

‘MENTAL ILLNESS’: ONTOLOGY, ETIOLOGY AND PHILOSOPHY AS ‘CURE’

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Abstract. This essay defines the ontology of mental illness or mental disorder in non-biomedical terms, as consisting of problematic propositional mental content rather than organic brain malfunction. This allows for a causal theory of mental disorder to be located within the parameters of existential difficulties rather than biological pathology, and contradicts the argument in defence of the necessity of psychotropic medications for the alleviation of mental distress. This in turn supports the argument that mental disorders can be treated, if not cured, by means of philosophy.

Keywords. Philosophical practice, Mental illness, biomedic, psychotropic

Resumen. Este ensayo define la ontología de la enfermedad o desorden mental en términos no biomédicos, la cual se funda en contenidos proposicionales mentales antes que en una disfunción orgánica del cerebro. Esto permite localizar a la teoría causalística del desorden mental dentro de parámetros de dificultades existenciales antes que dentro de los de la patología biológica y contradice el argumento que defiende la necesidad de los psicofármacos para el alivio de la tensión mental. Esto apoya el argumento de que los desórdenes mentales pueden ser tratados, si bien no curados, a través de la filosofía.

Palabras clave. Filosofía Aplicada, enfermedad mental, biomédico, psicofármacos.

Twenty-eight year old Byron told me he was presently on medication for depression. A psychiatric assessment had indicated that he had bipolar disorder or manic depressive illness. He said he was suffering from anxiety, a lack of self confidence, and extreme shyness, especially around ‘girls.’ He told me he was an only child, and still living at home with his elderly parents, and that he was a virgin until about a year ago when he paid to have sex with a prostitute. He explained that he had ‘obsessed’ about four different girls in his teen years whom he had only watched from afar but never asked out, and that in his early twenties he had asked a number of other girls out but he had not shown up for any of the dates they had agreed to. He apologized for his various nervous ticks, many of which often looked like sexually aggressive gestures. He wondered if a philosopher might be more helpful to him than the psychiatrists and psychotherapists he had visited in the past. Their main treatment approach

had been to put him on a regime of powerful psychotropic medications and anti-depressants.¹

It would be impossible for philosophy to be helpful in treating Byron's, or anyone else's, mental illness if mental illnesses were in fact biological diseases or deep neurochemical disorders of the organic brain. But philosophy has proven to be very effective in treating mental illnesses. How is this possible?

Since about the middle of the 20th century the biomedical paradigm of mental illness has been predominant. In our modern day Western society we have been led to believe that mental illness is the same as other physical human afflictions such as diabetes or heart disease, where the cause is internal or endogenous, due to a dysfunction of the biochemical mechanisms of the body itself. We have been told by professionals in the mental health care fields, and by professors in the universities, that a problem in the mind is like a disease such as influenza: mental illness is the *cause* of this or that type of suffering and distress. If this were true then philosophy would clearly not be very helpful in treating mental illnesses. But none of this is true.

Philosophy has been used to treat and 'cure' scores of diagnosed mental illnesses, such as depression, general anxiety disorder, sleep disorder, adjustment disorder, obsessive/compulsive disorder, bipolar disorder and its less severe manifestations dysthymic and cyclothymic disorders, attention deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), paranoia, borderline personality disorder, undifferentiated schizophrenia, schizophrenia-affective disorder, paranoid schizophrenia, and, yes, even demon possession. In the *Textbook of Anxiety Disorders*² the authors include a chapter on psychotherapy for each of the various psychopathologies discussed. The core element of psychotherapy is what's commonly referred to as talk therapy; talk therapy is simply philosophy under a different name. Since none of the thousands of diagnosed cases that were helped with talk therapy/philosophy can simply be dismissed as mistaken diagnoses by incompetent practitioners, there must be some sort of problem with the

¹This is from an actual case. Byron is not his real name.

² Stein, Dan J. and Eric Hollander. *Textbook of Anxiety Disorders*. Washington: American Psychiatric Publishing, 2002.

underlying assumptions about what mental illnesses actually are and what causes them. In order to locate the cause of a mental illness it must first be established what mental illness is. Ontology must precede etiology.

Ontology

Byron had been led to believe that he was primarily suffering from some sort of chemical imbalance in his brain. This was supposedly at the root of his strange behaviour. He was also told that many mental disorders were genetic weaknesses. His treatment had consisted almost exclusively of medications meant to reduce his agitation during his bouts of mania, and at the same time counteract his clinical depression when that arose. Byron explained that, unfortunately, the medications did not alter his negative opinion of women, nor did they improve his low self-esteem. And, while the drugs seemed to calm his disposition somewhat, they failed to eliminate his recurring bouts of hopelessness and apprehension. Each of his previous therapists had assured him that eventually the 'correct' medications would be found that would adequately manage the organic nature of his mental disorders.

