Re:visit
Humanities & Medicine in Dialogue

Caring with the Humanities. Integrating the Humanities into Psychiatric Care: A Curriculum Proposal for an Introductory Course for Mental Health Professionals

Steve Vilhem (Lausanne)

Abstract

This article presents the design and pedagogical rationale of *Caring with the Humanities* (Soigner avec les Humanités), a short course aimed at integrating humanities into psychiatric training. Grounded in philosophy, anthropology, and sociology, the course addresses four key axes: the conceptual foundations of psychiatric diagnoses, the caregiver-patient relationship, the ethical and power dimensions of clinical encounters, and the potential iatrogenic effects of psychiatric institutions. Drawing on thinkers such as Foucault, Goffman, Becker, and Hacking, the curriculum promotes epistemological decentring and reflective practice. It follows the FAIR pedagogical principles (Feedback, Activity, Individualisation, Relevance) and includes participatory modules, such as a diagnostic simulation to highlight interpretive divergences and the constructed nature of psychiatric categories. Through mixed-methods evaluation, including follow-up after three months, the course aims to cultivate humility, critical thinking, and culturally sensitive care. In doing so, it argues that the humanities are not a luxury but an essential dimension of good psychiatric practice.

Keywords

psychiatry, humanities in medicine, caregiver-patient relationship, mental health education, sociological aspects of psychiatry

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Introduction

The medical humanities can be defined as "all literary, anthropological, historical or philosophical approaches (among many others) to medicine".[1] Although they are playing an increasingly important role in medical studies, they remain insufficient, even in courses where the humanities would seem to deserve a more prominent place, such as psychiatry.[2] This is all the more unfortunate since "we now know that the medical humanities work",[3] *protecting mental health, improving levels of empathy and increasing tolerance of ambiguity among students who receive training*.[4] Moreover, recent philosophical scholarship has shown that engaging with philosophy in psychiatry enhances clinical reflexivity, promotes conceptual clarity, supports ethical sensitivity and reduces epistemic injustice in care.[5] These contributions are therefore not merely theoretical, but offer clinicians a practical framework to reflect critically on psychiatric knowledge, its methods, and its normative implications.

In France, humanities are insufficiently present (if not totally absent) in most of the postgraduate curricula,[6] and with them useful perspectives that call into question rep-

1 Alan Bleakley: Le développement des humanités médicales aux États-Unis et au Royaume-Uni: une biographie critique. In: Céline Lefève et al. (eds.): *Les humanités médicales: l'engagement des sciences humaines et sociales en médecine*. Arcueil 2020, 28.

2 "Unfortunately, despite the flourishing of the sister movements of contemporary philosophy of psychiatry and critical psychiatry, mainstream psychiatry has remained largely insulated from philosophical discourse." (Awais Aftab, G. Scott Waterman: Conceptual Competence in Psychiatry: Recommendations for Education and Training. In: *Academic Psychiatry* 45.2 (2021), 203-209. doi.org/10.1007/s40596-020-01183-3).

3 Bleakley, Le développement des humanités médicales, 24.

4 See Rebecca Garden: The Problem of Empathy: Medicine and the Humanities. In: *New Literary History* 38.3 (2007), 551-567; Eric J. Keller: Philosophy in Medical Education: A Means of Protecting Mental Health. In: *Academic Psychiatry* 38.4 (2014), 409-413. doi.org/10.1007/s40596-014-0033-y; Xin Zhang et al.: Educational Efficacy of Medical Humanities in Empathy of Medical Students and Healthcare Professionals: A Systematic Review and Meta-Analysis. In: *BMC Medical Education* 23.1 (2023), 925. doi.org/10.1186/s12909-023-04932-8.

5 See Aftab and Waterman, Conceptual Competence in Psychiatry; Christophe Gauld et al.: The Role of Clinicians in the Looping Effect: Epistemic Injustices and Looping Breaks. In: *Medicine, Health Care and Philosophy* 28.3 (2025), 561-576. doi.org/10.1007/s11019-025-10279-2; Zachary H. Schwartz: Psychiatric Skepticism in Medical Education: Why We Need Philosophy. In: *Academic Psychiatry* 43.4 (2019), 461-463. doi.org/10.1007/s40596-019-01049-3; Dan J. Stein et al.: Philosophy of Psychiatry: Theoretical Advances and Clinical Implications. In: *World Psychiatry* 23.2 (2024), 215-232. doi.org/10.1002/wps.21194; Damiaan Denys: Professionals in Psychiatry Need Reflective Competence. In: *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 23.2 (2024), 234-235. doi.org/10.1002/wps.21196.

6 See Christophe Gauld et al.: Conceptual Competences in Philosophy of Psychiatry: A Cross-Sectional Survey. In: *L'Encéphale* (2025), S0013700625000934. doi.org/10.1016/j.encep.2025.02.005. However, since recently, some initiatives are put into place in France to foster dialogue between psychiatry and humanities, notably (1) *La Chaire de Philosophie à l'Hôpital* (since 2016), initiated by Cynthia Fleury, see Nicolas El Haïk-Wagner, Charlie Marquis: Favoriser le dialogue avec les humanités en psychiatrie. In: *Gestions hospitalières : la revue du management hospitalier* 624 (2023), 141-145; Cynthia Fleury: *Le soin est un*

resentations of doctors, medicine, illnesses and patients, and in particular an approach that places greater emphasis on the possible sociogenesis of mental disorders.

Recent empirical research supports the pedagogical necessity of including conceptual and philosophical training in psychiatric education. For instance, a recent cross-sectional survey conducted in France among 353 psychiatry students and professionals demonstrated a high level of perceived need for training in conceptual competences, with 90% of respondents endorsing philosophical education as necessary and 80% supporting the development of such skills.[7] This reflects a broader international concern that psychiatry education often lacks integration of critical, conceptual, and ethical reflection,[8] which are essential to navigate the epistemological and normative tensions inherent to clinical practice. In a French context where the deterioration of training conditions and professional support in psychiatry has become widely acknowledged,[9] there is an urgent need to rethink psychiatric education – particularly in its humanistic and conceptual dimensions.

This article proposes a short introductory humanities-based curriculum aimed at fostering conceptual reflexivity, ethical awareness, and critical thinking in psychiatric practice. Drawing on foundational scholarship in philosophy of psychiatry and the medical humanities – particularly the work of Foucault, Becker, Hacking, and Goffman – this article aims to demonstrate how such training can enrich clinicians' understanding of their role, their patients' narrative, and the diagnostic categories they employ.

The article is structured in four parts. First, we provide a brief overview of the historical and epistemological justifications for integrating the humanities into psychiatric education. Second, we articulate the core objectives of the proposed curriculum, based on a model of fourfold decentring. Third, we describe in detail the structure and content of the short course. Finally, we outline the evaluation strategy and discuss future directions for expanding this initiative.

humanisme. Paris 2019, 2-46, https://doi.org/10.3917/gall.fleur.2019.01.0002 and (2) the *Diplôme Inter-Universitaire « Philosophies de la psychiatrie »* (since 2019), see Christophe Gauld et al.: Éléments pour une cartographie de la philosophie de la psychiatrie en pratique clinique. In: *Annales Médico-psychologiques, revue psychiatrique*, publication en ligne anticipée, 26 mai 2025, https://doi.org/10.1016/j.amp.2025.05.005.. Yet, these are optional courses and not part of the official curricula of medical students or psychiatrists.

7 See Gauld et al., Conceptual Competences in Philosophy of Psychiatry.

8 See Awais Aftab et al.: A Didactic Course on "Philosophy of Psychiatry" for Psychiatry Residents. In: *Academic Psychiatry* 42.4 (2018), 559-563. doi.org/10.1007/s40596-017-0853-7.

9 See Bernard Odier, Pascal Favré: Rattrapons, en dix ans, le retard pris dans les formations des professionnels travaillant en psychiatrie. In: *L'Information psychiatrique* 101.4 (2025), 211-213.

