The Disordered Mind
An Introduction to Philosophy of Mind and Mental Illness
2nd edition
George Graham
The Disordered Mind

*The Disordered Mind: An Introduction to Philosophy of Mind and Mental Illness* examines and explains, from a philosophical standpoint, what mental disorder is: its reality, causes, consequences, and more. It is also an outstanding introduction to philosophy of mind from the perspective of mental disorder.

Revised and updated throughout, this second edition includes new discussions of grief and psychopathy, the problems of the psychophysical basis of disorder, the nature of selfhood, and clarification of the relation between rationality and mental disorder. Each chapter explores a central question or problem about mental disorder, including:

- What is mental disorder and can it be distinguished from neurological disorder?
- What roles should reference to psychological, cultural, and social factors play in the medical/scientific understanding of mental disorder?
- What makes mental disorders undesirable? Are they diseases?
- Mental disorder and the mind–body problem.
- Is mental disorder a breakdown of rationality? What is a rational mind?
- Addiction, responsibility and compulsion.
- Ethical dilemmas posed by mental disorder, including questions of dignity and self-respect.

Each topic is clearly explained and placed in a clinical and philosophical context. Mental disorders discussed include clinical depression, dissociative identity disorder, anxiety, religious delusions, and paranoia. Several non-mental neurological disorders that possess psychological symptoms are also examined, including Alzheimer’s disease, Down’s syndrome, and Tourette’s syndrome.

Containing chapter summaries and suggestions for further reading at the end of each chapter, *The Disordered Mind* is a superb introduction to the philosophy of mental disorder for students of philosophy, psychology, psychiatry, and related mental health professions.

**George Graham** is Professor of Philosophy and Neuroscience at Georgia State University, USA. He is the author, co-author, or co-editor of more than a dozen books, including *When Self-Consciousness Breaks* (2000), *Reconceiving Schizophrenia* (2007) and the *Oxford Handbook of Philosophy and Psychiatry* (2013).
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An Introduction to Philosophy of Mind and Mental Illness

Second Edition

George Graham
For Patricia
We are … subject to infirmities, miseries, interrupt, tossed and tumbled up and down … uncertain [and] brittle, and so is all that we trust unto. And he that knows not this, and is not armed to endure it, is not fit to live in this world.


And I have asked to be
Where no storms come,
Where the green swell is in the havens dumb,
And out of the swing of the sea.


To try to be happy is to try to build a machine with no other specification than that it shall run noiselessly.

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In writing this second edition I continue to remember my parents, George and Catherine Graham, for their support for my interest in philosophy as a young man, and my brother, Paul, for his example of compassionate understanding of people who suffer.

My sister, Kaolin, and sister-in-law Catherine Sedgeman also deserve thanks, as does Cynthia Garrett. Each offered special forms of support and enthusiasm.

Last and most important: love and deepest thanks to Patricia, my wife, and to our daughter Kathleen, her husband Bill, and to their wonderful little son, our grandson, William George, wisdom in progress. This book is re-dedicated to Patricia, without whom it would not contain a single word.
It is with considerable appreciation that I accepted an invitation from the press to produce a second edition of this book. Below I repeat some remarks from the preface of the first edition, but I also add descriptions of where the second edition attempts to improve upon the first and contains material unavailable in the first.

This book tells two tales.

The first is a tale about mental illness or disorder. (I use ‘mental illness’ and ‘mental disorder’ interchangeably.) The book offers a theory of mental disorder. It provides an account of mental disorder’s reality, sources, causes or propensity conditions, contents and consequences, both symptomatic and therapeutic. The second tale is an introduction to elements of philosophy of mind, to the essentials of the subject. The book tells each of these two tales simultaneously. Each is tied up in the other. The two tales compose one story.

The second tale of elements of philosophy of mind derives its plotline from the first. It assumes that no sound and sensible philosophy of mind can be constructed without attending to the topic of mental illness and to human vulnerability to mental disorder: to such conditions as addiction, clinical or major depression, dysfunctional anxiety, paranoid distrust, and disorders of thought and comprehension.

The first tale of a theory of mental disorder inherits much of its cast of main characters from the second. It assumes that no conceptually regimented and normatively informed theory of mental disorder can be devised or constructed without taking philosophy of mind seriously and knowing something about this subject area of philosophy. This includes knowing of such topics as consciousness, Intentionality (I follow the philosophers’ common if not universal convention of capitalizing this technical word), personal identity, the mind/body problem, and rationality.

The book is written for multiple audiences. It is designed for undergraduate and graduate courses in various fields of study, philosophy foremost but not exclusively. So, for example, an
instructor in philosophy of mind may use it to introduce the subject in an interdisciplinary and clinically informed manner. For another example, an instructor in clinical or abnormal psychology may use it to complement exposure to clinical literature and case studies. I hope it may also be read with profit by academic philosophers, mental health professionals, and interested general readers. Comments received on the first edition have come from all such readerships. I am grateful to readers for sharing reactions.

Partly for the benefit of students, I include short chapter summaries and suggestions for further reading at the end of each chapter. Partly to avoid visual distractions, no footnotes or endnotes are used. Whatever is in the body of the text literally is in the body of the text. Partly for the benefit of selective users and browsers, some chapters or their parts have been composed so that they may be read independently of each other. Someone interested in, say, the topic of addiction could go directly to the seventh chapter and discover there a more or less self-contained discussion of that disorder. Or someone curious about the goals of a theory of mental disorder could read the second section of the second chapter and find there a unified statement of those goals. When read in order as a single book, however, the chapters offer the continuous development of a theory of mental disorder as well as of the role of philosophy of mind within that theory. The first three chapters introduce the topics of the book and offer suggestions for how to construct a theory of mental disorder that respects both the mind and disorder of a mental disorder; the middle chapters cover questions about the empirical reality of and evaluative standards or assessment norms for a mental disorder; and the final three chapters examine specific disorders in the light of the theory.

The book presents my own views. It argues for my own positions. This is not to banish other positions, but to provide unity and purpose to the book’s philosophical theorizing, which is to seek a general philosophical and, in particular, philosophy of mind perspective on mental disorder or illness.

Given that this is a second edition, readers familiar with the first edition may wish to know what revisions and changes have been made. The most obvious change is that the Epilogue has been dropped. Some new section heads appear in the Table of Contents. In content the book has been revised and reworked in a number of conceptually substantive or major ways.

Some changes were motivated by the desire to further describe what I mean by metaphysical realism about mental disorder as well as by the thesis that the explanations proper to a mental disorder or to conditions of mind and behavior that deserve to be classified as mental disorders are rooted in a distinction between rational person respecting explanations and brute causal or mechanical explanations. Theoretical understanding of a mental disorder or illness involves deploying these two types of explanation in joint or interactive concert in order to gauge and grasp different features of a disorder and integrate that understanding with effective and compassionate treatment of a person with a mental disorder.

Other changes were motivated by the desire to reinforce or clarify controversial distinctions or claims made in the book. One of these is that a mental disorder is or may be based in the brain without also being of the brain or a neurological disorder. Another is the proposition that mental disorders represent impairments or special sorts of truncations or incapacitations in the reason-responsive or rational operation of basic or fundamental psychological capacities. Still another is the related claim that failures of rationality (loosely and contextually understood) play, or should play, key roles in the diagnosis and classification of mental disorders.
There are no serious changes to the original positions put forward by me in the first edition. But I hope that the positions are more clearly stated here in the second edition and better defended as well as more accessible to a wider audience.

Some brand new material on the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has been included. This includes a new discussion of whether grief should count as a disorder in certain extreme cases, which possibility has been a subject of controversy in the construction of DSM-5, and of whether psychopathy (sometimes also known as anti-social personality disorder), a moral failure, also may deserve to be classified as a mental disorder or illness. Some additional information from relevant sciences (especially brain science) has been added, but this is not a book on philosophy of science and mental illness. It is a book on philosophy of mind and mental illness. Philosophy pursued with respect and admiration for relevant sciences, but not as subordinate to them. Mind disordered, not science regnant, is its main focus, and when a mind is disordered or ill that is character enough for a single book.
Alice trusted Howard, her husband. She had reason for doing so. He was devoted to her. Or so she thought.

When Howard died unexpectedly, Alice, in preparing for his memorial service, opened his computer file only to discover that Howard recently had been leading a secret and complex second life. He had married another woman, fathered a child with her, and periodically lived with both second wife and child, as he described things, while “out of town doing regular business” in Kansas City.

Alice’s grief over Howard’s death, which was profound, was mixed with anger and pain, which was deep. A positive interpretation of her husband’s character (“Howard was a good man; he loved me and our children; and, I will miss him terribly”) may have led to a better emotional and behavioral adjustment to the loss than her bitter negative evaluation (“He lied to me and to the children; I did not really know him”). Alice fell into a protracted despondent mood. Two years later, still despondent, she was diagnosed with clinical depression.

Ian believes that he is the victim of a government plot. He is convinced that he is the object of a conspiracy conducted by the Federal Bureau of Investigation (FBI). “The FBI believes that I am running a terrorist cell.” Ian refuses to leave his home for fear that he will be arrested. The business he owns, a men’s clothing store, is faltering in his absence. When asked to describe evidence of being persecuted, Ian says that he cannot discuss the matter lest agents overhear the conversation. “The shirts in my closets are bugged with voice detectors.” “The cuffs on my trousers contain electronic devices that signal my physical position to the FBI.” He is diagnosed with paranoid delusional disorder.

What to do with the Alice’s and Ian’s of this world? How should they be understood? Treated? Sigmund Freud (1856–1939), the Austrian psychologist and founder of psychoanalysis, famously
fretted over them. He tried to fathom the mind’s emotional and behavioral fault lines: the creaks, cracks, and crevices of persons divided within themselves. Freud also recognized that mentally disturbed human beings may and often do reclaim mental health and well-being. People recover from a mental illness. For Freud, though, there is a prudent precondition for taking wise and measured aim at reclamation or construction of mental health. This is not to set the bar for emotional and psychological well-being too high.

The philosopher Owen Flanagan eloquently writes of the “wish to flourish, to be blessed with happiness, to achieve eudaimonia – to be a ‘happy spirit’” (Flanagan 2007: 1). If Flanagan is right, that’s a wish we all share. Truly to be happy, to be blessed. Freud, however, promoted a more modest aspiration. When asked by a despondent patient how he hoped to assist her in regaining mental well-being, he had this to say: “No doubt fate will find it easier than I do to relieve you of your illness.” “But you will be able to convince yourself that much will be gained if we succeed in transforming your hysterical misery into common unhappiness” (Breuer and Freud 2000: 305).

Common unhappiness? Was Freud being ironic? In part, yes. Mainly, however, he was trying to be pragmatic or realistic. The conditions or circumstances of human existence, Freud thought, are such that an absolutely healthy, unified, orderly, stable, trouble-free mental life is much too optimistic for a person to expect, whether recovering from a disorder or not. Why so? Why not absolute mental health, behavioral and emotional well-being? Why not total and pure flourishing? Because, he said, “our body is doomed to decay and dissolution”, “the external world [rages] against us”, and suffering comes from our relations with other people. “The suffering which comes from this … source is perhaps more painful to us than any other” (Freud 1989/1930: 26). We are psychologically vulnerable and unstable creatures, whom the vicissitudes and tragedies of life may inevitably wear down or pull apart. As persons we must therefore try to live dignified, productive lives, all the while remaining susceptible to periods, perhaps pronounced or protracted periods, of distress, discord and instability.

In order to elicit an intuitive sense of our vulnerability to instability or distress, consider a brief thought experiment. The experiment is counter-factually presumptuous to be sure. Contrary-to-fact presumption, however, is no impediment to imagination.

Suppose you are none other than Mother Nature, although endowed with powers of deliberation, foresight, and decision making of which she herself is not privy. Imagine that humankind has yet to appear on the earthen landscape. You wish to build the sort of mind that will help us as human beings to engage with life on the planet. You are not going to rely on Father Time to do this. (He takes forever.) You are going to do it yourself. If a supernatural or divine agent is behind your efforts, you are not aware of its assistance. You are, as you conceive of the task, utterly on your own.

You wish the human mind to have different and various modes of operation and component psychological competencies, faculties or capacities. You want us to perceive, reason, desire, feel, remember, learn, intend, deliberate, and decide. You want us to enter into productive social relationships. You want us to be properly situated or embedded, not just in the natural landscape, but in multiplex social ecologies and forms of social and cultural life. You want our mental activities to initiate, guide and complete goal-directed behavior and bodily movement. You want us to walk, grip, grasp, run, swim, open, close and climb. You wish us to achieve
complex and ennobling purposes: to do philosophy, write memoirs, make art, organize religions, uncover scientific laws, found universities, and discover cures.

Suppose that for reasons of imaginative playful contrast and heuristic comparison, you narrow your conceptions of the possible human mind down just to two. Think of these as a stable and an unstable mind. You picture each as follows.

The Stable Mind. A human mind that is inherently stable and orderly. It possesses purity of heart and soundness of reason. It does things because it believes them to be desirable and is willing to face down the often and unanticipated aversive consequences of its actions. It assesses itself with equanimity, free of regret and self-doubt. It never loses control of itself. When entering into interpersonal relationships, it aims to insure that these are harmonious, coordinated and cooperative. When it confronts the vicissitudes of life, chronic pain, physical illness and death, it does so with courage and fortitude. It loves with magnanimity, dreams contentedly, and harbors a firm sense of personal dignity and self-respect. Its life, far from being an anarchic master, is the object of single-minded dedication and intelligent direction.

The Unstable Mind. A human mind that is inherently unstable and disorderly. It possesses conflicting motives, impulses, and inhibitions as well as biases of thought and impediments to reason. It does things because it believes them to be desirable, but is unwilling to accept the negative consequences of its actions and frequently is conflicted or befuddled about just what is desirable. It is prone to regret and self-doubt. It often loses its grip on itself. When it enters into social relationships, its agency is prone to be disharmonious, discordant and uncooperative. When it confronts the vicissitudes and heartaches of life, it seeks refuge or escape. It loves with rapturous passion but also with breathtaking infelicity and self-destructive inconstancy. Its self-criticisms are harsh and unforgiving. The demands of life drive it into disarray and dissolution.

Which sort of mind would you make if you were Mother Nature? “An absolute no-brainer”, you say. “The answer is obvious.” “Stability, most certainly.” True, stability lacks high drama. Its theatricality is thin. Instability, however, is riddled with dissonance and burdened with discomfort and unhappiness. It is also, of course, grossly incompatible with the desired ends of your creation. An utterly unstable mind could never do philosophy or do so sagaciously. Discover cures? Found universities? What sort of academic institutions would these be like? (If you answer, “Like those that exist today”, then you must be a professional academic.)

What has the real Mother Nature actually done? Here’s what, to the naked anthropological eye, she has designed for us. She has composed a type of mind that is both stable and unstable. She has mixed each form of mentality in us. She has made us orderly and disorderly, content and discontent, facing life’s vicissitudes but also seeking refuge from them. True, some folks are more temperamentally secure than others. True, some people are much less able to undergo various trials and tribulations than others. But beneath our individual differences, however, is a fusion of both. Each of us is endowed with a stable/unstable mind. No person has all of the one but none of the other. Even the most unstable or discordant individual is not without some small slice or sliver of stability. Even the most stable is not without a shadow of instability.

Periodically, of course, instability holds sway. When it does so, we become anxious about small things, develop imprudent patterns of thought, and slip or slide into emotional conflicts. Small influences may unhinge a person. Then, in more sadly serious cases, dissonance,
distress, and disturbance may seize truly powerful and persistent if, hopefully still only, temporary
dominion. A person’s mind may break down or become disordered or ill in a psychiatric or clinical
sense. One or more mental capacities or psychological faculties may dissemble into harmful
or hurtful incapacity, dysfunction or impairment. Thoughts may become obsessive, preferences
addictive, perceptions hallucinatory, beliefs delusional, and post-traumatic amnesia may
impose ignorance of significant parts of one’s past. Paralyzed by phobic anxiety, a person
may avoid any and all public places. Numb by major depression, an individual may listlessly
disengage from people and projects once held near and dear.