With his book *The Myth of Mental Illness* Thomas Szasz³ may not have been the first, but he is one of the earliest, and perhaps best known, professionals in the field of mental health care who said that the public has been duped, that we have been manipulated into believing that mental illnesses are scientifically validated bio-medical diseases when in fact they are nothing of the sort. Szasz was derided by many of his colleagues as a disgruntled psychotherapist who probably had some sort of grudge to settle. But in the last half of the twentieth century more and more practitioners came forward to agree with Szasz and support his claim that mental illnesses are not biological illnesses, that they do not and should not have any ontological status in the medical world because they are not caused by brain diseases or malfunctions. They are, as Szasz claimed, created by the very act of diagnosing and classifying. So, if not actual brain diseases or malfunctions, what are mental illnesses, and how exactly are they created?

The mind is not a material object like the brain. It is an abstraction consisting of beliefs, values, and assumptions. The brain is not an

³ Szasz, T. S. *The Myth of Mental Illness*. New York: Hoeber-Harper, 1961.

abstraction; it is an organic part of the physical body. Changing one's mind is not the same as changing one's brain. There is no such thing as 'mental content' defined as something *in* the mind. The content of the brain simply *is* the mind. The mind *consists of* the content. The mind is propositional, not biological. Mental propositions consist of propositional attitudes—such as doubt, belief, desire, value, and assumptions, toward propositional content—such as, for example, worthiness and respect. In other words, a person's mind may consist of the doubt that she is worthy of love and respect from others; the belief that she is unworthy of love and respect; the desire to be loved and respected; the valuing of love and respect; and the assumption that she will never be loved and respected. Notice that none of this propositional content has any material existence. The defining characteristic of the brain is its complex physical structure; the defining characteristic of the mind is its complex 'intentionality' as philosopher of psychology Franz Brentano called it.⁴ The mental is not a material entity, it is always thoughts or attitudes *about* something.

Although foetal alcohol syndrome, lime disease, Alzheimer's, Turret's, syphilitic dementia and other biological disorders affect thinking, they are not mental illnesses. Of course, they all interfere with the proper functioning of the mechanisms of the brain and prevent what is considered 'normal' thinking. These biological disorders *affect* the person's ability to effectively deal with beliefs, values, and assumptions, but they are not problems *caused by* the individual's beliefs, values, and assumptions. This is what differentiates brain diseases from so-called mental illnesses. As soon as mental confusion is found to have an organic cause it is no longer a mental problem; it is a brain problem. This is the point Thomas Szasz and other mental healthcare professionals have been making since the 1950's in response to the drive by psychiatrists to have biological psychiatry be the exclusive treatment paradigm in mental healthcare. But our society—and our minds—are so saturated with the medical/biological model of mental illness that their message has had only minor impact. For example, the Consensus statement of the National Depressive and Manic-Depressive Association, coauthored by twenty prominent psychiatrists, government officials, and mental health

⁴ Discussed in *A Brief Introduction to the Philosophy of Mind*. Neil Campbell. Orchard Park: 2005. p. 9.

advocates and published in *The Journal of the American Medical Association*, promoted the idea that

people who have depressive symptoms have a disease condition that, like untreated physical disorders, requires professional treatment. Untreated cases of depression, no less than untreated cancer, pneumonia, or diabetes cases, are serious public health problems that must be treated with high doses of medication⁵

Notice the so-called mental illness of depression is said to be like the biological diseases of cancer, pneumonia, and diabetes. Similarly, the host of a television program on how to overcome mental illness described depression and anxiety as signs of "a broken brain." But the biological model of mental illness that is common in Western societies, that 'mental illnesses are brain diseases,' is due far more to the cultural beliefs than to any empirical findings.

One of the strangest problems that exists, unexplained, within the definition of mental illness as organic brain disease is that there are significant differences from one culture to the next. This does not occur with organic diseases. For example, personality and eating disorders are not universal. They are found only in Western societies. And the diagnosed symptoms of depression and anxiety are highly varied from one culture to another. The recently 'discovered' mental illness of sexual addiction seems to be located exclusively within the North American culture.⁶ The biological brain is universal, but mental illnesses are not. Some mental illnesses are unique to particular cultures; some cultures do not recognise the diagnosis of a particular mental illness as legitimate. Biological psychiatry ignores cultural differences and isolates behaviours and experiences from their context when claiming mental illness as brain disorder.⁷ If mental illnesses are in fact bodily diseases, why is there such extensive ontological relativism? There should not be any.

⁵ Horwitz, Allan V. *Creating Mental Illness*. Chicago: University of Chicago Press, 2002. p. 99.

⁶ A new television series is being shown in North America titled "Sex Rehab with Dr. Drew." Dr. Drew Pinsky is a medical doctor who wears a stethoscope around his neck while talking with his supposedly sex addicted patients. He announces at the beginning of each episode of the program that sexual addiction is a "disease that is as dangerous as alcohol and drug addiction."

