Patient objectification in psychiatry

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Abstract

Psychiatry is characterized by several distinctive features: (1) it sometimes provides treatment against a patient's will or preferences; (2) it intervenes in patients' minds through physico-chemical means, such as psychotropic medication; (3) it treats patients' utterances not as reports of facts but as signs of illness; and (4) it may attribute patients' inappropriate words or actions to mental disorder, thereby exempting them from responsibility ordinarily borne by a moral agent. This paper reexamines the ethical unease inherent in these psychiatric practices through the lens of patient objectification and investigates the conditions under which such objectification may be justified.

Within feminist theory, objectification has been analyzed as a multifaceted phenomenon encompassing at least ten aspects, including instrumentality, denial of autonomy, inertness, fungibility, violability, ownership, denial of subjectivity, reduction to body, reduction to appearance, and silencing. Building on this framework, this paper examines objectification in medicine more generally by distinguishing four domains: decision-making, therapeutic intervention, information gathering, and the psychological defense of medical staff.

Psychiatry likewise involves patient objectification across these domains. However, because the symptoms of mental disorder extend into capacities central to agency—namely beliefs, emotions, and actions—psychiatric objectification stands in especially strong tension with respect for persons. Nevertheless, it cannot be regarded as uniformly impermissible. Mental disorders can impair the capacities that underpin personhood, and psychiatry aims at treating such impairments. Objectification can therefore be justified when it is undertaken for the patient's benefit, supported by sufficient justification, and restricted to the minimum necessary extent.

**Keywords:** anti-psychiatry; disorders of agency; involuntary treatment; objective attitude; personhood

## 1. Introduction

Psychiatry has long been the target of fundamental criticism. In the 1960s, the anti-psychiatry movement articulated a radical critique of psychiatry (Laing 1960; Cooper 1967; T. S. Szasz

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1974). Although the movement itself later lost momentum, what is now commonly called critical psychiatry emerged and continues to question the extent to which psychiatry is continuous with medicine and the natural sciences (Ingleby 1980; Middleton and Moncrieff 2019). More recently, the United Nations Committee on the Rights of Persons with Disabilities (2014), from a disability-rights perspective, has taken a strong stance against coercive treatment and involuntary hospitalization, bringing longstanding ethical controversies in psychiatry back into sharp focus.

One reason this criticism has persisted is that psychiatric practice gives rise to a distinctive form of ethical unease. Despite its firm institutionalization and professional endorsement, psychiatry often appears morally problematic when assessed against ordinary moral intuitions. Coercive treatment in mental health care is a conspicuous example, but the sources of ethical unease are not limited to such cases. In what follows, I examine four recurrent situations in psychiatric practice.

Irene, a patient with an eating disorder, had reached an extremely low body weight and collapsed while outside, after which she was transported to the emergency department. Blood tests revealed critically abnormal electrolyte levels, and the emergency physician informed her that hospitalization was necessary. Irene refused admission, explaining that hospitalization would involve the administration of fluids and nutrition and would therefore result in weight gain. She strongly requested to return home in order to continue her studies. The consulting psychiatrist judged that Irene's decision-making capacity was impaired as a result of her mental disorder and concluded that involuntary hospitalization was necessary to protect her life.

Phillip, a middle-aged man, became concerned about a possible colon tumor after developing constipation. Although medical examinations by an internist found no evidence of a tumor, he remained unreassured. He became increasingly distressed by fears that a serious illness would prevent him from working, exhaust his savings, and leave his family without support. At the recommendation of colleagues, Phillip consulted a psychiatrist, who explained that such excessively negative thoughts about one's health and finances are characteristic of depression and often respond to antidepressant treatment. Phillip was subsequently prescribed a selective serotonin reuptake inhibitor.

Edward, a university student who had previously been outgoing and socially active, began to withdraw from social interactions and stopped attending classes, spending most of his time at home. Concerned by this change, his family brought him to a psychiatric clinic. There, Edward claimed that he was being monitored by the FBI, followed by more than ten spies, and subjected to constant interference. The psychiatrist did not regard these claims as reports of Edward's actual circumstances but as delusional beliefs, and inferred that he had likely developed schizophrenia.

Deborah, a woman with schizophrenia, had generally responded well to pharmacological

treatment and had maintained employment. However, after discontinuing her medication, she experienced a recurrence of auditory hallucinations involving rumors about her. During a subsequent outpatient visit, Deborah shouted at her psychiatrist, accusing him of disclosing confidential information and calling him “the worst kind of person.” The psychiatrist interpreted these remarks as a manifestation of symptom exacerbation and remained calm, responding without resentment despite the unwarranted verbal abuse.

These four cases share a common feature: in each, the psychiatrist fails to treat the patient fully as a person and instead treats the patient, in certain respects, as a thing. Treating human beings as if they were things is commonly referred to as *objectification* (Papadaki 2007). The origins of the concept of objectification can be traced to Kant, who articulated the ideal of persons as autonomous, rational agents capable of self-legislation. According to Kant, to respect a human being as a person is to treat that person not merely as a means, but always also as an end (Kant 2017). On this view, to treat another human being merely as a means is to treat that person as a thing. Kant paid particular attention to sexual relations, in which another’s body is used as a means of pleasure, and argued that this practice stands in tension with the requirement to respect persons as ends in themselves (Kant 1963).

The concept of objectification was further developed within feminist thought to analyze the disadvantaged conditions faced by women. MacKinnon (1987) and Dworkin (1974) defined pornography as forms of representation that depict women as objects to be bought, restrained, and harmed, while presenting such treatment as essential to womanhood. They criticized pornography on the grounds that it promotes the sexual objectification of women.

Nussbaum (1995) subsequently offered a more general analysis of objectification and identified at least seven distinct aspects of the phenomenon. She further argued that objectification, typically regarded as morally negative, can under certain conditions have a positive significance. Building on Nussbaum’s account, Langton (2009) added three further aspects to the analysis of objectification.