Mental disorder, depending on its pulse and purport, may require professional mental health
treatment or clinical address. One hopes that assistance is sound and sensible, but treatment
and attention are unhelpful and even dangerous when resting on false or improper assumptions
about mind and illness. The history of medical treatment for mental disorder is a checkered
affair. It is benevolent and sensitive on occasion, given the state of medical knowledge at a
time or in a culture. But other chapters in that history are characterized by superstition, ignor-
ance, intolerance and inhumanity. The history of theory and treatment for mental illness is
recounted in numerous texts. (It is also briefly available in a short chapter of a long book that
helps to carry my name [see Fulford, Thornton and Graham 2006: 143–59].) I do not wish to
repeat it here. I do, however, want briefly to sketch more recent phases. This short historical
sketch should help to show why it’s important to have a sound and sensible understanding
of mental disorder. Such an understanding is one, I claim, in which the subject of philosophy
of mind, in particular, ought to play a prominent role, to be outlined in a moment and presented
in detail throughout the book.

ONE BRIEF HISTORY

In late nineteenth and early twentieth century in Western Europe the category of mental illness
or disorder was applied only to the most serious problems and pathologies of mentality, viz.
those identified, in effect, with psychoses, severe manias or depressions. Emil Kraepelin
(1856–1926), arguably the leading psychiatric taxonomist of the period, attended primarily to
three main types of disorder. Kraepelin spoke of dementia praecox (roughly, schizophrenia),
depressive illness, and paranoia, a term he used broadly to refer to delusional disorders
(one form of which is persecutory). For him mental illnesses fell into a small set of discoverable
types, identified by symptom and family history. Hospitals and asylums purported to treat (even
if all that they sometimes succeeded in doing was house) persons with such illnesses. Most
people who wished help for less severe or disabling disturbances, which went by names such
as “nerves”, “neurasthenia” or “hysteria”, did so with general medical practitioners. These
were doctors who did not identify themselves as specialists in mental health. Rest and diet
were popularly recommended cures for less severe cases. For the wealthy but worried well,
occasional respites at health spas aimed to regenerate one’s spirits. For all battered souls, the
clergy were available for counseling.

Then, later into the early twentieth century, mental illness diagnosis and treatment underwent a
dramatic transformation. Freud was the major force for change. He and his disciples helped to
turn clinical insight and therapeutic resource into a distinct medical specialty. This field is known now, of course, as psychiatry.

Freud published his first major work, *The Interpretation of Dreams*, in 1900 (1958 [1900]). He died in 1939. By the time of his death, in the words of Rutgers University’s Allan Horwitz, “the most basic ways of thinking about mental disorder had changed” (2002: 40). Psychiatry had become a distinct specialty within medicine. Its range of application had expanded to consider less severe disturbances than psychosis or incapacitating depression. The mental malaises or psychological infirmities that formed the focus of Freud’s psychological theory, such as anxiety, obsession, and sexual frigidity, were described as manifestations of unconscious conflicts festering within the lives of all human beings: the severely ill, the worried well (or non-severely ill), and even the well. The primary function of therapy or treatment was to uncover those hidden conflicts and the manners in which people effectively adjust, or fail to adjust, to social and cultural demands. Some attention was given to diagnosis and to identifying categories of disorder, but one and the same set of symptoms or patient complaints was thought, in theory, to stem from just about any form of disorder. So, taxonomic labels failed to carry uniform and reliable conditions of application. Chronic fatigue, headaches, and weight loss may signify obsession in one individual, phobia in a second person, or sexual frigidity in a third. Horwitz aptly sums up Freudian diagnostic practice: “only deep, extensive, and intensive exploration of the individual personality could indicate the true meaning of any symptomatic presentation” (2002: 45).

Freudian thought was widely endorsed and medically institutionalized. It dominated thinking about mental disorder until the 1960s, when it fell into quite rapid decline. The organizational, economic, and social situation of psychiatric medicine, once again, underwent a transformation. Weaknesses in the Freudian framework became apparent. To be sure, Freudian psychology was not well suited for understanding the nature of or best treatment for truly severe psychoses (Hobson and Leonard 2001; Beam 2001). A desire for detailed and reliable clinical diagnosis became widespread (Bentall 2004; Horwitz 2002). Psychiatry grew biomedical. Not without dissenters. (In Britain, R. D. Laing was one of the more prominent opponents of the biomedicalization of psychiatry.) But overall the field became convinced that patient distress and complaint were symptoms of specific and tractable illness types or disease categories, much like somatic or bodily illnesses, though housed in the brain. A proliferating range of ailments of consciousness and behavior were thought to merit classification as distinct and distinguishable disorders.

Drugs emerged as critical for the understanding and treatment of mental disorder. In many cases they were regarded as the first-line of treatment. The aim was to restore biochemical functionality or normality to a neural base of mental disorder and to reduce symptoms. Chlorpromazine was introduced in the 1950s for the treatment of severe psychoses like schizophrenia. Monoamine oxidase inhibitors and tricyclics were widely deployed for the treatment of major depression. Presuppositions of drug therapy, foremost, the assumption that specific illnesses require specific drugs, imply that it makes a difference for care and treatment whether a set of symptoms is diagnosed as, say, clinical depression or schizophrenia. Depression should be targeted with one drug. Schizophrenia addressed with another. No longer was one Freudian style of therapy sufficient for all disorders. References to Freudian phenomena such as “repression”, “sublimation,” “oedipal dilemma” as well as to the Freudian unconscious were charged with being
unscientific and clinically unsound (Grunbaum 1984; Horwitz 2002). Freudians, as they do today, continued to function in the profession, although Freudian style psychiatry and its conceptual brethren moved to the perimeter of psychiatric medicine. Freud was often cast as a scapegoat for problems or false-starts in the profession. Psychiatry as a profession did not blame Freud for contributing to its social and cultural prominence. Few professions lament prominence. Freud, however, was criticized for burdening the specialty with opaque concepts and elusive forms of clinical treatment. No doubt, certain effective counter-criticisms of the anti-Freudian momentum in psychiatry were willfully ignored (Lear 1998: 23). But non-Freudian biomedical trends became secure. Fine-grained diagnostics and illness-specific medication became the prescribed aspiration of the medical specialty.

The twentieth century has ended, of course, and the twenty-first has more than just begun. Understanding and treatment of mental illness is in post-Freudian biomedical full bore. Psychiatry has moved from the language of mind and mentality to that of brain science or to mixes of the languages of mind and brain science, in such fields as cognitive neuroscience and cognitive neuropsychiatry, but in which brain science more or less is the aspired canonical tongue. Preference for reference to the neural holds the day. The methods and manner of neuroscience, it is widely presumed, offer the best understanding of and treatment for mental disorder. It is only a matter of time, some say, before psychiatry will become a sub-discipline of neurology (Ramachandran 2003). Indeed, just such neurological sub-disciplinary status exactly is what one prominent observer says already has taken place in psychiatry. “Psychiatry and neurology [is] one specialty” (M. A. Taylor 1999: viii).

True, interest in the brain is not new to psychiatry. When Wilhelm Griesinger (1817–68), a professor of psychiatry at the University of Berlin, authored the first editorial of the Archives for Psychiatry and Nervous Disease, a journal he founded in 1867, he wrote: “Patients with so-called ‘mental illnesses’ are really individuals with illnesses of the nerves and brain” (see Bentall 2004: 150). (Freud himself attempted to take brain science seriously. After, however, an early effort to reconcile his developing psychological insights with the limited knowledge base of neuroscience available during his lifetime, he abandoned the attempt [Kitcher 1992].) But the immense popularity of neuroscience within psychiatry is a distinctively post-Freudian phenomenon and represents the “culmination of [the biomedical] trend within the profession” (Bentall 2004: 151).

Brain science, of course, is deeply and urgently relevant to the explanatory understanding and clinical treatment of mental disorder. No one should deny that. But does a danger of post-Freudian neuro-mechanical hubris lurk within preference for brain science and associated reliance on drugs and somatic disease modeled modes of treatment? Consider drug treatment. So-called ‘atypical’ antipsychotic medications (viz. drugs that produce fewer side effects than ‘typical’ antipsychotic medications) that were so vigorously endorsed, as recently as several years ago, for being more efficacious than psychotherapy and even more so than their immediate pharmaceutical predecessors (like the tricyclics), are now, in the words of psychiatrist Paul Appelbaum, “recognized as having substantial therapeutic limitations and often problematic effects of their own” (Applebaum 2004: vii). (One of the therapeutic limitations is that success with a drug does not necessarily correlate one-to-one with removal of the causes or sources of a disorder. Pathology may persist, although various evident symptoms may disappear or be reduced.)
Some critics complain that while Freud ‘pathologized’ or medicalized normal variations in human psychological diversity by portraying behavior as the expression of unconscious and unresolved conflicts, the pharmaceutical industry today exerts its own independent ‘pathologizing’ effect on our understanding of a mental disorder. Drug companies encourage the creation of what often in fact, if perhaps not necessarily in intent, are suspect categories of mental disorder (Horwitz 2002). Neuroscience may have exorcised the elusive Freudian Unconscious from the mind/brain. But commercial forces, critics say, are selling a bill of mixed neurochemical goods to a specialty of psychiatry that is over-enthused about an image of mental disorder as a subtype of brain disorder or neurological disease or neuro-biomedical condition (Luhrmann 2000; Elliott 2003 and 2004).

Is it wise to assume that mental disorders are forms of brain disorder or disease? Might not this assumption be an unreasonable or premature piece of conceptual legislation imposed on the domain of mental disorder? Might it not dangerously obscure the research validity and diagnostic and therapeutic utility of a category of disturbance or distress, like that of a mental disorder, which, although certainly involving the operation of neurobiological and neurochemical processes, does not mean that something is damaged or wrong with brain activities at levels describable by neuroscience? No doubt, mental disorders are problems or disturbances involving pathologies of various sorts, but might this be consistent with a healthy brain bearing a role in a mental disorder? Normative considerations relevant to the diagnosis of mental disturbance and distress, as well as to the explanation of such conditions, may not be identical to those for describing the physical biological base of distress. As a consequence, to the extent that mental disorders or illnesses constitute a coherent type or domain of disorder, it is most plausible (I believe and as the book argues) to maintain that they constitute primarily a psychological kind of some sort, not a neural or neurobiological kind or a condition specifiable at the level of biological neuroscience, although a kind that cross-cuts with descriptions of parts of its causal foundations in brain science terms.

Two analogies may help to explain the conceptual possibility that I have in mind here. Just because there are misspelled words on a book’s page does not mean that there is something wrong with its publisher’s printing press. Or again: just because when I gaze at a perfectly straight stick, which is submerged in a pool of water, it appears bent (at the point where it meets the surface of the water), and my visual system fails to compensate for the optical effect of refraction, does not mean that my visual system is damaged or disordered. The norms or standards for spelling words are not those for proper printing presses. The standards for perceptual veridicality are not those for computing and correcting for Snell’s law (about the path of light rays through refractive media). The printing press produces ink marks. The visual system implements the gazing. But at the levels of description of the activity of the press as a press or of the visual system as a visual or perceptual system everything may be in proper or healthy order, even if neither the page nor the visual information is as we desire or wish, that is to say, even if the spelling is a mistake, and the visual information is in error.

To assume that just because or if the brain is the physically existential base of a mental illness that therein neural processes are ill, disordered or diseased (or of the wrong or improper kind) is an unlicensed inference or non sequitur. Appreciating that the inference is a non sequitur is important because the effect of insisting that mental disorders are brain disorders (i.e. disorders
of and no just in the brain, as I wish to put matters) is to suppose that mental disorders are not even potentially compatible or consistent with normal (or normatively normal) brain function or neural activity.

There are heated debates in the neuroscience literature about just how to determine whether neural processes or activities are functioning as they normatively should in order to qualify as healthy or proper. The consensus of opinion, sometimes not explicit, but at least implicit in the clinical and experimental procedures that neurologists use to test whether a brain is functioning as it should, is that although it certainly is useful, on occasion, to distinguish between desired and undesired forms of brain activity, it is important not to confuse whether a brain itself is healthy or diseased with whether this, that, or another form of neural activity is desired, preferable, or prudent for a person.

When a person is mentally ill, there is necessarily something wrong or undesirable with their condition. But the relevant norms for mental illness wrongness are not necessarily neurological norms. So, just because Alice cannot cope with her husband’s death and adultery does not mean that her brain is not functioning as it should relative to biological norms. She is not functioning well or as she should or wishes, to be sure, but her neural processes may be, depending upon the criteria, in proper working order nonetheless.

WHAT IS THIS BOOK ABOUT?

This book articulates and defends a theory of mental disorder. It offers a conception of what a mental disorder both is and is like to its subject, how best to explain and understand it as well as to appreciate what human vulnerability to mental disorder reveals about the nature of mind and mentality.

The theory that the book proposes is distinguished by its attention to issues in empirically and clinically informed philosophy of mind and to questions about norms or standards for how best to assess, explain and understand a mental disorder. A rival brain science centered theory of mental disorder, which may be called the neurological disorder or broken brain conception of a mental disorder, is outlined and rejected. Not rejected because brain science does not or should not contribute to our understanding of a mental disorder. Clearly, brain science does and must contribute. I say ‘rejected’ because, I believe, if a disorder is mental, then human psychology (and not just neurobiology or neurochemistry) is part of its causal explanatory foundations.

The theory of mental disorder that the book defends is characterized, in part, by promotion of a concept of mental disorder that is closely tied to a description of the nature or character of the human mind as a rational mind or as reason-responsive, broadly understood. We persons are rational agents. We think, act or do things for reasons. We respond to reasons that we have for thinking and doing things. The theory of mental disorder offered in this book defends the proposition that elements of reason and rationality help to constitute or define distinctively mental activities such as believing, hoping, desiring, deciding, thinking and the like. The theory also holds that (i) the reason-responsiveness of a psychological faculty or capacity is impaired, truncated or significantly incapacitated in a mental disorder, but (ii) not obliterated, destroyed or totally incapacitated (as it occurs in severe brain disorders). Reason or rationality is partly but
not fully disabled in a mental disorder. It is also partly although not fully responsible for the occurrence or onset and progression of a disorder. So, no behaviors should be considered as symptoms of a mental disorder, as opposed to those of a purely neurological or brain disorder (such as cortical blindness or Parkinsonism), unless they satisfy (no matter how deficient, incapacitated or gummed up’ in manner) at least some minimal standards of rationality, coherence, or ‘logic’.

I describe various ways in which the reason or rationale associated with different mental disorders is truncated or impaired. In analyzing these impairments, I also claim that we need to refer not just to the role of reason-responsiveness in a disorder, but also to neural mechanisms functioning as instances of (what I like to call) unreason or as brute, a-rational forces.

Here is a short imagined illustration of what I have in mind. Suppose that Alice’s grief and depression over the death of her husband and her disappointment with his adulterous behavior is so enduring and intense that she becomes a victim of insomnia, weight loss, and an inability to properly care for her children. Now imagine that certain cortical regions of the brain have been shown to be implicated in the production and regulation of affective or emotional states. A background mechanical story about brain regions (that applies to her case) may go something like this.

