Beyond the Dodo: What 100+ Thinkers and Clinicians Actually Want Philosophy to Do for Mental Health Care



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In my last post, written right after the closing ceremony of INPP 2026, I shared a report on the inaugural Dodo Bird Prize—and how Elnathan Prinsen took the Dodo home for his winning plea to "bring the missing perspective into the room." Now that the dust has settled, participants have returned home and we've settled back into our autumn routines, Gemini and I sat down to comb through the data behind that session. Between the invited panelists, the live digital inspiration board, and audience input, we gathered over 70 distinct proposals and hundreds of votes on a single, deceptively simple question: ***What is your idea from philosophy to improve mental health care?*** What emerged was a collective plea for practical, embedded, and humanizing philosophy. Here is what the community told us—and what we can take away for the disicipline of Philoosphy and Psychiatry and for mental health care.

1. Conceptual Competence: The Missing Core Skill in Training One of the most heavily voted ideas—championed passionately by panelist Awais Aftab and echoed by dozens in the room—was that conceptual competence should become a core competency in psychiatric and mental health training. In medicine, we invest thousands of hours training clinicians in pharmacology, neurobiology, and diagnostic algorithms. But how many hours do we spend teaching them how to evaluate whether a concept itself is fit for purpose, how diagnostic categories construct our perception of distress or how unexamined normative and conceptual assumptions creep into clinical practice? The audience pushed this even further: calls for "assumption audits" on

research programs, joint fellowships between philosophy and psychiatry, and mandatory normative reflection courses. Philosophy is not an ornamental elective; it aids in the intellectual and ethical reflection that is essential to everyday practice. Now a skeptic might comment that is unsuprising that P&P attendees propose 'more P&P in training', and there is obviously truth there, but remember this is also about *where* we should be applying our efforts in order to improve practice, and this theme emerged above other ideas.

2. Train the Eye, Not the Checklist (Clinical Attunement) Another clear theme from the floor was captured by Anna Bergquist's phrase: “Train the eye, not the checklist”. The conference participants called for an ethos of *uptake before intake*. Drawing from phenomenological traditions, this means cultivating the clinical capacity to notice subtle disturbances in how a person inhabits their body, makes sense of time, or relates to the world—rather than (or before) asking: "In the past two weeks, have you felt down more than half the days?" More generally, this is a call for clinicians to see and practice the clinical encounter as first and foremost an encounter with another human being. This also means embracing what several audience members described as epistemic humility: recognizing the inherent limits of our diagnostic manuals, being willing to embrace uncertainty, and understanding the limitations of reductionism.

3. Move Philosophy into the Clinic (The Clinical Philosopher) Perhaps the most pragmatic cluster of ideas (including the winning idea) concerned *structural integration*. Participants wanted philosophers, philosophy and ethics embedded in the clinic. Suggestions ranged from creating permanent “Clinical Philosopher” roles on multidisciplinary teams—acting as a “critical guardian angel on the clinician’s shoulder”—to establishing regular philosophical and values rounds alongside standard clinical handovers. When clinical teams face difficult dilemmas around coercive care, voluntary commitment, or long-term suffering, the question is rarely a narrowly technical medical one. It is also fundamentally ethical, existential, and value-laden. Having structured, protected spaces for moral deliberation isn't a luxury; it prevents moral distress and professional emotional fatigue. This works two ways: from psychiatry through awareness, training and integration within both professional identity and notions of quality of care, and from philosophy in bringing knowledge, research, tools and especially engagement to psychiatry.

4. Philosophy in the Hands of service users Some of the most inspiring proposals from the audience argued for putting philosophical tools directly into the hands of service users: - Existential literacy: offering workshops and groups on existential themes—identity, agency, meaning, and narrative change—for people navigating mental distress. - Reclaiming language: equipping patients with phenomenological frameworks that give words to previously ignored or pathologized experiences, restoring self-trust and epistemic agency. - Redefining outcomes: evaluating recovery by what matters to the person—drawing directly on frameworks like Amartya Sen and Martha Nussbaum’s Capability Approach.

5. Ditch the Jargon: Ordinary Language and Public Engagement In keeping with the practical goals discussed, participants urged philosophers to be conscious of theoretical and language differences in engaging with professionals, service users and the general public. This is an inherent part of a bridge discipline such as philosophy and psychiatry and also works both ways and for both disciplines. If the discipline of philosophy and psychiatry is to make mental health care better, we need to translate its insights in public debates, i.e. on platforms like this, in newspapers (like Awais is going to for the NYT!), podcasts and wherever relevant issues arise. As Woordbridge and Fulford discussed in relation to **Values-Based Practice**, this also requires

communication skills in translating philosophy to daily practice and experience. Which is also what conceptual competence is about.

What Does This Mean for the Field? There are a number of concrete suggestions here, for different areas. For psychiatry: embedding conceptual competence in psychiatry residency programs and nursing education, and creating regular, institutional room for philosophical rounds and moral deliberation. Also, promote values-inclusive leadership in mental health, ensuring policy and board-level decisions are explicit about the human values they prioritize. Finally, a goal of philosophical empowerment: sharing philosophical concepts and expertise with service users. Of course, the next challenge is to take these ideas out of the conference hall and build them into the daily life of mental health care. Well, we're doing just that: the annual one-day conference for Dutch residents in psychiatry this November 13th is devoted to Philosophy and Psychiatry, see **here** for more information and registration, and next year we will be organizing, together with the Radboud Centre for Social Sciences, **an 8-part course on Philosophy in Psychiatric Practice for mental health professionals**.

So over to you: if you could introduce one idea or tool from philosophy into your local clinic, ward, or mental health service tomorrow, what would it be?