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MINDING MENTAL ILLNESS

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Psychopathology is the study of the origin, growth, and symptoms of mental illness and disorder. Individual psychopathologies are the types of mental illnesses themselves – e.g. panic disorder, bipolar depression, and so forth.

Psychopathology and psychopathologies have long been recognized to be philosophically perplexing and theoretically troubling.[1] This article reviews recent philosophical work on psychopathology and psychopathologies, but it goes well beyond a literature review in its defense of a thesis about the most central and widely discussed philosophical issue in psychopathology. This is the question of, 'What is mental illness?'

1 What is mental illness?

Or as this question may be put with a linguistic turn: To what do we refer when we refer to mental illness?

It is hard to say what mental illness is. It is remarkable that at this late date in the ongoing attempt to describe the nature of mental illness, there is little consensus about whether mental illness is a distinguishable or coherent type of illness. What makes for lack of consensus? Three factors may be mentioned, among others.

The first is conceptual. Although it is one sentence the question "What is mental illness?" actually is two questions.

Q1. When is something mental an *illness*?

[1] See Thornton, Fulford, and Graham (in preparation).

Q2. When is an illness something *mental*?

Philosophers and philosophically minded mental health professionals usually direct their attention to the first question and to the following worry: if something is mental, then how can it be ill? But although Q1 may be the most frequently discussed question about the nature of mental illness, it is not the only source of worry, at least not for those anti-dualists who also accept that the domain of the mental is not radically non-spatial, having neither size nor location. On the dualist view, a human being or person is a duality, a mind and a body paired. Non-mental illness is bodily illness. Mental illness is non-bodily illness. On the anti-dualist view, though we may distinguish between the mental and the non-mental, this distinction cannot be drawn as a distinction between the mental and the bodily. So mental illness cannot be understood as non-bodily. It must be described in other terms that are compatible with appreciating a role for the brain in mental illness. And it is not obvious what those other terms are.

"The" question about what is mental illness thus is two questions about mental illness. Indeed, the first is so familiar that we tend to overlook the second. And (as will be noted as the chapter progresses) in this chapter we plan to focus more or less on the second and not the first question, although we shall have things to say about the first question. This explains why the chapter bears the title of *minding* mental illness.

The second factor is recent history. In a once popular and unifying picture, famously championed by Freud, mental illness is depicted as unconscious mental forces, whose lively, fertile, and often repressive dynamics purports to explain everything from clinical depression to verbal slips. Freudianism has proven to be a failure as a theory of mental illness.[2] As numerous anti-Freudian criticisms have been shed on the causes, consequences, symptoms, and treatment of human illness, the Freudian notion of mental illness has not been replaced with an equally compelling unifying conception. One deep problem among others with the Freudian conception is how to determine when the attribution of mental illness is empirically testable and non-vacuously true. There is good reason to believe, in light of anti-Freudian attacks, that too much human mental disturbance qualifies as illness from a Freudian point of view. In the words of Allan Horwitz (2002): "The (Freudian) assumption of a near universality of psychopathology made the abnormal less strange and at the same time heightened the strangeness of the normal" (p. 42) (parenthesis added).

The third factor that will be mentioned here is connected with the first (above) and concerns social institutions and clinical practice. Mental illness is firmly established in social and institutional reality. Each year many thousands of people are diagnosed as suffering from some variety of mental illness. The legitimacy of such diagnoses is accepted by the vast majority of the public and, frequently, by the diagnosed persons themselves. A recognized medical specialty claims the treatment of mental illness as its professional competence and its practitioners receive compensation for their services from private and public payers. Fully accredited medical schools, Ph.D. programs, and other institutions provide training for mental health professionals and support research

[2] The proposition or claim that Freudianism is a failed theory of mental illness has been defended in a variety of different ways. See Grunbaum (1984), Kitcher (1992), and Horwitz (2002). See also Beam (2002) and Hobson and Leonard (2001). The claim that Freudianism is a failed theory is consistent, of course, with the claim that one or more insights of Freud into mental illness remain valuable or even necessary for the description or explanation of mental illness.

aimed at understanding and ameliorating mental illness. *However* all is not rosily united or smoothly integrated. The social institutions and clinical practices that buttress or confirm the reality of mental illness seem not always to reinforce or confirm the reality of the same thing and contribute to conceptual instability of the very idea of mental illness. Mental illness's supporters do not agree on how best to treat mental illness or on the causes of mental illness. This proliferation of therapeutic and etiological accounts fuels suspicion in the minds of mental illness's critics that there is little more to the concept of mental illness than a group of poorly organized ideas that ought to be abandoned.

Well-informed critics, many from within the mental health professions, regard mental illness as a misbegotten notion that obscures our understanding of human health and well-being. From one direction, critics[3] deny that mental illness represents a genuine illness. They see the notion as part of an attempt to medicalize the human condition: to classify familiar human failings, excesses, eccentricities, and other deviations from social expectations as diseases requiring medical intervention. They charge that this re-description of 'problems of living' as mental illness lacks scientific support and intellectual coherence. Other critics[4] accept that mental health professionals confront real illnesses, but deny that it serves any useful purpose to count these illnesses as mental. They maintain that so-called mental illnesses are diseases of the brain, not of the mind. They see no good reason to distinguish mental illness from other behavioral manifestations of brain malfunction such as movement disorders and aphasias.

Although advocates of these positions often work at cross purposes, it is quite possible, and perhaps reasonable, to combine them. That is, one might argue that some so-called mental illnesses, such as anti-social personality disorder or substance abuse, represent problems of living, whereas others, such as schizophrenia or bipolar disorder, are diseases of the brain. One can argue that the category of mental illness is a conceptual mistake, without offering or even believing that it is desirable or necessary to offer a unified account of all the conditions currently included within that classification. Moreover, even if we discount such wholesale criticisms of the notion of mental illness, we must still confront, in a wide range of cases, the problem of distinguishing mental illness from problems of living and from brain disease. The concept of mental illness is intellectually empty unless it provides us with principled guidance in discriminating mental illness from ordinary instances of imprudent or disruptive behavior, on the one hand, and brain disease, on the other.

So, what is mental illness? If the concept of mental illness is to not simply be abandoned, it must be recast or regimented in ways that permit plausible responses to critics. This must include showing how the concept makes relevant distinctions between mental illness, problems of living, and 'mere' brain diseases. It must explain why mental illnesses count as illnesses, while problems of living do not. It must show that, although mental illness certainly involves the brain, and is not a non-spatial illness, it is nevertheless worthwhile to distinguish mental illness proper from diseases of the brain, such as temporal lope epilepsy and Parkinson's disease that have psychological consequences but are not mental in nature. Finally, although there is little point in formulating a notion of mental illness that does not have substantial overlap with currently conceived paradigmatic cases of mental illness and with clinical practice, a

[3] Most famously Szasz (1961).
[4] Recent examples: Andraesen (1984, 2001), Hobson and Leonard (2001), and Taylor (1999).

suitably regimented notion of mental illness must contain the resources for revisionism at least around the edges of received conceptions and clinical practice.

So, what do (or should, for remember this is regimentation) we refer to when we say 'mental illness'?

Here is our proposal.

Suppose we know at least in serviceable terms what illness is (of which more below). *Something, therefore, that is an illness is a* ***mental*** *illness, prototypically speaking, when the conscious content or phenomenology of the illness, roughly, what both self and world appear like to its subject or victim, matters critically to the illness's (1) origin or onset, (2) symptoms, (3) consequences (including growth and behavioral variation), and (4) proper and effective treatment.*[5]

2 Clarification of proposal

There are several comments to be made in clarification of the above proposal (in addition to those made in the fourth footnote).