Suppose two reciprocally connected neural systems help to underlie emotions and emotional activity. One is the so-called ‘ventral’ system (including, in part, the amygdala and insula), and the other is the so-called ‘dorsal’ system (including, in part, the hippocampus and dorsolateral prefrontal cortex). Suppose that the ventral system is partly responsible for the recognition of emotionally significant stimuli, whereas the dorsal is partly responsible for effortful responses to emotional states (see Whittle et al. 2009: 43). Suppose also that these regions or systems have been designed by Mother Nature with a kind of emotional threshold or shear pin device that under the strain of protracted grief and dramatic disappointment puts a person into a state of lethargy or virtual tonic immobility (see McKay and Dennett 2009: 501). The associated action of the shear pin device is not ‘abnormal’, ‘improper’ or unhealthy in these situations, at least by strictly or narrowly biological or adaptational/genetic fitness standards. Alice’s brain is (I am assuming for purposes of illustration) functioning just as Mother Nature has designed brains to function under conditions like those of Alice. However, in upshot, in consequence of such a device, Alice fails to get out of bed. Although unwelcome as behavior and surely unhealthy psychiatrically as well as symptomatic of her diagnosis as a subject of clinical depression, Alice’s lethargy or immobility expresses the proper operation or designed function of relevant neural regions. Nothing in the brain is damaged or literally ‘broken’ or not functioning biologically as it should when she does not get out of bed. The threshold device temporarily shears a people off from the world and renders them more or less motionless, at least with respect to normal daily activities, so as to prevent (whether an individual like Alice’s appreciates Nature’s purpose or not) more harm to themselves – perhaps more losses, more disappointments, more shocks to the emotional system.

So pictured, Alice’s depression is best understood by deploying two general sorts of vocabularies or causal-explanatory languages. One is in terms of the annihilating loss of and disappointment in her husband. These are terms of (what I am calling) the reason-responsiveness or ‘rationale’ of the depressive or grieving process. If Alice did not believe that her husband was dead or if she
was not disappointed in his adulterous behavior, she would not be psychologically disturbed or upset.

The other parts of the story are couched in terms of emotional managerial processes operative at a neurobiological/neurochemical level of analysis i.e. in terms (like those mentioned above) that refer to brain processes as mere mechanisms. The mechanisms may be sub-personally purposive or teleological (to use a technical term of philosophers’ art) in certain operations (such as those of the imagined shear pin device) if selected for their ability to produce such effects by Mother Nature. However, they are not themselves therein rationally operative in such operations. They do not therein help to produce prudent behavior on Alice’s individual part. They operate in interaction with or ‘beneath’ Alice’s personal reasons for being disappointed and grieving. The mechanisms ‘weigh’ Alice’s body in bed. Her disappointment ‘stitches’ her mind beneath its sheets. Together both mechanism and mind significantly incapacitate Alice.

Reason’s deficiencies should be no surprise in a disorder, of course. Approach Ian and it is hard not to notice that he is devoid of good evidence for his fear that the FBI is conspiring against him. Spend time with Alice and it is difficult not to miss that her depression takes a heavy toll on her ability to care for herself and her children, whom she loves. Within the gloomy throes of a form of grief turned into depression, her volitional capacities are stymied. She lacks the will or sufficient energy to face the day.

It may help readers if I had a name for the theory of mental disorder that I offer in this book. Since I claim that our explanatory understanding of a mental disorder requires the twin frameworks of psychology and brain science, I am tempted to call it the twin theory. Since I give prideful or primary place in the theory to the truncated or impaired presence of rationality or reason-responsiveness in a disorder, I am also tempted to call it the truncated or impaired reason-responsiveness theory. In the end, though, I have no name for it. A thorn by any other name would still hurt as much.

The sort of theory I offer is not without kin or precedent. Various other discussions of mental disorder assume that mental disorders result from the interplay of rational and a-rational or brute causal sources. Freud made such an assumption. He proposed that psychiatric patients should be treated as rational agents, but whose reasons for behavior are distorted by the irruption of various forms of ‘a-rational noise’ (instincts, cultural and other forces) into their psychological space of reasons (a phrase of Wilfred Sellars 1997). Freud tried to finesse his ignorance of the neurobiological/neurochemical details. He relied imaginatively on the fact that remarkably good first approximations of explanations of disturbed behavior may be achieved by proposing that self destructive instincts and other forces operate beneath the horizons of a patient’s conscious and deliberate self-control. But whatever the theory’s name or label, this book offers a theory of mental disorder, a theory that is connected in robust measure with concerns in philosophy of mind.

Philosophy of mind. What is that?

Philosophy of mind is the subject or sub-discipline within the discipline or field of philosophy that systematically addresses several deep and puzzling problems of mind and mentality. The problems are deep and puzzling, in part, because they resist straightforward or direct scientific dissolution or empirical or clinical resolution. Psychiatry is not philosophy, of course, but it does presuppose philosophic commitments and in philosophy of mind uppermost. If certain deep and
puzzling philosophical problems are resolved in one manner rather than another, then much of psychiatric theory and clinical practice may thrive or flounder on such results (depending upon the resolution).

Once we excise the presumption that mental disorders are or must be brain disorders from our understanding of a mental disorder, a primary task for philosophy of mind in the theory of mental disorder, I believe, is to show how notions of consciousness, rationality, Intentionality, and psychological explanation (among others) can and should be deployed within a theory of mental disorder. They can be deployed without facing threat from neuroscience of being rendered explanatorily irrelevant or conceptually enervated or dismissed.

To take a quick example of the germaneness of philosophy of mind to the topic of mental disorder, clinicians and researchers schooled in a biomedical categorical approach to psychiatric diagnosis sometimes presuppose that disorders and ordinary mental disturbances are utterly different and belong to two exclusive and discontinuous categories or domains of distress. Think, for instance, of the phenomenon of delusions. ‘Either delusional or not delusional’ is a presupposition of this school of thought. But an ‘either/or’ pattern of botanizing a delusional/non-delusional distinction is indulged at the expense of truth. No matter how false or bizarre the attitudes of a mental health patient, it usually is possible to find people who hold equally false or bizarre attitudes, but who are quite normal and healthy. Avidly searching for a definitive or precise criterion of a delusion is hunting for a hard and fast border where none exists. A suitably philosophy of mind informed theory of delusion, based on exploration of notions such as rationality and self comprehension, should serve to caution clinicians about just when and how to proceed with a delusional diagnosis.

References to neither the unwelcome causes nor bizarre contents of a delusional attitude fully suffice to explain what makes a delusion a delusion. Or so I argue. Rather, in my view, the consequences of an attitude, by which I mean, in a case of delusion, the harmful or imprudent and reason-unresponsive manner in which a person manages the attitude and acts in terms of it helps to make it delusional. As between cause, content or consequence, it is on the cusp of consequence that the nature of delusion ultimately courses.

Ian is in the grips of paranoia. Understanding his delusional attitude requires a proper description of its consequences. Locked doors. A bankrupt business. Fear of others as unwelcome intruders. Inability to knowledgeably manage his own frame of mind.

That, in a nutshell, is what the book is about. It offers a theory of mental disorder that does not relinquish the theory to, but deploys, brain science. The theory also exhibits how elements from philosophy of mind should or at least may operate in an account of mental disorder. In pursuit of such ends and related others, the book argues that it is absolutely essential for understanding a mental disorder to appreciate the truncated or impaired presence of reason-responsiveness or rationality in a disorder. By talk of ‘reasons’ I do not mean to over-intellectualize the complexities of human psychology. In daily life, for instance, the recognition of reasons for thought or action often is achieved by feeling or emotion, and we are much more likely to be better off as rational agents if we are skilled in fearing, braving, loving or trusting the right things and people, then if we seek to purify our rational powers of emotive content.

The book promotes at least one other big thesis as well. This is metaphysical realism about mental disorder. A metaphysical realist about mental disorder is someone who claims that
mental disorders truly or objectively exist. They are real. By contrast: Those who assert that no condition of a person should ever be thought of as a mental disorder are mental disorder anti-realists. Mental disorders are not real. They don’t exist.

I am a mental disorder realist. How so? What does mental disorder realism mean to me and in this book?

The planet Mars illustrates one way in which something may be real. Mars depends upon no mind whatsoever for its existence. It is mind-independent. Objective. Real. If no mind existed Mars still would.

Not so a mental disorder. A mental disorder is a condition of mind. It is mind-dependent. If no mind existed, no mental disorder could exist. But the existence of mental disorder is not mind-dependent in the same way in which Mahler’s Fifth Symphony or the baby sitter’s favorite TV shows are mind-dependent. The existence of such things depends upon people’s thoughts about and classifications of them. The Symphony, for example, depends upon Mahler’s composing the score. The existence of the sitter’s favorite TV shows depends upon her selection of which specific shows to watch rather than others and her entertainment preferences and tastes. But no one composes a mental illness. No one selects which disorder to suffer.

Another way of thinking of something as real is to think of its existence as perceptually obvious or readily recognizable by the naked eye. For example, the fact that this or that table or mountain exists is perceptually obvious or readily recognizable by the naked eye.

Again, this is not true of a mental illness or disorder. A wide and complex range of behavioral activities are relevant to recognizing a mental disorder. When a disorder as such is observed, it is observed only in the context of a broad range of human practices and with a proper storehouse of empirical and normative concepts and categories at the observer’s disposal. No naked eye can spot the fact that a person has a mental disorder. Only one properly conceptually clothed and informed can recognize that fact.

Still another way of thinking of something as real is to think of it as something whose actual existence is so widely believed to be the case that no reasonable person doubts it. Again, though, that is not the case with mental illness or disorder. A goodly number of intelligent people deny the existence of mental disorders. Some theorists say that to speak of certain mental disturbances or distresses as mental disorders is an arbitrary or unwarranted medical convention. Other ways of talking about human mental distress can and should be deployed. Just as, say, we no longer classify phlogiston as a real or existing substance (although the phenomenon of combustion that we human beings used the concept of phlogiston to help to explain remains real), we should no longer classify conditions of depression or obsession as mental disorders or illnesses (although as disturbances those conditions remain real).

When I speak of mental disorders as real, I don’t mean that they are mind-independent. I don’t mean that they are obvious observationally. I don’t mean that their existence is immune to the skeptical doubts of reasonable people. I mean at least four things, each of which is defended in one place or another over the course of the book.

First: Mental disorders exist independent of whether we have a theory about them, think about them as such, or classify people as subjects of mental illness. Just as a person may have a somatic illness or bodily injury independent of whether we realize it, so a person may suffer from a mental disorder without anyone’s recognition of this fact. Mental disorders are not
mind-independent. But they are, as it were, act-of-classification-independent (or act-of-recognition-independent). Mars would exist whether we classify or recognize the orb or not. But this is because Mars could exist if no mind existed. Mental disorders could not exist in a mindless world. However, they could exist in a situation or world in which no one classified or recognized mental disorders. If our world was devoid of terms or concepts for a mental disorder, there still could be mental disorders.

Second: Mental disorders are empirically discoverable. By this I do not mean that mental disorders are precisely distinguishable from non-disorders or that they possess sharp edges or precise borders. Instead, I mean that they are suitable foci of investigation and analysis, that empirical or scientific generalizations can be made about them, and that whether someone is the subject of a disorder cannot be settled just by appreciating that they are disturbed or upset. To qualify as a disorder, a condition or disturbance must meet certain standards or norms. A disturbance’s success or failure in meeting relevant standards or norms also is discoverable.

Third: The evaluative standards or norms for being a mental disorder are such that, when a person is the subject of a mental disorder, there is something wrong with them, wrong, in particular, with their mental and behavioral activity. They are in a condition that they ought not to be in. Their behavior is not just harmful to them (and perhaps also to others), whether they realize it or not, but it represents a truncation or impairment in the reason-responsive operation of one or more of their basic psychological faculties or capacities. The behavior is no mere performance error, judgmental lapse, regrettable personality trait, or character flaw like laziness or nosiness.

Finally fourth: In speaking of realism about mental disorder, I also mean that fears about the displacement or dispensability of reference to mentality or psychology in our description and explanatory understanding of a disorder on grounds of its neurological basis are unfounded. In order to explain some human afflictions, such as blinding brain lesions, hemiplegic cerebral palsy, quadriplegia, conduction deafness, and so on, brain science and the associated language of neural disease or illness is canonical and exclusionary. Psychology as a science or discipline may help to describe some of the consequences or symptoms of those afflictions, but the discipline itself is not truly fit for grasping such afflictions’ immediate origins or causal explanatory foundations. However, psychology is needed to account for a condition that deserves to be called a mental disorder. A-rational (mechanical) and mind-infused rational (non-mechanical) factors each interact to produce a mental disorder. Though not the only signatory, the mind qua mind puts its inscription on the sources and progression of a disorder. We cannot recognize a condition as a mental disorder without uncovering that psychological mark or autograph, or so I argue.

Here are more advance details.

Numerous mental disorders are discussed in the book, some more than once. These include among others: clinical or major depression, dissociative identity or multiple personality disorder, acute anxiety (in some forms), addiction (in some forms), grandiose/religious delusions, and paranoia. Several non-mental neurological disorders that possess psychological symptoms also are examined. These include among others: Alzheimer’s disease, autism, Down’s syndrome, and Gilles de la Tourette syndrome.

In this book I outline a way in which to understand the distinction between mental disorders and (non-mental) neurological or brain disorders with psychological symptoms. I do this, in part,
in terms of exemplars, prototypes or more or less uncontested examples of each. (I use ‘exemplar’ and ‘prototype’ interchangeably.) I claim that the partition or boundary between mental and non-mental physical or neurological disorders is not a sharp chasm, although it is no less real or objective in spite of that fact. The boundary is, if not a hard fact, a soft fact.

Exemplars of a mental disorder may be displaced or dethroned, of course, if theory advances and clinical and scientific evidence progresses in new and different directions. The seizures understood as symptoms of an exemplary mental disorder decades ago may be reinterpreted today as brought about by damage to the temporal lobe and reclassified as signs of a neurological disorder.

Many mental disorders have features in common with non-mental physical or somatic illnesses including their forms of apposite or appropriate treatment. Drugs may help with an anxiety disorder as well as with Tourette’s. Psychotherapy may assist with some symptoms or aspects of Parkinsonism as well as of major depression.

While no single chapter is devoted to ethics, over the course of the book I briefly consider a few moral problems surrounding mental health research, clinical practice, and social policy. These considerations are influenced by stands I take on the place of philosophy of mind in the theory of mental disorder. One is the problem of whether benevolent or compassionate treatment of a victim of delusional paranoia morally requires empathetic understanding of their paranoid worldview. We persons, of course, differ in our capacities for empathy or emotional projection, just as we differ in our moral motivations. Some of us possess rather limited capacities to imaginatively simulate the inner lives or attitudes of others. But, morally, should possessing some empathy for deluded persons count as part and parcel of clinical care? That is one of the moral questions I examine in the book.

Generally speaking, one criterion for me in the proper treatment of mental disorders is to help people to maintain or recover their dignity and self-respect. The problem of dignity and self-respect preservation is viewed by me as a special instance of a challenge that we all face as human beings. The challenge is to achieve a responsible and productive response to life’s heartaches and misfortunes by giving them a “meaningful place in one’s progress through life” (Velleman 1991: 55).

To mend or heal from a disorder in a self-respecting and dignified manner requires discovering a positive or purposeful place for past or present episodes of disorder in the future course of a person’s life. The fact that a person has or has had a disorder is no personal discredit or sign of poor judgment or faulty character. It is an expression of vulnerability to instability that all of us harbor in our psychological makeup.

Achieving a purposeful place for episodes of disorder often consists of dealing with conflicting alternative interpretations of one’s past. Caution in interpretation is required however. Exaggerated emphasis or endless rumination on past episodes of disorder runs the risk of missing lessons that are present in other phases or chapters in one’s history.