Medicine and its 'two heads', between art and science, between caring for people and the humanities of care

On the strength of its countless therapeutic successes over the last two centuries, medicine wants to be recognised as an evidence-based science, which of course it is – but that's not all it is. It does have "two heads":[10] one is devoted to science and the other to the 'arts', i.e., the humanities and social sciences. Ideally, they should both be well-filled, because the reason why medicine is such a difficult exercise is that it requires the use of complementary skills, which are often perceived as opposites.

However, it seems that one of the heads in question is disproportionately well filled compared to the other. For example, many medical students and doctors seem to lack empathy. The fault can be attributed to an education system that leaves little room for the humanities[11] but that's not all. For example, the healthcare systems, particularly hospitals, where medical students are trained, are highly hierarchical and increasingly subject to oppressive administration, often under great strain, which very rarely leaves room for students "to articulate the general with the particular, to question the meaning of decisions and the values at stake, to question codes and behaviour".[12]

We can also lay the blame at the door of computerisation, which – for the time being at least – enslaves man to the machine and distances the student from the patient's bed.[13] This same extreme computerisation encourages them to remain in front of a screen where everything that is measurable is identified, all the more so when, conversely, "what is not measured, or even non-measurable, is disqualified".[14] Added to this is an exponentially increasing amount of scientific knowledge, which increasingly justifies a curriculum "standardised by hyperspecialisation and the model of the university hospital career, which idealises scientific research to the detriment of clinical practice".[15]

10 Michel Serres: L'éducation médicale vue par un philosophe. In: *Pédagogie Médicale* 7.3 (2006), 135-141. doi.org/10.1051/pmed:2006009.

11 See Reidar Pedersen: Empathy development in medical education – A critical review. In: *Medical Teacher* 32.7 (2010), 593-600. doi.org/10.3109/01421590903544702.

12 Lefève et al., Les humanités médicales, 37.

13 See Jean-Christophe Weber: Menaces sur la phronésis : l'impact de la nouvelle gouvernance hospitalière sur la pratique médicale. In: Lefève et al., Les humanités médicales, 66.

14 Idem. As an anecdotal illustration, this is explicitly stated in the recent French documentary on psychiatry *ÉTAT LIMITE* (dir. Nicolas Peduzzi, 2023), in which psychiatrist Jamal Abdel Kader, working alone in what he calls an "ill institution", repeatedly insists that "my work as a psychiatrist is not quantifiable."

15 Lefève et al., Les humanités médicales, 37.

The meagre proportion of humanities in the medical curriculum therefore goes hand in hand with the distance from the patient. This is justified by the growing need to acquire scientific knowledge, which is constantly expanding, and the need to understand diseases as well as possible. These same diseases are no longer observed and their mechanisms understood exclusively at the bedside, but in laboratories that can reveal what is invisible to the naked eye. The opposition between patient and disease seems to be mirrored by the opposition between the humanities and the sciences.

This opposition is rooted in two twin metaphors that have shaped modern medicine: "on the one hand, the image of the body as a machine, and on the other, medicine as a 'war' against disease".[16] 'Science', the promise of a better future, began to arouse justified hope in the 19th century, the century that saw the birth of positivist philosophy, the heir to Cartesian mechanistic thought. In the West, the nineteenth century saw the secularisation and medicalisation of society[17] and this saw medicine study the body as a machine, venturing to explore and understand its smallest workings. As a result, we have also seen it gradually segment itself according to the organs of interest. Hospitals were soon divided into as many specialised departments, making holistic patient care all the more difficult.

Psychiatry, a 'speciality without organs', currently dominated by a biological paradigm

Let us return to psychiatry. While there are now organ-based specialties in medicine, such as cardiology, pneumology, and neurology, there are also more cross-disciplinary specialists, such as family doctors, as well as doctors responsible for different stages of life: paediatricians and geriatricians. The question now is, in a mechanistic society, where the body-machine is considered soulless,[18] what do psychiatrists[19] specialise in? Do they treat brain disorders? Or 'simply' *problems of life*?[20] At a time when medicine was establishing itself as a science, ousting the Church as a hitherto legitimate actor in the treatment of

16 Alan Bleakley: *Thinking with metaphors in medicine: the state of the art*. London 2017.

17 See Joan Jacobs Brumberg: *Fasting girls: the history of anorexia nervosa*. Cambridge 2000, chapter 2; Laurent Visier, Geneviève Zoïa: La médecine, pratique culturelle et sociale. In: Lefève et al., Les humanités médicales.

18 See George Makari: *L'âme machine - L'invention de l'esprit moderne*. Lausanne 2023.

19 Psychiatrist, etymologically, comes from the Greek *psyche*, meaning soul or mind, and *iatreia*, meaning healing or medical treatment.

20 See Thomas S. Szasz: The Myth of Mental Illness. In: *American Psychologist* 15.2 (1960), 113.

human suffering, it brought in its wake the emergence of psychiatry, albeit without defining the 'organ' for which it was to be responsible.

In France, in 1968, as part of Edgar Faure's reform of the universities, two new *Certificats d'études spécialisées* (CES) in medicine were created: one in neurology and one in psychiatry. They replaced the former CES in neuropsychiatry, introduced in 1949 following the creation of the Social Security system.[21] The debates leading up to this split saw doctors endeavouring to place psychiatry back in the field of knowledge and practice. They all recognised the necessary link between neurology and psychiatry and the need for psychiatrists to receive basic training in brain sciences and neurology (since many differential diagnoses in psychiatry are neurological). Nevertheless, this necessary link, which is reaffirmed, is not a privileged one. Indeed, at the time, they did not fail to emphasise the links between psychiatry and other fundamental disciplines, such as the human sciences, or applied disciplines, such as psychology, general medicine, forensic medicine, psychotherapy, etc.[22] As a result, some have suggested that psychiatry should be redefined in relation to neurology.[23]

While psychiatry was developing as an autonomous discipline, it soon underwent a process of *schismogenesis*,[24] i.e., a process of differentiation and opposition between the standards of sub-groups within the same social group. Psychiatry was no exception to this process, and rapidly became an epistemological 'battleground' on which the proponents of the organogenesis, psychogenesis and sociogenesis of mental disorders clashed.[25] At the same time as psychoanalysis was advancing, the post-war period saw the discovery of the first neuroleptics, with the marketing of chlorpromazine in 1953, accentuating the split that already existed. Over the past few decades, the majority of research funding has been

21 See Romain Schneckenburger: La distinction entre neurologie et psychiatrie en France entre 1940 et 1968: le point de vue de quelques neuropsychiatres. In: *Les Cahiers du Centre Georges Canguilhem* 7.1 (2018), 33-54. doi.org/10.3917/ccgc.007.0033.

22 See idem.

23 "Neurology focuses on the nervous system, is based on anatomical and clinical research, and is practised and taught in a similar way to other branches of medicine. Psychiatry, on the other hand, focuses on behaviour, relies essentially on psychotherapy and cannot have clearly defined objectives. As for its training, rather than being technical, it must be essentially based on interpersonal relations" (idem).

24 See Gregory Bateson: *Naven: A Survey of the Problems Suggested by a Composite Picture of the Culture of a New Guinea Tribe Drawn from Three Points of View*. Stanford 1958.

25 See Édouard Zarifian: *Les jardiniers de la folie*. Paris 1999, 69.

increasingly directed toward the biological causes of mental disorders – with inconclusive results – while psychiatric care systems have remained chronically under-resourced.[26]

Nowadays, the psychiatric community sees the pathology as "biopsychosocial".[27] With the biologisation of psychiatry, the term 'biopsychosocial' has taken on a new meaning which gives primacy to the biological: psychiatric pathology is often considered to originate in the brain, and is then expressed by psychological dysfunctions which themselves have social consequences such as stigmatisation. Mental disorder is therefore "biopsychosocial", i.e., first "bio", then "psycho" and finally "social". For many historians and researchers in the humanities and social sciences in general, the paradigm tends to be reversed, with the mechanism being first "socio" then "psycho" then "bio", with the influence of the social taking precedence over the rest, with society shaping the psychic and then impacting the biological – pathology thus being a "social construct" before being a "biological reality".[28]

In this epistemological battlefield, the losers are the patients. In many countries, psychiatrists are trained in just one area: the organogenesis of mental disorders. Few countries offer dual training for psychiatrists and psychotherapists, Switzerland being an exception in this respect,[29] opening psychiatrists in training to a new vision, that of psychogenesis.[30] Regarding sociogenesis of mental disorders,[31] it is a view that is not widely held in the psychiatry community.