The objectification of human beings stands in opposition to treating them as full persons. In particular, the accounts developed by Nussbaum and Langton provide a conceptual framework extending beyond the feminist context of sexual objectification and enabling a fine-grained analysis of the ways in which people may fail to be treated as full persons. In this paper, I analyze psychiatry through the lens of objectification.

The central claim is that the persistent ethical unease surrounding psychiatry stems from the fact that psychiatric practice sometimes treats patients, in certain respects, as objects. At the same time,

a closer examination reveals that, under certain conditions, objectification may be unavoidable in psychiatric practice. The concept of objectification thus functions as a powerful analytical tool for capturing the complex and irreducibly messy reality of human life—one that resists neat adjudication in purely binary terms of right and wrong.

The structure of the paper is as follows. Section 2 outlines the seven aspects of objectification proposed by Nussbaum, together with the three additional aspects introduced by Langton. Section 3 examines objectification in medicine more generally, distinguishing four contexts: decision-making, therapeutic intervention, information-gathering, and psychological defense. Section 4 argues that psychiatry, as a practice concerned with disorders of the mind, gives rise to a particularly acute tension with the requirement to respect persons. Finally, Section 5 discusses the conditions under which objectification in psychiatric practice may be justified.

## 2. Ten aspects of objectification

Nussbaum (1995) examined feminist critiques of pornography and argued that objectification involves seven distinct aspects:

1. **Instrumentality**: treating a person as a tool for another's purposes.
2. **Denial of autonomy**: treating a person as lacking autonomy or the capacity for self-determination.
3. **Inertness**: treating a person as lacking agency or activity.
4. **Fungibility**: treating a person as interchangeable with others.
5. **Violability**: treating a person as lacking boundary integrity—as something that may be invaded, broken, or disassembled.
6. **Ownership**: treating a person as something that can be owned by another, and thus bought or sold.
7. **Denial of subjectivity:** treating a person as if they lack experiences or feelings, or as if their subjective experiences do not matter.

These seven aspects are logically independent: the presence of some does not entail the presence of others. Ordinary tools such as pens or hammers satisfy all seven conditions. By contrast, a slave is a human being who is owned and used instrumentally, but is useful precisely because the slave is active; inertness therefore does not apply. Similarly, a wife treated as a trophy displaying a man's social status may be regarded as inert and as lacking autonomy and subjectivity, yet not necessarily as fungible or violable. Nussbaum argues that among these seven aspects, the denial of autonomy and the treatment of a person as an instrument constitute the core elements of objectification.

Building on Nussbaum's analysis, Langton (2009) adds three further aspects of objectification.

8. **Reduction to body**: a person is treated as identical with their body, or with a part of their body. In social psychology, this aspect has often been operationalized by reference to images that exclude a model's face and instead present close-up shots of breasts, torsos, or thighs (Loughnan et al. 2010).

9. **Reduction to appearance**: a person is treated primarily in terms of how they look or appear to the senses. Beauty contests are frequently criticized as forms of women's objectification in virtue of this aspect. This aspect also underlies the notion of self-objectification—the tendency to become excessively preoccupied with one's own appearance on the assumption that one's value is determined by how one looks—which has been extensively discussed in relation to mental health (Fredrickson and Roberts 1997).

10. **Silencing**: a person is treated as silent or as lacking the capacity to speak. Silencing can occur either at the level of utterance or at the level of speech act, referred to respectively as locutionary and illocutionary silencing (Langton 1993; Langton 2009). Locutionary silencing refers to situations in which a person is prevented from speaking at all, including cases of physical restraint. It also includes what Dotson (2011) calls testimonial smothering, in which individuals in socially disadvantaged positions refrain from speaking, or limit their speech to what is convenient for their interlocutors, when their testimony is unlikely to be received safely and without misunderstanding. By contrast, illocutionary silencing—also known as illocutionary disablement—occurs when a person is able to utter words, yet the hearer fails to recognize those words as performing the intended speech act, with the result that the speech act misfires.

Nussbaum (1995) argues that not all forms of objectification are morally objectionable, and that some may be permissible or even desirable. For example, resting one's head on a lover's stomach while lying together in bed can be justified—and may even represent a desirable form of objectification reflecting intimacy—provided that the lover's consent can be presumed, that no significant discomfort is caused, and that a background understanding is in place in which the lover is recognized as more than a mere pillow, that is, as a person.

Nussbaum illustrates this point through an analysis of *Lady Chatterley's Lover*, drawing attention to scenes in which Constance and Mellors, during sexual intercourse, mutually identify one another with bodily parts such as sexual organs. She argues that such mutual objectification, understood as a reciprocal surrender of autonomy, can constitute a peak experience of sexual ecstasy.

Nussbaum's achievement lies in her careful articulation of the concept of objectification and in showing that the objectification of human beings cannot be captured by a simple good–bad dichotomy. In the following sections, I apply the analyses of objectification developed by Nussbaum

and Langton to medicine in general and to psychiatry in particular.

## 3. Patient objectification in medicine in general

Psychiatry is a branch of medicine, and the forms of objectification specific to psychiatry can be understood as extensions of those found in medicine more broadly. It is therefore helpful to examine objectification in medicine in general before turning to psychiatry.

From sociological perspectives, a range of critical arguments have been advanced against contemporary medicine, most notably critiques of *medicalization* (Illich 1975; Conrad and Schneider 1992). Medicalization refers to the process by which phenomena not previously regarded as medical problems come to be treated as such. Although these critiques do not explicitly invoke the concept of objectification, they presuppose that medical practices—by treating the human body as an object of scientific analysis and physico-chemical intervention—inevitably involve objectification, and they focus instead on the ethical and sociopolitical consequences of the expansion of such practices into everyday life.

Against this background, reproductive medicine—where concerns about medicalization intersect with feminist critiques—became an exceptional domain in which objectification itself was explicitly foregrounded. Advances in reproductive medicine in the 1980s, combined with appeals to fetal rights, prompted critiques that such practices treat women as mere "reproducers," subordinating them to fetal interests and thereby objectifying women (Roach 1989; Terry 1989).