Influential among efforts to emphasize thinking about the past in a process of recovery is the Freudian presumption that acquiring truths about one’s childhood is critical for mental health. Revive the distant past, remember forgotten experiences, and return to recollected trauma. As two observers put it, “to Freud ... falling like a shadow over every ... life is the significance of early injuries to the self.” “A kind of ... scar that then must burden ... later development.” (Gross and Rubin: 2002: 94).
I confess that I am personally leery about the therapeutic efficacy of persistent rumination upon past scars. Especially scars inflicted in the distant past. Two reasons constitute warrant for caution. One is sociological and comes from research on different ways in which people respond to bad experiences. Ruminative responding seems, for many people, to be immensely unhelpful. It leads to the recall of more negative memories, more negative interpretations of past events, and more pessimism about finding effective solutions to present and future personal problems (see Bentall 2004: 264).

The other basis for caution is epistemological or evidential and stems from appreciating that a person’s past often just is too vast, inaccessible, and riddled with heterogeneous and ambiguous events to serve as the primary focus of reconstruction or recovery. The past, especially the personally distant past, may be a highly indeterminate place when viewed from the vantage point of one’s current evidential or epistemic perspective. Not just in the ambiguities it presents to our feelings and recollections, but, perhaps more profoundly, in the indeterminacies it poses to our efforts at discovering interpretative significance. More helpful and optimistic, for me, is the forward-looking attitude of the philosopher and psychologist William James (1842–1910). James urges us to aim at constructing interpretations of the past that help to secure good results for future behavior. Past accuracy is less important than future utility, assuming that, normally, there often are numerous ambiguous past events about which factual surety cannot be achieved. “Few of us,” writes James, “are not in some way infirm [but] our very infirmities can help us unexpectedly” (James 2002: 29). To be helped, however, he notes, a person must realize that “there are dead feelings, dead ideas, and cold beliefs, and there are … live ones and … everything has to re-crystallize around [them]” (2002: 218).

James’s admonition to focus or crystallize on live ideas or attitudes that assist in future reclamation is not aimed at denying the past suffering and misfortune that is part of a disorder, but at trying to reverse its polarity. Negative past experiences of depression, acute anxiety, or delusion may become positive in delayed and deliberate consequence when they contribute to reconstruction, reconstitution or reformation – to determining how to behave or to think purposively in the future – and are viewed in a progressive light. Getting the past in accurate pictorial detail is less important than sculpting the future properly.

“My residents and I,” writes one senior psychiatrist, “end up teaching [patients] how to situate their symptoms, problems, and miseries within a larger life trajectory” (Sadler 2004a: 359). Constructing a future trajectory rather than achieving a past accuracy – if one has to choose where to devote one’s energies between them, the first, the future, is to be preferred.

Ask Alice. To overcome her anger and despondency, Alice should not deny that her husband lived a lie. He did. That fact painfully is obvious. But there may well be other aspects of her relationship with Howard that fail to admit of so obvious and negative an interpretation. One such aspect may be whether he loved his second wife more than he did Alice. Perhaps he did not. Perhaps Howard’s trips to Kansas City stemmed from a desire to hide a shameful and embarrassing relationship with the second woman rather than from a deep and preferential love for his second spouse or a child who may have been accidentally conceived. The attempt to hide is not a welcome trait on his part, to be sure, but it does not necessarily reflect a preference for the second woman.
Alice needs emotionally to breathe again. She needs to feel that she mattered much to Howard. If it is not obvious whom he preferred, then, other things being equal, she may have good reason to believe or hope that she herself was his deepest and most important love. Persistent brooding over the fact that he deceived her and fathered another child offers no such relief.

A few brief and final words are in order in this introductory chapter before beginning the project of theory construction that I have described above.

If mental disorders are real, and qualify as conditions aspects of whose occurrence are controlled or explained, in part, by reference to forces described in mind-language terms, a theory of mental disorder should illuminate just what it means for mentality to exert partial control over a disorder. The problem of finding a role for mind in a disorder is especially challenging for a theory of mental disorder like the one offered in this book. This is because the theory offered here also locates or describes some of the controls behind a mental disorder in the language of brain science, although it says that subjects of mental disorders do not suffer from damaged brains or neurological disorders. Meanwhile, if it is empirically possible for neurological disorders and mental disorders to pull apart in a causal-explanatory way, although the boundaries between them may not be sharp or precise, considerable theoretical or conceptual elbow room is then left open for mental disorders to be real and theoretically distinct disorders.

One aim of this book is to delineate that theoretical or domain space for mental disorder. It is to identify categorical elbow room for a type of disorder that deserves to be classified as a mental disorder. It is to show how if a disorder harbors certain psychological features in its pathogenesis or causal explanatory foundations, it should qualify as a mental disorder. Philosophy of mind, then, can help us to identify and understand those features.

In psychiatry most problems are not those of philosophy of mind, to be sure, but helping, along with other disciplines, to conceive of conceptual or categorical elbow room for a category mental disorder partly is a job for philosophy.

**SUMMARY**

This first chapter introduced the main topics of the book and outlined the general manner in which I plan to address them.

The chapter offered a general orientating and heuristic description for why we persons are vulnerable to mental disorder. The human mind is a mix of the orderly and disorderly, the stable and unstable. When this mix goes awry, mental disorder may ensue. It noted the importance of Freud to the history of psychiatry. It urged that a theory of mental disorder should acknowledge its need for assistance from philosophy of mind. It noted that, in order to recognize that disciplinary dependence, this book describes elements in philosophy of mind of special relevance to the theory of mental disorder.

All of us are prone, at least at times, to spiral out of rational or reason-responsive control. Such spirals or episodes, when they constitute a mental disorder, cannot fully be understood just in terms of the language of mind. Brain science, too, must enter into the explanatory picture. But
the chapter claimed that mental disorders need not be brain disorders even if or though mental disorders somehow are based in the brain. This claim awaits detailed defense in the book. It is one of its main themes and central to what I mean by realism about a mental disorder.

SUGGESTED READING

I state an obvious fact. The task of describing the conceptual makeup of the category or domain of mental disorder is truly daunting.

*Mental disorder* is such a big and varied category of states and conditions. How can it be meaningfully decided what mood disorders, anxiety disorders, personality disorders, delusional disorders, impulse control disorders, etc., have in common? But this chapter aims to give the task a try. Or more exactly: it aims to begin the task. The chapter is about how to construct a sound and sensible concept of mental disorder. Not just of disorder and not just of the reference of the term ‘mental’ in the expression ‘mental disorder’, but of the category of *mental disorder*. This chapter helps to set the stage for the theory of mental disorder to be constructed and applied in the rest of the book.

**MENTAL DISORDER HAS CONSEQUENCES**

The very idea of a *mental disorder* has numerous consequences of diverse types. Classification deploying the concept affects millions of people in a variety of different ways and settings.

Scientists and mental health professionals specialize in the study and treatment of mental disorder. Patrons, benefactors, and governments support mental disorder research. Psychiatric drugs and therapies are dedicated to the amelioration of mental disorder. Lawyers and legal advocates argue that if their clients suffer from certain disorders this reduces liability for crimes. Consumers select insurance companies on the basis of whether they reimburse for treatment of mental disorder. Scientific journals, professional associations, patient support groups, book publishers, and websites devote themselves to the topic of mental disorder. Reference to mental disorder is prominent in the autobiographies, biographies, and memoirs of scientists, statespersons, soldiers, scoundrels and saints. People’s self conceptions, family aspirations,
and social goals often are affected by whether they or those whom they love are classified by mental health professionals as subjects of a mental disorder. Talk of disorder, albeit in this particular type of case, more often than not, loose and informal, appears in descriptions of ordinary moods, problems and emotional disturbances. We speak of ourselves as ‘seriously depressed’, being prone to ‘panic attacks’, or ‘addicted to work’, and so on.

It is difficult to escape from the idea of mental disorder. Indeed, difficult, it seems, to escape from disorder oneself.

A recent survey by R. C. Kessler and associates, published in the prestigious Archives of General Psychiatry, claims that nearly half of the citizens of the United States suffer from a mental disorder at some point in their lives (Kessler et al. 1994). Is that true? Does a label or concept with that many personal and social consequences apply to so many individuals in just one country alone? The accuracy of statistics like those offered in the survey depends, of course, on the validity or legitimacy of the concept of a disorder that it deploys or presupposes. Skeptics charge that such surveys typically fail to deploy sound and sensible concepts of a mental disorder (see Elliott 2003; Horwitz 2002; Horwitz and Wakefield 2007; Wakefield 1999). Unsound and insensible instruments, they charge, misclassify numerous cases of non-disorder as disorders and therein overestimate the prevalence and epidemiological range of instances of mental disorder. Some skeptics assert, too, that legitimate boundaries have yet to be drawn around a concept of mental disorder (see Bentall 2004; Poland, von Eckardt, and Spaulding 1994). One well-situated observer even claims that “psychiatrists do not know what they mean explicitly by mental illness/mental disorder” (Columbo 2008: 70).

Robert Schumann (1809–56), no doubt, had a mental disorder. To all informed ears Schumann is one of the greatest composers of classical music who has ever lived. But, tragically, Schumann suffered from a profound and periodically recurring depression. So profound, in fact, that he starved himself to death in an asylum, where he had insisted that he be placed after a failed suicide attempt. He had jumped into the Rhine River (Ostwald 1987).

Just as we don’t wish people who lack mental disorders to be classified as if they harbor them, we don’t wish people, like Schumann, who are subjects of a disorder being treated so poorly or incorrectly that they become suicide statistics. So: We need a good concept of mental disorder. We need a concept that identifies real cases of disorder and helps us to properly treat people with disorders. We need to enact what may be called conceptual rectitude in the very idea of a mental disorder. Or we need to do this as best we humanly can.

A tangle of different and competing concepts of mental disorder is available in the literature. I do not intend to survey them all, though some will be examined in the course of the book. This is because I assume that no concept of a mental disorder other than that which is proposed by a good theory of mental disorder suffices as a good concept. A concept with rectitude. We need a good theory before we can have a good concept and assess the strengths and weakness of competing concepts.

WHAT SHOULD A THEORY OF MENTAL DISORDER DO?

So, what should a theory – a good theory, a sound and sensible theory – of mental disorder do?

A theory of mental disorder should consist of several components. Five in all.
First and foremost, it should describe what a mental disorder is. It should offer a concept of mental disorder. This means it should offer a concept that captures the basic nature or constitution of a mental disorder and helps, in concert with other concepts, to distinguish mental disorders from disorders that are not mental, such as purely somatic illnesses like breast cancer or diabetes, as well as from non-disorders or ‘mere’ problems or disturbances in living, such as normal grief over the death of a loved one, anxiety over exams or fear about the possible loss of a job.

The need to offer or describe a concept of mental disorder does not mean that the concept must be constituted by a clinically tractable list of necessary and sufficient conditions for membership in the category mental disorder. That is, it does not require a hard and rigid categorical definition of mental disorder. If a hard and rigid definition for a mental disorder was to exist, disturbances or distresses would count as in the extension or compliance class of ‘mental disorder’ just in case they satisfy each and every condition on the list. No non-mental disorders would be corralled into the category of a mental disorder. No mental disorders would be outside the conditions in the list.

Consider an imaginary template for a list of the necessary and sufficient condition type.

\[C_1\] –.
\[C_2\] –.
\[C_3\] –.
\[C_4\] –.

Now imagine filling in the blanks with descriptions of purported conditions or characteristics of a mental disorder, whatever they may be. Once filled in, if the list is correct or accurate and captures necessary and sufficient conditions, and we wish to know whether a particular distress or disturbance counts as a mental disorder, then we should consult the list and compare the constitution of the list with the character of the disturbing condition. When a disturbance possesses each and every element in the list, then and only then does it count as a mental disorder.

Lists of necessary and sufficient conditions or hard and fast definitions for being a mental disorder are notoriously hard to devise. No such list has attracted the consensus of informed professionals. Indeed, whenever such a definition or list is proposed by someone, which occurs rarely, other theorists tend to be skeptical. Rightly so, I believe.

I assume that the concept of a mental disorder lacks necessary and sufficient conditions for its application. In so doing, I am agreeing with psychiatrist Nancy Andreasen, when she says that it possesses “debatable boundaries” (Andreasen 1984: 35). I am, however, disagreeing with various other theorists who charge that its debatable boundaries mean that the concept of a mental disorder just is a catchall concept, utterly resistant to regimentation or conceptual rectitude (Gorenstein 1992: 14). Plenty of good and useful empirical concepts have debatable boundaries, even if they don’t have necessary and sufficient conditions for their application. Take the notion of a ‘book’, for example.

You, I assume, are holding an instance of the proper application of this concept in your hands right now. You know how to talk about books and to recognize them. But, I suspect, you appreciate that there is plenty of conceptual elbow room for debate over what exactly counts as a book. There are fuzzy borderline (non-exemplary, non-prototypical) cases. Must a book have
pages? Must it be printed? Can it be stored in a computer file? Can an author carry a book around in their head? Is a comic book truly a book? To debate how best to answer questions like those is neither to deny that, objectively speaking, books really do exist nor to doubt whether you are reading a book. It is not to assert that ‘book’ is a catchall term or that we don’t have the foggiest idea whether books are housed in libraries or may be purchased in stores.

Eleanor Rosch understands how sound and sensible empirical notions like that of a book or of a mental disorder are best defined (Rosch 1978; see also Margolis and Laurence 2003). Rosch, a psychologist at the University of California at Berkeley, says it goes something like this. People begin by using a word to describe cases to which the word initially is intended to apply. Over time the word’s application may then be extended to novel cases by a successive series of similarities, resemblances, and analogies with the initial cases. So, for instance, someone first calls an object a ‘book’ if it is a set of written printed and bound pages, and so on. Then someone calls a second object a book because it resembles the original object in certain ways, if not in every way; then, the process continues. Up to a point. What point? That depends. Sometimes the resemblances in the mind of the speech community are too thin, metaphorical, or confusing to merit the term ‘book’. Or other terms may do a better job. The book on my desk is a book. The ‘neural code’ in my head, unwritten and unbound, is not. It’s just a neural code. But extensions sometimes stick. Comic books cost much more today than they did when I was a child. They’re also books despite not possessing truly protective covers.

Failure to possess necessary and sufficient conditions is no liability for an empirical notion that like of a book. Nor, I assume, is it a liability for the empirical notion of a mental disorder. Besides which, for a concept like that of a mental disorder to possess such conditions (or more exactly conditions believed to be necessary and sufficient) arguably is not a blessed event. A list of purported necessary and sufficient conditions (especially depending upon the alleged necessary conditions) may overly or unwisely constrain whatever empirical investigation may discover about a disorder.

Suppose the American Psychiatric Association decrees that something is a mental disorder only if it is a brain disorder or a neurological malfunction, impairment, disease, deficit or disability viz. the expression of a broken brain or ‘mechanism’. Mental disorders are types of neurological disorders, so dictates the higher councils of the Association. Call this purported necessary condition ‘C3’.

Faced with this piece of judgment or legislation, psychiatrists, neuroscientists, neuropsychologists and others would be encouraged or urged to try to discover, identify, and describe impaired or disabled mechanisms within the brain that C3 says are properly referred to as mental disorders. If C3 is true, it must be possible, in theory at least, to tell a brain damage or neural malfunction story for any and all properly classified mental disorders. Indeed, a lot of mental health professionals are already attracted to a broken brain/neural disorder conception of a mental disorder. A psychiatrist, for example, may tell her depressed patients that depression is “a brain disorder, just like epilepsy”. “Just as you would take drugs for epilepsy, you should take them for your mental disorder.”

Some of the reasoning behind the broken brain conception of a mental disorder is represented by the following line of argument.
1. The mental is physically based or realized in the brain or the neural.
2. X is a mental disorder.
3. So, X is a neural physical disorder, a disorder of the brain.