First: We assume that the concept of mental illness does not conform to what is called a *classical definition* of a concept. By this we mean that it does not encode a simple or tractably specifiable set of necessary and sufficient conditions for being a mental illness. We assume that the concept of mental illness is best pictured on regimentation as possessing what is called a *probabilistic* or *feature based* structure. This means that the concept does not encode necessary and sufficient conditions, but, rather, features or characteristics that cases in the extension of 'mental illness' *tend to have*. Cases of illness are classifiable as mental when they are sufficiently similar to an exemplar or target case of mental illness. The exemplar or target case is sometimes referred to as a *prototype*. Conditions (1) through (4) above constitute, we propose, features of the prototype of mental illness. When present they make for a clear cut case of mental illness. Given the assumption that the concept *mental illness* has a probabilistic or feature based structure, we refer to an illness as mental "prototypically speaking".[6]

Second: To get a quick gist of the above proposed *mental illness prototype* (henceforth 'MIP' for short) let us pick a candidate mental illness entry from the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (APA 1994). One such entry is panic disorder (being prone to panic attacks) with agoraphobia (APA 1994, pp. 396-99).

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[5] 'Matters to origin or onset' means that reference to conscious content helps to causally explain the occurrence or presence of the illness. 'To symptoms' means that symptoms include conscious content. 'Matters to consequences' means that conscious contents help to produce or control the variations and behavior associated with the illness. 'To treatment' means that the illness can be treated or therapeutically ameliorated by direct address of its conscious content. For the immediate present we use the expression 'conscious content' in an unexamined or intuitive way. The expression is clarified a bit later in the chapter.

[6] In assuming that *mental illness* fails to admit of a classical definition, we are agreeing with Andreasen (1984) that the concept possesses "debateable boundaries" (p. 35). But in assuming that it possesses a prototype structure, we are disagreeing with Gorenstein (1992, p. 14) that it merely is a "catchall" concept. On our view, efforts at conceptual regimentation can be useful and successful especially if conducted – as we plan to conduct ours in this chapter – in an interdisciplinary spirit. Conceptual boundaries, at prototypical peaks, can be defended against unwelcome intruders and suspect conceptual innovations (see Graham and Horgan 1998, Ramsay 1998, and Laurence and Margolis 1999).

Panic disorder with agoraphobia (literally 'fear of the market place') contains conscious content. The content includes, during panic attacks, fear and anxiety directed at or responsive to situations (called 'panicky situations') where escape appears to be difficult or impossible to a victim. Typically it also appears from the victim's point of view as if she is ill, going crazy, or even dying. If these contents of panic disorder help to explain its origin or onset, help to constitute its symptoms, play a causal role in the behavior or variable forms of expression that result from a panic attack, and are the foci of effective therapeutic intervention (a topic to be examined much later in the chapter), then panic disorder conforms to MIP. It qualifies as a clear cut case of mental illness.

Several disorder entries in DSM-IV conform to MIP. In our judgment these include among others (in addition to panic disorder): Stress-related adjustment disorders, conversion disorders, situation-sensitive mood disorders, some cases of impulse control disorder, and personality disorders that reflect personality changes after traumas – "stressors that are . . . so serious, so overwhelming in their impact, that we must give them (special) status" (Wheaton 1999, p. 188). Some of this will be explained later in the chapter.

Although disorder entries that conform to MIP are not hard to find, a number of entries in DSM-IV depart from MIP. In some cases, such as various movement disorders (see below), the entries conform to a contrary prototype of non-mental illness. So, if MIP is adopted, they should not be classified as mental illnesses or disorders. Still other DSM-IV entries share some but not all four features of MIP. So, it is worth classifying such entries as mental and non-mental but in different respects or to varying degrees. Alzheimer's type dementia (APA 1994, pp. 139-143), for example, is both mental and non-mental. Conscious content plays a role in Alzheimer's symptoms. Victims may suffer, for example, from thoughts of theft and paranoia, which, in the context of the amnesia and confusion associated with the condition, may be interpretations of mislaying or misplacing objects. In advanced Alzheimer's patients, however, therapies that directly address the conscious content associated with the disorder are ineffective given the cognitive disabilities or impairments of victims (Lovestone 2000, pp. 393-394). Additionally, on the question of mattering critically to the consequences of the disorder, reference to content may help to explain the depressed mood sometimes associated with Alzheimer's, perhaps reflecting changes in a victim's perception of disturbed social relationships and diminished personal autonomy. However, in its origin or onset Alzheimer's appears to be due to plagues and neurofibrillary tangles that form in the hippocampus and spread throughout the cerebral cortex. These are areas of the brain associated with the onset of both dementia and amnesia (Andreasen 2001, pp. 263-265; Lovestone 2000, p. 392). Conscious content plays no causal role in Alzheimer's origin. So, Alzheimer's is removed in certain significant ways (including origin and, at advanced stages, proper treatment) from MIP, although it is not so far removed as to count as non-mental in every aspect.

Third: MIP presupposes, as we noted, that we know what illness is. This claim is, to say the least, not something what we are prepared to defend here. However, fortunately for the advocate of the concept of mental illness, there is a vigorous cottage industry whose purpose is to explicate the notion of illness. Typically, this is done in terms of functional impairment and etiology. An illness may be said to consist in the impaired and harmful functioning (or hurtful malfunctioning) of an organ system, part or

faculty (including neuropsychological faculty) of a person. Illustration: A heart's function is to pump blood because hearts' pumping blood in the past has given them a selection advantage and so led to the survival of more animals with hearts. Heart tumors that cause life-threatening heart malfunctions are illnesses (or diseases).[7]

We use the word 'illness' as a general term for a negative state of unhealth. We picture illnesses (whether non-mental or mental)) as negative states of unhealth that cause (or severely increase the likelihood of[8]) persons in them to be harmed or hurt and that reflect impairment or disability in the operation of one or more parts or faculties of persons. We also picture the harm or hurt as, in some sense, stemming directly from the impairment.

We use 'parts' and 'faculties' broadly. Bones are parts of persons. So, bone fractures are negative states of unhealth just when they impair the natural operation of bone structure (keeping the body erect, for example) and therein harm or hurt a person (causing severe pain, for example). Visual perception is a faculty of persons. So, blindness is a state of unhealth since it means that the operation of visual perception is dramatically impaired. Blindness of course also disables a person's freedom of movement and general personal liberty and therein is harmful.

This is not a chapter on illness per se.[9] In order to focus on MIP, we cannot fully defend our definition or picture of the term 'illness' or explicate associated terms (e.g. 'faculty') here. However we suggest in partial defense that by embracing our picture a vexing problem associated with mental illness and mentioned earlier in the chapter can perhaps be solved. We will address the important question of how we are using 'conscious content' in a moment. First, briefly, let us turn to the problem.

3 Mental distress

The problem that we are about to mention appears in one form or another in a variety of different places in the mental health literature. These include discussions of philosophical counseling (Marinoff 2000, Raabe 2000), histories of concepts of mental health and illness (Radden 2000), cross-cultural analyses of mental illness (Kleinman and Good 1985) and critiques of the over-medicalization of mental distress (Horwitz 2002, Wakefield 1999).

Mental illness or disorder is a type of mental distress or disturbance. It is different in kind from other types. Some types are best classified as problems in living. The human condition, tragically, is riddled with problems in living. Abnormally

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[7] See (with respect to mental illness) Mechanic (1999), Murphy and Stich (2000), Wakefield (1992 and 1999) and Woolfolk (1999). Compare Wakefield (1992 and 1999) with Murphy and Woolfolk (2001).

[8] Reference to 'increased likelihood' is meant to cover a case like the following: a broken bone that has not begun to hurt but will under conditions of further decay or continued use. The unhealth of the break is a function, in part, of the relevant increased likelihood. We will drop the clause from further mention in the chapter.

[9] If this was a chapter on illness per se, regimentation of the notion of illness would have to include discussion of the relationships between notions like the following: that of illness, disorder, disease, malady, and affliction. Each is or can be used to identify a negative or unwanted health state but they may not be used synonymously. For example, one may wish to speak of some negative states of unhealth as diseases, in a semantically strict or classically defined sense of 'disease', which applies only to organ systems of a person (e.g. a diseased liver), and to reserve the word 'ill' for the whole person or for the subjective experience of disease (e.g. "he feels ill with liver disease"). See Fulford (1989) and Mechanic (1999) for discussion.

prolonged or intractable grieving over the death of a loved one is one such problem. Other types are best classified as sub-cultural patterns of social deviance. Various types of religious hysteria and vagabondage fall into this category. Finally, some forms of distress are mental illnesses. How should mental illness be distinguished from other forms of mental distress, particularly from problems in living?