Recent philosophy of medicine has increasingly recognized that medical practice inevitably involves some degree of patient objectification (Timmermans and Almeling 2009; Schwartz 2019; Varga 2024). These authors argue, however, that contemporary medicine's emphasis on efficiency and scientific objectivity risks marginalizing patients' agency and subjective experience. In particular, Schwartz (2019), drawing on Nussbaum's and Langton's analyses, develops a systematic account of *moral respect* by contrasting it with objectification.

Research on *dehumanization* in medicine also offers important resources for analyzing objectification in healthcare (Capozza et al., 2016; Haque & Waytz, 2012; Leyens, 2014; Trifiletti et al., 2014; Vaes & Muratore, 2013). These two concepts are closely related. LeMoncheck (1985), for example, argues that the central harm of sexual objectification lies in dehumanization, understood as the failure to regard the other as a moral equal.

By contrast, Li et al. (2014) propose a systematic classification of dehumanization, distinguishing four types on the basis of whether an individual is denied *human uniqueness*—that is, characteristically human capacities such as rational and logical judgment and refined emotions—or *human nature*—that is, more fundamental human qualities such as emotional warmth and empathy that humans might share with other animals. Within this framework, objectification is positioned as the most severe form of dehumanization, insofar as it involves the denial of both human uniqueness

and human nature.

As the foregoing discussion shows, objectification in medicine has been examined from multiple perspectives, including critiques of medicalization, feminism, philosophy of medicine, and empirical research on dehumanization. In what follows, drawing on this body of work, I analyze how objectification arises in medicine by distinguishing four domains: decision-making, therapeutic intervention, information gathering, and psychological defense.

### 3.1. Objectification in decision-making

In contemporary medical practice, informed consent is widely regarded as a prerequisite for medical intervention (Faden and Beauchamp 1986). In clinical settings, however, this requirement is often reduced to a procedural formality.

Because physicians possess expert medical knowledge while patients are medical laypersons, treatment decisions are sometimes made unilaterally by physicians, leaving patients with little option other than to accept or reject an already determined plan. In this context, consent forms for invasive procedures often function less as tools for shared decision-making than as *legal disclaimers* (Bito 2023). By listing a wide range of possible complications and obtaining the patient's signature, physicians can later claim that the risks were explained and accepted, thereby shifting responsibility onto the patient.

Moreover, the authority gradient between physicians and patients can make it difficult for patients to express their views openly. Interview-based research shows that patients often withhold their opinions in order to avoid being perceived as "difficult" patients (Frosch et al. 2012). This pattern suggests that testimonial smothering can occur in medical decision-making contexts.

These phenomena observed in medical decision-making contexts correspond, among the aspects of objectification proposed by Nussbaum and Langton, to the *denial of autonomy* and to *silencing*, and can therefore be understood as instances of patient objectification.

### 3.2. Objectification in therapeutic intervention

Therapeutic interventions in medicine exert direct physical or chemical effects on patients' bodies by crossing the boundary of the skin, a feature that distinguishes them from ordinary interpersonal interactions. During surgery, patients are anesthetized and immobilized, and their bodies are physically incised. Even in the case of medication—an action initially performed by the patient—the drug subsequently acts within the body independently of the patient's consciousness or will, rendering the patient a passive bystander to the process. In these respects, therapeutic intervention involves several dimensions of objectification identified by Nussbaum and Langton, including *violability*, *inertness*, and *reduction to body*.

Haque and Waytz (2012) argue that, in performing medical procedures or making clinical

judgments, clinicians must attend to patients not as whole persons but as assemblages of interacting organs. Excessive attentiveness to the patient as a person during a procedure can be distracting and may increase the risk of error. In surgery, for example, patients' bodies—often including the face—are draped outside the operative field not only for sterility but also to facilitate clinical focus on the targeted bodily area.

Moreover, medical treatment is typically applied independently of who the patient is, so long as their biological characteristics are the same. Regardless of social status or moral identity, the same intervention is judged appropriate when diagnosis and physical conditions coincide. Agledahl et al. (2010), based on recordings of physician–patient interactions, describe how clinicians bracket patients' existential concerns and extract only clinically relevant elements, reconstituting them as medical problems—a process termed *clinical essentialising*. Although each patient has a unique life narrative, patients are treated as individual "cases" in medical practice. This corresponds to the aspect of fungibility in objectification.

Upon entering the medical world, patients may feel alienated as their social identities are stripped away and they are placed in an impersonal environment in which everyone wears the same hospital gown. Yet fungibility is also a cornerstone of modern medicine, since the accumulation of medical knowledge depends on the assumption that similar treatments are effective for biologically similar patients. Patients are therefore ambivalent about their fungibility: they wish to be treated as unique individuals, yet they also recognize that it would be troubling if their illness were entirely singular. For their conditions to become medically intelligible, patients must be classified within existing disease categories.

Objectification arising from therapeutic intervention is, to some extent, unavoidable. As Schwartz (2019) argues, medicine is inherently objectifying insofar as it treats the body as a physiological object and aims at the production of generalized knowledge. Timmermans and Almeling (2009) similarly note that contemporary medicine depends on mass-produced pharmaceuticals and devices, standardized treatment protocols, and bureaucratized healthcare institutions. To benefit from modern medical care, they argue, a certain degree of objectification, commodification, and standardization must therefore be accepted.

### 3.3. Objectification in information gathering

In the course of analyzing the concept of knowledge through linguistic exchanges among people, Craig (1990) introduced a distinction between *informants* and *sources of information*. We can obtain information from natural objects. For example, we may come to know that it is raining outside by hearing the sound of rain. In this case, the sound of rain functions as a source of information about the weather. By contrast, when we ask a family member who has just returned home, "What was the weather like outside?" and are told, "It was raining," that family member is functioning as an informant.

To regard someone as an informant is to treat them as a member of an epistemic community that shares the aim of truth-seeking and the accumulation of knowledge.

