimate. However, since the institutional definition makes legitimate psychiatrization dependent on the full situation in our society, it is relevant what the alternatives for the psychopath are. If the alternative to psychiatrization is that the psychopath would be imprisoned, then it may turn out that psychiatrization actually *does* benefit the individual (though much depends on the details). If the alternative is that the psychopath lives a successful life as a businessperson or politician, then that is a problem of our other social institutions unjustly rewarding psychopathic behavior—a problem which psychiatry is ill-equipped to deal with.

As I have defined it, showing that a given individual’s condition is a psychiatric condition is rather demanding, since it must meet *both* the individual *and* collective requirements. I consider this to be an advantage of the view, which can help to keep psychiatry from improperly exerting power in ways that undermine individual or collective well-being. The individual requirement provides a check against unjustified paternalism, while the collective requirement calls on psychiatry to serve the public good.

3. Individual Well-Being. Because Kukla’s definition focuses on the collective, they do not say much about individual well-being. Since my account makes individual well-being central, in this section I take up the question of the attitude psychiatry should take towards the diversity of individual ways of understanding well-being in a cosmopolitan society.

Drawing on Haybron and Tiberius’s work on well-being policy, I argue that psychiatry should take on an attitude of “pragmatic subjectivism” towards well-being, on which “policies aimed at promoting well-being are justified only when they are grounded in the conceptions of well-being of those on whose behalf policy is being made” (2015, 713). The idea is that whether well-being turns out to be objective or subjective, policy-makers ought to enact policies which respect the subjective conceptions of well-being of individuals impacted by the policies.

Haybron and Tiberius have two compelling justifications for this approach. The first is purely pragmatic: “it represents a workable approach given the diversity of values in modern democratic societies” (2015, 714). The second, however, is a moral argument based on a commitment to respect for individual autonomy in a democratic society: “deference to citizens’ values in promoting their interests is a plausible requirement of democratic governance and respect for persons” (2015, 714).

It seems to me that these arguments apply equally well to the institution of psychiatry. Given the extent of controversy over psychiatry in contemporary societies, it would be of practical benefit to psychiatry to take an approach which attempts to respect the diversity of values held in the society in which it is embedded. On the moral side, insofar as psychiatry is a medical specialty committed to respecting the autonomy of patients who fall under its care, it must take a pragmatic subjectivist stance and aim to promote the well-being of the people who come under its power according to their own ideas of what well-being consists in.

To motivate this commitment, consider when psychiatry (now infamously) pathologized homosexuality. As I see it, part of what went wrong in this case is that psychiatry unduly placed restrictions on what could count as a person achieving well-being, by assuming that well-being objectively required a heterosexual lifestyle. Once psychiatrists were presented with evidence that in fact homosexuals could achieve well-being in their own subjective way, and psychiatry began to take the subjective conception of well-being of homosexuals themselves seriously, the continued psychiatrization of homosexuality rightly became untenable.

Though I have argued that psychiatry must understand individual well-being in terms of the conceptions of well-being of the individuals in question, this view does *not* imply that what is in the interest of an individual's well-being is reducible to merely whatever they think or express that it is. In their argument for pragmatic subjectivism, Haybron and Tiberius address this problem by asserting that well-being policy should attend to what they call “*personal welfare values*’: *those values—and not mere preferences—that individuals see as bearing on their well-being*” (2015, 712). Pragmatic subjectivism does not entail a preference-satisfaction view of well-being. Rather, what in fact contributes to a person's subjective well-being is what follows from their most deeply-held personal values about well-being. Importantly, this means that a person can be *wrong* about what would contribute to their well-being. But there can be no fact about a person's well-being which is not grounded in some value that they themselves hold.

As I see it, this view of individual well-being is closely aligned with Sharon Street's “Humean constructivist” view about metaethics and practical reason (2012; 2017). For Street, an agent's reasons are a function of the contingent evaluative starting points and normative commitments that they in fact have. But in order to determine what reasons a person has, we must determine what follows from their starting points and commitments, given the non-

normative facts and the constraints of logic and rationality. It is therefore quite possible for a person to be in error about what follows from their value commitments, and by extension about what reasons they in fact have. Nevertheless, it is possible for two people in identical situations to have radically divergent and mutually inconsistent sets of reasons, if they have radically different evaluative starting points. Further, Street insists that a person's reasons are not a function of their mere desires, but of what follows from what they most deeply *value*.