Consider, though, a somewhat analogous inference about your computer. A software state of your computer is physically based in a hardware state. So, a software malfunction is a hardware malfunction. Or:

1*. A computer software state is based or realized in a hardware state.
2*. Y is a malfunction in the software.
3*. So, Y is a hardware malfunction, a disorder of the hardware.

But, of course, it does not follow that if a computer’s software fails to function properly, then its hardware base is broken. If my computer finds the wrong price for a desired airline ticket, this could be a hardware problem, a software problem or a simple, albeit frustrating, instance of misinformation at the airline’s website. Peculiarities in software or in an environmental source of information may be responsible for errors in processing even if there is no corresponding malfunction in the computer’s physical machinery (see Arpaly 2005: 283).

I believe that a distinction between a brain disorder and mental disorder, if it can be established, and a mere analogy with a computer does not establish it, for that’s a big and complex ‘if’, would be immensely important theoretically. I am in favor of drawing it (a topic discussed throughout the book). I am in favor of saying that a mental disorder may be based in an unbroken or healthy brain. I am not alone in holding the view that mental disorders may be based in unbroken or healthy brains (see Arpaly 2005; Poland 2013; Nesse and Jackson 2011; see also Graham and Stephens 2007 and Stephens and Graham 2009a), although I may be willing to understand, extend, develop or hold fast to this possibility in ways in which other theorists are not, such as by making it central to the very idea of a mental disorder in which conceptual rectitude is enacted as well as to metaphysical realism about mental disorder.

If we understand a mental disorder as a type of brain disorder and recount its story just in terms of a damaged or malfunctioning brain, while this does not imply that we are mistaken in thinking of the condition as a disorder (after all, it is a neurological disorder), it does rule out thinking of the disorder as a mental disorder (or so I hold and plan to argue). Realism, for me, about mental disorder says that mental disorders are honest-to-goodness mental conditions or states of persons. While this needs not entail that they are non-physical in nature, it does preclude, as I plan argue, understanding a mental disorder in exclusively and exhaustively neuroscientific or neuro-mechanical malfunction terms – as is the case with conditions that are brain disorders or cases of broken or malfunctioning brains.

Of course, it may be objected that any pattern of neural activity that serves as the physical or existential basis of a mental disorder qualifies, by this very fact alone, as a brain or neural disorder. Such a piece of conceptual legislation, however, is not what neurologically enamored investigators typically mean when they propose that a mental disorder is nothing other than a type of neural or brain disorder. An enormous scientific investment is being made in many quarters in finding the neural mechanisms that underlie mental disorders. Often this investment
is based on the premise that mental disorders are nothing other than disorders or impairments of brain mechanisms – or brain diseases, as the premise sometimes is put. Nancy Andreasen writes in a chapter of *Brave New Brain* entitled (and note the title) “Broken Brains and Troubled Minds” that “Psychiatrists … have steadily recognized that mental illnesses are … cells in our brain [gone] bad [and] this is expressed at the level of systems such as attention and memory [in disorders] such as schizophrenia and depression” (Andreasen 2001: 7; see also Andreasen 1984: 8). (Here and hereafter in this book words in brackets that appear in quotations are inserted by me.)

What normally is meant by referring to mental disorders as disorders of the brain or cells gone bad is that various neurologically specifiable breakdowns or malfunctions occur in the brain (due to a developmental trauma, anatomical injury or chemical pathogen, just to name three sorts of causes) and that such breakdowns help to constitute or compose the conditions that are referred to as mental disorders. So, a mental disorder is a type of brain disorder. It is not merely realized or existentially embodied in the brain (in its cells, as it were), but is itself a form of bad cells or neural damage or impairment.

Given the purpose or intent behind the broken brain view, it is contrary to its scientific aspiration to propose that ‘brain disorder’ should be defined first in terms of the conceptually prior notion of a mental disorder, and then and then only recommend that the notion of a mental disorder should be re-described as that of a brain malfunction or disorder, all the while continuing to use the criterion of a mental disorder as the criterion for a brain disorder. The whole effort of identifying a mental with a neural impairment would be viciously circular. It would make the notion of a brain disorder depend on the notion of a mental disorder rather than the other way around. The identity of a mental with a neural disorder (urged by Andreasen and others) is supposed to mean that the very ideas of a neural disorder and of how the brain is supposed to operate if healthy, properly regimented or explicated, should be used to describe what makes something a mental disorder. It is not supposed to mean that the mere fact that the brain is the physical basis of a mental disorder means that the brain itself is disordered or damaged in cases of mental disorder, viz. possesses ‘cells gone bad’, to restate Andreasen’s catchy phrase.

As it happens, the general distinction that I am suggesting here between that of a disorder being in Z (in Z, the brain, as its existential base) versus of Z (a brain disorder) is quite orthodox in medicine. Consider the domain of somatic or bodily illness or disease. The presence of pain, fever, cough, nausea, vomiting, diarrhea or fatigue does not necessarily mean that something is wrong or malfunctioning with a person’s body or soma even though, of course, such events are unpleasant and often need to be addressed medically. Fevers and diarrhea, for instance, may, on occasion, be a body’s defenses against disease, danger or bodily damage (see Nesse and Williams 1996). Fever or diarrhea may mean that the body is functioning well by personal preference-indifferent biological standards. Perhaps it is ridding itself of dangerous toxins. So: Some somatic distresses, including discomforts whose aversive or harmful qualities warrant medical treatment and amelioration, may not therein actually be physical illnesses or diseases (depending upon the criteria for such). In such cases we need not speak of a disorder (an impairment, dysfunction, breakage or incapacity) of the body in order to identify the physical sources of discomfort. A fever or case of diarrhea may be a disturbance in the body without being an illness or malfunction of the body.
I am suggesting that insisting upon brain disorder status for qualifying as a mental disorder goes conceptually overboard. Of course, even assuming the conceptual possibility of being able to distinguish between explanatory standards for brain and mental disorders, it may be difficult empirically (even given the theoretical wisdom of the distinction) to tell apart the identity of a healthy or ‘ordered’ brain that underwrites a mental disorder from that of a broken brain that underwrites a neurological illness with psychiatric symptoms. Consider Tourette’s Syndrome, which, I assume, is a neurological disorder. It is marked by tics, forced vocalizations and involuntary profanities. There are number of hypotheses for the possible forms of brain disorder responsible for the Syndrome, early brain damage or childhood infection among them. But it is not obvious just from what the Tourettic person says whether they are suffering from a neural impairment (brain damage or infection) with psychiatric symptoms or, instead, angrily, as part of a mental disorder (paranoia perhaps), intending to indulge in hateful speech acts under conditions, say, of stress or emotional arousal. We may be inclined to say things about them like “As part of her illness she really hates me and wants to insult me”. But suppose the proper scientific picture is: “No, no, no, she does not hate you or intend to insult you”. “Her speech reflects no deliberate intention and is not infused with real conceptual content” “She is undergoing a burst of impaired electrical activity in her brain.” “The sounds appear as speech, real profanities, but they aren’t.” “Her cells have gone bad.”

There is a difference between saying that the subject of Tourette’s irrationally hates or distrusts the people at whom they curse and that this explains why they curse, and saying that their profanities are not speech acts (or real or intended curses) at all, but the expressions of impaired electrical activity. The first would be apposite in describing or understanding Tourette’s symptoms as expressions of a mental disorder (wherein explanatory reference to the neural is incomplete and psychological explanation partly is called for). The second is the sort of remark appropriate to thinking of Tourette’s as a neurological disorder.

As for conceptual rectitude and the concept of mental disorder: If conceptual rectitude cannot be achieved by reference to necessary and sufficient conditions or to disorders using bio-neurological criteria or standards of brain damage or malfunction, then how is it best achieved? Fortunately, there is another way in which to begin to characterize mental disorder – at least as a revisable working hypothesis or starting position for a theory of mental disorder. It has been hinted at above in the example of a book. This is to recognize that the concept of a mental disorder has uncontroversial or prototypical instances of application or exemplars, as they may be called. An uncontroversial instance or exemplar is a case that competent and clinically informed observers or qualified judges agree (or at least currently widely agree) is a mental disorder. Then, reference to prototypical or exemplary features of such cases provides some initial working information about how best to characterize the idea of a mental disorder. Reference to a disorder’s prototypical features also fallibly characterizes a disorder. If a disorder now is consensually classified as mental but somehow later is discovered to be a neurological disorder, then the condition should fall out of the category of a mental disorder. It should be reclassified as a deficit or disorder of a broken or diseased brain. A condition may fall out (or in) the evolving compliance class of mental disorders.

Ian’s paranoia may be thought of as a mental disorder until perhaps it is discovered that a specific site in his limbic system is damaged and is responsible for his reason-unresponsive or
general distrust of other people. If so, it would be time then for brain science to take over the explanatory understanding of his condition.

So, what about a good theory of mental disorder? A good concept of disorder is needed from that theory. A theory of mental disorder should have elements other than a concept for the domain of mental disorder. It’s not all about the idea of a mental disorder. And it’s not all about disentangling relationships, if they deserve to be disentangled, between the idea of a mental disorder and that of a brain disorder.

Second, there should be a list that specifies types or kinds of mental disorders. Such a list is known as a taxonomy or nosology of mental disorder. The taxonomy should identify categories of mental disorder, such as ‘major depression’ and ‘paranoid delusional disorder’. It should contain descriptions of the compositional or constitutive details of particular disorders. What makes depression a case of depression? Delusion a delusion?

Third, the theory should explain why disorders are undesirable conditions of persons and normally require medical/psychiatric address or clinical amelioration. Or as I like to put it: The theory should answer the following question: What impairments of basic or fundamental psychological capacities or mental competencies or faculties make them disturbances of clinical importance or psychiatric significance? These may be conditions that need to be ‘fixed’ or repaired.

Fourth, the theory should offer or provide explanations of the occurrence or onset of disorders as well as of the emergence and progression of their symptoms. This fourth element is worth a short pause or commentary.

Explanations clarify or illuminate. They identify how something comes to be, or why things happen as they do. So, for instance, an explanation of the occurrence of a mental disorder, say, a case of major depression, MD, may claim that the immediate origins or proximate causes of the disorder lie in certain sorts of conditions or events (X) rather than others (Y). In so doing, the explanation may deploy counterfactual claims or statements of the following sort. If, contrary to fact, X had not happened, or Y had happened rather than X, then the mental disorder, MD, would or probably would not have occurred. An explanation may therein contain predictive power among its warrant or grounds. If reference to X (rather than to Y) explains the present occurrence of a disorder, MD, then the reappearance of those very same conditions predicts the future or likely future occurrence of the very same sort of disorder. If this prediction holds true, then this is one good reason for preferring the explanation of MD in terms of X rather than the explanation in terms of Y.

Finally, fifth, a theory of mental disorder should tell us how to treat or care for people with a mental disorder and how persons may recover or reconstitute their mental health. One of the main goals of medicine is the care and cure (if possible) of those with a malady. It is immensely consistent with the rest of medicine, of course, for a theory of mental disorder to be aimed, in important part, at the care and ideally cure of individuals with a mental illness. Indeed, I think this is one of the background considerations relevant to how we should try to explain the occurrence and progression of a mental disorder. With multiple and sometimes conflicting theories and descriptions competing as explanations of a mental disorder, our notion of a best theory of disorder calls for some connection with clinical demands and the morality of care and treatment of disorder. When we widen our purview to take in not just our scientific research but our clinical
practice, and not just clinical practice but its moral or ethical dimensions, we should be cautious in embracing explanatory hypotheses about a disorder that are not focused on or applicable to therapeutic recovery and reconstruction of mental health and well-being.

Philosophers sometimes talk of so-called ‘superempirical’ virtues of a scientific theory, by which they mean things like its simplicity, power of explanatory unification, and coherence with background knowledge and understanding. To this I would add, in the case of a theory of mental disorder, a theory’s clinical utility or promise of positive therapeutic applications. This ‘superempirical’ medical virtue should not force dismissal of a theory with independently strong evidential and explanatory grounds. Sometimes the truth does not help but hurts. But a theory’s clinical utility should encourage (other things being equal) the theory’s at least pragmatic adoption or temporary embrace over less useful competitors.

A concept of mental disorder. A nosology of disorders. An identification of undesirability. Explanations of disorders. A path to clinical utility. These are the foci of a theory of mental disorder. I will have things to say about each of these five topics or elements over the course of the book, although not much about the fifth. First things first, however.

The question being asked is: What is mental disorder? How should the category or concept of a mental disorder be characterized? At this point, since we do not yet have a theory of mental disorder, we cannot trot out and fully describe the concept that is or should be part of our theory. But a foretaste or pre-statement of it may prove useful, prior to development or analysis.

Consider a real case of a mental disorder or least one that I assume is a real mental disorder (if clouded in history and contestable in interpretation). Consider the case of Virginia Woolf (1882–1941), English novelist and essayist. Woolf committed suicide by drowning herself. Why did she do such a dreadful thing? Here’s a plausible hypothesis: Woolf feared a complete depressive breakdown (having had major depressive episodes in 1895 and 1915) from which she believed that she could not recover. In a suicide note to her husband, Leonard Woolf, she wrote that “I shan’t recover this time.” “I begin to hear voices.” “I can’t fight it any longer” (quoted in Slavney and McHugh 1987: 31). Quentin Bell wrote of Woolf’s episodes as follows: “Her sleepless nights were spent in wondering about whether her art, the whole meaning and purpose of her life, was fatuous, whether it might be torn to shreds by a discharge of cruel laughter” (quoted in Slavney and McHugh 1987: 31). Woolf’s disorder, in the words of Philip Slavney and Paul McHugh, two psychiatrists at Johns Hopkins who have studied her case in retrospect, “shaped her development as a person and as a writer, affected her closest relationships, and eventually claimed her life” (Slavney and McHugh 1987: 116).

The symptoms of Woolf’s particular disorder consisted, in part, of a complex set of conscious experiences of self and world: anxious sleepless nights, doubts about her art, fear of public humiliation, grief over the loss of her London homes during the Blitz, and so on.

A large body of research examines the general sort of subjective situation and social circumstance in which someone like Woolf appears to have been embedded (see Klinger 1977; Emmons 1999; see also Abramson, Metalsky, and Alloy 1989). When a person is committed to a life defining goal (in Wolfe’s case, that of being an accomplished and admired writer), persists in intense and challenging efforts to achieve it, but simultaneously fears or believes that the likelihood of success is negligible or slim-to-none, they may feel trapped or intractably stymied, helpless or impotent. They may believe that they can neither approximate that goal nor
effectively disengage from its pursuit, since so much of their labor has already been mixed with its land, so to speak. Perhaps such a person’s conception of their own merits as a person may depend on the goal’s pursuit but is, as the person fears, most likely to be frustrated. When this happens, when a person is driven to succeed but feels bound to fail, their commitment to themselves and to their own personal well-being may collapse or tumble. They may become incapable of prudently taking care of themselves or of protecting their own welfare or well-being. Whether this describes Woolf’s situation and some of the psychological forces behind her depression (viz. a sense of entrapment or helplessness) may be debated, of course. (I am assuming, for purposes of illustration, that it does describe such things.) But certainly Woolf lacked a prudent capacity for responsible self management. Despite her successes and the attentions of those who loved her and admired her work, she ended up committing suicide.

So, what, then, is a sound and sensible concept of mental disorder? Rather than travel through this and a number of chapters to reveal my final answer, I shall state it now. Then, after working through the next several chapters, I plan revisit the statement in the sixth chapter, having in the meantime detailed both its meaning and rationale and adding additional features to it.

There are four main and different, although interconnected, parts to the concept of a mental disorder that I propose. It goes like this (remember, subject to later refinement and addition).