Natural objects can function only as sources of information, whereas human beings can function both as informants as well as sources of information. For example, if a person's stomach growls, we may come to know that the person is hungry; in this case, the person is functioning as a source of information. By contrast, when a person conveys the same information by saying, "I am hungry," they are functioning as an informant who communicates that information linguistically.

Fricker (2007) connects this distinction to Kant's maxim that persons should be treated not merely as means but also as ends. Treating someone as a source of information amounts to treating them as a means, whereas treating them as an informant involves recognizing them as an end. On this basis, Fricker argues that reducing a person to a mere source of information constitutes a form of objectification, which she terms *epistemic objectification.*[2]

Sakakibara (2023) points out that epistemic objectification is widespread in medical settings. In contemporary medicine, alongside history taking and clinical interviews with patients, the collection of objective information through physical examinations, blood tests, and other diagnostic procedures is highly valued. In this context, patients function as informants insofar as they respond to medical interviews, whereas they function as sources of information insofar as they undergo physical examinations and diagnostic tests. In current medical practice, however, increasing emphasis on objective data means that patients are often treated primarily as sources of information, with their role as informants correspondingly marginalized.

Baron (1985), in an article subtitled *I can't hear you while I'm listening*, vividly illustrates the tension between treating patients as sources of information and treating them as informants. The remark was made while the physician was auscultating the patient's chest, capturing how attention to diagnostic signals can displace attention to patients' verbal reports. More generally, the development of diagnostic technologies tends to sideline patients' subjective complaints. In the context of information gathering, objectification thus involves the *denial of subjectivity*, *reduction to body*, and *instrumentality*.

Peptic ulcer disease was once diagnosed primarily on the basis of patients' reports of epigastric pain (Aronowitz 2004). With the advent of X-ray imaging and endoscopy, diagnosis increasingly required objective confirmation of mucosal lesions. However, it then became clear that

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[2] Fricker (2007) introduced the notion of *epistemic injustice* to describe cases in which a speaker's status as a rational epistemic subject is unjustly undermined on the basis of prejudice attached to particular social identities, such as being a woman or being Black. She further argues that epistemic objectification lies at the core of the harms of epistemic injustice. This latter claim, however, has been contested; see Hawley (2017), Pohlhaus (2014), and Sakakibara (2023) for detailed discussion.

subjective complaints and objective findings did not coincide: many patients had ulcers without pain, while others continued to report pain after ulcers had healed (Peterson et al. 1977). As a result, an overemphasis on objective findings can result in patients being left behind when their lived experiences fail to align with diagnostic criteria.

Prioritizing objective test results can be justified in the treatment of acute conditions. In diagnosing appendicitis, for example, physical examination and imaging findings are often more decisive than patients' subjective complaints. By contrast, in the management of chronic illnesses—which make up the majority of diseases in advanced societies—patients' subjective symptoms, their trajectories over time, and their life goals play a central role in clinical decision-making (Sakakibara, 2023). In such contexts, continued reliance on objective findings at the expense of patients' accounts as informants constitutes a problematic form of objectification.

### 3.4. Objectification as psychological defense

Vaes & Muratore (2013) presented a fictional case vignette of a patient in their forties with terminal cancer to 78 healthcare professionals working in hospices and general hospitals for cancer patients, and asked them to indicate how well 28 different emotions applied to the patient. Half of these emotions were uniquely human emotions, such as pessimism, regret, and shame, while the other half consisted of basic emotions shared by both humans and animals, such as anger, irritation, and fear. The study found that among hospice staff—who regularly care for patients nearing the end of life—lower attribution of uniquely human emotions was associated with lower levels of burnout, including professional inefficacy, disillusionment, and exhaustion.

Similarly, Trifiletti et al. (2014) examined 109 nurses across diverse healthcare settings and investigated how strongly they attributed to patients uniquely human characteristics, such as rationality and moral capacity, as opposed to more basic, non-uniquely human traits including instinct and impulse. The nurses also reported their levels of emotional commitment to their organization and patients, as well as their experienced stress. They found that among nurses with high emotional commitment to their organization and patients, greater attribution of uniquely human characteristics was associated with higher levels of stress.

What these findings suggest is that healthcare professionals may, as a coping strategy, come to view patients in animal-like terms, as falling short of full humanity. Those engaged in patient care acknowledge that patients have animal needs—such as eating and defecation—as well as basic sensory capacities, including the experience of pain. However, they tend to neglect the fact that each patient is a devastated individual with a unique personal history, since fully acknowledging this would be too psychologically overwhelming. This defensive distancing lies on a continuum with objectification, insofar as it involves attenuating recognition of distinctly human forms of subjectivity and autonomy.

Agledahl et al. (2011), based on an analysis of videotaped physician–patient interactions,

found that physicians often adopt a courteous demeanor toward patients while nevertheless avoiding engagement with patients' existential concerns and confining their responses to mechanistic explanations of disease. They illustrate this with the following example. When a 60-year-old man who had been living with metastatic cancer for several years and had undergone one surgery and seven rounds of chemotherapy reported that his appetite was declining, a physician responded by saying: "Yes, I can tell from your blood results that you… you are in what we call a catabolic state, which means that you break down a little more than you build up." At first glance, such responses may appear to reflect a lack of empathy or sensitivity to patients' existential suffering. However, an alternative interpretation is that physicians may be intellectualizing tragic clinical situations by focusing on biomedical explanations in order to protect themselves from being overwhelmed by patients' existential anxiety in the face of impending death. In this sense, *reduction to body* and *denial of subjectivity* can function as psychological defense mechanisms in medical practice.

### 3.5. Unavoidability of objectification in medicine

There is longstanding disagreement over whether objectification is necessarily morally wrong. Dworkin (1974) and MacKinnon (1987), in their critiques of pornography, regarded sexual objectification as inherently objectionable. By contrast, Nussbaum (1995) argued that objectification can be morally permissible, and even valuable, provided that the other person is basically recognized and respected as a person.