I hold that psychiatry must understand individual well-being in this way: as what follows from an individual's most deeply-held personal welfare values, which may conflict with their conscious and/or expressed preferences and desires. Of course, in the psychiatric context in particular determining the difference between these two things will often be extremely difficult. For instance, one might be tempted to think that a drug-user's desire to continue using a certain substance is merely an expression of shallow preferences or desires. Yet some, like psychologist and neuroscientist Carl Hart, assert that they "take drugs as part of [their] pursuit of happiness, and they work" (2021, 17), which would seem to indicate that drug-taking can be an integral part of a person's subjective conception of well-being. How is a particular psychiatric clinician meant to tell the difference between these types of cases in practice? This is an important and vexing question, but not one that I can hope to give a satisfying answer to here. However, I would urge that psychiatrists in these types of situations be open to the possibility that a person they are evaluating may be acting in line with their own personal welfare values and subjective conception of well-being, even if they act in ways that seem to undermine well-being as the psychiatrist themselves understands it.

4. Collective Well-Being. Kukla (quite reasonably) leaves aside questions about how to understand collective well-being, instead hoping to provide a definition that can be compatible

with many different accounts. I likewise cannot hope to resolve all questions about the nature of collective well-being, since, as Kukla says, this is “roughly equivalent to the question of the nature of justice” (2015, 526). Nevertheless, in this section I will address how the framework I am recommending for psychiatry should understand well-being at a collective level. I argue that decisions about the vision of collective well-being that ought to guide psychiatry should be made via processes that conform to the standards of “social objectivity.” I then suggest certain desiderata for any understanding of collective well-being emerging from such a process.

I do not think the understanding of collective well-being that ought to guide psychiatry can be reached purely from the philosophical armchair, but rather must emerge from a process of productive dialogue among those who will be impacted by it. I suggest that such a process be carried out for psychiatry using the framework of “social objectivity,” which has been suggested both as a way to effectively deal with the role that values inevitably play in psychiatry (Gagné-Julien 2020; 2021; Knox 2022), as well as a way for scientific investigation of well-being to be objective (Alexandrova 2017; 2018).

Drawing from the account of Helen Longino (1990; 2002), the social objectivity framework provides criteria that a scientific community must conform to for its processes of knowledge production to be considered objective. These criteria call on the community to engage in a process which brings a diverse array of individuals with a broad range of normative assumptions together into a productive dialogue. This is meant to ensure that the knowledge produced is not biased by any one normative perspective (or small set of perspectives).

Alexandrova’s (2018) account focuses on the scientific study of well-being, and is meant to provide a method to deal with inescapably value-laden claims (what she calls “mixed claims”) in that science. But her account provides a useful framework that seems equally useful in

psychiatry, especially if (as I am suggesting) claims about the proper scope of psychiatry are themselves value-laden, since they depend on concepts of well-being. I cannot go into detail here, but the idea is that there would be a productive dialogue about the concept of collective well-being that should govern psychiatry, which would bring together many experts and stakeholders. This should include psychiatric practitioners, as well as non-psychiatrist experts such as psychologists, social scientists, and philosophers with relevant expertise. Given psychiatry's history of pathologizing social difference (as with homosexuality), it is also essential that this process include a diverse array of social identities. But perhaps most importantly, it should include those whose conditions are psychiatrized (or are being considered for psychiatrization).

Though the exact details of an understanding of collective well-being for psychiatry must emerge from a socially objective process, there are certain desiderata which I suggest such an understanding should strive for. First, it should aim to promote a diverse plurality of individual understandings of well-being. Second, it should aim to make effective use of psychiatric resources in a way that promotes justice in the distribution of well-being in society. Third, it should aim to resist (or at least not reinforce) social injustice and oppression. Though I cannot defend these desiderata at length here, I think they are a productive starting-place for further debates about psychiatry's understanding of collective well-being.