⁷ *Ibid.* p. 136, 108.

Professor of Psychiatry Dan Stein points out that “there are no fixed boundaries between normal variations [in human emotions] and psychiatric disorder—rather the latter category reflects cultural and historical theories and values.”⁸ With the recognition of the importance of cultural context and social influences in the definition of mental illness it becomes clear that these illnesses are aspects of social movements. Societies ‘discover’ and allow certain behaviours and experiences to be officially classified as mental illness, and then sustain and reinforce them by both professional endorsement and public consent. Once a diagnosis has been created, it enters academic and professional curricula, specialists emerge to treat it, conferences are organized about it, research and publications deal with it, and careers are built around it. Interestingly patients formulate their symptoms to correspond to it in what is referred to as “doctrinal compliance”—patients alter their beliefs about themselves and their ‘conditions’ in ways that “conform to the theoretical orientations of their psychotherapists.”⁹ Furthermore, parents demand that their children be labeled with it in order to hide their own parenting failures.

The splitting of psychological problems into illness categories is a social, not a scientific, endeavor.¹⁰ When common professional consent declines or a particular diagnosis becomes the target of too much public opposition, that mental illness is declassified by the board of professionals which produces the classificatory and diagnostic manuals. It thereby simply vanishes into thin air. Multiple personality disorder, homosexuality, and masturbation, all at one time considered serious mental illnesses requiring extensive treatment, have all been voted out of the official diagnostic manuals. General anxiety disorder and dysthymia are currently under consideration for possible removal, while a variety of sexual behaviours, such as cross-dressing are being considered for inclusion.

The diagnosing of certain behaviours and experiences as mental illness, or the removal of a mental illness from diagnostic manuals, is under continued political disputation. For example, a conservative US

⁸ Stein, Dan J. *Philosophy of Psychopharmacology*. New York: Cambridge UP, 2008. p. 53.

⁹ Jopling, David A. *Talking Cures and Placebo Effects*. New York: Oxford UP, 2008. p. 153.

¹⁰ Horwitz. p. 80.

group calling itself the “Traditional Values Coalition” has mounted a campaign to have homosexuality reinstated into the diagnostic manuals.¹¹ They hope their lobbying will prompt the decision-makers to vote homosexuality back into existence as a mental illness. What sort of ontological status does a mental illness have which can simply be *voted* into and out of existence? The psychiatric ‘creation’ of mental illnesses, because mental illness is based on the dominant social and political environment—not to mention a confused and contradictory ontology—has been and remains deeply problematic.¹²

Allan Horowitz is a professor in the Department of Sociology and Institute for Health, Healthcare Policy, and Aging Research at Rutgers University. His research into the ontology of mental illness has led him to conclude that

...the symptoms of most psychological dysfunctions are not direct indicators of discrete underlying disease entities. ...Culture, not nature, influence how most disorders become real both to the people who suffer from them and to those who treat them.”¹³

Biologic psychiatry makes two critical errors in defining mental illness. First, it adopts a realist epistemology concerning mental illness. It assumes that the knowledge that is the mind and mental functions are reducible to the chemical or electrical operations of the organic brain. This reductionist model of the mind is an essential aspect of biological thought. The biological model reduces the operation of complex wholes to the properties of their individual parts—neurons, ganglia, chemicals, and so on. The logic of this realist model reduces mental illnesses to disordered molecular or cellular structures in the brain. Realist biological models of mental function and mental illness claim that the primary causes of mental ‘diseases’ are in genetic and biochemical factors. They locate the pathological qualities of psychological conditions in the

¹¹ See the website at <http://www.traditionalvalues.org/read/3645/diagnostic-and-statistical-manual-of-mental-disorders-under-attack-by-lgbt-activists/>

¹² Fulford, Bill, Tim Thornton, and George Graham. *Oxford Textbook of Philosophy and Psychiatry*. Oxford: Oxford UP, 2006. p. 317.

¹³ Horwitz. p. 131.

material properties of brains, not in the symbolic systems or propositional content which constitutes the mind.¹⁴

The second mistake is that biological psychiatry reifies mental illness by defining symptom-based diagnoses as ‘quasi-disease’ entities. But reifying a diagnosis is committing a category mistake: an epistemic problem is defined as faulty biology or chemistry.

A symptom of mental illness, or even a cluster of symptoms, is not an objective natural entity. This would be like saying that a *belief* (such as that one is unworthy of love and respect) is an organic disease, or that values, desires, doubts, and assumptions are some sort of biological substances. Realist assumptions are valid in relation to the physical brain but not when it comes to propositional attitudes and propositional content, such as beliefs, values, desires, doubts, and assumptions, which constitute the dynamic subject matter of the mind.

