Research Statement

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My research is situated within the scope of empirically informed philosophy of mind, psychology, and cognitive science. This growing trend and its interdisciplinary aspirations are vital to my central project: Using the conceptual and critical tools of philosophy, I seek to understand how human minds are both shaped by and integrated with our physical and social environments. Ultimately, I believe that appreciation of these perspectives—what are sometimes called 'externalist' or 'ecological' viewpoints—and their normative implications can inform and improve human lives.

As an ecologically-minded philosopher, I have had the opportunity to explore several interconnected research questions, including work on implicit racial biases and social cognition, culture and the construction of psychiatric diagnoses, as well as on agency and well-being. In the future, I plan to extend my work by building a rigorous understanding of the concept of mental health that makes room for individual differences in values and what is in our best interest when it comes to the quality of our mental lives. This is significant not only because of its theoretical connections to concepts of the good life, but because I hope my project will help shape future discussions of mental illness in clinical and practical arenas, and in improving human circumstances as well.

Implicit Cognition

Joining ongoing efforts to understand how recent insights in social psychology cast much of our behavior as 'automatic' and 'unconscious', somehow operating outside of our control and without our explicit knowledge, I have two papers which consider how responsibility for our actions is distributed in our moral ecology.[1] In 'Who's Responsible for this: Moral Responsibility, Externalism, and Knowledge about Implicit Bias', with Dan Kelly, I argue that individuals who do not know they have implicit racial biases can nevertheless be held responsible for behaviors that were crucially influenced by those implicit biases **[1]**. In 'Implicit Cognition and Gifts: How does Social Psychology Help Us Think Differently about Medical Practice', with Nicolae Morar, I

[1] *Moral ecology* refers to "[t]he circumstances that support and enable exercises of agency in ways that respect and reflect a concern for morality." Vargas, M. (2013). *Building Better Beings*. Oxford: Oxford University Press.

examine the influence of pharmaceutical representatives on the medical profession, and argue that this influence has been mischaracterized in the bioethics literature due to confusion about the facts of human psychological nature [2]. Both of these papers push us to think about how our social roles and moral and epistemic environments shape facts about agency and responsibility. In a forthcoming chapter with Valerie Tiberius, "Practical Reason and Social Science Research" I extend this thinking to consider the ways in which recent research in the social sciences is reshaping our notion of agency more generally. Drawing on Andy Clark's notion of ecological control, I argue that, once we recognize the ways in which psychological biases influence us, we can choose situations that will facilitate action in accordance with the reasons we endorse.

Clinical Psychiatry

My work in the philosophy of psychiatry, investigates the theoretic and conceptual foundations of psychiatry as a science and as an evaluative system, and how psychopathology can be used as a lens through which to view human psychological nature. In 'Culturally Unbound: Cross-Cultural Cognitive Diversity and The Science of Psychopathology' I criticize a view proposed by philosopher of psychiatry Dominic Murphy, and argue that extant, cross-cultural cognitive diversity caused by variability in contingent, social and environmental conditions poses a problem for psychiatric methodology [3]. In a paper forthcoming from *Philosophy, Psychiatry & Psychology*, I argue that, in order to avoid the problem of paternalistic diagnoses which exacerbate rather and alleviate mental suffering, psychiatry must ground what it means to be mentally ill or mentally healthy in the concerns of individual patients [4]. Together, these papers contribute to the task of negotiating the tricky philosophical territory where the normative and descriptive meet in creating a *cognitive ontology*, in tandem with the National Institutes of Mental Health's recent effort to revolutionize how psychiatric phenomena are schematized, using the Research Domain Criteria (RDoC),

Taking a bottom up approach to the same question, I am also investigating a particular pathology, namely the neural activation patterns and structural changes associated with trauma and Post Traumatic Stress Disorder (PTSD), using brain imaging techniques. It has long been proposed that small scale slights and stressors endured by women and marginalized groups cause similar psychological and behavioral symptoms, despite these individuals not having access to the diagnosis without having experienced a singularly traumatic event. Working along with psychologist

Laura Niemi, our experimental design examines the neural underpinnings of being granted or denied credibility, with the hypothesis that individual differences subjects' past experiences with prejudice will mediate their reactions [5]. This project has been generously funded by the Duke Institute for Brain Sciences' (DIBs) Summer Seminars in Neuroscience and Philosophy (SSNAP) program.