In the previous section, I argued that psychiatry ought to understand individual well-being in terms of the subjective understandings of well-being of the individuals it purports to care for. Similarly, any understanding of collective well-being that emerges to govern psychiatry ought to respect the diversity of individual subjective understandings of well-being in a cosmopolitan society. This requires psychiatry to commit to a certain kind of pluralism about

well-being. By “pluralism” here I mean something quite specific: psychiatry must aim to respect as wide a diversity of individual ways of achieving well-being as possible, though many of these may be mutually incompatible.³ But even stronger than this, I take it that having a diverse array of members achieving well-being in different ways is *itself* a collective good for any society. As such, psychiatry must aim not just to *tolerate* a plurality of ways of achieving well-being, but also to *cultivate* such a plurality.

Though I cannot explore this issue in detail here, I believe this commitment to cultivating a diversity of ways of achieving well-being may have profound implications for how psychiatry ought to respond to arguments from the neurodiversity movement, for example. If a group of people claims that psychiatry is wrongfully psychiatrizing them by pathologizing natural human diversity in ways of living and achieving well-being, that is a charge that psychiatry ought to take quite seriously.

Though the well-being of individuals within a society is an important aspect of the well-being of that society as a collective, the way that well-being is distributed among individuals in that society is an important good which is not reducible to the sum of the well-being of the society’s individual members. As such, psychiatry should understand collective well-being as partly a matter of just distribution of its resources among the population it attempts to serve. This can help us delineate cases of treatment of psychiatric conditions from cases of unjustified “enhancement” using the tools of psychiatry. If the resources of psychiatry were infinite, devoting psychiatric resources to any problem they could effectively address would not be an issue. But given that psychiatric resources are scarce, they ought to be distributed so as to prioritize cases where they can be used to effectively alleviate great suffering and ameliorate the

³ This may only require a commitment to what Polly Mitchell and Anna Alexandrova call “constitutive pluralism” rather than the stronger “conceptual pluralism” (2021, 2422).

unjust distribution of suffering. Something could be excluded from counting as a genuine psychiatric condition if psychiatrizing it would be an unjust use of psychiatric resources that could be put to better use elsewhere.

Finally, given psychiatry's unsavory history of pathologizing social difference, any account of collective well-being that would govern psychiatry must actively strive to resist forms of social injustice in the society in which it is located. This must include a commitment to resist such systems of oppression as racism, sexism, cis- and hetero-sexism, and ableism (among others). If psychiatrizing some condition reinforces systems of oppression—for instance, as Nancy Nyquist Potter (2014) has argued may be the case for the diagnosis of Oppositional Defiant Disorder and racist oppression—that alone is good reason to think that the condition is not legitimately psychiatric, since its psychiatrization undermines collective well-being by reinforcing injustice.

5. Conclusion. In closing, let me attempt to illustrate how the framework I have outlined in this paper can be helpfully applied to a recent controversy over psychiatrization. The most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5-TR, included a controversial new diagnosis: “Prolonged Grief Disorder” (APA 2022), which generated discussion and debate about whether or not extended grief is a legitimate psychiatric condition (e.g. Barry 2022). If a scientific definition of psychiatric condition is right, the answer to this question may turn on something like whether or not there is an identifiable neuropsychological dysfunction in people who suffer from prolonged grief. On a purely social constructivist view, there is nothing more to say than that our culture has decided to psychiatrize this condition, and that is that.

But on the institutional definition of psychiatric condition that I have suggested, the answer to whether or not Prolonged Grief Disorder really is a psychiatric condition turns on whether or not psychiatrizing extended grief benefits the well-being of both the individuals in this condition and society in general. It seems to me that this is the right way to have debates about whether or not a controversial psychiatric category like Prolonged Grief Disorder is legitimate. Does treating prolonged grief as a psychiatric condition pathologize a natural process in a way that does damage to society? Does psychiatrizing prolonged grief benefit individual patients by allowing them access to psychiatric care they might not otherwise receive? I cannot answer these questions definitively here, but they seem like the right questions to be asking when we consider whether or not Prolonged Grief Disorder is legitimate. In fact, in my experience this is often how these kinds of debates are already being had, at least when they go well.