The view that objectification is inherently morally wrong is often grounded in the idea that it involves an epistemic error—namely, treating as a mere thing something that is not in fact a thing (Nussbaum 1995). When we turn to objectification in medicine, however, this assumption becomes less straightforward. Human beings have a dual nature: they exist both as persons and as living things. As living things, they are subject to biological constraints—such as birth, reproduction, illness, aging, and death—that cannot be derived from the concept of personhood alone. Objectification occurs frequently in medicine precisely because medical practice is oriented toward these biological constraints rather than toward the personal dimension of human beings. For this reason, objectifying patients in order to engage with their biological aspects does not involve an epistemic error and is not inherently morally wrong.[3]

Cussins (1996), drawing on interviews with women attending infertility clinics, shows that patients may actively embrace forms of self-objectification. In infertility treatment, women are

[3] Similarly, sexual objectification may not be inherently wrong, insofar as sexuality is an activity in which the biological aspects of human beings—particularly those not uniquely human but shared with animals more generally—play a central role. Cahill (2011) analyzes sexual objectification through the concept of embodied intersubjectivity.

routinely treated, through procedures such as pelvic examinations, ultrasonography, and hormone injections, as collections of bodily organs that can be medically observed and manipulated. While this clearly constitutes a form of objectification, the women involved actively adopt medical explanatory models of infertility and internalize bodily disciplines—such as monitoring basal body temperature and adhering to regimented injection schedules.

Crucially, this form of objectification is connected to the goals the patients seek to achieve, namely pregnancy and childbirth. Cussins argues that insofar as treatment focused on organs such as the ovaries and uterus remains meaningfully connected to patients' lives and reproductive goals, it exemplifies what she calls a *synecdochal relation*, in which bodily parts maintain reference to the person as a whole. In this respect, infertility treatment differs from problematic forms of objectification that reduce persons to mere bodily parts.

Synecdochal relations arise not only in infertility treatment but also in many other areas of medicine. Successful medical care involves an ongoing movement between the patient's lived body (*Leib*) and corporeal body (*Körper*), and between illness as experienced and disease as medically diagnosed (Fernandez 2020). Patients typically seek care when disruptions in everyday bodily experience—such as pain, fatigue, or impaired movement—give rise to concern. Clinicians then focus on identifying and treating abnormalities in specific organs or tissues responsible for these experiences.

Imagine a patient who presents with fatigue and a sore throat. They are found to have a bacterial infection of the pharynx and are treated with antibiotics. The pharyngeal infection resolves, and the patient regains their sense of well-being. In such cases, a synecdochal relation between organ-level intervention and the person as a whole is preserved so long as the treatment is successful, even if the course of treatment includes a stage in which attention is focused on a specific organ and medical intervention is directed at it.

Centering medical attention on a specific bodily part becomes a harmful form of objectification when physicians persist in such focus after the synecdochal relation between bodily part and person has broken down.

First, a synecdochal relation may break down when treatment is unsuccessful. Cussins (1996) found that patients whose infertility treatment failed later reflected on their experiences of objectification in negative terms.

Second, the synecdochal relation may be undermined when a disease does not give rise to a corresponding experience of illness. Examples include treating asymptomatic hyperglycemia diagnosed as diabetes or surgically removing an early-stage cancer discovered incidentally. Although such interventions aim at protecting patients' long-term health, patients may experience alienation if this rationale is not adequately communicated.

Third, the synecdochal relation may be compromised when patients experience subjectively distressing symptoms despite the absence of objectively identifiable abnormalities. In conditions such

as chronic fatigue syndrome and fibromyalgia—where pathophysiology remains poorly understood and diagnosis relies largely on patients' reports—physicians may regard patients' complaints with suspicion, sometimes assuming fabrication or exaggeration (Blease et al. 2017; Buchman et al. 2017). Yet, as the adage "absence of evidence is not evidence of absence" reminds us, equating the absence of objective findings with the dismissal of patients' subjective experiences constitutes a morally problematic form of objectification.

## 4. Disorder of agency and objectification in psychiatry

### 4.1. Szasz's radical criticism of psychiatry

Szasz advanced a radical criticism of psychiatry by denying that mental illness exists as a genuine category (e.g., T. Szasz, 1991; T. S. Szasz, 1974). While he acknowledged the existence of mental suffering and behavioral deviance, he rejected the view that such phenomena should be conceptualized as mental "illnesses" or "diseases." For Szasz, the concept of disease properly applies only to conditions involving observable bodily lesions or pathological changes. On this view, so-called mental illnesses are either bodily diseases misclassified as mental, or metaphorical extensions of disease concepts used to regulate socially deviant behavior. Psychiatry, he therefore argued, commits a category mistake by applying the predicate "disease," which belongs to the bodily domain, to the mind (Ronald W. Pies 2019).

However, while the concept of a person as a fully rational and autonomous agent represents an idealized model, actual mental capacity is grounded in the biological foundations of the human organism, particularly the nervous system. It is therefore unsurprising that the biological underpinnings enabling personhood may be impaired, or that individuals may fall short of such ideals (Daly 2019). Just as the body is born, grows, ages, and eventually dies, so too the mind comes into being, develops, deteriorates, and may have its capacities compromised in various ways.

If one holds that the body can be ill but the mind cannot, then the very concept of mental illness would indeed amount to an erroneous objectification of the mind. Such a view, however, presupposes a sharp mind–body dualism that treats the mind as an immaterial entity independent of the body. Once this dualism is rejected and the mind is acknowledged to have material underpinnings, it can no longer be maintained that employing the concept of mental illness—and thus objectifying aspects of mental life—is always mistaken.

Nevertheless, objectification in psychiatry involves a stronger ethical tension than objectification in medicine more generally, because the symptoms of mental disorders extend into the domain of mental attitudes such as beliefs and emotions. Put differently, psychiatry is concerned not only with *agents with disorders*, but also with *disorders of agency.*[4]In this section, I examine how these

[4] The notion of "disorders of agency" is drawn from Pickard (2013). Although she applies this

distinctive features of psychiatry shape objectification by distinguishing four domains corresponding to those identified in medicine more generally.