The answer to this question that our use of the word 'illness' and related terms helps to warrant or support goes something like this.

> *Provided that the faculties of persons are in proper operation and that persons are neither harmed nor hurt by mental distress, mental distress fails to qualify as mental illness.*

Consider, as an example of a complex form of mental distress that is not also an illness, not grief or vagabondage, but the belief system of someone who is in *philosophical despair*. By this we mean, following Richard Garrett (1994), that a subject in philosophical despair embraces pessimism about whether anyone's life is good or meaningful or has the potential of being good or meaningful. Human existence to a philosophically despairing person is believed to be utterly absurd and worthless.

Bertrand Russell (2000) advocated it. So did Schopenhauer (2000) as well as Richard Taylor (1970), Joel Feinberg (1980) and numerous others.

Philosophical pessimism is more than occasionally distressing or melancholic. Some elements of the mood and belief system of a philosophically despairing person may be indistinguishable from that of a victim of clinical depression. But various similarities between depression and philosophical despair do not mean that someone with this philosophic outlook is mentally ill. Since it is eminently possible to formulate a competent intellectual justification for philosophical despair, we cannot presume that proponents of philosophical despair are impaired. Since it is also eminently possible to embrace philosophical despair without undue suffering for oneself (given his episodes of depression[10] Russell is not an instance of non-suffering pessimism, but the cases of Feinberg and others are), we cannot presume that proponents are harmed or hurt. One therefore must be careful not to confuse the two psychological economies: the one of depression, the other of philosophical despair.

Nancy Andreasen (1984, p. 144) commits just such a confusion in the following instance. She writes of St. Augustine as follows:

> No medical texts are extant from the early medieval period, but literary and historical evidence indicates that the absence of texts does not bespeak the absence of illness. St. Augustine has confessed to his struggles with the hopelessness and despair of depression.

Andreasen is referring to Augustine's soul-searching quest described in <u>The Confessions</u>. However because Andreasen confuses philosophical despair with depression, she describes his struggle in backwards fashion. Augustine did not confess to his struggles with the hopelessness of depression, he confessed to his struggles with the hopelessness of philosophical despair. Augustine's quest was an effort to avoid the doctrinal

[10] See Brink (1989).

conviction that life is meaningless and absurd. The intense saint was not on a prescient search for a good psychotherapist or fluoxetine (Prozac). He was searching for a cosmic meaning of life.

Philosophical despair reflects neither impairment nor harm. It is mental distress, of a sort, without illness. What, however, of mental distress that unlike philosophical despair is harmful but (like philosophical despair) does not reflect impairment or disability in a faculty or part of a person? This seems to be a promising way in which at least to begin to describe the category 'problems in living'. Problems in living are (at least in part) harmful distresses that are not reflective of impairment. Let's consider as illustration, very briefly in this context, the question of whether alcoholism is a problem of living or mental illness.

Assume that human beings have a faculty for exercising prudent control over alcohol consumption. Just how we describe this faculty is not something we are prepared to discuss here, but, roughly, let's refer to it as a combination of foresight and self-discipline. Clearly, failure to exercise control over alcohol consumption harms the subject. The question of whether alcohol consumption is an illness, then, comes down (we may assume) to the question of whether or not the relevant faculty of foresight and self-discipline is impaired in persons with alcoholism. What has to be decided to settle that question?

Showing that alcoholics fail to exercise prudent control over their drinking would not demonstrate that their foresight and self-discipline are impaired. All sorts of plausible explanations may be given other than impairment that account for failure to exercise control. An alcoholic might have false beliefs about the costs and benefits of drinking. Or various emotional distractions might prevent him from giving sufficient attention to the future negative health consequences of drinking. The assumption here is that impairment is a matter of competence rather than performance. Failure to perform is not proof of incompetence or impairment. If therefore it can be shown (as some critics of the alcoholism-is-a-mental-disorder model have argued that it can be shown [see Fingarette 1985]) that alcoholics do frequently exercise prudent control over their drinking in a variety of settings or in the long term, then this would be a big step towards showing that impairment is not present and that at least in such cases alcoholism is a problem of living and not illness.

The purpose of the above remarks is to suggest that the definition of 'illness' which we have offered, by way of background to MIP, likely is on the right track and helps to distinguish mental illness from other forms of mental distress including problems in living. More complete analysis would be needed to more systematically distinguish mental illness from problems in living. But let us return to MIP.

4 Conscious Content

What about the expression 'conscious content'? This expression is the linguistic centerpiece of MIP. The conscious content of a mental illness is said by MIP to be critical to the illness as mental. What do we mean by this expression, in general, and what does it mean with reference, specifically, to mental illness?

Presumably, of course, there is a difference between being conscious and not being conscious. Presumably, also, there are different types of states in which one can be when one is conscious. Precisely what counts as a type of conscious state or experience

is not entirely clear, since one can distinguish types in a variety of different ways and for different purposes. We assume that the most interesting types of conscious states (especially for purposes of understanding mental illness) are those that are most often identified or individuated in terms of their *content* (sometimes called 'representational content' or 'Intentional content'). Conscious content state types represent the world or the self as being one way or another. They help to constitute a person's conscious point of view or (to use a technical term) phenomenology. If the representation is veridical, the world or the self is the way that the content represents it as being. If the representation is faulty or misleading (perhaps hallucinatory), then the world or self is other than the content represents it as being. We mean to refer to such contents when we speak of 'conscious content'. Conscious content is conscious representational content. It is content that represents the world or self as being one way or another.

Disorders of the sort that are paradigmatically cited as mental are filled with conscious content, that is, conscious experiences with representational content. Usually the content is specific in type or kind to the illness or disorder. So the conscious content of depression is distinguishable (despite some overlap) from the conscious content of panic disorder. When a person suffers from a major depressive episode, for example, the experience of being depressed typically includes thoughts of death or suicide or personal worthlessness. In panic disorder, by contrast, a person consciously believes themselves to be losing control or going crazy.

In personality disorders with grandiose delusions people are convinced that they have great talents or supernatural powers. In symptoms of depersonalization parts of one's body or actions are consciously represented or experienced as not belonging to the self. And so on.

Consider an example of conscious content not associated with mental illness. Suppose I am dining in a restaurant.[11] Suppose I have the conscious visual experience of something in my soup. Suppose I visually represent this as a bug. Or perhaps, alternatively, I perceive it as a leaf or as a small, unidentifiable foreign body. Either way, any way, insofar as I consciously experience something in my soup, I experience it as something (as a bug, etc.). It appears to me as being one way or another.

The content specific to an experience may be described by saying that the experience "says" or "means" something to the subject of the experience. The visual experience of a bug in my soup says or means to me that a bug, leaf, or foreign object perhaps (depending upon how it is specifically represented) is in my soup. What it says or means is in the experience. This should not be confused with the meaning *of* the content or experience for the person. Suppose, for example, I perceive a bug in my soup. Visually experiencing such a bug may signify for me that the restaurant has a sloppy cook or that my eyesight is acute. Either interpretation may be part of the meaning of the content for me. However this is not the content in the experience, but is added, typically *ex post facto* or perhaps immediately via inference or interpretation to memory or description of the experience.[12]

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[11] The first person singular is occasionally be used as a stylistic device.

[12] Here is another example of what we have in mind by talking of conscious content. Suppose you are a native English speaker and you are reading the following marks: [*Snow is white*]. If so, you see the set of marks that we have just typed as the English sentence 'Snow is white'. That is the conscious content in the experience.