Most recently I have turned to considering how constructs like PTSD, as well as familiar labels like 'anxiety' and 'depression' function in our social and epistemic environments in their roles as diagnostic categories. Drawing on Ron Mallon's work on the social construction of human kinds, I argue that our psychological, social, and environmental practices of representing psychiatric kinds are so deeply entrenched that they present a special problem for explanation and prediction about, as well as intervention on psychiatric phenomena [6].

Mental Health

The future of my theoretical research on mental health is enormously exciting to me. There are two big questions left over from my past work which I plan to pursue. First, thinking about mental health has led me to closely examine the theoretical difficulties that arise from the task of integrating our normative and scientific goals more generally. In particular, there is a common intuition that it is our own individual goals and desires that ground the normative in the natural world. I will argue that, because most problem contexts admit of many possible solutions, much less about what we ought to do in the pursuit of our best interests can be drawn from goals alone than is commonly done [7]. Understanding this, I believe, can illuminate what is at the heart of many crucial debates about disability and disease.

Second, emerging from these contextual considerations, I plan to turn to the topic of clinical intervention, and develop an ecological account of psychiatric therapy that casts human agents as stewards of their own, and others', cognitive ecology. This will involve recasting therapeutic processes and techniques as exercises of agency with an 'indirect', 'collaborative' or ecological character [8]. As I extend and develop this account further I see this work evolving into a manuscript that will be of use to philosophers and healthcare professionals alike.

Abstracts

[1] The main claim we aim to defend in this paper is that people can be responsible for actions that are influenced by implicit biases they do not know they have, and that they would disavow if they were made aware of. Our defense of that claim will involve framing the issue in terms of kinds of control-based and knowledge-based exculpating conditions commonly taken to excuse actions, laying out the core features of implicit biases, and considering whether anything about the character or operation of implicit biases themselves satisfies those conditions, or guarantees that actions influenced by them should be excused. We formulate and reject several arguments that suggest a positive answer. We then present a thought experiment designed to support our central claim, and pump the intuition that not all of the knowledge relevant to moral responsibility and exculpation need be "in the head" of the agent whose actions are being evaluated. Finally, we comment on some general features of our approach and the questions that it raises.

[2[In this paper, we are interested in the negative effects of the practice of gift-giving between medical professionals and medical and pharmaceutical industry representatives, and in recent attempts to mitigate these effects. We believe that in order to address this problem, the ethical debate surrounding gift-giving practices must be reoriented. The problem with gift-giving is largely not a matter of malicious or consciously self-interested behavior, but of well-intentioned actions on the part of physicians that are none the less perniciously infected by the presence of the medical industry. Indeed, without fully appreciating the social-psychological mechanisms of implicit cognition, policy makers are likely to overlook significant aspects of how gifts influence doctors. Ultimately, we argue that argue that effective solutions to the problem of gift-giving should have an ecological character—they take into account 'indirect' nature of dealing with hidden features of our psychology.

[3] In this paper, I consider how human psychological variation should affect methodology in two-stage psychiatric research. I examine recent empirical evidence and develop what I call the Cross-Cultural Diversity (CCD) picture of the human mind, according to which, variation in the underlying causal structure of the human mind implies variation in mental illnesses. I then examine the implications of the CCD view for a discipline which tries to separate the descriptive from the evaluative in taxonomization of mental disorders, by examining one methodological proposal given by philosopher Dominic Murphy in his book *Psychiatry in the Scientific Image*. I

argue that, even in an idealized case, Murphy's methodology is hindered by its reliance on a conception of 'normal human nature', and thus does not adequately accommodate cognitive diversity. Next I sketch a promising way to revise Murphy's proposed methodology, by examining Grant Ramsey's recent work on human nature and his Life-history Trait Cluster (LTC) view. I end with some notes on how these considerations are beginning to shape inquiry in the form of the Research Domain Criteria (RDoC) project.

[4] If the goal of psychiatric practice is to alleviate the suffering caused by mental illness, what kinds of standards are the right ones to use in determining what counts as mental illness? In this paper, I address the problem of paternalism in psychiatry, the frequent occurrence of clinical intervention—including diagnosis itself—on the basis of unjustified standards. Following Daniel Groll's work on paternalism, I argue that, in face of avowals from competent patients that they are not ill, the burden of proof falls on the clinician to show that a diagnosis is justified. Further, following Valerie Tiberius and Alexandria Plakias's discussions of well-being, I argue that a theory with properly justified evaluative standards for psychiatric diagnosis must have normative authority. I examine how several theories of mental disorder fail to have normative authority, and conclude that clinical psychiatry must ground what it means to be mentally ill or mentally healthy in the concerns of individual patients.