26 For an illustration of the current degradation of psychiatric resources in France, see Nicolas Peduzzi's documentary *ÉTAT LIMITE* (France, 2023). For an analysis of similar dynamics in the United States, see Ellen Barry: The 'Nation's Psychiatrist' Takes Stock, With Frustration. In: *The New York Times* (22 February 2022). Available at: www.nytimes.com/2022/02/22/us/thomas-insel-book.html (14.12.2025); and Thomas R. Insel: *Healing: Our Path from Mental Illness to Mental Health*. New York 2022.

27 George L. Engel: The Clinical Application of the Biopsychosocial Model. In: *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 6.2 (1981), 101-124. doi.org/10.1093/jmp/6.2.101.

28 Steve Vilhem: Redefining Anorexia Nervosa and Its Causes to Rethink Its Care. In: *Ethical Human Psychology and Psychiatry* 26.1 (2024). doi.org/10.1891/EHPP-2023-0009.

29 See Jean-Nicolas Despland, Sylvie Berney: Psychiatre et psychothérapeute ? Petite histoire suisse. In: *L'information psychiatrique* 88.7 (2012), 535-542. doi.org/10.1684/ipe.2012.0956.

30 In contrast, in France, the teaching of psychotherapy remains entirely optional, cf. A. van Effenterre et al.: Enquête auprès des PU-PH sur la formation en psychiatrie en France. In: *L'Encéphale* 40.3 (2014), 208-215. doi.org/10.1016/j.encep.2013.05.001.

31 Beyond sociogenesis in the strict sense, society and culture also shape the culturally specific form that a mental disorder takes, a dimension that ethnopsychiatrists refer to as pathoplastia or *modèle d'inconduite*: "Sometimes culture itself provides explicit guidelines for the misuse of cultural materials, especially in situations of frequent but atypical stress. The directive that interests us here is the following: 'Beware of going mad, but if you do, behave in such and such a way.' Every society has ideas about 'how mad people behave.'" (Georges Devereux et al.: *Essais d'ethnopsychiatrie générale*. Paris 1970).

Conceptual framework of the curriculum

Before presenting the structure and content of the curriculum, we propose a conceptual framework that underpins its pedagogical orientation: the diagnostic quadrilateral – *Physician, Patient, Malady, Medicine* (see Figure 1). This model situates psychiatric diagnosis as a nodal point connecting four interdependent dimensions of care[32].

The vertical axis represents a *relation of power*, between the patient (P), traditionally placed at the bottom of the clinical hierarchy,[33] and the physician (P'), positioned above as the knowledge bearer and legitimizing figure. In psychiatry, this asymmetry is often exacerbated by the nature of the disorders themselves, which may affect judgment, communication, and perceived credibility. The horizontal axis represents a temporal and epistemic sequence: from the malady (M), the subjective and pre-diagnostic experience of suffering, to medicine (M'), the system of remedies and solutions mobilized in response. The patient (P) represents the lived, embodied experience of distress. The physician (P') embodies medical authority and the interpretive framework through which symptoms are made intelligible. The malady (M) is the presenting problem – what brings the person to consult – and often a mystery in search of meaning and resolution. Medicine (M') refers to the therapeutic arsenal – pharmacological, psychological, institutional – that acts upon the illness to alleviate suffering.

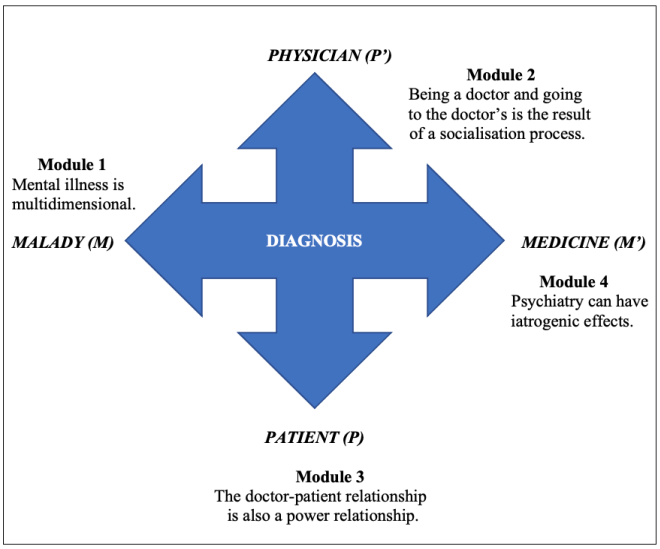

Figure 1: Fourfold decentring, diagnosis as a nodal point and the topics of the modules[34]

32 See Steve Vilhem: Aphérèse et apocope du diagnostic psychiatrique : la narration comme remède à la réification du diagnostic. In: *Soins* 70.901 (2025), 59-63.

33 Despite the shift from a paternalistic model to informed or even shared decision-making, the physician remains the holder of medical authority and knowledge.

34 See Vilhem, Aphérèse et apocope, 59-63.

At the intersection of these four poles lies diagnosis, which plays a mediating role:[35]

1. It translates the patient's experience into clinical language.
2. It renders it legible within the physician's epistemic framework.
3. It enables the formulation of a named disorder.
4. It legitimizes therapeutic action.

Far from being a neutral tool, diagnosis performs a transformative and performative function: it names, orients, and modifies the relationships between the four poles. It is not merely a description of reality, but a speech act that reshapes clinical and personal identities.[36]

This conceptual framework echoes Ian Hacking's distinction between natural kinds (e.g., chemical elements) and human kinds (e.g., psychiatric categories), the latter being subject to what he calls the looping effect: once named and institutionalized, such categories act back upon the people classified, shaping their behavior, self-perception, and trajectories.[37] Psychiatric diagnosis is a paradigmatic example of a practical kind – a socially embedded category with powerful normative and performative consequences.

The model also resonates with Jean Naudin's notion of psychiatric objects as conceptual unicorns[38] – neither natural nor purely symbolic, but hybrid constructs that resist objectification. These are not entities we can isolate and measure like a rock or a tumor, but rather entities that emerge at the intersection of subjective experience, clinical gaze, and institutional context. Finally, as German Berrios reminds us, psychiatric diagnosis is best approached through a narrative model – one that acknowledges the irreducible complexity of lived experience, the co-construction of meaning, and the unavoidable interpretive lens through which psychiatry operates.[39]

35 Ibid.

36 Steve Vilhem, Thomas Her: Nommer, soigner, figer ? Usages et mésusages du diagnostic en pédopsychiatrie. In: *Revue hospitalière de France* 627 (2025), 52-55. https://www.revue-hospitaliere.fr/article/nommer-soigner-figer-usages-et-mesusages-du-diagnostic-en-pedopsychiatrie/ (22.12.2025).

37 See Ian Hacking: *Rewriting the Soul: Multiple Personality and the Sciences of Memory*. Princeton 1998; Ian Hacking: *The Social Construction of What?* Cambridge 2000. doi.org/10.2307/j.ctv1bzfp1z.

38 See Jean Naudin: Préface. In: German Elias Berrios, Jean Naudin (eds.): *Pour une nouvelle épistémologie de la psychiatrie*. Paris 2019.