4.2. Involuntary treatment

In medicine, treatment decisions for unconscious patients are often made by surrogates or medical professionals acting on the patient's behalf. Psychiatry differs in that interventions may be imposed even when patients are conscious and able to articulate their wishes. As illustrated in the introduction, Irene, who has an eating disorder, was hospitalized against her will on the grounds that her decision-making capacity was impaired by mental illness. Such practices—commonly referred to as involuntary hospitalization or involuntary treatment—are legally authorized in many jurisdictions under mental health legislation.

Even in medicine more generally, denials of autonomy and forms of silencing can arise when patients are guided by paternalistic medical recommendations or refrain from expressing their wishes. By contrast, the denial of autonomy and silencing that can occur in psychiatry are more pronounced, insofar as they involve the negation of patients' expressed will and preferences despite their having been clearly articulated. In Langton's (1993) terms, this amounts not only to locutionary silencing but also to illocutionary silencing, insofar as patients' speech fails to count as a refusal within the relevant normative framework.

Involuntary treatment remains highly contested. The United Nations Committee on the Rights of Persons with Disabilities (2014), for example, argues that involuntary hospitalization should be prohibited without exception. Distinguishing *legal capacity* from *mental capacity*, the Committee maintains that legal capacity is never diminished, and on this basis rejects all involuntary interventions. This position closely parallels Thomas Szasz's claim that by sharply distinguishing between mind and body, the mind—as a subject of decision-making—cannot be diseased.

The Committee's stance diverges sharply from those of other UN treaty bodies and has raised serious concerns among psychiatric and legal experts in many countries (Freeman et al. 2015; Szmukler 2019). Moreover, the claim that the present will and preferences of persons with disabilities should always be given absolute priority sits uneasily with the spirit of the Convention on the Rights of Persons with Disabilities itself, which affirms rights to health and to life. When hallucinations, delusions, or thought disorders associated with mental illness impair a person's mental capacity, withholding treatments of established effectiveness solely on the basis of that person's momentary will and preferences risks undermining the patient's own health and, in some cases, endangering the lives of the patient and others.

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concept primarily to personality disorders and substance use disorders, it appears that it can be extended to mental disorders more broadly.

4.3. Physico-chemical interventions on the human mind

Phillip, introduced as an example in the introduction, was advised to take antidepressant medication to address his negative thoughts concerning illness and property. Even in medicine more generally, therapeutic interventions such as pharmacological and surgical procedures bring about changes within the body by crossing the boundary of the skin. What is distinctive about psychiatry, however, is that it directly intervenes in the nervous system, through psychotropic drugs as well as neuromodulatory techniques such as electroconvulsive therapy and transcranial magnetic stimulation.

Human physiological responses are typically endowed with a form of purposiveness oriented toward the preservation of life. Fever associated with infection, for example, inhibits the proliferation of pathogens, and coughing expels foreign substances from the airways. In this sense, the use of cough medication involves temporarily suppressing the very function that coughing is meant to serve. Yet, in the treatment of bodily disease, such suppression does not ordinarily imply a denial of the patient's self or agency.

By contrast, Phillip's suspicion that he may have a tumor in his colon and his anxiety about becoming destitute would ordinarily be understood as expressing his commitments and concerns as a person. In this respect, they differ decisively from physiological responses. Construing such beliefs or anxieties as symptoms of mental disorder, and intervening in them by physico-chemical means, therefore implies—at least temporarily—bracketing the meanings and reasons the patient assigns to those mental attitudes.

Therapeutic interventions in medicine more generally involve aspects of objectification such as *violability*, *inertness*, and *reduction to body*. In psychiatric treatment, however, the target of intervention includes mental attitudes that lie at the core of the patient's self-understanding and personal identity. Psychiatric interventions may therefore be experienced as a "personal attack," insofar as they act directly upon beliefs and emotions the patient takes to be constitutive of who they are.

Human mental attitudes are characterized by intentionality: they are always *about* something beyond the mind itself, and it is this intentional content that distinguishes one mental attitude from another (Crane 2001). Phillip's anxiety about losing his property and becoming destitute, for example, differs both from Jessica's anxiety about her daughter's safety and from Phillip's anxiety that he may have cancer. In physico-chemical treatments for mental disorders, however, clinical decisions are typically made not in light of such differences in intentional content, but primarily on the type and intensity of emotions such as anxiety or depression.

In medicine more generally, patients—despite their diverse social backgrounds and relationships—are categorized and treated on the basis of biological characteristics, and are thus rendered fungible in this limited sense. In psychiatric practice, physico-chemical treatments extend

this fungibility further by abstracting away from differences among mental states that are, in principle, individuated by their intentional contents. Patients may therefore experience their individuality as being effaced in a deeper sense. At the same time, this deeper fungibility is not always experienced negatively: when the situations to which their mental attitudes are responsive cannot be directly addressed, treatments that operate independently of intentional content may themselves be a source of relief.

### 4.4. Objectification of utterances

In the previous section, I argued that patients function both as informants and as sources of information, and that in contemporary medicine objective test results tend to be prioritized, often at the expense of patients' own words. Psychiatry differs from other medical fields in this respect, since imaging techniques and laboratory tests for psychiatric disorders remain underdeveloped. Even today, much of the information used to establish diagnoses and determine treatment plans relies on testimony from patients themselves and from those around them. In this sense, psychiatry may appear to be a medical specialty in which objectification in information gathering is less pronounced.

However, even in psychiatry, patients are not treated solely as informants. Physical examinations such as auscultation and palpation are rare; instead, clinicians rely on mental status examinations based on features such as appearance, behavior, and manner of responding. A patient's level of grooming, for example, is taken to indicate their capacity for self-care, while vocal volume or response latency may be interpreted as signs of vitality. Facial expressions and tone of voice likewise function as clues to the patient's emotional state. In these contexts, patients are treated both as informants who report their experiences and as sources of information to be observed.