Perhaps the greatest advantage I see in the institutional definition is that it allows the legitimate domain of psychiatry to be fluid and constantly open to revision. As psychiatric interventions improve (or worsen) in efficacy, as other social institutions undergo change, and as the values of our society evolve, the boundaries of legitimate psychiatrization will shift as well. Yet even as the domain of psychiatry is continually updated, the institutional definition gives us standards to appeal to when we seek to adjudicate boundary cases. Under the institutional definition of psychiatric condition, arguments for or against psychiatrization must justify themselves based on the impact that such psychiatrization will have on the well-being of individuals and the society as a collective.

References

- Alexandrova, Anna. 2017. *A Philosophy for the Science of Well-Being*. New York, NY: Oxford University Press.
- Alexandrova, Anna. 2018. "Can the Science of Well-Being Be Objective?" *The British Journal for the Philosophy of Science* 69 (2): 421–45.
- APA (American Psychiatric Association). 2022. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed., text revision: DSM-5-TR. Washington, DC: APA.
- Barry, Ellen. 2022. "How Long Should It Take to Grieve? Psychiatry Has Come Up With an Answer." *The New York Times*, March 18, 2022, sec. Health.
<https://www.nytimes.com/2022/03/18/health/prolonged-grief-disorder.html>.
- Corstens, Dirk, Eleanor Longden, Simon McCarthy-Jones, Rachel Waddingham, and Neil Thomas. 2014. "Emerging Perspectives From the Hearing Voices Movement: Implications for Research and Practice." *Schizophrenia Bulletin* 40 (Suppl_4): S285–94.
- Gagné-Julien, Anne-Marie. 2020. "Towards a Socially Constructed and Objective Concept of Mental Disorder." *Synthese*. doi:10.1007/s11229-020-02647-7.
- Gagné-Julien, Anne-Marie. 2021. "Dysfunction and the Definition of Mental Disorder in the DSM." *Philosophy, Psychiatry, & Psychology* 28 (4): 353–70.
- Hart, Carl L. 2021. *Drug Use for Grown-Ups: Chasing Liberty in the Land of Fear*. New York, NY: Penguin Press.
- Haybron, Daniel M., and Valerie Tiberius. 2015. "Well-Being Policy: What Standard of Well-Being?" *Journal of the American Philosophical Association* 1 (4): 712–33.
- Knox, Bennett. 2022. "Exclusion of the Psychopathologized and Hermeneutical Ignorance Threaten Objectivity." *Philosophy, Psychiatry, & Psychology* 29 (4).
- Kukla, Rebecca. 2015. "Medicalization, 'Normal Function,' and the Definition of Health." In *The Routledge Companion to Bioethics*, ed. John D. Arras, Elizabeth Fenton, and Rebecca Kukla, 515–30. New York, NY: Routledge.
- Longino, Helen E. 1990. *Science as Social Knowledge: Values and Objectivity in Scientific Inquiry*. Princeton, NJ: Princeton University Press.
- Longino, Helen E. 2002. *The Fate of Knowledge*. Princeton, NJ: Princeton University Press.
- Mitchell, Polly, and Anna Alexandrova. 2021. "Well-Being and Pluralism." *Journal of Happiness Studies* 22 (6): 2411–33.
- Potter, Nancy Nyquist. 2014. "Oppositional Defiant Disorder: Cultural Factors That Influence Interpretations of Defiant Behavior and Their Social and Scientific Consequences." In *Classifying Psychopathology: Mental Kinds and Natural Kinds*, ed. Harold Kincaid and Jacqueline A. Sullivan, 175–94. Cambridge, MA: MIT Press.
- Street, Sharon. 2012. "Coming to Terms with Contingency: Humean Constructivism about Practical Reason." In *Constructivism in Practical Philosophy*, ed. James Lenman and Yonatan Shemmer, 40–59. Oxford: Oxford University Press.
- Street, Sharon. 2017. "Nothing 'Really' Matters, But That's Not What Matters." In *Does Anything Really Matter? Essays on Parfit on Objectivity*, ed. Peter Singer, 121–48. New York, NY: Oxford University Press.
- Washington, Natalia. 2018. "Contextualism as a Solution to Paternalism in Psychiatric Practice." *Philosophy, Psychiatry, & Psychology* 25 (4): 235–43.
- Wren-Lewis, Sam, and Anna Alexandrova. 2021. "Mental Health Without Well-Being." *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 46 (6): 684–703.