Now consider a full-blown case of mental illness. Consider the case of Virginia Woolfe (1842–1941), English novelist and essayist. Woolf committed suicide by drowning herself, fearing a depressive breakdown (having had mental crises in 1895 and 1915) from which she would not recover. She suffered from manic or bipolar depressive illness. In a suicide note to her husband she wrote:

> I feel certain that I am going mad again: I feel we cant go through another of those terrible times. And I shant recover this time. I begin to hear voices, and cant concentrate. So I am doing what seems to be the best thing to do . . . . I don't think two people could have been any happier till this terrible disease came. I cant fight it any longer . . . . Everything has gone from me but the certainty of your goodness. I can't go on spoiling your life any longer.[13]

Of her depressive episodes, Quentin Bell wrote: "her sleepless nights were spent in wondering 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."[14] Of her manic episodes, Leonard Woolfe wrote: "she was extremely excited . . . talked volubly and, at the height of the attack, incoherently; she . . . heard voices."[15]

It should be noted that the overall character of Virginia Woolfe's manic depression is a structurally rich (albeit of course profoundly disturbing) conscious experience of both self and world. The experience or content is of an apparent whole array of events, activities, properties, and relations – including the experience of voices, sleepless nights, fear of laughter, doubts about her art, and so on. It is the complex experience for her of appearing to be a disturbed and disturbing wife and writer. One may engage in the behavior of writing a suicide note, for example, because one is consciously bored, play-acting, or exploring new literary styles. Or one may do this because one is Virginia Woolfe and is depressed and self-consciously wishes to discontinue living. The note appeared to Woolfe as a suicide note and not as a literary exercise.

Woolfe's illness "shaped her development as a person and as a writer, affected her closest relationships, and eventually claimed her life" (Slavney and McHugh 1987, p. 116). Conscious contents specific to her type of illness critically and, indeed, tragically, mattered to her illness. They contributed to its onset. They were characteristic of its symptoms and helped to lead her to suicide.

Roughly, our view on all this is that when conscious contents enter into the onset or origin of an illness this may help to constitute something we call a *stream of influence* through different phases of the illness, its symptoms, consequences, and (conditions permitting) proper treatment. The manner in which both self and world appeared to Wolfe was not just involved in producing the onset of her depressive episodes, but in producing its cyclical (bipolar) symptom expression and consequences. The content exerted a stream of influence from one phase of her illness to the next.

It should be remarked that the notion of conscious content that appears in our description of MIP is intended to combine reference to two notions of the mental widely

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[13] Quote as cited together with primary source in Slavney and McHugh (1987), p. 31.
[14] Slavney and McHugh (1987), p. 31.
[15] Slavney and McHugh (1987), p. 31.

examined in the philosophical and cognitive science literature. One is the notion of *phenomenal* content. The other is the notion of *representational* or *Intentional* content. The phenomenal feature of mental life is often thought to be primarily associated with sensory and perceptual experience: the distinctive taste of dark chocolate, the distinctive feel of a toothache, and the distinctive appearance of bright red. It is sometimes said that there is something it is like to undergo or experience such contents, and you can't really know what the experience is like unless you have had the contents – phenomenal contents -- in your experience. So Ned Block (1980, p. 278) responds to the question of what is it that philosophers call 'phenomenal content' with the quip: "As Louis Armstrong said when asked what jazz is, 'If you got to ask, you ain't ever gonna get to know'".

Examples that are typically given of elements of our mental lives with representational or Intentional content are beliefs, desires, and memories. These are features of mental life that carry information (ideally but not always veridical information). We may believe that our paper is widely read. We may desire that our paper is widely read. We may remember that our paper is widely read. That the paper is widely read is the representational content of the belief, desire, and memory. Representational content, it is often said, may fail to be consciously explicit to its subject. It may be implicit and non-conscious or inaccessible. Our desire that the paper is widely read may be implicit in our behavior and not apparent to us.

We assume that the two sorts of mental content are not unrelated. They are thoroughly and deeply intertwined in that much (if not all) of our mental (including mentally ill) life is constituted by of a blending or fusion of phenomenal and representational content. The fusion has been aptly called 'phenomenal Intentionality' by Terence Horgan and John Tienson (2002) [see also Horgan, Tienson, and Graham 2004]. In this chapter we are referring to it as conscious content (partly so as to avoid various other connotations of 'phenomenal' and 'Intentional') and we are saying that, typically, just which sorts of content are involved in an illness is specific to the type of illness. Like Horgan and Tienson (2002) we suppose that conscious content is not restricted to sensory or perceptual experiences. We assume that the content of thoughts, attitudes and other non-sensory, non-perceptual states may be consciously apparent to their subjects.

To accept the proposition that conscious content is the form of mentality to which reference should be included in a regimented description of the prototype of mental illness certainly does not exclude other forms of mentality or non-conscious content from playing a role in mental illness. Woolfe no doubt had unconscious or implicit representational content as part of her depression. Perhaps these included unconscious emotional memories triggered by real or imagined failure in her literary career. However it should be appreciated that MIP's reference to conscious content as prototypically central to mental illness does assume that conscious content is the form of mentality or mental content that operates in clear-cut *qua* clear-cut cases of mental illness.

5 Restricting the mental

Remember, as a major part of getting clear about 'mental illness', we are hoping to identify how something ill can be mental. We aim to distinguish mental *qua* mental illness, as it may be put. We propose to do this by reference to prototypical mental illness. So, we need to identify a form of mentality or mental content such that if it is of the obvious or most uncontroversial type, and matters critically to the illness, then an

illness is sufficiently mental to count as mental. Since conscious content surely counts as mental if anything does, then, if we are right, no one should deny that an illness in which conscious content matters critically is mental.

Prototype or no prototype, however, just how generous is the very idea of the mental in mental illness? Should we classify as mental an illness in which conscious content plays utterly no role? The extension of 'mental' in discussions of mental illness sometimes possesses much wider scope and referential generosity than that of conscious content. DSM-IV, for example, treats various motor deficits or movement disorders as mental disorders (e.g. APA 1994, pp. 53-55). In some such cases 'mental' seems to be semantically functioning as co-extensive with 'sub-personal, sub-conscious informational'. We doubt that sub-personal, sub-conscious informational content suffices to identify an illness as mental.

Fred Adams (2003, pp. 161-2) has helped to argue that some theories of content attribute content to things that they shouldn't. Some theories attribute too much content, as Adams notes. Adams calls this the problem of *semantic promiscuity* for a theory of content. In the case of a theory of mental content and mental illness, we call the analogous problem the problem of *mental content promiscuity* for a theory of mental illness. Calling certain kinds of sub-personal, sub-conscious informational content 'mental' is too promiscuous and is not consistent with a notion of mental *qua* mental illness that is even modestly prototypical.

There is both utility and wisdom in speaking of sub-personal, sub-conscious information processing in describing or explaining certain features of mental illness as well as, of course, human and animal behavior generally (Bechtel, Abahamsen, and Graham 1998). Do these facts mean that we should identify mental illness in terms of reference to non-conscious information processing full stop? That kind of conceptual generosity towards the mental if taken as constitutive of mental *qua* mental illness makes it a mystery, we claim, how mental illness is or can be distinguished from non-mental illness. Some types of informational content enter the world exclusively as a result of objective probability relations between events (Dretske 1981). The movements of a barometer needle (when operating properly) carry information about changes in atmospheric pressure. The posture of a joint carries information about perturbations in the shifting equilibrium points of muscles (Brooks 1986, pp. 204-205). However barometers cannot be mentally ill. Ideomotor apraxia (see Rogers 1999, pp. 104-5) is a disorder in the coordination of movement, but describing it as a mental or neuropsychological disorder is an unwarranted verbal gloss on a preferably more strictly neuromuscular description of the disorder as a non-mental physical illness. We don't need to apply a notion of mental illness to that sort of disorder anymore than we need a notion of mental disorder to understand dysfunctional barometers.

Again: Sub-conscious, sub-personal informational content of different sorts can and does certainly play a causal-explanatory role in mental illness. However, we believe, it does not play a critical role, prototypically, in mental *qua* mental illness.