39 See Berrios and Naudin, Pour une nouvelle épistémologie de la psychiatrie.

Objective of the curriculum: Toward a fourfold decentring

The course aims to foster not only knowledge acquisition but also a profound shift in clinical perspective – what we propose to call a *fourfold decentring*. These decentrings invite participants to critically reflect on the conceptual, relational, social, and institutional foundations of psychiatric practice. Each of the four axes in the Figure 1 corresponds to a distinct area of epistemological decentring, guiding the objectives of the curriculum:

1. *Deconstructing the current reification of mental illness:* Linked to the axis between *malady (M)* and *medicine (M')*, this first dimension invites participants to explore the multidimensional nature of mental illness – as biological, psychological, social, and narrative phenomenon – challenging reductionist views that treat diagnoses as natural, fixed entities. Psychiatry must remain attuned to the meanings that patients give to their suffering, beyond symptom clusters.
2. *Interrogating the figure of the doctor and the patient:* This corresponds to the vertical axis of the diagram, which illustrates the asymmetry between the physician (P') and the patient (P). The course foregrounds the idea that being a doctor and being a patient are not natural facts, but socially constructed positions. These roles are shaped by cultural norms, institutional expectations, and professional socialisation. Understanding these dynamics fosters critical reflexivity regarding authority, expertise, and relational positioning in care.
3. *Making power visible in the therapeutic relationship:* Situated at the intersection of all four domains, the act of diagnosis mediates between clinical knowledge, subjective experience, and institutional norms. This objective aims to render the power dynamics embedded in psychiatric acts – diagnosing, prescribing, hospitalising – visible and discussable. The course encourages ethical sensitivity and promotes shared decision-making.
4. *Recognising psychiatry's potential for iatrogenesis:* This final axis explores how diagnostic categories and therapeutic interventions may shape patients' identities and trajectories – sometimes with unintended harm. By reflecting on iatrogenic risks, participants are invited to consider psychiatry not only as a healing discipline but also as a social practice with the potential to stigmatise, exclude, or silence.

Taken together, these four dimensions structure the epistemological core of the curriculum. They aim to foster conceptual vigilance, ethical reflexivity, and a richer understanding of psychiatric practice. In this sense, the course is not an abstract theoretical detour, but a clinical tool to equip practitioners to think and act more justly. By learning to decentre themselves, participants are ultimately invited to recentre their clinical gaze upon the patient's perspective.

Curriculum content

Drawing on the work of thinkers such as Erving Goffman, Michel Foucault, Ian Hacking, and Howard Becker, the curriculum is divided into four modules (see Table 1), each lasting two hours, which will be described in turn below. It is aimed at psychiatrists and child and adolescent psychiatrists (whether in training or not) as well as psychotherapists and psychiatric nurses. The course has been designed in accordance with the FAIR principles of effective medical education,[40] by providing regular *Feedback*, encouraging *Active* learning, adapting to *Individual* learners' needs, and ensuring *Relevance* to their clinical practice.

Module 1 – Introduction to human and social sciences

- Distinction between the main humanities disciplines and discussion of their relevance to psychiatry
- Introduction to philosophy in psychiatry: what is a mental disorder?
- Introduction to the anthropology and sociology of health

Module 2 – Becoming a carer, becoming a patient

- Exploring the process of becoming a 'doctor' and describing the 'Making of a Physician'
- Analysis of therapeutic itineraries and the process of becoming 'ill'

Module 3 – The care-giver-patient relationship

- Analysis of the doctor-patient encounter and exploration of the asymmetrical dynamic between 'truths and lies'
- Exploring the concept of 'deviance' from the point of view of interactionist sociology, specifically with regard to mental disorders and its influence on the relationship between carer and patient

40 See Ronald M. Harden: *Essential Skills for a Medical Teacher: An Introduction to Teaching and Learning in Medicine*. Edinburgh 2020, 15-16; Ronald M. Harden, Jennifer M. Laidlaw: Be FAIR to Students: Four Principles That Lead to More Effective Learning. In: *Medical Teacher* 35.1 (2013), 27-31. doi.org/10.3109/0142159X.2012.732717.

Module 4 – The iatrogenic risk of psychiatric care
○ The risk of false diagnosis in psychiatry ○ Reflection on the possible iatrogenic consequences of institutional psychiatric care: the example of patients suffering from anorexia nervosa ○ Conclusion of the course and evaluation by the participants

Table 1: Proposed programme of 4 modules as part of a course entitled "Caring with the Humanities"

First module: an introduction to the human and social sciences and an invitation to take a fresh look at mental illness

The first module aims to enable participants to identify the main humanities and social sciences, in particular the medical humanities. Its secondary objectives are to differentiate between the methodologies specific to each of the humanities and social sciences and to examine some of the contributions of the humanities to psychiatry, taking as a prime example the definition of mental disorders.

Distinction between the main humanities disciplines and discussion of their relevance to psychiatry

The 19th century saw the secularisation and medicalisation of society.[41] In parallel with this secularisation, new humanistic sciences emerged, focusing on man and society such as sociology and anthropology.[42] They quickly began to take an interest in health, medicine and psychiatry, each with its own methodology: philosophy focusing on the study of concepts, history on the basis of sources, sociology and anthropology on the basis of surveys, using statistics (especially for sociologists), interviews and participant observation. This is an opportunity to illustrate with participants the different types of subjects that can emerge from each of these sciences.

Introduction to philosophy in psychiatry: What is a mental disorder?

The aim is to propose an initial example of decentring in relation to practice: What is a mental disorder? In the Alma-Ata Declaration of 1978, the WHO defined health on the

41 See Brumberg, Fasting girls, chapt. 2.

42 Auguste Comte and then Émile Durkheim founded sociology in France, while the American L.H. Morgan and the Englishman E.B. Tylor founded ethnology, which later evolved into social and cultural anthropology. These new human and social sciences gradually took their place alongside philosophy and history in making sense of the world and human practices.

basis of two criteria: a positive one, which defines health as "a state of complete physical, mental and social well-being", and a negative one, which defines health as "the absence of disease or infirmity". Extending this definition to the field of "mental health" is problematic for several reasons. Firstly, how would this state of mental well-being be manifested? It is hard to see what criteria could be agreed upon to assess mental health, given that it refers to an internal and subjective state, at the crossroads of intimacy and society, which eludes any unambiguous and generalisable definition.

At present, the positive side of the term is mainly used: mental health. The transition from the concept of mental hygiene (dating from the 19th century) to that of mental health during the 1940s-1960s provided a vague, unifying term that was a strength for the health authorities, who could easily use this new term to guide their research and care policies. However, over the decades, mental health has become part of a 'biopolitics of emotions and affects', i.e., the management of individuals' mental phenomena by the mechanisms of power. What does psychiatric care mean? What or who is being treated? Are we treating an illness or social problems?

The concept of "mental health", which emerged and was put into practice from the second half of the 20th century onwards[43] was a response to the criticisms levelled by the anti-psychiatric movement, which described asylums as coercive spaces[44] and rejecting psychiatry as a science. Although psychiatry claims to deal with 'mental disorders', as a science it has proved very difficult to define their limits, particularly in terms of nosography, and to establish sensitive and specific diagnoses. The difficulties in clearly defining mental disorders have now spanned several decades and are the subject of much criticism. The current DSM is the embodiment of an attempt at consensus, but in order to achieve this, it limits itself to highly descriptive elements of the disorders.[45]

The main criticism came from Thomas Szasz, a psychiatrist and supporter of the anti-psychiatric movement who, in his 1960 article *The myth of mental illness*, stated that all illness presupposes an organic lesion. For this reason, since psychiatric pathology has no biological basis, it is nothing more than a myth.[46]

43 See Claude-Olivier Doron: L'émergence du concept de «santé mentale» dans les années 1940-1960: genèse d'une psycho-politique. In: *Pratiques en santé mentale* 61.1 (2015), 3. doi.org/10.3917/psm.151.0003.

44 See Erving Goffman: *Asiles: études sur la condition sociale des malades mentaux et autres reclus*. Paris 1968.

45 See Steeves Demazeux: *Qu'est-ce que le DSM?: genèse et transformations de la bible américaine de la psychiatrie*. Paris 2013.