The ontology of mental illnesses then is founded on two misconceptions: that the epistemic content of the mind is physical material not unlike the brain, and that the diagnosis of a mental illness is identical to the discovery of an organic disease. Neither of these perspectives is justified in light of the fact that a mental illness is entered into diagnostic manuals and into professional practice, not by empirical biomedical research, but by a majority vote of an editorial committee.¹⁵ Furthermore, the subsequent definition of any new mental illness is squarely based on the mistaken assumption of epistemic realism not on biology. Fortunately, in recent years the mental healthcare profession has been slowly shifting away from the disease model of mental illness due to mounting criticism from inside psychotherapy as well as from philosophers outside the field of practice. Evidence of this is the fact that the term ‘mental illness’ has been replaced by the less biomedical-sounding ‘mental disorder.’ In light of this dubious ontology of ‘mental disorders’ what can be made of the claims about their causes?

¹⁴ Ibid. p. 143, 3.

¹⁵ For a discussion on how a collection of symptoms are given the status of a mental illness see *Psychiatric Diagnosis and Classification*. Mario Maj et al editors. West Sussex: John Wiley & Sons, 2002.

Etiology

Byron said that his psychiatrists, psychotherapists and other mental health care professionals had assumed that the cause of his mental disorders was probably a neurochemical imbalance in his brain.

Byron told me how, when he was six years old, his father had punished him for being afraid to go to school on the first day by making him kneel on dried kernels of corn for several hours. He said his father was very strict, and that he spoke mainly in the form of criticisms and insults. He resented his mother for being weak and submissive and for not defending him when his father flew into dangerous rages against him. He mentioned that his mother found comfort in her frequent visits to church, and that his Catholic upbringing had taught him women are either mothers or whores. He said he was disgusted by women, and yet he adored them. He also told me how his father often made jokes about 'dirty' bodily functions, women's 'dirty' body parts, and Byron's big nose and his painful shyness which would never get him a woman. His father worked as a janitor at Byron's high school. He often made fun of Byron in front of other students, and repeatedly reminded him that he was good for nothing.

Mental health experts had suggested to Byron that the cause of his mental disorders was likely to be some sort of genetic predisposition or weakness.

The three main projects in the psychiatric diagnostic manuals are the description of mental states and behaviors regarded as symptoms, classificatory grouping of those symptoms into syndromes, and the diagnosis of mental disorder according to those syndromes. Note the difference between diagnostic manuals in the mental healthcare field as compared to those in the field of medicine: there is no attempt in the diagnostic manuals referred to by mental healthcare practitioners to specify a cause for any of the syndromes listed.¹⁶ And there is no attempt to portray mental disorder in a naturalistic framework. But while this is true on the formal level of sanctioned diagnostic manuals, the specialty literature of psychotherapy, psychoanalysis, psychology, and counselling is replete with naturalistic causal claims.

The etiology or cause of any classified mental disorder is dependent on the actual ontology of that disorder. As explained in the previous section, the ontology of mental disorders is a very confusing issue. Mental events continue to be described as being the same as biological brain events, when in fact they are nothing of the sort. For example, the

¹⁶ Bolton, Derek. *What is Mental Disorder*. Oxford University Press, 2008. p. 34.

third chapter in a very recently published book, titled simply *Depression*, is titled “Pathogenesis” which suggests the cause of depression is biological pathology or disease.¹⁷ But doubts, beliefs, desires, values, and assumptions, which are what constitute the mind, are not material entities, so mental disorders can clearly not be biological diseases. Since mental disorders are not like biological diseases they cannot be caused by the same sort of organic causal factors that bring on bodily disorders. The mental disorders do not have the same one-to-one cause and effect relationships found in biological diseases. Part of the reason for this is the indistinct ontology of mental disorders consisting of ambiguously clustered symptoms that make it impossible to determine a particular cause for any particular disorder.

The onset of any so-called mental disorder is a process not an event. So-called ‘severe,’ ‘serious,’ or ‘clinical’ mental disorders do not appear instantaneously; they develop over time. For an individual’s distress to develop into what is diagnosed as a ‘serious’ mental disorder at least one of two conditions is necessary: either the initiating life situation was extremely distressing, or the suffering extended over a prolonged period of time. The claim that serious mental disorders *must* have neurobiological cause merely because of their severity ignores the long and troubled existential life histories of the patients who have been labelled with these ‘clinical’ diagnoses.

Mental health literature rarely if ever differentiates between simple mental distress or suffering and so-called serious mental problems. Yet most of the literature critical of psychiatry and psychotherapy, much of it written by philosophers, insists that this distinction is crucial because serious mental disorders more readily allow or invite naturalistic or medical descriptions of (endogenous) brain disorders, while simple mental distress is always deemed a reasonable reaction to difficult (exogenous) life circumstances. But the definition of those ‘serious’ mental disorders is typically based on the fact that some people’s thinking is so strange, and the belief that their behaviour is potentially harmful to themselves or others that medication is administered. This defines ‘serious’ mental disorders as ‘those for which medication is typically

¹⁷ Lam, Raymond and Hiram Mok. *Depression*. New York: Oxford UP., 2008.

administered.' This is clearly a case of circular reasoning: medication is administered in cases of serious mental disorder, and the definition of serious mental disorders are those which are treated with medication.