6 Broken brain

Reflecting on the unneeded or unhelpful conceptual promiscuity of including deficits in sub-personal, sub-conscious information processing as constitutive of mental illness may produce the contrary impression that clinging to a concept of mental illness

wedded to reference to conscious content is an unwelcome theoretical conservatism. Perhaps we are not at the hard-nosed medico-scientific cutting edge in describing mental illness. We are aiming to show what constitutes mental illness. But when is illness mental? It might be replied in two sentences: 'No illness is ever mental.' 'So-called mental illnesses are all and only diseases of the brain.' As Michael Alan Taylor (1999) writes, "psychiatry and neurology (constitute) one field." "Mental illness is . . . not 'mental' at all, but the behavioral disturbances associated with brain dysfunction and disease" (p. viii). [Parenthesis added.]

Advocates (like Taylor) for replacing the concept of mental illness in favor of that of a notion of behavioral disturbance caused by a (to appropriate Nancy Andraesen's [1994] expression) broken or diseased brain presuppose that it can be known when the brain is broken or diseased. But advocates (not Taylor) sometimes overlook the significance of the fact that whether the brain is broken or diseased is unintelligible without presupposing reference to its role in our conscious and social lives. And it must be remembered: we do have conscious and social lives.

An important conceptual constraint on conceiving of mental illness as brain disorder is that the very idea of brain health or disorder is governed by our sense of just what it means for the brain to operate normally or to properly function. Meanwhile, our sense of just what it means for a brain to properly function is tied to our picture of healthy conscious and environmentally situated lives and of how the brain contributes to leading those lives. Consider the following analogy. The very idea of a 'healthy' automobile engine is not derived from our picture of the basic physics or quantum mechanics of locomotion. We explain how the engine works by taking it apart and examining its functional units (cylinders, pistons, rods, etc.) and the roles that these units play in generating motion in environments for which the engine is suited. Each unit makes a contribution that we articulate in terms of producing locomotion. If locomotion occurs we assume that the engine – its cylinders, pistons, etc. -- is functional and not broken. If locomotion fails to occur we look for either a dysfunction (e.g. busted rod or cylinder) or the engine's foiled attempt at locomotion in an environment for which it is ill suited (e.g. it is trying to move a car through 3 feet of northern Ontario snow).

Something analogous is true of the brain. Whether we understand the brain as healthy or broken depends, in part, upon whether our conscious and social lives – of motivation, affect, decision, belief, social relationships, interpersonal behavior and so forth – are or appear to be healthy and well. If our conscious and socially situated life is or seems healthy and well, we assume that to that extent (independent of whatever brain activity is associated with non-mental forms of wellness) our brain is functional and healthy. If conscious/social life appears unhealthy or unwell we may wish to invoke brain dysfunction or neurological causes to explain poor mental/social health. Or we may search for a disconnection or mismatch between an otherwise healthy brain and environmental circumstances (e.g. the brain is skidding over social landscapes packed ice tight with learned helplessness reinforcement schedules). Either way, rather than conceiving of the brain as an engine that operates in a phenomenological and social vacuum, we should recognize that the healthiness of neural activity is judged in goodly measure in terms of facts or assumptions of conscious and social-environmental sorts.

One way to approach the issue of how best to understand the role of the brain in mental illness is to argue that when the brain is healthy and unimpaired, but if there is

conscious mental distress that is harmful to its subject, there is a case to be made that the subject might be suffering from a problem in living. In any case: He or she is not mentally ill. If not, if the brain is impaired or disabled and because of this the subject is in mental and harmful distress, there is case to be made the subject might be suffering from a mental illness. So understood the impaired brain is the underlying (i.e. within the organism) mechanism for mental illness.[16]

The question then arises: how do the conscious contents that MIP says matter critically to mental illness relate to the impaired brain? An immediate worry is that if mental illness consists in a consciously harmful neural impairment, we do not need to suppose that conscious content is causally involved in the onset (or growth and consequences) of mental illness at all. The broken brain packs the causal clout sufficient for mental illness. So: By acknowledging that the brain is the underlying mechanism aren't we saying that reference to the conscious content of mental illness drops out of the influence stream of mental illness?

Elimination of reference to conscious content as not needing to do any work in mental illness seems to us to be a grossly injudicious interpretation of the proposition that the brain is the mechanism underlying mental illness. There seem to be at least two main options for the friend of conscious content in the understanding of mental illness here. Firstly, one could assert that there are causal or causal-explanatory gaps in the neural mechanisms underlying mental illness that are filled in by acknowledging a causal role for conscious content in the influence stream of mental illness. On this view, one or more characteristics of the onset and course of mental illness are not determined by the broken brain alone. Processes involving conscious content play a physically irreducible role. The most popular version of this sort of view is Descartes's mind-body dualism (which we are not accepting), but this sort of view is also compatible with an "emergentist" view in which conscious contents are special neurophysically irreducible features of the brain and have "downward" causation effects on the brain and behavior. Secondly, one could accept that even if from a God's eye point of view there is some manner in which the disabled brain is responsible for mental illness, there is no general consensus at present about how this is done, and no bright prospects for a neural story to appear soon. It is obvious also that various features of actual accounts of mental illness depend upon assumptions about the role of conscious content in mental illness. In cases of prima facie prototypical mental illness we have antecedent evidence that conscious content figures in the influence stream of these illnesses and we have no idea of how to understand those illnesses in purely or narrowly non-conscious terms. So (given our current state of brain ignorance) we can and must make reference to conscious content in our understanding of mental illness.

For at least one of us, we think that in some ways the emergentist view is most appealing, but this is largely grounded on worries about conscious epiphenomenalism whose force is unclear. Suffice it to say, the choice between these two views depends in large part on issues in metaphysics and the philosophy of science whose discussion and settlement far outstrip the resources of this paper (or our own resources).

Choice between *two* views? It should be mentioned that some may add a third option. This would be a reductive consciousness/brain process identity theory. However

[16] Granted, many underlying impairments are not identified or understood, there is then an epistemic cavity in the identification of many so-called mental illnesses; if empty of impairment they are not illnesses.

the consciousness friendliness of a reductive identity option depends upon what sort of reduction is intended. If the reduction contrasts with elimination, and preserves reference to conscious content as conscious content, then a reductive theory is an option. But if the reduction is a so-called eliminative reduction, which replaces reference to conscious content in the understanding of mental illness by reference to brain processes, then a reductive theory is not an option.[17]

But, in any case, as we see it, there are some options on the table, each of which is compatible with saying that although neural impairment underlies mental illness this does not preclude conscious content mattering to mental illness or at least to our understanding of (what we take to be) mental illness.

Likewise in acknowledging sympathy for the brain as the mechanism behind mental illness, a second worry is whether we mean to preclude a causal role for the environment in the onset or course mental illness. No, most certainly we do not. If the environment also needs to do some work in producing mental illness (and not just in problems in living), this is consistent with saying that an impaired brain is the underlying (proximate) mechanism.

So we have arrived at the following question. How does reference to the environment as well as to conscious content figure in the account of the onset or origin of mental illness? Answer: Reference to the environment often does this by describing the environment *as consciously interacted with*. (The brain interacts with the environment *as* the consciously meaningful environment.) Reference to conscious content often figures in the account of the onset of mental illness by describing conscious content in *environmentally represented terms*. To illustrate: Suppose I have a panic attack. My brain activity somehow carries or produces conscious content about the environment as an environment with such-and-such panicky properties. Whether the environment does possess such properties depends upon the representational content of a victim's consciousness. The facts by reference to which the onset of a panic attack is explained must include at least some reference to how the environment appears to its victim. This is partly how, according to MIP, conscious content figures in the prototype of mental illness. How the world appears to a subject of mental illness is part of mental illness.