Psychiatry also has a distinctive feature not found in other medical fields: at times, patients' utterances themselves are construed as manifestations of mental disorder. Edward, mentioned in the introduction, claimed that he was being monitored by the FBI. The psychiatrist judged these statements to be delusional and inferred that Edward might be developing schizophrenia. Here, the patient's utterances were not treated as testimony whose content was to be assessed for credibility, but rather as diagnostically relevant signs, where the fact that the utterance was made mattered more than what was said.

Sakakibara (2023) refers to this practice—where psychiatrists detach patients' utterances from their semantic content and treat them as materials for diagnostic and treatment decisions—as the *objectification of utterance*. In psychiatry, features such as the frequency of delusional utterances, the persistence with which claims are asserted, and the degree of elaboration in reported content are used not only for diagnosis but also for assessing treatment responsiveness. For example, if, following the administration of antipsychotic medication, Edward's spontaneous reports of being "monitored by the FBI" decrease in frequency, this may be interpreted as a reliable basis for assessing pharmacological

effectiveness.

The objectification of utterance is not limited to schizophrenia. An elderly patient's claim that "my cosmetics were stolen at home" may be taken as a sign of short-term memory impairment associated with dementia. Inappropriately cheerful remarks that do not fit the patient's circumstances may be interpreted as indicators of a manic state. Persistent worries about having a serious illness, accompanied by repeated demands for medical examinations, may raise suspicion of illness anxiety disorder. Likewise, the statement "I am not worth living" is commonly interpreted as expressing the negative cognitions associated with depression.

Under certain conditions, such attitudes on the part of psychiatrists are unavoidable and can be justified in the treatment of mental disorders. Patients may lack sufficient *insight*—that is, the capacity to understand their experiences as reflecting something that is wrong with themselves and to report them appropriately. In such circumstances, attending not to the content of an utterance but to the fact that it is made can function as a crucial behavioral clue for diagnosis and treatment planning, and may ultimately alleviate suffering and open up possibilities for effective intervention.

### 4.5. Objective attitude

Gray et al. (2007) propose that the human mind is characterized by two dimensions: experience and agency. Human experience includes not only basic sensations and emotions shared with non-human animals, such as pain, excitement, and fear, but also complex emotions distinctive to humans, such as gratitude, regret, respect, and jealousy. Although this framework is a psychological model describing how people perceive others, in philosophical and ethical contexts the capacity to be a subject of rich experience that grounds moral respect is referred to as *moral patiency.*

Human beings, moreover, are not merely entities whose bodies react to stimuli; they are agents who act for reasons and purposes. The capacity to choose one's actions on the basis of reasons and to bear responsibility for their consequences is known as *moral agency*. Ordinarily, human beings are treated as persons who possess both moral patiency and moral agency.

In medicine more generally, healthcare professionals may at times objectify patients as a form of psychological defense in order to avoid confronting their suffering. In terms of the foregoing distinction, such objectification involves a partial denial of patients' subjective experience and, accordingly, of their moral patiency.

By contrast, in psychiatry, objectification as a form of psychological defense may take the form of temporarily bracketing a patient's moral agency. Strawson (1974) famously argued that *reactive attitudes*—such as resentment in response to ill will, or gratitude in response to goodwill—constitute a basic mode of human interpersonal relations. When the other is a young child or someone suffering from a severe mental disorder, however, one may refrain from holding them morally responsible and suspend such reactive attitudes, much as it would be pointless to direct anger at a

storm for the damage it causes. Strawson referred to this stance as the *objective attitude*.

Deborah, a patient with schizophrenia mentioned in the introduction, experienced a relapse of auditory hallucinations and directed abusive remarks at her psychiatrist, saying, "You disclosed information I had kept secret to others. You are the worst kind of person." If this utterance were taken as a genuine claim, the natural reactive attitude would be indignation at the unfounded accusation, accompanied by protest or criticism in return. An experienced psychiatrist, however, would regard such hostile remarks as part of the patient's symptoms, compose themselves, and respond calmly—for example, by saying, "I'm a doctor, so I wouldn't disclose your information to others"—while reconsidering the treatment plan in light of the patient's deteriorating condition.

Taking the objective attitude toward a patient can be understood as a form of objectification that temporarily brackets the patient's moral agency and exempts them from moral responsibility, which ordinarily stands in a reciprocal relation to autonomy. In clinical contexts involving severe mental disorders, adopting this attitude is often indispensable. Natural reactive attitudes toward patients with disorders of agency frequently involve emotions such as anger or contempt, and expressing these directly risks harming the patient and undermining the therapeutic relationship.

By understanding a patient's words and actions not as expressions of ill will or character flaws, but as manifestations of illness, clinicians can maintain the therapeutic relationship without harboring negative emotions toward the patient. In this sense, adopting the objective attitude functions as a form of psychological defense that protects not only patients but also clinicians.

## 5. Justifiability of objectification in psychiatry

Because objectification involves an act or attitude that at least partially denies one's personhood, the question of when and how it can be justified has been a matter of concern since the concept was first articulated. Kant (1963), for example, held that sexual intercourse involves using another person's body as a means for the satisfaction of one's sexual desire. At the same time, he argued that sexual intercourse is indispensable for humankind and can be justified within a monogamous marital relationship, insofar as it establishes a reciprocal relation in which each spouse mutually makes use of the other's body.

By contrast, the relationship between healthcare professionals and patients is fundamentally asymmetrical. Objectification in medicine consists in healthcare professionals unilaterally objectifying patients and not vice versa. For this reason, objectification in medical practice cannot be justified by appeal to reciprocity. Instead, a central ground for its justification is *informed consent* (Faden and Beauchamp 1986). Causing bodily injury with a knife is ordinarily illegal; a surgical incision is justified precisely because it is performed on the basis of the patient's consent.

When seeking consent for diagnostic tests or therapeutic interventions that treat the body as an object, it is crucial that patients understand what Cussins (1996) describes as a *synecdochal relation*:

the potential or actual connection between subpersonal abnormalities in the bodily organs and the patient's personal experiences and life goals. This is why healthcare professionals must provide sufficiently clear explanations of the significance and implications of medical examinations and procedures.