Serious mental disorders, when they are not organic brain problems, are the result of severe life circumstances rather than organic malfunction. Even physical symptoms like hormonal imbalance, neurological failure, or abnormal brain activity do not necessarily have organic causes; they can be the result of unresolved life difficulties and the body's stress reactions to long-term mental suffering. Conventional wisdom acknowledges that schizophrenia is caused by organic brain malfunction. But this wide-spread belief is not supported by medical evidence. In fact it has long been known that there are always significant existential life stressors that have played a major role in causing the onset of this disorder. Schizophrenia is typically not diagnosed on the basis of a single symptom; it requires multiple symptoms in a complex and interrelated pattern. To claim that schizophrenia is caused by a chemical imbalance in the brain is a simplistic reductionist error. Research on the families of individuals diagnosed with schizophrenia shows that this disorder is clearly not endogenous to the patient. Its cause is external to the individual, and the result of a stressful social setting, primarily troubling and often disturbingly ambiguous¹⁸ family dynamics.¹⁹

The case histories of even the most psychotic patients reveal a childhood filled with mental and/or physical mistreatment, often the consequences of shockingly incompetent parenting practices. These detrimental practices may actually be the result of the parents' best intentions, such as when parents drive a son or daughter to excel at school, in the arts, or in sports. Blaming adult patients for what has been done to them in childhood or in their early adult years, by claiming their mental disorders are the result of endogenous or internal biological causes, is unjustified and completely inexcusable. It is a case of blaming

¹⁸ One of the 'ambiguous family dynamics' is the contradictory messages given to a child such as "I love you; don't touch me."

¹⁹ See *Cognitive Therapy of Schizophrenia* by David G. Kingdon and Douglas Turkington. New York: Guilford, 2005. See also Barham, Peter. *Schizophrenia and Human Value*. London: Free Association, 1993.

the victim. But that's exactly what occurs with the biomedical approach to mental disorder.

In a university-level psychology textbook, in the chapter on psychological disorders, the authors list a number of factors that possibly contribute to a fictional character's panic attacks. They suggest that this psychopathology may have an organic cause and they list the following as possible causes: a brain tumour, endocrine dysfunction, genetic tendency, and neurotransmitter imbalance.²⁰ Notice that two of these possible causes—brain tumour and endocrine dysfunction—can be discovered by means of readily available medical tests, while the other two—genetic tendency and neurotransmitter imbalance—can not. These last two possible neurobiological causes are merely theoretical speculations, but they have gained enormous weight in the field of mental healthcare. They are so popular in fact that they have significantly overshadowed three other explanatory models: psychodynamic, social-cognitive, and sociocultural. The neurobiological/medical explanatory model of mental disorder, although almost completely theoretical, is now the predominant rationalization for the employment of psychoactive medications as treatment, not for brain disorders but for problems in the beliefs, values, and assumption which constitute the mind.

During the 1980's there was strong lobbying to define mental disorders, such as schizophrenia and other psychotic disorders, as biological diseases generated within the suffering individual. This effectively cut the link that had been discovered between disorders in children and bad parenting methods and other traumatic childhood experiences. When mental disorder was defined as endogenous there was no more need to focus on improving parenting skills or creating a more child-friendly social environment.

While parent groups have fought hard to maintain the biomedical causal model of the mental disorders in their children in order to avoid parental responsibility, advances in the research on the functioning of the brain have not led to any significant advances in knowledge about the organic *causes* of mental disorders.²¹ Contrary to popular belief, there is no laboratory evidence that any of the many diagnosed mental disorders

²⁰ Bernstein, Douglas A. et al. *Psychology* 6th ed. Boston: Houghton Mifflin, 2003. p. 560.

²¹ Horwitz. p. 156. Italics in the original.

has a clearly established biological or organic origin. As the authors of the *Oxford Textbook of Philosophy and Psychiatry* put it, "For all the advances in brain sciences since 1969, biochemically based causal theories remain promissory."²²

And yet even those who are opposed to the biomedical paradigm for the cause of mental disorders fall into the trap of using inaccurate causal language. For example, in his book *Creating Mental Illness*, which is actually critical of the biomedical view of mental disorder, sociology professor Allan Horwitz writes "Depression is perhaps the most widespread mental disorder and the cause of an immense amount of human suffering."²³ Notice he says that depression is the *cause* of human suffering. But this is not the case at all. Depression simply *is* human suffering; the word 'depression' is descriptive or definitional not causal. In effect the symptoms cause the diagnosis of depression. The same thing is done with the word 'schizophrenia.' Any number of books have been written about how schizophrenia *causes* confused thinking, delusions, flat emotions, inappropriate laughter, rambling, unfocused speech, and so on. But schizophrenia doesn't *cause* anything. Confused thinking, delusions, flat emotions, inappropriate laughter, rambling and unfocused speech simply *define* schizophrenia. Again, the symptoms cause the diagnosis to be made; they cause the patient to be labeled. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Illness* (DSM) lists these symptoms as the features which define the disorder, in a sense saying, 'These problems are what the disorder is.' This is a very important point that most of the professionals working within our mental health care system seem to be confused about: Mental disorders are not causal; they are always the *effect* of some other cause.