Let us consider two ways in which reference to conscious interaction with the environment plays a role in the explanation of the onset of mental illness. For proponents of referring to conscious content in the influence stream of mental illness, whilst at the same time acknowledging that there is a sense in which mental illness is a brain disorder, these two ways help to provide a picture of how conscious content can matter to the onset or occurrence of a mental illness, prototypically speaking.[18] One we call *situation sensitive* conscious interaction. The other we call *culturally scaffolded* conscious interaction.

7 Conscious Content and Environmental Interaction

Consider the case of Charles Darwin. Darwin suffered it seems from panic disorder. He wrote of his episodes of panic attack as follows:

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[17] See, for related discussion, McCauley and Bechtel (2001) and Place (2003).

[18] Conscious content matters to onset in other ways. It fits into structural aspects of some disorders reinforcing vulnerability conditions for a disorder. See Stephens and Graham (2000).

> The heart beats quickly and violently so that it palpitates and knocks against the ribs . . . the skin instantly becomes pale as during incipient faintness . . . under a sense of great fear . . . in connection with the disturbed action of the heart, the breathing is hurried . . . one of the best marked symptoms is the trembling of all the muscles in the body. (quoted in Ballanger 2000, p. 807)

Barbara Grizutti Harrison, recipient of the O. Henry Prize for short fiction, like Darwin was, also is a victim of panic disorder. She describes the meaningful conscious content of her attacks as follows:

> I am living inside my fear . . . I cannot bring myself to walk the familiar path . . . I shrink the world around me and cocoon myself. . . A panic attack as the force of an oncoming train. Panic is anxiety severely, grotesquely heightened. . . Life is hard; perhaps you've noticed. (Harrison 1998, pp. 3-7).

DSM-IV includes symptoms like those mentioned by Darwin and Harrison in its list of symptoms of panic disorder, adding that victims often feel that "they are 'going crazy' or losing control or are emotionally weak" (APA 1994, p. 398). "A sense of great fear", to use Darwin's expression, or of "pain . . . grotesquely heightened", to use Harrison's expression, are part of the specific conscious content of the disorder as well as of what DSM-IV means when it says that victims feel that they are losing control or going crazy.

What of the environmental situatedness of attacks? James Ballenger (2000) notes that the highest reported rates of panic disorder "occur in widowed, divorced, or separated individuals living in cities" (p. 807). Assuming that reported rates are comparable to real rates, why is that? A promising hypothesis offered by Ballenger (which we must endorse here without argument, referring the reader to Ballenger and elsewhere[19]) is that such individuals live in environments with more robust 'stressors' or situations that cause or induce panic. Stressors help to produce panic attacks in people of certain personality types or with certain learning histories.[20] Relevant city-wise stressors for some people (especially those who have panic attacks with specific sources of anxiety such as agoraphobia) may include public transportation, shopping malls, tunnels, elevators, and crowded city streets.

Mention of explanatory reference to stressors prompts an observation that needs to be made. What stressors are found in a city or elsewhere depends upon the definition of "stressor", an issue more conceptually elusive than it may first appear.[21] There is a big

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[19] See also Cockerham (2003, pp. 76-89) and Wheaton (1999).

[20] 'Stressors', so called, should not be confused with what are sometimes called 'environmental insults'. These are identifiable environmentally induced neuromolecular traumas (such as malnutrition, viruses and toxins) which cause cell death or interfere with critical transduction pathways and leave distinguishable neurochemical footprints. Although some insults are stressors (insofar as persons react to the insults as stressors) and some stressors are insulting (in the previous mentioned technical sense), there is no necessity (other perhaps than the expectation on the part of investigators) that a stressor will contribute to cell death or interfere with brain circuits or that insults will register in behavioral disturbance.

[21] We are about to introduce a distinction between 'stressor' defined in non-stress nominally physical terms and in stress related terms. We must also distinguish between stressors that are essential or internal parts of

difference between physically defined and salient stressors. The stressors just mentioned – tunnels, elevators, crowded city streets, etc. – concern, in some sense, physically defined stressors. Each has distinctive physical features or configurations of parts or of people in those configurations. Tunnels are designed one way. Crowded streets are configured another.

There is obviously another side to stressors. Why should certain objects or situations "stress" some people and create panic attacks? The answer, we presume, doesn't lie just in physics or optics or neurophysiology. It does not consist in reference to architectural features or to the population density of tunnels or city streets. It requires reference to the conscious interactions of susceptible persons who interact with stressors. Stressors in the salient sense consciously mean something to persons whom they disturb. They induce and are constituted by conscious contents. Being in a tunnel for someone may appear like an uncontrollable threat to her physical safety. Walking on a crowded street may say to a person that he is living in isolation and loneliness among strangers and from which there is no escape. Either of these contents can contribute to a panic attack. Consequently, if an illuminating appreciation of the role of stressors or situational factors in understanding a disorder such as panic attacks is sought, it must be recognized that there is nothing intrinsically stressful about the physicality of objects like tunnels or crowded streets. Scores of people are exposed to these situations but never experience panic. Clearly most people cope, master, or buffer against anxiety. A relative few, however, do not. For them panic is a response to those situations: to the environment as represented in the conscious content of a panic attack. Certain aspects of those situations "say" or "mean" something panicky to such people.

What role or function is there for the brain (broken or otherwise) in stressor induced or situation sensitive panic attacks? Regardless of the precise and ultimate neuroscientific details, and whether they are mechanically gappy or not (see above), whatever the brain does in such situations, it encodes information and carries memories about stressors as well as relevant learning histories. Some of this information must somehow be translated or readied for presentation in consciousness in the form conscious content as when, for example, a victim explicitly believes that her physical safety is threatened in a tunnel and this leads to panic. If conscious content is not at least in some measure immediately responsible for the situational sensitivity of a panic attack, then we shall have to show either one of two things. One is that a derivative of conscious content (e.g. unconscious memory of prior attacks) is potent in an attack. The other is that reference to sub-personal neural activity in tunnels and streets together with reference to physical properties of those situations accounts for the attack. The first explanatory option continues to give conscious content etiological traction in the account since it backtracks to previous instances of panic and to memory traces of those experiences. The second option must cite the *situational identity* (to a victim of panic attacks) of circumstances like tunnels and crowded streets in order to hold the stressor class together as a distinguishable or identifiable stimulus class across a wide array of realizations or

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an illness (such as a frightening delusion to a schizophrenic) and external stressors that help to produce instances of an illness (such as uncertain threats to physical safety as antecedents of a panic attack). Another useful distinction is between proximate stressors, which occur just prior to an episode or instance of illness, and distal stressors, which may have occurred previously but with long-term effects. (See Zuckerman 1999, p. 424-425.) we aim to be talking, in what follows, about proximate external stressors that help to produce instances of an illness.

instances. We doubt that the causally potent identities of stressor classes are explicable by reference, for example, to the optical properties of the ambient illumination of tunnels or city streets given the multiple realizations and diverse lighting conditions associated with such circumstances. Reference to what stressors "say" or "mean" to susceptible people seems unavoidable as a means to account for the onset of mental disturbance. Such reference grounds our ability to group city-wise configurations into instances of stressors.

We are not saying that mental illnesses (or panic attacks) are always situation sensitive or that the sole purpose of reference to conscious content in the origin or onset of mental illness consists in explaining situational onset or sensitivity. However we are saying that some mental illnesses owe their origin or onset to situational circumstances as defined by how they are consciously represented. Obsessive-compulsive disorder provides a second example of a mental illness with situation sensitive behavioral onset. The door that may be unlocked or the hands that may be unclean are experienced in the case of some victims of OCD as an occasion for "that awful anxiety (that) keeps me checking", as one victim puts it (Rappaport 1998, p. 16). Other illnesses with situational sensitivity and thus contribution from conscious content include some major depression, post-traumatic stress disorder, and borderline personality disorder.

Situational sensitivity is not the only manner in which the conscious content of environmental interactions is linked causally or influence-wise to illness onset. Secondly, there are cases of the *cultural scaffolding* of mental illness. Here, again, reference to how the environment appears to a victim is necessary in order to explain the origin or occurrence of illness and, in particular, its symptom expression. We will be brief.