The notion of a mental disorder, prototypically understood and conceptually regimented, is the notion of (i) a disability, incapacity or impairment in one or more basic or fundamental mental faculties or psychological capacities of a person – not a complete and utter or total incapacity, but an incapacity or impairment, that (ii) has harmful (or likely harmful) consequences for its subject. The disability, incapacity, or impairment possesses a special sort of proximate or immediate origin or source. It is (iii) brought about by an interactive mix of mental forces, on the one hand, and (what may be called) brute a-rational neural mechanisms (although not of the pathological sort operative in a case of brain damage), on the other, and (iv) in which the interaction or intersection of these two forces endows the disorder with a truncated ‘logic’ or an impaired or compromised rationale that is distinctively a disorder’s own.

A depressed Alice may not get out of bed. A paranoid Ian may remain locked inside his home. Woolf may commit suicide. Just why such people do such things rather than others is explained, in part, by the rationales behind or within their depressions and paranoia. The depressed Alice does not wish to face the day, so she stays in bed. The paranoid Ian does not wish to engage with other people and possible agents of the FBI, so he locks his door. Woolf fears another breakdown. For her death is the answer.

If I am right and this notion of a mental disorder is sound and sensible, then Woolf’s depression, Alice’s depression, and Ian’s paranoia qualify as instances of mental disorders if each reflects a harmful disability of one or more of their basic psychological capacities, and springs from two sorts of factors, one characterized in mental terms, the other in neural terms (see just below), and that put each of them at serious risk for harm (e.g. for committing suicide). For instance (to oversimplify for illustrative purposes): One possible neural mechanism behind certain aspects or features of depression may be high levels of emotional activation or arousal produced by the limbic system. Eventually, this activity may cascade into the hypothalamus and from there into the autonomic nervous system, preparing a person for, for example, a suicide attempt. Meanwhile, one set of mental forces (among others) behind a depression (or certain
cases of depression) may be a belief in one’s personal helplessness, impotence or inability to reach desired goals. This belief may lead a person to a severe decline in self care. “I can’t help myself, so why bother to try?” The mood effects of levels of emotional arousal combined with belief in personal helplessness and a decline in prudent self care may help not only to bring about a depression but to ‘rationalize’ some of a depressive’s behavior. Committing suicide may possess a sad, sorry and truncated rationale.

Andreasen appears to recognize the power and relevance of the two sorts of forces that I mention as responsible for a disorder (in [iii] above). She writes: “As we think about mental illnesses, we will be mindless if we address only the brain and brainless if we address only the mind” (Andreasen 2001: 29). Properly interpreted, that’s part of my position or of the concept of a mental disorder that I believe we should adopt. However, I hasten to add that in identifying mental disorders with disorders of the brain (or with cells that are gone bad), as she does, Andreasen accepts a form of explanatory reduction of mental disorder to that of a neural disorder. And that most certainly is not my view: neither the identification nor the reduction.

How do I come up with the above characterization of a mental disorder? Is it warranted? What does it mean? Which concepts in philosophy of mind are presupposed by it? What do those concepts mean? The four sub-theses (of [i] through [iv]) of the concept that I propose require substantial analysis and motivation. This they hopefully do receive over the course of the next several chapters. One key concept must also be added to the mix of notions in the concept of mental disorder. This is appeal to the notion not just of mind or mentality, but of the rationality or reason-responsiveness of a person.

I plan to proceed as follows. I will divide up the question of ‘What is mental disorder?’ into two sub-questions. One is: What is mental about a mental disorder? The other is: What constitutes the disorder of a mental disorder?

In one way or another, these two questions occupy me all the way up to nearly the end of Chapter 6, when I return to the above concept of a mental disorder. Hopefully, by then, I will have successfully explained what a proper concept of a mental disorder is like or is best understood to mean and why it is worth endorsing. I am acutely aware that my concept and its background theory may not strike each and every reader as plausible. But I shall stand by it. At best, it is a sound and sensible theory and worthy of further development. But even at worst, if the theory is grossly mistaken, its mistakes may be illuminating. The theory may serve as one example, an extended case study, of possible connections between philosophy of mind and mental disorder.

THE MIND OF MENTAL DISORDER

A huge book sits on my shelf. It’s a reference book that I sometimes consult when conducting research on mental disorder. It’s nearly 1,000 pages long and entitled Neurobiology of Mental Illness (Charney, Nessler and Bunny 1999).

It’s a book with a big hole in it. Not a physical hole. A semantic hole. For despite its title, the word ‘mental’ is not mentioned in the index, let alone described or defined in the book. So, then, how on earth was it decided by the editors which illnesses to examine in the book?
Anxiety and mood disorders are examined. But so, too, are tic disorders. Schizophrenia is examined, but so, too, are Alzheimer’s and autism. Depression surely is a mental disorder. But tics? Alzheimer’s? Such classifications are dubious and need argument. It needs to be shown why, say, Alzheimer’s possesses not just mental symptoms (which, of course, it does) but the sort of causal origin or immediate source that makes it a mental disorder. The big book offers no such argument. In the title the word ‘illness’ wears the conceptual pants. ‘Mental’ is left conceptually naked or without explication.

In the literature on mental disorder, applications of the term ‘mental’ are often deployed without conceptual attire or semantic explication. Bengt Brulde and Filip Radovic note with a tone of lament that in “almost everything that has been written about the concept of mental disorder … focus has not been on what makes a disorder mental, but on what makes a mental disorder a disorder” (Brulde and Radovic 2006: 99). The philosopher Dominic Murphy bemoans this same neglect. “Psychiatry,” he says, “contains no principled understanding of the mental” (Murphy 2006: 61).

Brulde, Radovic, and Murphy are right. The very idea of the mental deployed in psychiatry as well as in the theory of mental disorder typically is unexamined or at least under-examined by psychiatrists and others writing on mental disorder. That is unfortunate. Witness the book on my shelf.

Murphy does try to offer a start, however. He writes: “‘the mental’ covers states and processes that play a very direct role in intelligent action, including processes such as perceiving, remembering, inferring, and a wide variety of motivational states” (Murphy 2006: 63).

Not bad – for a start. But the question arises as to just what constitutes the mentality of the states and processes that he mentions. What is the principal or foremost difference between mentality and non-mentality? Why, for instance, is my perceiving or remembering the hair on my head mental, but growing the very same hair not? Murphy seems skeptical about being able to answer such general questions about mentality without, as he says, waiting to learn what the “sciences recommend” (Murphy 2006: 64). But we don’t need to hold our semantic breaths. There is no need for that. We may offer some analysis of mentality and then empirical science, broadly understood, so as to include cognitive science and the neurological and social sciences, may, of course, try to refine or revise our effort. In the meantime we are not in the pre-scientific dark.

We may pick out the domain of mental by identifying various prototypical examples of mentality (e.g. thinking, sensing, perceiving, and so on), as Murphy in effect does, and then extrapolating a general description. As the philosopher Eric Olson remarks:

We agree on a wide range of typical and characteristic mental phenomena. ... No one doubts that beliefs, memories, intentions, sensations, emotions and dreams are mental phenomena, and that earthquakes and temperatures are not.

(Olson 2007a: 264)

If we do so, if we extrapolate a general description, and this is the actual technique used in philosophy of mind, then what do we find? What we find, I believe, is that states of mind or mentality are constituted by either or both of two elements, aspects or features. These two features are consciousness or conscious phenomenology, on the one hand, and Intentionality (a technically named feature to be explained just below), on the other.
“The mental begins and ends with consciousness and intentionality.” “Consciousness and intentionality help to define the mental *qua* mental.” So write Terence Horgan, John Tienson and me in summarizing what the philosophy of mind tells us about the very idea of mind (Graham, Horgan and Tienson 2007: 468). That’s what philosophy of mind says is the mental: states or conditions of persons (and of other creatures) that are conscious as well as states or conditions possessed of Intentionality. I need to explain.

Presumably, among all the things that there are, some are mindless, some minded. A brick is mindless; so, too, is an earthquake. But we persons possess minds of our own. What is the basis for this distinction? Between being minded and mindless, between person and brick? In what does it consist? It consists, in the broadest sense, in the fact that neither bricks nor earthquakes harbor perspectives or possess the power or ability to consciously represent their selves or the world. A brick is unaware of itself. A quake, although it may bring devastating horrors to the world, bears no thought of the world that it effaces. By contrast, all sorts of things (including us ourselves) appear to us persons in all sorts of different and distinct ways. A box of chocolates may appear to us as a thank-you for a job well done. An architect’s papers may appear as a blueprint, prescribing the construction, measuring the spaces and places of our intended home.

To say that we have perspectives or powers of representation is to say two things. One is that representations of self or world are subjective, in the sense that they exist only as had by us as subjects. They mean something for us as well as to us. They mean something for us insofar as they give us reasons for acting in one way rather than another. It is because I see a snowball heading at my face that I duck rather than confront another person head on. It is because I can distinguish between wine that was bottled in France and wine that was bottled in North Dakota that explains why I purchase the French wine rather than the Dakotan variety. Perspectival representations mean something to us, insofar as, if we notice differences in how we experience or represent our selves or the world, we can do something about those representations or how we experience the world. We may learn that we are addicted and decide to try to refrain. We may inherit religious attitudes and aim to replace them with secular attitudes. We may try to modify our own perspectives.

The other feature of our perspectives or power of representation is that our experiences and conscious representational states are about things, or directed at things, other than themselves. This second or directedness aspect of possessing a perspective means that our mental states are about something – the world or ourselves. Franz Brentano (1838–1917) called this aspect of mindedness ‘Intentionality’. (The adjectival form of the word is ‘Intentional’, but use of this term should not be confused with calling something intentional in the sense of its being purposeful or deliberate. See just below.) The word ‘Intentionality’ refers to the aspect of a mental state or representational attitude in virtue of which it is directed at, is of or about, or represents something other than itself (Brentano 1995 [1874]; see also Searle 1983). Intentionality is exemplified when a desire is for dark chocolate, a fear is of flying, or a mathematics professor wonders how best to describe a Cauchy sequence for her students.

Intentionality, it should be noted, has no special connection with intending or being intentional in the common English sense, in which, for example, I intend to eat dinner tonight or intend to begin a new aerobic exercise regime. Intending is but one form of Intentionality, among
numerous others. (So as not syntactically to confuse ‘intending’ or ‘intentionally’ with ‘Intentionality’, I deploy a convention, rather common among philosophers, of capitalizing the first letter in ‘Intentionality’ when used to refer to Intentional phenomena i.e. mental phenomena possessed of aboutness or directedness.) Thus, for examples, beliefs, perceptions, desires, intentions, and memories are Intentional (note the “I” in a capital) states (i.e. states with Intentionality or directedness), as are emotions such as fear and joy, pride and shame, love and hate. Any mental state that is directed at or about something other than itself is an Intentional state. Your visual perceptual experience of this page, for instance, is possessed of Intentionality. Note, too, that although this page certainly exists, some purported things or events that a mental state or attitude is about or that fall within someone’s subjective perspective may fail actually to exist. A song says, “I saw Mommy kissing Santa Claus underneath the mistletoe last night”. Mother was there. Mistletoe was in place. But Santa, of course, was nowhere to be found. Mother cannot kiss Santa for he does not exist, although children may sing of him or misperceive of Daddy as Santa (see Harman 1998).

While the basic idea behind that of Intentionality or Intentional states or attitudes is that of directedness to a thing or object, ‘thing’ or ‘object’ is interpreted in a very broad way: material entities (cars), abstract (numbers) objects, properties (standing under the mistletoe), states of affairs (kissing mommy), or facts (that Dad is dressed up like Santa). Indeed, anything whatsoever that a person may think about, or direct their attitude towards, may count as an object of thought. Even, as just noted, non-existent objects may count as the Intentional objects of Intentional states.

A perspective may be conscious, too, of course. Some things that we do do for reasons that are not conscious. I place a food receipt in my pocket without thinking about it. But some elements or episodes in our perspectival life are conscious – we experience what it is like to undergo them.

Conscious (also called ‘phenomenal’) experiences come in many varieties. Talk about consciousness permeates all discourse, prose and poetry, ordinary and special. Consciousness is the most vivid or explicit feature of our mental lives – of our being minded or possessing a perspective. As William James (1997/1910: 71) put it: “The first and foremost concrete fact which every one will affirm to belong to inner experience is the fact that consciousness of some sort goes on.”

One of the most striking features of conscious experience is that the content or directed character of experience or of a conscious representation is directly apparent or immediately evident to its subject. You know directly of what you are thinking. You know, for instance, whether you are thinking of, say, chocolate ice cream or mother kissing Santa. You needn’t observe the expression on your face in a mirror to decipher such facts. Mirror observation does not tell you. You know immediately or non-inferentially of the content of your thought. If, however, another individual is sitting next to you, they must rely on your behavior and verbal report to identify what you are thinking of or even if you are thinking about anything at all. As the head of a coma research group recently put it, “conscious awareness is a subjective experience that is inherently difficult to measure in another human being” (Laureys 2007: 87). Indeed it is.

Jones shot Phaedeux (pronounced ‘Fido’), his dog. Jones gave a lot of conscious thought to shooting Phaedeux. Jones did so on purpose or deliberately. But we may wonder, what was
Jones thinking about in shooting the poor little creature? That the dog barks too much? That Phaedeux is getting too old and arthritic and needs to be put out of his misery? That the dog had bitten his little son, Jones Junior? (Jones would not tolerate that.) What was on his mind? Jones had a conscious perspective, a conscious perspective of his own, in shooting his dog. But what was it? We need to ask him. He, by contrast, knows first-hand. “Phaedeux bit Junior”, he thought to himself and then shot the poor creature.

A second prominent feature of consciousness is that even if some conscious states are not possessed of Intentionality, an important and pervasive number of conscious states are Intentional or possess directedness or aboutness. Your present visual experience, for example, would not be the visual experience that it is if it did not seem to you to be directed at a book on the subject of mental disorder. My present thought would not be the thought that it is unless it appears to me that I am thinking of Jones and Phaedeux.

Intentionality, if perhaps not as dramatically vivid as consciousness, is just as central to mindedness or to our being minded or having a perspective. One of the most significant aspects of Intentionality, evident on reflection, is that Intentional states have a structure analogous to acts of speech. Just as I may ask whether such-and-such is the case or promise that so-and-so will be the case, so I may hope that something is the case, fear that it is the case, or desire that it be the case. In each instance, the Intentional or representational content of an Intentional state (what it’s about) is describable by a sentential clause or propositional phrase or that-clause. I fear that Woolf suffered from a severe form of depression. I know that Santa was not under the mistletoe last night.

Many items in the world other than minds seem to possess Intentionality or aboutness. They serve as apparent vehicles of Intentional content. They include things like the blueprints of a house, maps, representational paintings, words of a language, speech acts, novels, and road signs. The Intentionality of mentality, however, is unique. Mentality has Intentional content built right into it, as it were, as opposed to the map of a city, which derives its Intentionality from the manner in which it is designed or interpreted. A map expresses a perspective (that of the cartographer). But it does not have a perspective. The perspective is not in the map. It must be read into the map. The mind’s Intentionality or aboutness is underived. It inheres in or is intrinsic to it. Something literally was on Jones’s mind when he shot his dog.

Underived or intrinsic Intentionality is sometimes referred to as original Intentionality. The words or verbal inscriptions in this book mean and refer, and thus have a form of Intentionality, but it is extrinsic to them and originated or derived from me, when I wrote them down. For instance, suppose I write the string of letters or word ‘bello’. If I were a speaker of Latin, I might mean war by this word; if Italian, I might mean beautiful. The point is not that such a string is devoid of Intentionality. The point is simply that the string’s Intentionality (that is, what the string symbolizes, represents or is about) is a function of what I and other speakers use the word to mean or refer to.