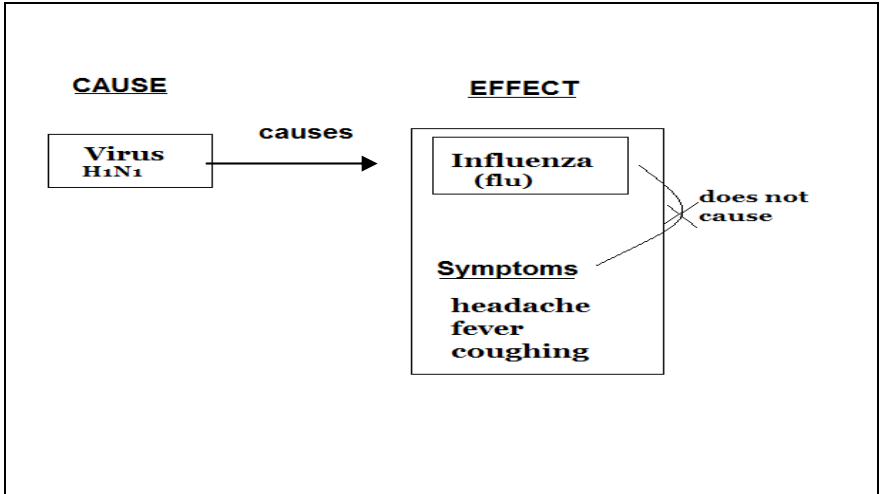
A mental disorder is not an organic problem of the material brain. It is a problem within a person's mental narrative, within the mind's propositional attitudes and content: contradictory beliefs and values, misguided assumptions, confused perceptions, and so on. The mental disorder that is referred to as depression is the result of painful external factors or difficult and confounding life circumstances that result in

²² Fulford, K.W.M., Tim Thornton, and George Graham. *Oxford Textbook of Philosophy and Psychiatry*. New York: Oxford UP, 2006. p. 252

²³ *Ibid.* p. 96.

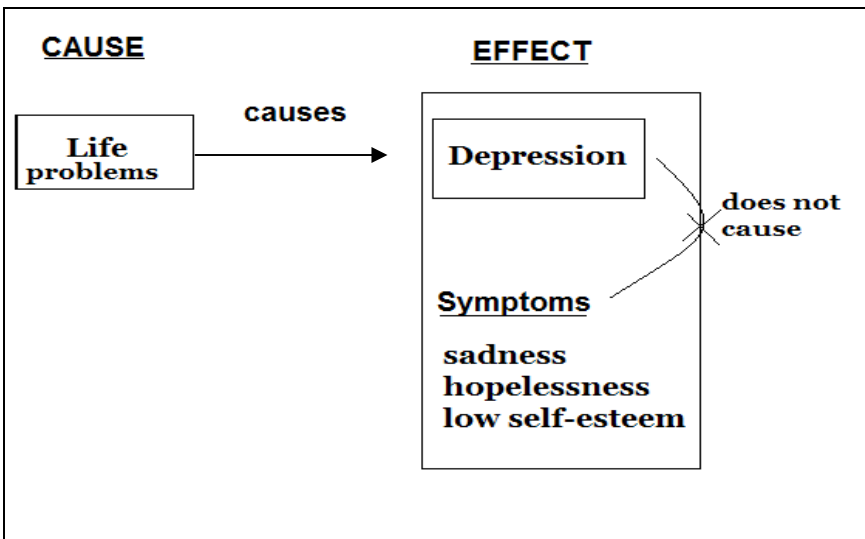
cognitive distress and emotional suffering: such as, for example, a man's justified but mistaken belief that his wife is being unfaithful. The belief may be false but completely justified, based on the knowledge that his wife was not at home on a number of evenings and then was not truthful about the reason. The cause of the depression is not at all a so-called chemical imbalance in the man's material brain.²⁴ That would be a mistaken causal assumption. But it would also be a mistaken causal assumption to say that the man's depression *causes* him to have feelings of sadness, hopelessness, and low self-esteem. Again, depression doesn't *cause* anything. The word 'depression' is a diagnostic label that always only refers to a collection of symptoms that are noticed in, or presented by the sufferer. The patient's feelings of sadness, hopelessness, and low self-esteem *cause the diagnosis* of depression.