Consider impulse control disorder. Types of this disorder typically partition along gendered lines. A compulsive male might become a victim of obsessive compulsive disorder (OCD) in one social environment or a gambling addict in another. A compulsive female might develop anorexia nervosa. Social context including culturally conditioned gender expectations seem to exert a powerful influence on types of disorder and symptom character. Linking particular types of disorder to cultural contexts without reference to conscious content appears impossible. One female victim of anorexia nervosa 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, pp. 243-244). A male gambler notes: "Winning big made me feel important . . . and potent" (Heineman 1998, p. 161). How a thin female body or a male gambler's reinforcement schedule appears -- what it consciously means to its subjects -- plays a critical role in the occurrence and consequence of these compulsions. Different people have different reactions to the appearance of thinning bodies or to winning at horses. Most people of course do not become compulsive about such activities when engaging in them. If anorexia or heavy betting is to have any explanation, it seems, reference to aspects of the environment (to the fly in the soup as it were) as they "consciously speak" to a subject must be part of the story.

The cultural scaffolding of mental illness has received considerable scrutiny in the sociology of mental illness and cross-cultural studies of symptom expression (Horwitz and Scheid 1999 and Horwitz 2000[22]). Horwitz refers to it as the "structuring of mental

[22] See also Cokerham 2003 and Schumaker 2001.

illness" (Horwitz 2000, p. 113). "In the broadest sense," he writes, "symptom profiles are structured to fit the illness norms of particular cultures" (p. 116). The symptom character of dissociative identity and recovered memory disorders, eating disorders (such as anorexia and bulimia), depression, and a host of other illnesses or disorders seem to rest in part on cultural and therein conscious content scaffolds.

Unfortunately the picture of mental illness as that of a broken brain is sometimes the result of an environmentally de-situated and 'aconscious' caricature of what happens in mental illness. Existing evidence for the etiology of mental illness sometimes focuses on the impaired brain as the most proximate, common or sustaining cause of mental disorder and neglects extra-neural environmental components and the critical role of conscious content in interaction with those components. De-situated, 'aconscious' neural focus simply buries interesting constituents of mental illness in superficial neuroscience. Such burials, we hope, are not the necessary result of taking the brain seriously in an informed picture of mental illness. Taking the brain seriously means, in part, taking its functional role in conscious environmental interactions seriously.

Andreasen (1984, p. 219), who does know better (see below), remarks "when we talk, think, feel, or dream, . . . these mental functions (are) due to electrical impulses passing through . . . the human brain." "Mental illnesses are due to disruptions in the normal flow of messages through this circuitry." If one agrees with Andraesen one might be tempted to refer only to disrupted electrical impulses or to some other sort of neural impairment rather than also to conscious content to explain panic attacks and compulsive gambling. In the case of gambling, for example, one may wish to refer to "disrupted" neuronal activity in the ventral tegmental area that are involved in reinforcement processing as part of the explanation for the behavior (Montague and Dayan 1998). However we cannot see why anybody would be tempted to promote such an explanatory strategy independent of acknowledging the role of conscious content in situation sensitive and culturally scaffolded forms of mental illness. The overall problem is to characterize the distinctive role of neural impairment in mental illness as well as those conscious contents that figure in the illnesses onset and influence stream. Mental distress without impairment (disruption, disorder) isn't illness. Impairment without conscious content isn't prototypical mental illness.[23]

8 Mental Illness Regimented and Treated

The concept of mental illness would be regimented with trumpets were it to be decided that MIP is the preferred concept. Suppose, then, that thanks to the efforts of numerous books and articles, and robust clinical and experimental evidence, MIP has been accepted as the preferred concept of mental illness. The DSM of the future, say, uses it. Suppose that we describe many individual cases of illness so that they conform to the prototype. Some conform in all four critical respects; others conform in most

[23] Leslie Brothers (2001, see also Brothers 1997) uses the expression 'social neuroscience' to refer to the research program of developing models of brain activity that is selectively responsive to conscious aspects of the social and cultural environment. It's not clear precisely how Brothers believes that social neuroscience is to be conducted or what its environmental interactive data should be. However the phrase "social neuroscience" is helpful for marking the task facing a friend of the proposition that mental illness is a brain disease and of MIP. The task is to investigate the causal-explanatory roles associated with the conscious content of environmental interaction at several levels of detail or resolution – beginning with facts like the following. Crowded streets may signify loneliness. Tunnels or subways may say that one's personal safety is threatened.

respects. Here's one instance of illness that we are going to stipulate or assume (for purposes of illustration) conforms in all four respects.

> *The patient, a male professor of mathematics, comes to the clinic seeking antidepressant medication and medicine for sleep disturbance. He reports that his appetite has diminished, and that he lies awake long into the night contemplating his death. He reports that he feels guilty for having squandered a Ph.D. in mathematics from Princeton. He is fatigued and lacks energy. He reports that he feels extreme sadness and emptiness, as well as absence of pleasure in daily activities. He says that he continually shows up for class late and unprepared, and a colleague has reported that he told her that he wished to commit suicide. The professor is barely managing to hold back tears.*

The patient described in the above vignette is properly diagnosed, we may suppose, as suffering from a major depressive episode. Of course, the distress experienced by the professor is similar in some ways to non-illness distressed mood, but suppose that the patient has been referred to the clinic for chronic depression. This is not his first major depressive episode and, apparently, without treatment, it will not be his last). Suppose we have MIP in hand.

We describe the professor's symptoms as follows. The symptoms with conscious content include depressed mood over the course of his life or circumstances, diminished pleasure in activities, recurrent thoughts of death and suicide, and feelings of guilt over a presumed wasted graduate career. Then, as we leave a description of symptoms, we identify (again supposing this here) that the professor's depressed mood is a partial cause of various other symptoms of his condition, including fatigue and loss of energy. We believe that because he is depressed, the professor arrives late for class and is unprepared. Symptoms, causes, and consequences: three forms of mattering for the presence of mental illness are all in place for the professor. The list could continue and the vignette expanded, but what then of treatment? Thus far we have said absolutely nothing about treatment.

Suppose we embark on treatment. Some people become so depressed that they experience delusions or hallucinations. Their memory and attention become impaired. They may become paranoid, so that they fear that their depression is going to be "found out". The professor, say, does not fall into that severity category.

The professor's depression may be due, in part, to pathogenic or harmful information that he acquired during his lifetime.[24] This information may include faulty judgments of personal worth, grossly inappropriate vocational aspirations, negatively valenced emotional experiences, and other disturbing matters. Let's suppose that this is the case. His depression is situation sensitive as well as scaffolded, though, again, the precise details must be omitted here.

Some forms of treatment for depression are sensitive to and directly address pathogenic information that is harbored in a person and surfaces in conscious symptoms and behavior. Typically these forms of treatment are embedded within a general

[24] His susceptibility to this information may be due, in part, to abnormally high levels of adrenal stress hormones and/or to some other neuronal impairment or disruption (such as an overactive amydala). We shall not speculate here on the details (see Hobson and Leonard 2001, p 170f for discussion).

psychotherapeutic orientation: cognitive therapy, cognitive behavioral therapy, rational emotive therapy, and interpersonal therapy – to name various therapy types with widely practiced programs. The general goals of treatment, for example, in depression consist in providing a desirable and believable measure of optimism, addressing accumulated intra-personal conflicts, blocking overgeneralization of negative attitudes, and gradually mobilizing a person's skills at recognizing conditions that may be responsible for the onset or persistence of depressed mood. For example, blaming one's own person for wasted opportunity may require very little by way of personal failure. One doesn't have to consistently falter to accuse oneself of wasting a Princeton Ph.D. Questions of whether personal blame truly is deserved are perhaps best put to the test by counter-consideration of particular forms of competence and concrete achievement. In the deflated subjective world of a depressed person the standards of success and wisely chosen opportunity tend to be too demanding and unrealistic. Witness the case of Virginia Wolfe. Her standards should have been less elevated and more self-forgiving (on self-forgiveness see Garrett 1989).