46 See Szasz, The myth of mental illness, 113.

A few years later, in the 1970s, Rosenhan compounded the criticism with an experiment in which psychiatrists proved incapable of detecting false patients (students feigning symptoms) among new admissions to a psychiatric institution. This highly publicised experiment gave rise to an epistemological reaction, with other intellectuals attempting to define the concept of 'mental disorder', following the example of Boorse's naturalistic (i.e., non-judgemental) attempt in the 1970s, for whom a mental disorder is linked to a dysfunction. The latter is defined as 'the impossibility, for part of an organism, of achieving the goal that is typical of the way of surviving and reproducing that is peculiar to similar organisms'.[47] Unsatisfactory and widely criticised (thinking of the example of homosexuality), this proposal was supplemented in 1992 by Wakefield, who proposed the notion of "harmful dysfunction". According to Wakefield, for a state to be pathological, it is necessary and sufficient that there be (1) harm and (2) dysfunction, adding that dysfunction is defined as 'a failure to adapt to an environment that has shaped the species through its selective pressure at some point in its evolution'.[48] Although this definition has been attacked many times, it has remained the benchmark for all analyses of the concept of mental disorder.[49]

To open this part of the course, it is worth noting that trainees begin by watching a short video featuring a standardized patient – an actor simulating psychiatric symptoms – without being informed of the simulated nature of the case. Each participant is asked to formulate, individually and in writing, a diagnostic hypothesis based on the observed clinical signs. This silent phase is followed by a collective discussion, where the range of proposed diagnoses is revealed and debated. Only then is it disclosed that the patient was in fact an actor. This exercise – a brief reproduction of Rosenhan's experiment – serves as a powerful demonstration of the variability in diagnostic interpretation among trained professionals, and the difficulty of detecting simulation in psychiatry. It also foregrounds a central theme of the course: the fragility, normativity, and constructed nature of psychiatric categories.

Introduction to the anthropology and sociology of health

The last part of this first module proposes to pursue the same line of thought using anthropology and sociology. "Two twin metaphors have shaped modern medicine: on the one

47 Christopher Boorse: On the Distinction between Disease and Illness. In: *Philosophy & Public Affairs* 5.1, 49-68.

48 See Jerome C. Wakefield: The Concept of Mental Disorder. In: *American Psychologist (1992),* 16.

49 Maël Lemoine: La définition des « troubles mentaux » : Brève introduction à une question fondamentale de la philosophie de la psychiatrie contemporaine. In: *L'enseignement philosophique,* 62.2 (2012), 58-70. https://doi.org/10.3917/eph.622.0058.

hand, the image of the body as a machine, and on the other, medicine as a 'war' against illness",[50] but what illness are we talking about in psychiatry? In the previous section, emphasis was placed on the difficulty of precisely defining mental illness as a diagnostic entity from a philosophical point of view; now it is a question of seeing what sociology, and particularly anthropology, can contribute to this reflection. As part of this reflection on psychiatry enriched by the humanities, it is essential to differentiate and understand the concepts of 'disease', 'illness', and 'sickness'[51] which represent three complementary facets of health and illness, often confused in everyday language but crucial to a holistic approach in psychiatry.

The term 'disease' refers to the strictly medical and biological aspect of the condition. It refers to scientifically identified organic alterations and physiological dysfunctions. In psychiatry, this could be manifested by neurochemical imbalances or brain abnormalities detectable by clinical examinations or medical imaging. 'Illness', on the other hand, concerns the patient's experience of the illness. This refers to the subjective perception of the disease, encompassing pain, symptoms and fears, as well as the impact on personal identity and functional abilities. In psychiatry, this can include the way in which an individual experiences and interprets their own symptoms, for example, paralysing anxiety or anguish, or hallucinations. This dimension of illness underlines the importance of the human sciences, which enable us to understand not only what the patient is going through, but also how they make sense of their suffering and their condition.

Finally, 'sickness' is the term used to describe the social dimension of illness. It is concerned with how society perceives and responds to illness, including stigma, social roles affected by illness, and cultural expectations. Sickness addresses issues of the social acceptability of mental illness, impacts on the social status of the patient, and institutional responses to illness. In psychiatry, the concept of sickness can explore how mental disorders are viewed by the patient's relatives, by health professionals, and by society in general, thus influencing health policies, access to care and available support.

This first module therefore concludes by offering a rich vision of the definition of mental disorders, which is not limited to disease but also embraces illness and sickness, enabling health professionals to recognise the complex entanglements between biology, personal experience and social context. The module concludes with an exposition of the

50 See Bleakley, Thinking with metaphors in medicine.

51 See Bjørn Hofmann: Disease, Illness, and Sickness. In: Miriam Solomon et al. (eds.): *The Routledge Companion to Philosophy of Medicine*. New York, London 2016, 16-26.

biopsychosocial model as presented by G. L. Engel *The clinical application of the biopsychosocial model* (1981) (see Figure 2), insisting on the fact that caring for a psychiatric patient requires intervention at several levels, and following Natalie Banner's philosophical advocacy of defining the 'affected organ' in psychiatry as 'the person, within their environment' – considering it a fallacy to suggest that the brain is the locus of disorder.[52]

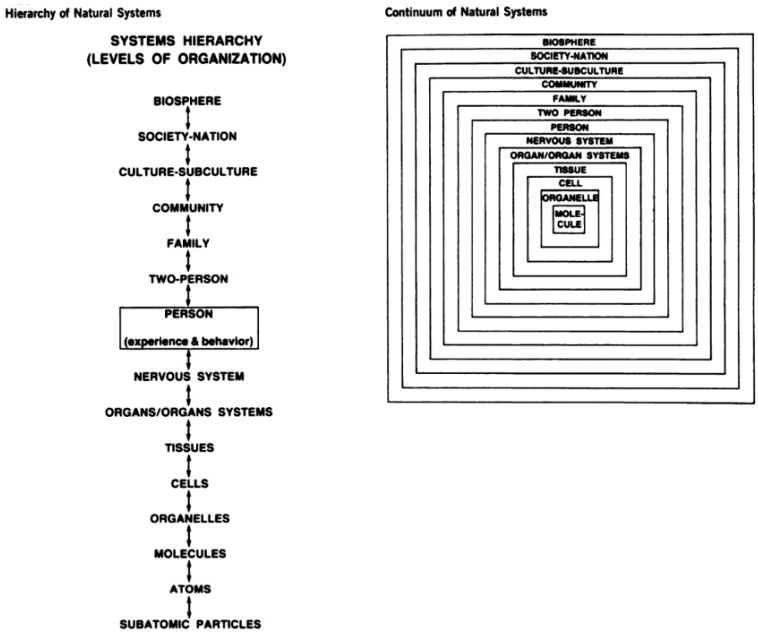

Figure 2: G.L. Engel (1981): The clinical application of the biopsychosocial model

Second module: Becoming a carer, becoming a patient and decentring from the medical role

The aim of this second module is to acquire basic anthropological knowledge that will enable us to understand how both the doctor's identity and the patient's therapeutic itinerary are constructed.

An introduction to anthropology through key concepts and definitions

The first part of the module explores the process of 'becoming a doctor', highlighting how medical identity is shaped. To help participants better understand this process, the course begins with key anthropological definitions to better understand the object of study for anthropologists (see Table 2).

52 See Natalie F. Banner: Mental Disorders Are Not Brain Disorders. In: *Journal of Evaluation in Clinical Practice* 19.3 (2013), 511. doi.org/10.1111/jep.12048.

"How can we understand ways of thinking that we ourselves cannot formulate and that a priori appear to be completely irrational?": This is the fundamental question that anthropology has sought to answer from the outset. Anthropology's quest to grasp the a priori irrational ways of thinking in other cultures resonates with that of psychiatry, which shares this interest in understanding behaviours perceived as irrational.

Other introductory definitions are discussed: in particular the concept of 'status', which implies that an individual occupies several positions in the course of his or her life, and how these positions influence his or her perception of the world. Other definitions explored include: society, culture, norms, values, and the phenomenon of socialisation, which describes how individuals internalise elements of society, particularly through the family, their primary space for socialisation. Before turning to these definitions, participants are asked to note the cultural and societal subsets with which they identify, in order to explore their sense of belonging and identity.

Anthropology:

A science whose general aim is to understand man as a social individual. In anthropology, man is necessarily a social individual, i.e. an individual inserted into a society, from which he will construct his ways of being, his attitudes, his thoughts, his knowledge, his certainties, establish reasoning, make judgements about himself and others, about the events he will encounter, about the world in which he lives, make decisions, and think about his daily actions, including in the field of health.