Below are two diagrams to illustrate the difference between a cause and a bundle of symptoms which lead to a diagnosis. The first one shows how the effect — influenza — is often mistakenly cited as being the cause of the various symptoms.



²⁴ If the man was happy about his relationship with his wife no one would say his happiness is due to a chemical imbalance in his brain. If so then this would imply that a "normal" chemical balance in his brain is an absolutely flat emotional state, which is not normal at all on the human level.

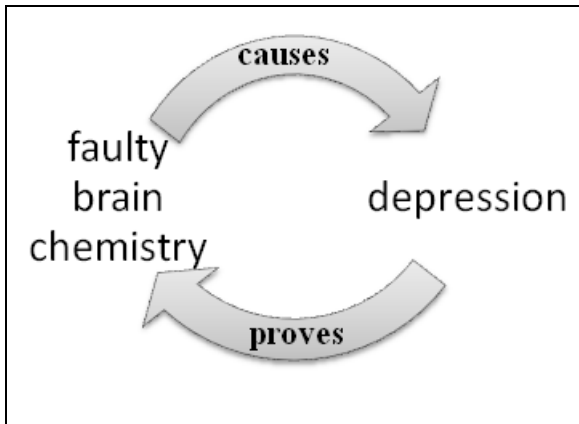
Influenza does not cause a headache, fever, and coughing. A virus causes those symptoms. The symptoms in combination are labelled ‘influenza’ or ‘the flu’. Medication can be given to alleviate the symptoms: the headache, fever, and coughing. But in order to heal the body when a harmful virus attacks, medication must be given which fights the virus itself and not just the symptoms. Medication that is meant to alleviate the symptoms will not necessarily eradicate the actual cause: the virus. The second illustration shows how the effect — depression — is often mistakenly cited as being the cause of the various symptoms.



Depression does not cause sadness, hopelessness, or low self-esteem. Life problems, such as the husband’s belief that his wife is cheating on him, cause those symptoms which are then labelled ‘depression’. Unfortunately, merely stating that mental disorders are themselves not causal agents does not explain what it is that in fact causes mental disorders.

Could it be the case that faulty brain chemistry is the cause of severe, serious, or ‘clinical’ mental disorders? It is often claimed that clinical depression, anxiety, paranoia, schizophrenia, and so on are all caused by

some sort of chemical imbalance in the brain. But what is the evidence supporting this? The only proof that is offered is the fact that the patient is suffering from ‘clinical’ depression, anxiety, paranoia, schizophrenia, and so on. Notice the circularity of this argument: the diagnosis of depression proves the existence of faulty brain chemistry, and faulty brain chemistry is said to cause the depression. But there is no biomedical evidence supporting the claim that a chemical imbalance in the brain is the cause of the disorder. The diagnosis itself is the only proof offered in support of the causal claim.



Brain chemistry does affect the human emotions, but human thoughts and emotions also alter the chemistry of the brain. Because the brain is a material organ and part of the physical world it is seen as subject to laws of cause and effect rather than social frameworks of motives, actions, meanings, values, beliefs, and responsibilities.²⁵ But empirical evidence of abnormal brain chemistry must always be considered in the context of that individual’s life. Stress, strong emotions, and the long-term ingestion of psychotropic medications to treat mental disorders have all been shown to cause alterations in both the chemistry of the brain and in the actual structures of the brain. Although many current psychology and psychiatry texts assure their readers that the predominant cause of mental

²⁵ Horowitz p. 5

disorders are chemical imbalances in the brain and structural brain abnormalities, there is simply no conclusive biomedical evidence that altered brain chemistry and abnormal brain structures are the *causes* of mental disorders. Diagnostic psychiatry is officially agnostic about the variety of factors that lead people to develop mental disorders, but the medicalized system of classification it uses largely ignores life stressors in favour of the unsupported assumption that there are underlying organic pathologies.²⁶

There is a conspicuous lack of any empirical medical evidence in support of the biological causal model of mental disorders. Most of the categorical disorders in diagnostic psychiatry do not predict the cause, course, or treatment of the conditions they are meant to classify. In fact the diagnostic manuals are not at all helpful in the search for the causes of mental disorders. The criteria that guides the classification of mental disorders is not scientific knowledge or empirical research. It's simply "the need to achieve professional consensus... without regard to etiology."²⁷ The assumption is that the cause doesn't need to be known if the treatment is effective. The problem is that while pharmaceutical treatments of mental disorders may serve to reduce some symptoms in the patient, they do not address the underlying exogenous or external causal factors.