The notions of consciousness and Intentionality are critical (as we will learn in detail later) for understanding the role of the mental in mental disorder. The philosopher Jennifer Church, in discussing the conscious Intentional states distinctive of depressed people, quotes a remark of a forlorn character in a movie by the distinguished late Swedish film director, Ingmar Bergman (1918–2007). Everything in the world, the character says, is getting “meanner and grayer”
An explanation of what it is like to be depressed, Church observes, “must take account of [a] correspondence between what is ... felt and what is ... perceived” (175). “The felt qualities of [a] depressed state ... are the perceived qualities of the objects around” the depressed person (Church 2003: 176). Depression is the state; grayness and meanness appear in the world outside the depressed person. To feel depressed is (in part) to perceive the world as mean and gray.

Church’s observation generalizes to other sorts of mental disorders. In disorders the mental or psychological states typically cited as conscious and Intentional or possessed of Intentionality (such as being depressed or anxious about something) possess Intentional contents that are inseparable from their subjective, what-it’s-like or phenomenal character. ‘The ... qualities of a depressed state are the perceived qualities of the objects around.’ Woolf’s conscious Intentional states of depression, for example, were part of her experience of self and world – a self and world that had particular depressing qualities to her and that, to use Church’s term, corresponded to her depressed mood or feelings. The same may also be said of, say, an anxious state. The qualities of an anxious state are the perceived qualities of various objects around the anxious person. My present state of agoraphobia, for instance, would not be the state that it is if it did not seem to me as if the crowd in the mall where I shop is dangerous, not to be trusted and threatening.

While philosophers of mind agree that the marks of mentality are consciousness and Intentionality, they disagree over how best to understand these features as well as about the relationships between them. Brentano, for his part, claimed that Intentionality is irreducible to and not constituted by anything physical. It’s something non-physical. The challenge presented by Brentano is to characterize the relation between vehicles (like brains) of Intentionality and contents of Intentional states or attitudes. But some philosophers try to show that Intentionality can and should be understood in physical and impersonal terms. Fred Dretske (1988 and 1997) has been one of the leading theorists in trying to formulate a response to Brentano that is compatible with thinking of Intentionality and Intentional content in physical and not inherently subjective terms.

Some philosophers claim that Intentionality and consciousness are inseparably connected and that neither Intentionality nor consciousness, in an ultimate sense, can occur or is possible without the other (see Graham, Horgan and Tienson 2007 and 2009). But other philosophers argue that Intentionality can and commonly does occur without consciousness and/or that consciousness can and commonly does occur without Intentionality. Some Intentional states or attitudes (say, unconscious beliefs or desires) are not conscious. Some conscious states (say, generalized moods of anxiety or nervousness) are not about anything. The relevance of such claims and debates to our effort in this book to enact rectitude in the concept of a mental disorder and construct a theory of disorder is difficult and complex to appraise. This is because such claims are rarely raised in the context of discussions of mental disorder (remember the big book on my desk), and because debate about the nature of consciousness and Intentionality is one area in which something like Murphy’s hesitancy to speculate about the mental before science has contributed may be methodologically prudent. As we talk more about mental disorder and about the roles of the mental in a disorder, we may be in a better position to assess claims about just what Intentionality and consciousness may involve.
So, how does mentality (Intentionality and consciousness) figure in mental disorder? What role or roles do conscious and Intentional states or attitudes play in a mental illness? I offer a few brief remarks about this topic here, but plan to return to it in more detail periodically throughout the rest of the book.

M. S. Moore claims that whether a disorder is mental is “related in some way to the symptoms exhibited by the person, not to the species of causation involved” (Moore 1980: 57). I agree with the first half of Moore’s claim.

Appearing as symptoms and in the content or character of symptoms constitutes a truly important role for the mental (for consciousness and Intentionality) in a mental disorder, as witness the list of exemplars that I plan to offer in the next section of the chapter. Each and every disorder on that list is constituted, in part, by vivid and often harmful symptoms of consciousness and Intentionality. As Richard Bentall puts it: “[C]ommonly recognized forms of psychopathology involve some kind of abnormality of conscious awareness” (Bentall 2007: 130). Bentall offers two brief examples of the relevance of conscious symptoms with Intentionality to the concept of a mental disorder:

[D]epressed patients are usually excessively aware of negative aspects of themselves, and are often tormented by memories of enterprises that have ended in failure. Anxious patients … are typically extremely vigilant for potential threats in their environment.

(Bentall 2007: 130)

Vigilance directed to the outside world and its threats are distinctive of anxiety. Tormented negativity about self haunts the severe depressive. Each of these sorts of states is both conscious and Intentional (possessed of directedness). There is something it is like to be tormented about oneself as well as to be anxious about perceived threats.

Moore denies, in the second half of his statement, that mentality plays a definitive role in the causation of a mental disorder. He says it helps to constitute symptoms, but fails to help to constitute the proximate origins of a mental disorder. We should disagree. Visual blindness is a mental symptom, certainly, but if it is caused by a cortical lesion, or damage to the retina, it is not a mental disorder. Contrary to Moore, mental causation (or causal-explanatory reference to a disorder’s proximate psychological origins or propensity conditions) is also an important role for mentality in a mental disorder. None of the exemplars as exemplars (again, to be discussed momentarily) are best understood in their conditions of immediate onset or emergence without some or partial reference to conscious and Intentional states in which the contents of these states are causally efficacious in helping to bring about the disorder. Mere mental or psychiatric symptoms are insufficient for calling a condition a ‘mental disorder’.

Consider depression. Strokes affecting the frontal area of the brain, especially the orbitofrontal cortex, can trigger something called “vascular” depression (see Kramer 2005: 174). But should we call the stroke a mental illness, just because depression is a symptom? It is necessary to look more closely at the causes of a stroke and the role that the mental may play (or not play) in the condition before a symptom can be categorized as a symptom of a mental disorder. A sound understanding of the causal foundations of a disorder is necessary before we know what kind of disorder a disorder it is.
Did Woolf kill herself and do so intentionally because she felt hopelessly trapped or did she do so accidentally because of a defective alteration of neurotransmitter function due to, say, Parkinson’s disease? It’s critical to know what causes or helps to cause a set of symptoms if we are to grasp what sort of disorder a disorder is and often just what sorts of behavior its symptoms themselves are. Depression-related deliberate suicide is one thing; accidentally annihilating oneself because of a prefrontal lobe dysfunction in episodic loss of motor control is another. Did Woolf come to be depressed partly because of her assessments of her situation and habits of punitive self-evaluation – despite the fact (if it was a fact) that nothing was wrong with her brain?

Moore’s view confuses the type of disorder a disorder is (whether mental or non-mental) with the type of symptom. Moore also unwisely assumes that symptoms themselves may be properly individuated and understood, at least for purposes of classifying a disorder type, independent of uncovering a disorder’s origins. Often symptoms cannot be so identified. Remember Tourette’s and the strange symptoms (involuntary cursing) and tics that Tourette’s patients may suffer from. We may not know the explanation of Tourette’s yet, but if its curses stem directly from damaged bits of electrical discharge, they are not really curses or intentionally nasty speech acts. The same sounds are perhaps curses from the mouth of someone else, an angry client or irate neighbor, but not from the tongue of someone in the verbal fits of the disorder.

Here is an analogy for mental disorder (and pace Moore) from somatic medicine about the importance of causation for nosology or classification. Suppose that each of us has a sore throat, which type of sore throat do we have? If mine is caused by streptococci and yours is not, mine is a strep throat and yours is not. Or: If mine is caused by tonsillitis and yours by mononucleosis, we each have a different sort of sore throat, and each sort requires a different sort of treatment. Causes make a difference. Symptoms reveal a disorder. Causes help to determine a disorder’s type as well as the foundations and underlying identity of many of its symptoms.

So, we have to be careful in using disorder words or terms for disorders. Given that each of us is ‘depressed’, does this mean that we each are subjects of a mental disorder? No. It does not. Words can be used with different senses. If my depression is part of the fact that I have had a stroke or have Huntington’s disease, which is a chronically progressive neurodegenerative disorder characterized by a movement disorder, dementia, and psychiatric disturbances (including paranoia and depression), my depression, so-called, is an aspect of a neurological disorder (or so I assume). But if your depression is caused, in part, by the stressful experience of job loss, perception of marital decay or career entrapment, and if, more generally, it somehow requires partial reference to causes in psychological or Intentionalistic terms (terms that presuppose Intentionality) for its explanation, then, in my view, it is a mental disorder. It is (what I would call) a clinical or major depression of the sort that belongs in a manual of psychiatric taxonomy.

Note, I say, ‘in part’ or ‘partial’. I am not claiming that for the explanation of a mental disorder nothing needs to be said about neurobiology, neurochemistry or neural circuitry or (in a fuller or more synoptic account) about more or less distal causes (background culture or sub-culture, autobiographical histories, problematic inter-personal relationships etc.). I am speaking of the proximate causes or sources of a disorder and of psychological descriptions contributing essentially, but not exclusively or exhaustively, to their specification and analysis.
I have much more to say about the causes or sources of disorder as well as of symptoms in the course of the book. Right now, though, I want quickly to turn to the problematic question of how to identify exemplary disorders.

**EXEMPLARS OF MENTAL DISORDER**

Here in a nutshell is a problem. How can we at least begin to conceive of forms or examples of mental disorder or of types of mental illness? There are no sacred texts to consult. Naked eyes fail to perceive disorders as disorders. Word worship will not help. Just because the word ‘depression’ or ‘obsessive-compulsive’ (or ‘addiction’, etc.) is used does not mean that a mental disorder is being spoken of. Sometimes these words are deployed as colloquial terms, picking out conditions that involve suffering or disturbance, but without implying or meaning to imply that an illness is present. Or sometimes they may be used to identify symptoms or instances of brain damage. Not mental disorders but brain disorders.

Perhaps the demands of clinical diagnosis and theoretical (psychiatric as well as anthropological and sociological) research may help to keep the very ideas of mental disorders under some sort of semantic control. So I assume the following: A good general way in which to introduce or devise a list of mental disorders is to pick out the most conspicuous and frequently identified disorders as exemplary, using distinct but overlapping standards of clinical and theoretical conspicuousness and frequency. This in itself is a complicated procedure, but a brief effort along these lines will, I believe, serve to identify a set of disorders that attract sufficiently wide consensus and consent.

Anthropology first. Arthur Kleinman, a professor of psychiatry and anthropology at Harvard, remarks that “many medical anthropologists are suspicious about the idea of culture-bound disorders” (Kleinman 2000: 302). The suspicion is not unfounded. A mental disorder if prototypical is not a disorder just of the Chinese or French Mind but of the Human Mind. Symptoms may be culturally or environmentally variable, of course, but a disorder, prototypically speaking, lays more firm or exemplary claim to qualifying as a disorder of mind if it afflicts people across distinct cultural or contextual niches. (Compare: Diabetes is not Canadian diabetes. It is, as it were, diabetes-diabetes. True, an outbreak of diabetes may appear in one place. But being place-bound is not essential to the condition.) So, one way in which to identify an exemplary disorder is to assume that a disorder is exemplary or prototypical when it is cross-cultural and then seek to identify cross-cultural disorders. Non-exemplary disorders may be culturally unique, and certainly certain symptoms may be niche specific, but not a disorder of a broadly consensual sort.

A possible example of a culture bound (hence not exemplary) disorder that Kleinman mentions is known as Chinese railroad psychosis, which also is known as *shenjing shuairuo*, although this perhaps is more likely to be a culturally specific manifestation of neuroasthenia (chronic fatigue) or a symptom of (the more general disorder of) depression. But what are some cross-cultural disorders?

Kleinman claims that five general types of disorder are cross-cultural. These are: Major or clinical depression, bipolar depression, schizophrenia, brief reactive psychoses, and a range of anxiety disorders “from panic states through phobias through to obsessive compulsive disorder” (Kleinman 2000: 302).
Insisting that exemplars must be cross-cultural is not free of empirical difficulty. It may be tough to distinguish between, on the one hand, cultures functioning as varying and shifting contextual scaffolds for a cross-cultural disorder’s expressed symptoms and, on the other, cultures as harbors of specific disorders. Might not the defining features of a disorder include *niche specific* features, wherein a disorder is “comprehensible only in relation to some [cultural] norm or other cultural factor” (Murphy 2006: 253)? Take eating disorders, for instance, such as bulimia. Young white American females feel pressure to be thin more so than do their Navajo Indian counterparts. Quite generally, the epidemiology of bulimia tends to follow Euro-American ideas of beauty as they spread through other cultures. The conscious perception by young women of Euro-American ideas of thinness and beauty and the attendant social pressures on them to be physically attractive reinforce thinness as something desirable. This may help to explain the incidence rates and epidemiology of bulimia in certain cultural settings.

Is bulimia more like Chinese railroad psychosis (culture specific) or more like major depression (cross-cultural)? If Kleinman’s list is sound and exhaustive, bulimia (not mentioned on his list) is not an exemplary disorder. It’s more like Chinese railroad psychosis (assuming this is a culture specific disorder). Or perhaps it is a culturally tethered or socially structured set of symptoms of one of the general disorders which Kleinman lists. Perhaps it is a form of depression, anxiety or obsessive compulsive disorder with a distinctive grip on young women. One female victim of anorexia nervosa, a condition similar to bulimia, reports: “I knew that I had a certain strength ... that would really show up somewhere.” “I skipped breakfast.” “I just couldn’t fit the calories into my regimen.” “I always ‘watched it’.” (Costin 1998: 243–44). She obsessively compulsively watched it.

Allan Horwitz remarks that “in the broadest sense symptom profiles ... fit the illness norms of particular cultures” (Horwitz 2000: 116). Symptom profiles may be culturally tethered, but exemplary disorders themselves? With Kleinman I shall assume not. To be an exemplar or prototype (I am using these two notions interchangeably) is to be cross-cultural. In this way suitably informed observers, whether in Dakota or Singapore, should be able to reach agreement on certain cases of a disorder viz. an exemplary disorder.

Another sort of challenge arises when a list, like Kleinman’s, contains one or more disorders that some observers are inclined to believe reflect brain damage or impairment – like bipolar disorder, which appears on his list. For me, if this were true, if conditions that are brain disorders may be on the list, it would force a relevant disorder off of the list and into the category of a brain disorder. Or perhaps it would serve notice that there are two variants of the disorder. One is in the domain a mental disorder; the other in the domain of a brain disorder. This possibility might show that the category of, say, bipolar disorder is poorly unified or disjoint, and that diverse perspectives need to be applied to the disorder’s disjuncts, psychiatry in one type of instance, neurology in another. However, for the nonce, I want to postpone hard questions about the ultimate categorization of and presuppositions behind the exemplars until more is understood about just where there is conceptual elbow room for the category of mental disorder.

In any case: It would reinforce the wisdom of adopting a list of exemplars like or similar to that of Kleinman if its same or similar members were also identified on grounds other merely than cross-cultural presence. Are there other grounds? Yes, at least two of them.

So, here is a second and connected way in which to devise a list of exemplary disorders. Epidemiology. It consists of examining surveys or reports of the prevalence or incidence rates of
mental disorders worldwide and then picking as exemplars only those that are most prevalent or possess the highest rates of global incidence. Skeptics do question, as earlier noted, and perhaps sometimes should question, the methods employed for gathering prevalence rates in statistical surveys. Methods used in such surveys? Sometimes just self-reports of symptoms when elicited in standardized interviews conducted over the telephone. “Diagnoses based on [personal] recollection,” Randolf Nesse complains, “are biased by strong tendencies to forget” (Nesse 2001: 180). For that and other reasons, self-reports may be unreliable. But the following two facts are striking and useful for us to note about the main surveys that, to my knowledge, have been conducted to date.