Society:

A society is a group of human beings endowed with the capacity to self-reproduce their collective existence according to a system of norms and rules for action, and whose lifespan exceeds that of each of the individuals who make up the society.

Culture:

"A set of patterns (of thoughts, behaviours, feelings, beliefs, modes of production and reproduction) that are socially learned and globally shared, at a given time, by a group of people forming a people or a society" (E. Tylor, 1870).
"A complex set of skills, values, beliefs and knowledge about the world that enables each of us to make sense of it. This body of knowledge is acquired by human beings living in society, in order to think about, manipulate and control their environment" (R. Redfield, early 20th century).

Status:

Throughout their lives, individuals occupy one or more positions in society (student, teacher, etc.). These statuses mean that we belong to groups; they give us specific, one-off identities and have an impact on our ways of being in the world. Note that 'role' is the dynamic dimension of 'status'.

Norms:

It is what is expected, a prescribed way of doing things, and therefore socially accepted. It is a valued attitude. Norms vary from one society to another, and also within a society, depending on the social environment or group to which one belongs.

Values:

A normative cultural trait, these are the ideals that a society or group sets for itself and that will constitute a moral code that will guide behaviour, thanks to which the individual builds a personal ethic, and makes it possible to understand attitudes, behaviour and the direction of individual and collective actions.

Socialisation:

A central concept in the human sciences that enables us to study the tensions between societies and individuals. It refers to the way in which society shapes and transforms individuals.[53] The first place where each of us is socialised is the family, which enables these elements of society, culture, rules, ways of being and values to be instilled in each child.

Disease, Illness and Sickness:

- *Disease:* Defined by biomedicine. Dysfunction objectified by science, objective biomedical alteration produced by the knowledge of medical doctors.
- *Illness:* Subjectively experienced by the the individual. Perspective of individuals, taking into account their point of view, their 'truth'.
- *Sickness: A* social view of illness. Collective dimension: what society means by a problem.

Therapeutic itinerary:

A process that focuses on all the medical and social factors involved in seeking care for a sick individual, from the onset of a disorder to its resolution. It consists of three stages: identification of an event as being problematic, causal attribution and the search for a solution.

Table 2: Main anthropological definitions

Exploring the process of becoming a 'doctor' and describing the 'Making of a doctor'

The process of becoming a doctor involves specific stages of socialisation. In the foreword, emphasis is placed on the fact that many medical students come from high socio-cultural backgrounds, illustrating the importance of cultural capital as highlighted by Bourdieu.[54] The second element highlighted is that the medical profession has historically been built by fighting against potential competitors, using the example of the slow construction of medical authority in 19th-century France.

In this context, where medical students are not 'just anyone' and are joining a profession – that is, a professional activity that uses abstract knowledge, which takes a long time to acquire, to solve concrete problems in society, and is validated by a collective

53 See Muriel Darmon: *La socialisation*. Cambridge 2017, 6.

54 See Pierre Bourdieu: Les trois états du capital culturel. In: *Actes de la recherche en sciences sociales* 30.1 (1979), 3-6.

of peers[55] – it is necessary to understand the stages that mark out this medical training. According to Hughes,[56] it begins by *separating the future professional from the lay world*. This fundamental stage prepares the student to break with the beliefs and perceptions of the lay world. It is essential for adapting to the new norms and values of medical culture. It involves learning biomedical concepts that define a specialised vision of the human body, very different from that of the everyday world. This is followed by *a passage through the looking glass*: the student learns to see the world through the eyes of the doctor. This stage requires a change of perception and attitude to view patients and health objects from a medical perspective. In this way, students adopt the attitudes and ways of thinking specific to the profession. Then, in the third stage, the medical student must learn to reconcile his or her lay culture with his or her new professional identity, a process often experienced as *a splitting of the self* between the "lay person" and the emerging professional. They have to reconcile these two aspects, without setting them in opposition to each other, by mobilising them according to their professional activities. The final stage is *the identification with the professional role*: this final phase involves crises and dilemmas, as the student has to give up elements of their previous identity. This process of identity conversion involves changing the way you look at yourself, your patients and the role of the doctor.

Separation from the profane world, passage through the mirror, splitting of the self, and identification with the expected role: these four stages describe a process that leads to a transformed sense of reality and to the habituation of the medical gaze.

Analysis of therapeutic itineraries

The final aspect covered in this module is the patient's therapeutic pathway. This often complex pathway is influenced by multiple factors, including personal beliefs, cultural norms, and the social and medical structures available. Through this prism, we study how an individual becomes 'ill' not only in the biomedical sense (disease) but also in its personal (illness) and social (sickness) dimensions. This includes the recognition and interpretation of symptoms, the search for treatment, and the way in which these experiences modify identity and social interactions.

55 See Catherine Paradeise: Comprendre les professions: l'apport de la sociologie. In: Catherine Halpern (ed.): *Identité(s)*. Paris 2016, 197-209. doi.org/10.3917/sh.halpe.2016.01.0197.

56 See Everett C. Hughes: The Making of a Physician — General Statement of Ideas and Problems. In: *Human Organization* 14.4 (1956), 21-25.

More specifically, the therapeutic pathway encompasses the stages an individual goes through in seeking care, from the onset of a health problem to its resolution. It is a multidimensional concept that highlights the influence of sociocultural factors on the process of seeking care.

Anthropologists generally identify three main stages in the therapeutic itinerary:[57]

1. **Problem identification**: The individual recognises a symptom or discomfort as a health problem.
2. **Causal attribution**: The individual attributes causes and meaning to the problem, drawing on cultural models, personal beliefs, and social representations.
3. **Search for solutions**: The individual explores different treatment options based on his or her interpretations and the resources available.

This therapeutic itinerary is not linear, and can be influenced by various factors such as social representations of the disease, the healthcare systems in place, and past experiences. This process is marked by constant negotiation between the patient's own experiences and the medical and cultural interpretations of their condition.

This module shows that becoming a doctor is a process that takes place over a long period of time. It is the result of societal struggles (particularly in the 19th century) that have given biomedicine the monopoly of care, while gradually instilling in individuals the idea that the 'normal' therapeutic route in our Western societies is to consult a doctor (and not a traditional healer, shaman or priest, for example).

Third module: the care-giver-patient relationship and decentring of the patient's role

The aim of this module is to examine the relationship between the carer and the cared for and its recent evolution, in particular through the analysis of informational interactions. This is a potentially idealised relationship, particularly on the part of doctors, which often conceals the power relationship superimposed on the care relationship.

57 Andras Zempléni: *La maladie et ses causes*. Paris 1985.

Analysis of the doctor-patient encounter and exploration of the asymmetrical dynamic between 'truths and lies'

In her book *La relation médecin-malade, entre information et mensonges* (2008), Sylvie Fainzang explores the issue of lying in the therapeutic relationship, based on fieldwork carried out in oncology and internal medicine departments. It analyses the implications of sharing partial or false information, as well as the underlying reasons for these practices. It highlights a discrepancy between the views of doctors, who often believe that patients prefer not to be fully informed, and the needs expressed by patients themselves, who want a better understanding of their condition.

Fainzang reveals that the majority of doctors share only *part of* the information available, a practice justified by a widely accepted doctrine which advocates only informing patients if they explicitly express the wish to be informed. This practice raises important ethical questions, particularly concerning patients from less privileged socio-economic backgrounds, who are less likely to ask for information, often due to a lack of knowledge about what they can ask for or intimidation.

These observations are part of a broader perspective in which the doctor-patient relationship is influenced by power dynamics, as Michel Foucault points out. The transition of medicine from the paternalistic model to that of informed and shared decision-making[58] shows a move towards greater patient autonomy. However, despite these advances, interactions are still marked by inequalities in access to information, reflecting persistent asymmetries of power in medical care.

Fainzang's contribution is crucial to understanding how doctors' behaviours and expectations can paradoxically perpetuate a reluctance to communicate openly, thereby fostering a form of 'lying by omission' that can undermine care and trust in the doctor-patient relationship. This demonstrates the need for ongoing reflection on medical practices and the ethical paradigms that underpin them, to ensure that the rights and needs of all patients are respected and fairly addressed.