[5] Project Summary--The Experience of Being Taken at Your Word: A Multi-Method Investigation--This research investigates whether having one's testimony persistently and unjustly questioned is experienced behaviorally, physiologically, and neurally in a manner similar to the experience of hostility. If credibility threats can affect the brain in a manner indistinguishable from hostility (hostile threat being typically understood to qualify as a 'traumatic' stressor) this would suggest that testimonial injustice is traumatic in a clinically relevant sense. Women, people of color, socioeconomic minorities, and those with prior history of multiple stressors and traumatic life events (i.e., sexual assault and chronic identity-based injustice), are expected to show behavioral, physiological, and neural responses to credibility threats that appear most similar to those responses associated with the experience of hostility, as they may be sensitized to credibility threats as indicative of the presence of other more serious personal threats. Findings consistent with this hypothesis thus lend credence to the idea that testimonial injustice and other 'microinjustices'

qualify as traumatic for their experiencers, even without the presence of discernibly hostile speech acts. This research represents novel interdisciplinary work bridging neuroscience and social epistemology within philosophy, and aims to have real social significance. If it turns out that the neural markers of credibility threats are substantially similar (or even indistinguishable) to those associated with PTSD and other forms of traumatic stress (e.g., race-based, sexual assault-based), then we may have good reason to rethink the clinical constructs (e.g., DSM diagnostic criteria and their relationship to cognitive ontology). Moreover, this research directly investigates testimonial injustice as a relatively "soft" way to perpetrate real harm toward targeted groups.

[6] Over the past few decades, diagnostic constructs in psychiatry which rely on accounts of mental disorders as natural kinds—like those in the DSM—have failed to be empirically validated. In response to this failure, a new consensus is emerging in the philosophy of psychiatry which stresses the seriousness of the discipline's multiple, and inherently normative goals (cf: Tekin, 2016; Tabb, 2016; Murphy, 2015; Theurerer & Hartner, ms; Friesen, ms). Under consideration is a kind of pluralism about diagnostic constructs which may, for example, taxonomize phenomena based on statistical atypicality in one arena, and on impacts on well-being in another. In this paper, I consider an additional way of schematizing psychiatric phenomena. Following Ron Mallon's work in his 2016 book The Construction of Human Kinds, I examine the possibility that familiar diagnostic categories like 'depression' and 'bipolar disorder' are shaped by our psychological, social, and environmental practices of representing psychiatric kinds. I argue that these practices are so deeply entrenched and causally powerful that accounting for diagnostic constructs without accounting for how we understand them individually and collectively, is both practically impossible and theoretically misleading. At the same time, while diagnostic categories—like racial categories—share the relevant properties to be considered real, natural, socially constructed kinds, the speed at which our practices and the phenomena they represent coevolve presents a special problem for explanation, prediction, and intervention.

[7] In this paper, I take issue with Peter Railton's account of *naturalized norms* in his 1986 paper 'Moral Realism', and with their ostensible place in theorizing about what is known as relational or instrumental good, good for-ness, or what is in our best interest. My primary purpose is to complicate a piece of the puzzle which has all too often been used unquestioningly by theories of

health and disease. First, I will closely examine the notion of a naturalized norm as it appears in Railton's original architectural example (known as the *snow and rooves case*). I will argue that Railton infers more than what is justified from the facts surrounding the snow and rooves case by overlooking hidden assumptions about what is central and what is peripheral to achieving a particular goal. Then, by introducing my own example (which I will call the *pegs and holes case*), I will extrapolate on what is and isn't implied by having a fixed goal in mind. Finally, I will return to well-being, and examine how naturalized norms can and have been used in establishing what ought to be done in the pursuit of health. It is this same confusion about naturalized norms, I argue, which lies at the heart of many crucial debates about disability and disease, as well as how to achieve the good life.

[8] Understanding how therapeutic change occurs in clinical psychiatry depends non-trivially on how we understand human cognition and human agency. In this paper I closely examine what an ecological perspective on cognition and agency tells us about what has gone wrong in cases of mental illness, and how successful therapeutic interventions generate change. Briefly, an ecological perspective casts human beings as stewards of the mind—ecological agents that manage cognitive ecology. Manifest variation in individual cognitive ecology, then, implies that there will be variation in the ways we achieve, maintain, and improve mental health. From this ecological perspective, therapeutic techniques are best conceived of as a species of *agential technologies*; a set of often non-obvious methods and strategies of control, whose pathway of influence over behavior and psychological functioning often loops outside the boundaries of the skin and skull.