One is that reports come from several different sources and survey instruments including the World Health Organization, the United States Epidemiological Catchment Area (ECA) survey, and the National Comorbidity Survey (NCS) (Kessler 2005; Kessler, Bergland et al. 2005; Kessler, Chiu et al. 2005; WHO World Mental Health Survey Consortium 2004). The other is that whether occurring in the United States or elsewhere depressive disorders and anxiety disorders are thought to be the most prevalent, often followed, in some countries, such as the United States, by substance or alcohol abuse or impulse control disorders (also known as addictions) (see also ESEMeD/MHEDEA 2000 Investigators). This fact about prevalence rates for depression and anxiety disorders dovetails more or less with part of Kleinman’s list. Depression and anxiety disorders are prominent on his list. Substance abuse or addiction also is present on his list, if understood as instances of (what Kleinman calls) compulsive disorder. (Later in the book, in Chapter 7, I explore whether addiction is a form of compulsion.)

Taxonomic apostasy. A third method for identifying exemplars is owed to a mental health theoretician and clinician who is one of the most prominent critics of standard manners and modes of disorder categorization. “Psychiatry”, he says, “has suffered from a poverty of ideas” (Bentall 2011: 167). It treats superficial and artificial categories as identifying homogeneous groups of illnesses, when the domain of mental illness itself is filled with heterogeneity at all levels of analysis and treatment.

I have already mentioned the critic in this chapter. It is Richard Bentall (2004). Bentall’s rather iconoclastic (albeit not totally idiosyncratic) alternative idea about categorizing types of mental disorder goes something like this.

Popular taxonomies of mental disorder are either, at best, grossly unhelpful and misleading or, at worst, rest on a serious category mistake. The category mistake is that they encourage or presuppose a biomedical disease model of mental disorder. Disease models should be rejected, says Bentall. (I myself plan to examine disease models of mental disorder in the next chapter.) Mental disorders, says Bentall, are not diseases. Diseases typically have discrete edges, which distinguish themselves from each other and are discontinuous from normal variations in health. The sorts of mental health problems faced by the patients of psychiatrists just are not like that, says Bentall. Psychiatric troubles or maladies do not have discrete edges. They are hard to distinguish from normal, albeit otherwise immensely distressful, conditions. There is, for example, no obvious cut off point in the diagnosis of depression that suggests a uniform basis for distinguishing between being grief stricken or profoundly sad, on the one hand, and being clinically depressed, on the other. So, it is best not to think of people’s psychiatric troubles or complaints as disorders if this means thinking of them as diseases – as hard
edged, homogeneous phenomena. It’s best to think of them, says Bentall, as just that viz. troubles or complaints with which people need help. As Bentall puts it, once troubles or complaints have been identified and explanatorily understood, there is no “ghostly” illness, disorder or disease “remaining that also requires explanation.” “Complaints are all there is.” (Bentall 2004: 141). Complaints are classes of disturbances that are “troublesome” and “worthy of [professional] attention” (Bentall 2004: 142). They are symptoms, to use the parlance of psychiatry. And it is pointless to try to bring tighter disease-like unity to them.

Bentall is not making Moore’s claim that causation or causal explanatory understanding is irrelevant to the classification of a mental disorder. He is saying that a ‘disorder’ consists in symptoms or complaints plus causal origins of a non-disease type. Origins may operate at several different levels of analysis involving individual life-problems, failures to perform social functions, distress, and so on, but sums of such causes issue in “specific types of abnormal and cognitive functioning (Bentall 2011: 168).

Complaint- or trouble-orientated lists of ‘disorders’ like the one I am about to mention of Bentall are not without critics. Bentall is not without replies (Bentall 2004: 144). I don’t wish to endorse his approach or complaint terminology in this context. I simply wish to cite his list. Bentall mentions the following complaints as the ones most commonly seen by clinicians (Bentall 2004: 488). Complaints about or disturbances of: depression, mania, paranoia, cognitive incoherence, hallucinations, and negative symptoms (including flat affect, affective blunting, anhedonia, apathy, impoverished speech, among others).

What is striking about Bentall’s list, at least to me, is that it overlaps with Kleinman’s in certain respects as well as with global prevalence rates and incidence data, although it is devised from an utterly different taxonomic perspective. This is the perspective of someone who is deeply skeptical about current diagnostic practices and labels. Depression (major or clinical depression) is mentioned on each list. ‘Mania’ is part of what it means for a depression to be bipolar. But mania may also count, depending upon how it is described or understood, as a feature of a range of anxiety and impulse control disorders. Blunting, apathy and anhedonia are features of depression as well, of course. Incoherence and hallucinations are constituents of schizophrenia that are mentioned by Kleinman. Paranoia may be part of depression as well as mania and anxiety.

We certainly don’t get a perfect match between the three lists. Perhaps such imperfection spells doom for thinking of mental disorder in terms of prototypes or exemplars. I think not. The proposed list of exemplars (which follows below), which is for something as complex as a mental disorder, unlike something as simple or relatively straightforward as a book, just is (in my book here) a sort of heuristic or organizational device. It offers reference points for regimenting or constructing a concept or notion of mental disorder. The proposed list is not, as noted above, intended as an unquestioned creed or without potentially contestable conditions of application. Some members may need to be deleted as we learn more about various conditions. Other conditions may need to be added. In any case, the three lists overlap in various ways. Some items are mentioned or appear on each. So, with such similarities or overlaps in mind, I assume that we are warranted in considering the following as mental disorder exemplars or prototypes.

- Depression (including major depression and depression with mania).
- Anxiety disorders (including phobias and some types of paranoia).
• Disorders of incoherence (including delusional disorders).
• Disorders of reactivity or impulse (including addiction or substance abuse and some forms of both mania and obsession).

So, back to the question: Just what chores or functions does mentality (consciousness and Intentionality) play in disorders or conditions of the above mentioned sorts? For a disorder to be a prototypical or exemplary disorder, it must include roles for the mental. What are they?

**ROLES OF THE MENTAL IN MENTAL DISORDER**

The mental plays various roles in a mental disorder. I mentioned the two primary roles earlier in this chapter. The first consists in its role as main or central symptoms or symptomatic contents of an illness. The second consists in being part of a disorder’s proximate propensity or onset conditions, origins or causes.

Figuring in both symptoms and onset conditions or immediate causal sources are not the only roles of mentality in mental disorder. Psychotherapy for mental disorders, with reliance on reasoning and conversational address, focuses directly on a subject’s conscious Intentional states. So, mentality or states of consciousness and Intentionality may also play roles as focal points for a disorder’s therapeutic address.

Still another role? Some subjects of certain disorders know that they have a disorder or that something is wrong with them. This first-person knowledge is sometimes referred to as diagnostic ‘insight’ and is, as a form of self knowledge, constituted by conscious Intentional states. I say “some disorders”, since for other types of disorder diagnostic insight on the part of a subject is absent. In delusional disorders, for example, diagnostic insight is missing and often disturbingly so, making it difficult to offer therapy voluntarily to a person (Fulford 1989 and 1994; Currie 2000). Deluded people don’t think of themselves as deluded. After all, how could they? If I believe that I am God incarnate, but also believe that I am deluded in believing this, then the conviction that I am God incarnate will impress me as unwarranted or unfounded. So, in my own eyes, I should abandon it. It will hold no grip on me. Insight, however, is present in certain other sorts of disorder. Victims of obsessive thinking, for example, often complain of the obsessive and interruptive character of anxieties and thoughts, and this fact helps to distinguish, clinically, between a deluded subject (who may think that nothing is wrong with them) and a victim of obsessive thinking (Goodwin and Guze 1996: 4).

Aside, however, from certain forms of therapy and cases of illness insight, consciousness and Intentionality have two main roles, as already noted, in a mental disorder. In symptoms. In sources or causes. What, then, about sources?

To be brief and to pick up on threads of our earlier discussion: Something is seriously incomplete and over-broad in a concept of mental disorder if it is applied only on the basis of a disturbance’s being mental in symptoms alone. Only if our causal explanatory understanding of a condition refers to feelings, beliefs, memories and other mental states or attitudes as causes or sources is a disorder mental. Why so? The answer, as noted in criticizing Moore, is that to understand what type of disorder a disorder is (whether mental or non-mental), it is necessary
to go behind or inside symptoms to learn how the symptoms arose, as part of what sort of condition, otherwise even symptoms themselves may not be properly describable or understandable. This is a point I have made earlier but it bears repeating. The causes of a disorder help to contribute to the identity of symptoms.

Parkinson’s disease is a degenerative disorder of the brain characterized by progressive tremor, slowness of movement, and rigidity (Litvan 1999: 559–64). Mental symptoms may be part of the symptom profile of this disorder in the form of failing memory, problems with concentration, and difficulties in initiating intentional or goal-directed activity. But do such symptoms make Parkinson’s a mental disorder? No, they do not. Consciousness and Intentionality play no role whatsoever in the proximate onset or course of the condition. Degeneration of part of the midbrain (known as the substantia nigra) with subsequent decrease of a chemical messenger known as (striatal) dopamine is a probable cause of Parkinsonism. It is a purely neurological disorder or disease, viz. a disorder of the brain, albeit a disorder with harmful symptoms of a mental sort. (Or so I assume.) Neurological problems or deficits irrupt into the space of reasons or reason-responsiveness in Parkinsonism and in severe cases essentially swamp a person’s ability to control various forms of bodily activity.

How do the rigid motions of a victim of advanced Parkinsonism compare with Alice’s remaining in bed in the morning? How much like the slow movement of the Parkinson’s patient are the lethargic and unwelcome motions taken by Alice, when she spots a window that needs to be closed from a bitter winter wind and tries to rise from underneath her bed covers, but can’t? Compare the explanation for Parkinson’s disease with that for Alice’s loss of motivation (which, I am assuming, for purposes of illustration) stems in part from her protracted grief and perception of personal helplessness (Abramson, Metalsky, and Alloy 1989; Abramson, Seligman, and Teasdale 1978). To explain the failure of Alice’s effort we must refer to her self conception and to how she thinks of her personal situation. We may ask: Why does she perceive herself to be helpless? No doubt, the experiences that led to her becoming depressed offer part of the answer. Her grief and disappointment (in her husband’s behavior) may have strengthened her expectation of negative results for other commitments or behavior. So: If we are to intervene in her depression, we may try both to influence how she understands her husband’s attitudes towards her and to provide optimal conditions for her learning to be more optimistic. In a case of Parkinson’s, we would aim directly to manipulate its neurobiology/neurochemistry (no small chore as diminishing returns from dopaminergic therapy may sometimes contribute to further motor performance deterioration [Litvan 1999: 563]). No causal connection or association between impaired motor performance and a person’s self comprehension is at all evident.

A key feature of Alice’s sort of depression is that her conscious representations of self and world, viz. her states of consciousness and Intentionality, play (I am assuming for purposes of example) critical roles not just in the symptom profile or progression of her depression but in its immediate origins or conditions of onset. It is, in particular, in attitudes of a self-referential or self-interpretative nature that people experience themselves as helpless or as personally overwhelmed and therein may become depressed.

That a depression (or a type of depression like Alice’s, sometimes labeled as a learned helplessness depression) may spring from such mental sources as perceived helplessness and a sense of hopelessness, does not mean that the psychology at the foundation of a disorder
functions to the exclusion of brute a-rational somatic/neural conditions. It is my view (mentioned earlier and to be discussed throughout the book) that mental disorders are produced by a mixture of mental and brute mechanical factors. In mental disorders both mentality and neurobiology/neurochemistry partially incapacitate or ‘gum up’ the operation of (basic faculties) mind and behavior. Perhaps the brain of a subject of learned helplessness depression suffers a decline (not to be confused with ‘cells gone bad’) of neurotransmitter function, which is derived in part from interpretations of their own helplessness or frustrated efforts to avoid negative outcomes. The subjective experience of a helplessness depression may exemplify the interplay between such perceptions and an underlying neurobiology/neurochemistry.

One proposal for understanding the interplay in a mental disorder between psychological factors and neural activities is to think of them as operating at different levels of analysis or description and to depict the causal foundations of (or propensity conditions behind) a mental disorder or illness as consisting of the two different levels operating in interactive or dynamic concert and in a two-dimensional final pathway leading to disorder. The result is an inter-level inter-active organization of a mental disorder’s causal explanatory foundations, in which any given psychological state or condition is influenced by and in turn influences mechanisms described in neurobiological terms. For example: Perhaps lowered serotonin does not as such cause depression directly or on its own, but permits hopeless attitudes and beliefs in one’s own helplessness to get stuck in a person’s stream of consciousness and to produce depression.

It’s easy to see, by comparison and contrast, that nothing like a key causal explanatory role for psychology (consciousness and Intentionality) occurs in exemplary cases of somatic or bodily illness. Breast cancer neither immediately arises from nor disappears under pressure from a person’s Intentional states (states with Intentionality). Cancer growth has somatic sources and may remit only under chemical forces. It would be ridiculous to try to cure breast cancer by, say, doses of Freudian psychotherapy.

Assuming that mentality plays a key causal role in exemplary mental disorders, it is worth wondering how we should answer questions about the legitimacy of the diagnosis of a mental disorder. Behavioral symptoms often present a nasty practical problem to the diagnostically conscientious clinician, who must spend time and effort in deciding (i) whether a particular cluster of mental symptoms expresses a mental illness rather than a brute somatic or neurological disorder or perhaps (ii) whether the symptoms represent compensatory psychological adjustments that a patient makes in a case of brain damage. Borrowing a term introduced by the philosopher Nelson Goodman to distinguish, in the visual arts, between original paintings and inauthentic copies, exemplary mental disorders in their proximate origins bear an autograph (stamp or mark) of mentality (Goodman 1968: 113). They carry the mark of the mental on some of their sources or immediate propensity conditions. A mental autograph on some sources of a disorder helps to distinguish a disorder that is authentically or legitimately mental from one that is not.

Compare and contrast a case of mental disorder with Alzheimer’s disease. Alzheimer’s is characterized by progressively worsening memory, language and visual spatial skills, as well as changes in personality. Victims may also become depressed, apathetic, aggressive, and lose insight into their condition. As the disease progresses, delusions and paranoia may occur. But is Alzheimer’s a mental disorder? Although its precise proximate physical origins are not known, it is wise, I assume, to classify Alzheimer’s as having exclusively brute somatic or neuronal
sources viz. likely degeneration of various sorts of processes in cortical and possibly subcortical neurons. So, it is not a disorder in which consciousness and Intentionality figure in its onset. No ‘autograph of mentality’ is present in its immediate sources, although mental decrements are present in symptoms and some of its symptomatic contents do, in fact, help to produce or sustain their own elements of dramatic personality change. (The disorientation or sense of helplessness produced by severe memory loss may be responsible, for example, for the depression and paranoia often observed in victims of Alzheimer’s.) Moore may wish to classify it as a mental disorder for this reason. I believe we should not.

There is much more that can, should and will be said as the book continues about exemplary mental disorders being mental in aspects of their production and persistence as well as symptoms. For the nonce, however, I am done with the topic of the mind of mental disorder. I plan to turn in the next chapter to our second question about mental disorder. This is: What makes a mental disorder disorderly – a disorder? I approach this question by asking what makes a mental disorder undesirable.

SUMMARY

Mental disorder? What’s that? Properly counting anything as a mental disorder requires having a sound and sensible theory of mental disorder. This chapter offered a brief sketch of the aims of a theory of mental disorder. Coming up with a good concept is one of them. It argued that exemplars or prototypes of mental disorders may serve as a constructive basis for a concept of mental disorder. The character of each exemplar is not written in stone and each example or case of disorder must ultimately be understood in terms of its proximate origins or sources and symptoms.

The chapter also described the concept of mind that applies to a mental disorder. It is that of a condition that possesses both consciousness and Intentionality. The chapter claimed that in mental disorders consciousness and Intentionality play two primary roles. One is in helping to constitute the symptoms of a disorder and the threat that the contents of such symptoms (say, the persistent global sadness and pessimism of depression) pose to a person. The other is in a mental disorder’s immediate origins or sources.

SUGGESTED READING