58 See Marie Charavel: La relation médecin-patient vers la décision partagée, un nouveau champ d'investigation en psychologie de la santé. In: *Bulletin de psychologie* 56.463 (2003), 79-88. doi.org/10.3406/bupsy.2003.15198.

Exploring the concept of 'deviance' from the point of view of interactionist sociology, specifically with regard to mental disorders and its influence on the relationship between carer and patient

In interactionist sociology, deviance is not a quality intrinsic to certain behaviours or individuals, but the result of social interactions and the application of labels. Howard Becker, in his book *Outsiders: Studies in the Sociology of Deviance* (1963), explains that deviance is created by society through rules, the breaking of which constitutes a deviation, and through the labelling of certain individuals as deviant, thereby reinforcing their non-standard behaviour. This process of 'labelling' has a profound effect on a person's identity[59] and can influence the relationship between carer and patient in psychiatry, where patients may be perceived and treated not only on the basis of their symptoms but also on the basis of their presumed 'deviance' from social norms. This perception can lead to increased stigmatisation and therefore limited empathy in the carer-patient relationship, with a negative impact on the quality of care and the patient's recovery.

Howard Becker also develops the notion of a 'career' for a deviant by analysing it through the prism of interactionist sociology. This approach shows that deviance, resulting from social interactions and the labelling that follows, can be analysed from the angle of a career, which has several stages:

1. **The initial act of deviance**: Everything generally begins with an act that is perceived as deviant by society or a social group, such as drug use or behaviour deemed inappropriate. This act is not necessarily recognised by the individual as deviant.
2. **Detection and labelling**: The next stage occurs when society (through its agents, such as the police or other authority figures) detects and labels the act as deviant. Labelling can profoundly affect the identity of the person concerned.
3. **Acceptance of the deviant role**: Once the label has been applied, the individual may begin to accept and internalise their role as a deviant. This can lead to a change in self-image and an adaptation of behaviour to match this new identity.
4. **Membership of a deviant subculture**: Individuals labelled as deviant often find a community of peers with similar identities. This can reinforce their deviant behaviour, as the subculture offers support, justifications for deviance, and sometimes role models.

59 Steve Vilhem: Enveloppes et symptômes, le regard clinique mis au défi. In: *L'Information Psychiatrique* 100.6, 428-434. https://doi.org/10.1684/ipe.2024.2743.

5. **Professionalisation**: In some cases, the individual may become a professional deviant, meaning that deviance becomes a central part of their identity and way of life. This can include learning specific skills and participating in wider deviance networks.

These stages of the deviant career have profound implications for the carer-patient relationship in psychiatry, where patients can be labelled and treated according to their perceived 'deviance', impacting on the quality of care and the recovery process.

Fourth module: the iatrogenic risk of psychiatric care and a shift away from medicine

The main aim of this last module is to explore the possible iatrogenic consequences of psychiatric care through the prism of the social sciences, while questioning the fundamental concepts of psychiatry, recalling its specific features in relation to other medical specialities, and promoting a more humanistic approach to patient care.

The risk of false diagnosis in psychiatry

The risk of misdiagnosis in psychiatry is significantly high due to the inherent subjectivity of the assessment of psychiatric symptoms and the great variability in the manifestations of mental disorders from one individual to another. Added to this is an over-reliance on diagnostic classifications that can only partially capture the complexity of individual experiences. The consequences of misdiagnosis can be serious, including inappropriate treatment and worsening symptoms and suffering for the patient.

Rosenhan's experiment, already discussed, is a striking example that questions the reliability of psychiatric diagnoses. In his study *On Being Sane in Insane Places* (1973), employees with no mental disorder, known as "pseudo-patients", were sent to various American psychiatric establishments. Despite their normal post-admission behaviour, they were all diagnosed with psychiatric disorders and were kept hospitalised. This experience highlighted the inability of medical staff to identify deception (as they continued to believe in the presence of symptoms of mental illness), the risks of dehumanisation and stigmatisation, and also called into question the validity of psychiatric diagnoses, particularly when it is noted that "With remarkable ease, diagnoses can transform the fear of chaos into the comfort of the known; the burden of doubt into the pleasure of certainty;

the shame of hurting others into the pride of helping them; and the dilemma of moral judgement into the clarity of medical truth".[60]

Reflection on the possible iatrogenic consequences of institutional psychiatric care: the example of patients suffering from anorexia nervosa

The fact that psychiatric institutions can generate chronicity is not a recent observation.[61] Taking the more specific example of individuals suffering from severe and chronic anorexia nervosa as an illustration, the hospital setting, far from being unwelcoming, can transform into a space fully devoted to their symptoms, enabling their pathological intentions to thrive.[62] Patients with chronic and severe conditions, who resist the institutional environment, often describe their experience as a "struggle," a "fight," or even a "game",[63] mirroring the observation that "the institution sometimes appears as an adversary in a kind of serious game whose goal would be to score points against it".[64] The research of another anthropologist, Megan Warin, who performed her field studies in Australia, is also highly relevant as it revealed that the notions of "performance" and becoming a "better anorexic"[65] prominently feature in patient narratives. These aspects of resistance to the institution and inter-patient competition are often concealed from healthcare providers – and are thus mainly revealed through anthropological research.

Accordingly, the hospital facility aggregates similar disorders (adhering to a 19th-century model of care) and allows those with anorexic behaviors to socialize, meet, exchange, and evolve weight-loss tactics they had previously practiced in isolation. It also encourages a form of mutual support in the resistance against the institutional framework, to the extent that this resistance can evolve into 'a game.' This setting also provides opportunities for those exhibiting anorexic behaviors to measure themselves against each other and engage in a form of pathological competition and/or mimic their symptoms.

60 Walter Reich: Psychiatric diagnosis as an ethical problem. In: Sidney Bloch et al. (eds.): *Psychiatric Ethics*. Oxford 1999, 193-224.

61 See Georges Lantéri-Laura: *La chronicité en psychiatrie*. Le-Plessis-Robinson 1997.

62 Steve Vilhem: "From pourquoi to pour quoi." What is anorexia nervosa? A philosophical and historical perspective in favour of a pathology of intentionality. In: *Analysis* 5.3 (2021), 289-295. https://doi.org/10.1016/j.inan.2021.10.010; Vilhem, Redefining Anorexia Nervosa.

63 Muriel Darmon: Devenir anorexique: une approche sociologique. In: *La Découverte poche* 270 (2007), 313.

64 Goffman, Asiles, 366.

65 Megan Warin: *Abject relations: everyday worlds of anorexia*. New Brunswick 2010, 77.

Ultimately, this institutional iatrogenesis exacerbates the symptomatology to such an extent that each individual becomes undifferentiated. The 'anorexics' morph into 'the' anorexic archetype, shedding any personal identity they previously held. This milieu can inadvertently foster severe forms of anorexia nervosa, resistant to conventional treatments, and intensify the disorder in a cycle that may deepen patients' involvement with their anorexic identity.[66]

Conclusion: Medical Humanities as "the care of care"

> "[Medical] student, my friend, how can you learn your art without this art? How can you keep your statistics-laden head in balance if you do not bring the other one into the humanities? [...] Culture will therefore teach you medicine better than the amphitheatre, because these authors explore and describe individual experiences such that you will inevitably encounter them and *will certainly miss them if, limited to crude reason, you remain an uneducated scholar*. The good doctor keeps his two heads full and well made."[67]
>
> – Michel Serres (2006)

Psychiatry is one of the most humanistic medical specialties, precisely because it deals with thoughts, emotions, and meaning.[68] Moreover, following Natalie Banner's proposal that the "organ" of psychiatry is "the person, within their environment"[69], it may be more accurate to say that psychiatry does not exist in the singular: there are only *ethnopsychiatries*, each rooted in specific cultural, linguistic, and institutional contexts. For any psychiatrist, becoming aware of the context in which they and their patients are embedded is therefore indispensable, and requires substantial training in the humanities and social sciences, in addition to medical and neuroscientific education. Far from being a luxury or an abstract exercise, the integration of philosophy and the humanities in psychiatric

66 See Steve Vilhem: Le risque iatrogénique des soins institutionnels dans la prise en charge des patientes souffrant d'anorexie mentale. In: *Soins* 70.892 (2025), 59-63.