Capozza et al. (2016) argue that, given human cognitive limitations, it is difficult for healthcare professionals to simultaneously treat a patient as a full person and focus on parts of their body in order to address functional or mechanical problems. When an orthopedic surgeon reduces a dislocated shoulder, for example, they must concentrate on the spatial relations of bones and joints, which requires temporarily setting aside the perspective of the patient as a person. Capozza therefore suggests that clinicians should warn patients in advance—so that they are not surprised by being treated in a thing-like manner—by saying something like, "During the procedure, it will be difficult for me to attend to your concerns for a while."

Objectification in psychiatry, like objectification in medicine more generally, may in some cases be justified through prior explanation and the patient's consent. However, forms of objectification in psychiatry that involve involuntary treatment or the objectification of utterance cannot be justified solely within the framework of informed consent. Even if a psychiatrist were to explain in advance to a patient with schizophrenia who has delusions, "From now on, I will evaluate your statements not as reports of facts but as part of your symptoms," it is inconceivable that the patient could meaningfully consent to such an evaluative stance.

Forms of objectification in psychiatry that cannot be justified through informed consent must therefore be justified instead on the basis of the principle of *beneficence* (Beauchamp and Childress 2006). Sakakibara (2023) argues that the objectification of utterance in psychiatry is permissible provided that it is (1) undertaken for the patient's benefit, (2) grounded in sufficient justification, and (3) limited to the minimum necessary extent. This principle can plausibly be extended to justify objectification in psychiatry more generally. In what follows, I examine each of these conditions in greater detail.

First, for objectification in psychiatry to be justified, it must be undertaken for the patient's benefit. Involuntary hospitalization aims to prevent patients with severe mental disorders from harming themselves or others. Pharmacological treatment with psychotropic medication is administered to promote symptom remission and improve well-being. The objectification of utterance is employed to obtain diagnostically relevant information and to assess the patient's condition. Likewise, adopting the objective attitude helps clinicians avoid harming patients in the course of treatment.

Second, the requirement that objectification be grounded in sufficient justification demands evidence beyond the patient's mental states or utterances that are the immediate targets of objectification. For instance, judging the statement "I am monitored by the FBI" to be delusional

requires evidence other than the statement itself. Such evidence may include the patient's inability to articulate adequate grounds for the belief, the presence of other psychiatric symptoms (e.g., thought disorder or auditory hallucinations), or collateral information indicating a decline in functioning. This requirement functions as an epistemic constraint that guards against the arbitrary expansion of objectification in psychiatry.

Third, the requirement of minimal necessity holds that patients should be treated as persons by default, and that objectification should be restricted to cases in which it is both beneficial and sufficiently justified. In particular, clinicians must avoid objectifying patients solely on the basis of diagnostic labels—for example, claims such as "people with dementia are incapable of making any decisions" or "everything a patient with schizophrenia says is delusional." If objectification were justified merely by diagnosis, it would license treating patients as objects across all contexts. Such generalized objectification is indistinguishable from prejudice against people with mental disorders. Accordingly, objectification in psychiatry should be as partial and as limited as possible.

In considering the justification of objectification in psychiatry, there is another important background condition in addition to those discussed so far. Nussbaum (1995) argues that, for an act such as using one's lover's stomach as a pillow to be justified, it is essential that there be a background condition in which the lover is ordinarily treated as more than a mere pillow. Drawing on this insight, I propose adding a fourth condition for the justifiability of objectification in psychiatry: respect for persons as a background presupposition.

Szasz (1974) rejected the concept of mental illness on the grounds that it entails the objectification of the human mind. At first glance, this position may appear morally elevated, insofar as it purports to treat human beings unconditionally as persons. However, denying the existence of mental illness directly amounts to denying the necessity of psychiatric treatment itself. Psychiatry takes the remediation of mental capacities as a therapeutic goal precisely because it recognizes that there are circumstances in which the mental capacities underpinning human personhood can be impaired. Rejecting the objectification of the mind therefore leads to denying that there are cases in which human mental capacities are undermined and in need of recovery. Such a denial is far removed from an attitude of genuine respect for persons.

Respect for persons in psychiatry is reflected not only in recognizing patients as persons, but also in a commitment to restoring their personhood when it is compromised. Causing bodily injury with a knife is ordinarily impermissible, yet it is justified in the context of surgical procedures performed for the purpose of restoring health. Analogously, objectification in psychiatry may be justified when it occurs within therapeutic contexts aimed at restoring the patient's personhood.

## 6. Conclusion

In this paper, I have examined the ethical unease inherent in psychiatry through the lens of

patient objectification. Drawing on the analyses of Nussbaum and Langton, I argued that objectification in psychiatry can involve the *denial of agency*, *instrumentalization*, *inertness*, *denial of subjectivity*, *violability*, *fungibility*, *reduction to body*, and *silencing*. By contrast, features central to analyses of the objectification of women—such as *reduction to appearance* and *ownership*—do not play a prominent role in psychiatric contexts.

In medicine more generally, objectification may arise in decision-making, therapeutic intervention, information gathering, and as a form of psychological defense on the part of healthcare professionals. In medical practices focused explicitly on bodily treatment, such objectification is often more readily accepted. In psychiatry, however, objectification carries a heightened ethical tension, insofar as its effects extend into the domain of the human mind and agency.

Nevertheless, objectification in psychiatry cannot be categorically rejected as morally impermissible. Just as the body can become ill, so too can the mind. When the mental capacities that ordinarily warrant treating a patient as a full person are compromised, some degree of objectification may become necessary.

Although objectification sits uneasily with the ideal of always treating patients as full persons, psychiatry can nonetheless be understood as a practice that respects persons insofar as it is oriented toward restoring the mental capacities that underpin personhood. Objectification in psychiatry can therefore be justified when it occurs within a therapeutic context aimed at such restoration, provided that it is undertaken for the patient's benefit, grounded in adequate justification, and limited to the minimum necessary extent.

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