The conception of treatment at issue in the above case of the professor, which we shall label 'conscious content driven' (hereafter simply 'content driven'), can be stated a bit more exactly. Content driven treatment at least of a paradigmatic sort rests on the following three premises, two regarding the nature of an illness and the third regarding treatment or therapy:

(1) *Cognitive competence*. The illness does not prevent the person either from understanding the conscious contents of the illness as symptoms of the illness or from appreciating factors of personality or circumstance that may be responsible for illness origin or persistence.

(2) *Motivational focus*. The illness does not undermine the patient's desire or willingness to improve his or her condition (i.e. to eliminate or ameliorate the illness).

(3) *Therapeutic feedback*. For a given illness or symptom the person is able to understand and appreciate when improvement is or is not achieved. He or she recognizes positive progress as well as negative outcomes.

One may weaken the set by restating the demands of each premise. Some illnesses or symptoms, for example, strip a person of insight into the fact that they are ill. In such cases a less cognitively demanding form of cognitive competence than (1), which requires illness recognition, may permit some version of content driven treatment. We shall not explore such revisions or the conditions that may warrant them (delusions characteristic of schizophrenia are among them [see Stephens and Graham 2004a and 2004b]) or therapies that address them here.

Let's assume that each of the above premises is satisfied in the case of the professor. Unsurprisingly, he appreciates that he is not well and he wants treatment. At the same time, he recognizes that much of his conscious life is taken up with being depressed. Moreover he is able to recognize when symptoms are being ameliorated or eliminated. He also does not go blithely when therapeutic effort fails.

Content driven treatment has been the subject of rancorous debate in the therapy literature. Some of this has been focused on the comparative merits of different therapeutic orientations. Some has been aimed at the merits of combining therapies (including drug and content driven therapies). Some has been targeted at the

economically overweening character of the therapeutic profession and medical sub-culture. We cannot even begin to address various terms of that complex debate. We only wish to point out the following. Content driven treatment expresses the fourth manner in which conscious content matters to mental illness, prototypically understood. Content is the focus of content driven treatment. This focus may be combined with therapies, including various drug therapies, which while not content driven address behavioral disturbances associated with illness, in the case of depression, sleep disturbance, whose amelioration contributes to receptivity to content driven treatment.

When the therapeutic goal is illness reduction or elimination, and the course is content driven, one can proceed by attempting modifications of the "unhealthy personality" behind the specific conscious content of the illness. Or one can address, if they exist, the situations or sub-cultures that help to provoke or scaffold the illness. Address may take the form of avoiding eliciting situations. Avoiding eliciting situations may often be no easy matter, but the emphasis seems more focused than transforming a person's conscious outlook or personality type. The recovering gambler is better equipped to avoid gambling if he associates with non-gamblers and commutes away from the track. The depressed professor is better able to avoid depressed mood if he cultivates relationships with colleagues of prudent aspiration and refrains from submitting manuscripts to highly selective journals. The city-dwelling victim of panic attacks may travel by taxi rather than subway. Situated change or address may also be achieved often more prudently or usefully (especially when situations cannot be avoided) by various techniques of confrontation and desensitization that render stressful situations and cultural factors less potent. Circumstances need not be avoided if they can be met with new conditioning histories or behavioral skills. For example, the depressed professor and his therapist together might identify situations that trigger thoughts of wasted career and other misspent resources. The professor might be taught to correct those thoughts or to substitute more positive self-assessments in their place.

Personality transformation of a pan-situational or cross-cultural sort is a therapeutic exercise without much current guidance as compared with the strategies of desensitization and avoidance. But let's suppose that by the time, say, DSM-VI appears we have learned a thing or two about how to transform the personalities of some of the mentally ill. An influential program of transformation has worked its way into therapeutic practice – perhaps combining elements of philosophical counseling with therapeutic tools from social or preventative medicine central to mental health. These may include imitative modeling (emulating the behavior of healthy people) and understanding and appreciating lifestyle risks and liabilities.

It must also be mentioned that the discovery of non-mental origins of an illness does not automatically preclude therapeutically addressing it, at least in part, with content driven treatment.[25] To support and clarify the point, let us shift briefly to schizophrenia. Suppose that schizophrenia does not fully conform to MIP. Suppose that it is non-mental physical (perhaps genetic or neurochemical, clearly dopamine is critically involved) in origin or onset. Even so, clinical evidence suggests that content driven cognitive

[25] Partly because we have written of symptoms of schizophrenia elsewhere (Stephens and Graham 2000) but mainly because of the controversy and complexity surrounding this illness (see Chung, Fulford, and Graham 2004) we have as yet not mentioned schizophrenia in this chapter. That is about to change, albeit only briefly.

behavioral interventions can sometimes be useful in the diminution or reduction of the delusional experiences that constitute some of the conscious content (including attention deficits) characteristic of schizophrenia.[26] Content driven treatment is impossible in severe delusions, where minimal cognitive competence is compromised. However in less severe cases it can foster diagnostic insight[27] and reduce the resistance to extinction or incorrigibility of delusions.

The possibility of limited application of content driven treatment for schizophrenia contains a general moral about prototypes that applies to MIP. Elements of a prototype typically have a weighted or graded structure.[28] Some count more heavily towards application of a concept than other elements. A fuller investigation of MIP than we are able to offer in this chapter would propose candidate comparative weightings among the four ways in which conscious content matters to mental illness. Whatever the nitty-gritty details we believe that the less robust the causal role of content in the origin or onset of an illness, the less clear-cut or prototypically mental it is. If an illness such as schizophrenia is non-conscious physical in its conditions of onset or persistence, there may be little reason to classify it as mental in any respect, unless its content driven treatment yields some success. Successful content driven treatment cannot by itself make for a clear-cut case of mental illness, but failure of such treatment when combined with non-content origin makes it difficult to conceive of an illness as mental no matter the vividness of its conscious symptoms (in the case of schizophrenia, voices and delusions).

9 Conclusion

In this chapter we have tried to take seriously a problem about mental illness – or pair of problems – that remains with us despite decades of analysis by philosophers and others. This is the (what may be called) *Two Problem Problem of Mental Illness*. One is the problem of how something mental can be ill (and not just a problem in living) and the other is the problem of how an illness can be something mental (and not just a brain disease). On these issues dissensus reigns. "The" problem of mental illness is still with us.

It should also be noted that we certainly are not alone in saying that conscious content matters to mental illness, although our terminology and emphasis is different from others. The physician and philosopher Karl Jaspers[29] and the tradition of descriptive psychiatric phenomenology that he helped to found vigorously endorse the proposition that understanding the conscious experience of the mentally ill is critical to understanding and treating mental illness.[30] Numerous efforts by both psychiatrists and philosophers have been made to deepen our appreciation of what mental illness is like for those who suffer from it and to deploy that appreciation in characterizing the role of consciousness in mental illness.[31] On one interpretation of this chapter, we are merely

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[26] See Fowler et al. 1995, Kingdom and Turkington 1994, and Munro 2000.

[27] Absence of diagnostic insight is a hallmark of delusional experience. See Fulford 1994 and Stephens and Graham 2004a and 2004b for discussion.

[28] See Hempel (1965) and Laurence and Margolis (1999).

[29] See Jaspers (1997).

[30] For introduction to and discussion of descriptive psychopathology, see chapters 8, 9, and 10 in Thornton, Fulford, and Graham (2004, in preparation) as well as Doerr-Zegers (2000).

[31] See, for one of dozens of examples in the philosophical literature, Stephens and Graham (2000). Additional references to this literature may be found in Graham (2002).

reinforcing the general wisdom of such attempts. However it is also to avoid a promiscuous view of the mental in psychopathology and to argue that consciousness has a fundamental place in mental illness that we have written this chapter. There is something it is like to be mentally ill. To fail to recognize this fact is to fail to be prototypically mindful of mental illness.

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