67 Michel Serres: L'éducation médicale vue par un philosophe. In: *Pédagogie Médicale* 7.3, 135-141. https://doi.org/10.1051/pmed:2006009.

68 See Brian S. Appleby: Should we be teaching philosophy to psychiatrists-in-training? In: *Academic Psychiatry* 31.3 (2007), 246-247. doi.org/10.1176/appi.ap.31.3.246.

69 Banner, Mental Disorders.

education can be seen as "the care of care"[70] and responds to a concrete need for what Aftab and Waterman[71] call "conceptual competence": the ability to understand how implicit conceptual assumptions shape clinical decisions, institutional policies, and patient outcomes.

The training proposed in this article is deliberately introductory as introducing philosophy and humanities into psychiatric training does not require an overhaul of the curriculum, but rather modest and targeted additions across three domains: metaphysics (the nature of mental disorders), epistemology (how we know what we claim to know), and ethics (how to care and decide well).[72] The course, first held in 2024, will be evaluated by participants, and its impact on clinical practice will be assessed through open-ended questions (see Table 3 in Appendix). The results of this evaluation will be presented in a separate publication.

This introductory course also lays the groundwork for other forms of training and new ways of relating to patients, such as narrative medicine, which originated in North America.[73] Narrative medicine offers a compelling alternative to the growing rationalization of care by refocusing attention on the patient's subjective story and their capacity to make meaning of their experiences.[74] Moving away from the promises of ever more precise and objectifiable diagnoses – promises which have yet to fully materialize in psychiatry –[75] this approach emphasizes the necessity of giving the patient a voice. This need is all the more pressing in contemporary societies where, as philosopher Byung-Chul Han argues, an overflow of digital information leads to "denarrativization" with a human experience which becomes fragmented, reduced to raw data.[76] In psychiatry, this has direct consequences: at a time dominated by Diagnostic and Statistical Manual of Mental

70 See Lefève et al., Les humanités médicales.

71 See Aftab and Waterman, Conceptual Competence in Psychiatry.

72 See Appleby, Should We Be Teaching Philosophy to Psychiatrists-in-Training?

73 See Nathalie Dzierzynski: Médecine narrative et psychiatrie. In: *PSN* 19.2 (2021), 69-79; François Goupy et al.: V. Former a la médecine narrative: un retour vers le futur. In: Pauline Bégué, Zona Zarić (eds.): *Soin et compassion.* Paris 2021, 89-99.

74 See Dzierzynski, Médecine narrative et psychiatrie.

75 See Steeves Demazeux, Lara Keuck: Comment peut-on être précis les yeux fermés ? In: Christophe Gauld et al. (ed.): *Promesses et limites de la psychiatrie de précision*. Paris 2023, 201-230. doi.org/10.3917/herm.gauld.2023.01.0201; Maël Lemoine: Les promesses de la psychiatrie de précision. In: *Psychologie, Droit, Santé et Société* 34.3 (2017), 31-34. doi.org/10.3917/dsso.043.0031.

76 Byung-Chul Han: *La Crise Dans Le Récit*. Paris 2025, 14-26. www.edenlivres.fr/p/809310?f=epub.

Disorders (DSM) criteria and standardization,[77] what is often lost is the opportunity to hear the singularity of a patient's suffering – not just to label it.

Ultimately, integrating the humanities into psychiatric training also supports the development of a 'clinic of humility' amongst psychiatrists:[78] a reflective stance grounded in the recognition of the limits of knowledge, the *value-based* nature of psychiatry,[79] the acceptance of uncertainty, and attentiveness to the intersubjective relationship with the patient. Cultivating such an attitude of humility fosters a more humane and nuanced practice – one better equipped to navigate the grey zones of psychiatric care.

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Address of Correspondence:
Steve Vilhem[1, 2, 3, 4]
MD, MPH, PhD
(1) Les Toises - Centre de psychiatrie et psychothérapie, Av. des Mousquines 4, 1005 Lausanne, Suisse
(2) Institut des sciences humaines en médecine, Centre Hospitalier Universitaire Vaudois (CHUV), Université de Lausanne (UNIL), Suisse
(3) Psychiatrie du développement et trajectoires, INSERM U1018, CESP, Hôpital Cochin, Maison de Solenn, Paris, France
(4) Service de psychiatrie de l'enfant et de l'adolescent (SPEA), Hôpitaux Universitaires de Genève (HUG), Suisse
E-Mail: steve.vilhem@hug.ch

77 See Demazeux, Qu'est-ce que le DSM?

78 See Gauld et al., Éléments pour une cartographie de la philosophie de la psychiatrie en pratique clinique; Edvin Schei et al.: Reflection in Medical Education: Intellectual Humility, Discovery, and Know-How. In: *Medicine, Health Care and Philosophy* 22.2 (2019), 167-178. doi.org/10.1007/s11019-018-9878-2.

79 See Arnaud Plagnol: Psychiatrie et médecine fondée sur les valeurs. In: *Annales Médico-psychologiques, revue psychiatrique* 171.10 (2013), 716-719. doi.org/10.1016/j.amp.2013.09.009.

Appendix

1. Pre- and post-course questionnaires

Participants complete a structured questionnaire **before** and **after** the course. The aim is to evaluate the evolution of their epistemological, ethical, and clinical representations of psychiatry. Questions are formulated using a Likert scale (1 to 5), with the values in brackets indicating the two extremes of each dimension.

1. *Do you consider psychiatric disorders to be natural kinds, social constructs, or both?*
   [1 = Entirely natural kinds | 5 = Entirely social constructs]
2. *To what extent do you think psychiatric diagnoses can be free from value judgments?*
   [1 = Completely value-free | 5 = Always value-laden]
3. *Do you believe that diagnostic categories are influenced by the interaction between the psychiatrist and the patient?*
   [1 = Not at all influenced | 5 = Strongly influenced]
4. *Do you think that the patient-psychiatrist relationship involves power dynamics?*
   [1 = Completely egalitarian | 5 = Strongly hierarchical]
5. *To what extent do you think culture influences the expression and interpretation of mental suffering?*
   [1 = Not influenced by culture | 5 = Strongly shaped by culture]
6. *Do you consider reflective thinking to be a core clinical competence in psychiatry?*
   [1 = Not important at all | 5 = Absolutely essential]
7. *Do you feel equipped to critically assess the theoretical underpinnings of current psychiatric practices?*
   [1 = Not at all equipped | 5 = Very well equipped]
8. *Do you believe that history and philosophy of psychiatry are relevant to everyday clinical work?*
   [1 = Not at all relevant | 5 = Highly relevant]
9. *Should training in psychiatry integrate more content related to ethics, philosophy, or social sciences?*
   [1 = No integration needed | 5 = Strongly needed]
10. *Do you think conceptual clarity improves the quality of psychiatric care?*
    [1 = No impact | 5 = Major impact]

At the end of the post-course questionnaire, an open-ended section will allow participants to provide free comments, constructive feedback, and suggestions for improvement.

2. Three-month follow-up

Three months after the course, participants will be invited to respond to a short set of open-ended prompts designed to explore the potential long-term impact of the training. This qualitative feedback will focus on the integration of conceptual and ethical reflection into clinical practice, including the following questions:

1) *Since the course, has your way of listening to patients or engaging with their narratives changed? If so, how?*
2) *Have you found yourself reflecting differently on diagnostic decisions or questioning categories you once took for granted? Please give examples.*
3) *Did any ideas or discussions from the course resurface in your clinical work or professional relationships? If yes, in what context?*

Participants will also be invited to share any additional comments, critiques, or suggestions. This long-term evaluation aims to shed light on the durability, applicability, and perceived value of the course in day-to-day psychiatric practice.

Table 3: Evaluation of the course