Recently there was much excitement about the use of genetics in causal explanations. Genetics was seen as a vindication of the medical model. The specificity of genetic claims was believed to be the 'missing link' that would finalize the universal adoption of biological causal claims for mental disorders. There was a sudden flurry of increasingly optimistic published materials during the past twenty years in which the cause of mental disorders was reduced to defective genes. But a careful study of genetics reveals that genes are not a simple causal factor. Allan Horwitz explains it this way:

In contrast to straightforward genetic diseases, the genetics of psychiatric disorders are very complicated. They probably stem from several genes, they have high prevalence, they may be expressed through many different symptoms, they overlap

²⁶ Ibid. p. 3

²⁷ Ibid. p. 108, 73.

significantly with other disorders, and they are profoundly affected by environmental forces. In addition, the symptoms relatives display are often different from those of the focal individual...²⁸

Notice the author uses the words “the genetics of psychiatric disorders,” and says that they probably “stem from several genes,” clearly indicating that the term “psychiatric disorders” is meant to refer to biological conditions. This begs the question, are so-called psychiatric disorders organic diseases or are they mental disorders? If the latter then are we to assume problems in beliefs, values, and assumptions are genetically inherited? It is extremely doubtful that any genetic scientist would agree to such an assumption. Also, if mental disorders are genetically inherited then why is it that the so-called mental disorders of depression and anxiety are highly variable across cultures even where genes have crossed national boundaries?

Genetic studies into mental disorders are no longer as prominent as they were in the recent past, in part because of the recognition that social and familial settings may have a much stronger influence on individuals than their genetic inheritance. Neither adoption studies nor twin studies into the genetics of mental disorders are as ideal as they are portrayed in the scientific, medical, and psychological literature. A multitude of variables, problems with designated control groups, as well as small sample sizes make any conclusions based on adoption and twin studies unreliable. Those who make strong causal claims about a high genetic influence in mental disorders fail to acknowledge the non-specific, limited, and contextual effects of genes.

Recent developments in the field of epigenetics have added a whole other dimension to the discussion of genes: the fact that genes are themselves affected and altered by the environment of their host. In other words it has been discovered that the successes, the failures, and the suffering in an individual’s life, rather than being caused by their genes, actually function as a subtle but substantial gene-altering mechanism. Furthermore, claims of so-called genetic weakness as a causal factor have proven to be completely unsubstantiated. For example, a meta-analysis of research data has shown that there is no laboratory evidence that the

²⁸ Ibid. p. 140.

serotonin transporter genotype has anything to do with a genetic weakness that increases the risk of depression in either men or women.²⁹ In fact, more than thirty years of biological research "have not been able to identify a specific [genetic] marker for any of the current diagnostic categories."³⁰

Ironically research has shown that often the 'cause' of so-called mental disorders is the professional treating the patient, as well as the actual diagnosis the practitioner ascribes to the patient. When a person's confused thinking is diagnosed and labelled as a symptom of schizophrenia, it is often irrelevant to their care giver that the person's confused thinking is the result of a reaction to severe distress or a coping mechanism employed by that individual to deal with difficult life circumstances.

This irony extends to the medical committees that decide which new symptom groups to include as 'newly discovered mental disorders' in their diagnostic manuals. The 'cause' of these mental disorders is not just a political decision—a committee's consensus vote. It also depends on how many times this previously unknown mental disorder has been 'observed' and diagnosed by practitioners in the field. And the frequency of diagnosis depends in large part on how often a new illness has been discussed in journals and books, and how much publicity these publications, and this new disorder, have received in both academic circles, on the Internet, and in the public media. For example, the number of individuals diagnosed as having multiple personality disorder grew to pandemic proportions when books were written about these unusual cases, the books' authors and their patients were interviewed on television, and then movies were made about them. But this 'mental disorder' never actually existed; it was simply created and promoted by over-zealous practitioners and the always eager media. The cause of this mental disorder was the distorted perception of those medical

²⁹ Risch, Neil et al. "Interaction between the Serotonin Transporter Gene (5-HTTLPR), Stressful Life Events, and Risk of Depression." *Journal of the American Medical Association*. Vol. 301 No. 23, June, 2009.

³⁰ Maj, Mario et al, eds..Preface. *Psychiatric Diagnosis and Classification*. West Sussex: John Wiley & Sons, 2002.

professionals who ‘saw’ the non-existent symptoms in their troubled patients.

Biological psychiatry is based almost exclusively on nothing but unsupported theories about the organic origins of mental disorder. It is sometimes claimed that the success of some pharmaceuticals in treating the symptoms of mental disorders proves their biological origins. But the fact that psychopharmaceuticals benefit individuals who have been diagnosed with a mental disorder is not proof that mental disorders are actually the result of biological causes. Psychotropic medications work in general, not specific, ways. They are not illness-specific but work across different conditions.³¹ For example, anti-anxiety drugs don’t target any sort of specific ‘anxiety disorder’ in the brain. They work in the same general way to depress the turbulence in the patient’s mind as alcohol does.

A quantity of scotch, like a psychotropic medication, will dull the brain of the sufferer to the point where the existential reason for the mental distress is simply temporarily forgotten. But forgetting doesn’t eliminate the reason for the suffering. That’s why going off medication, just like sobering up, returns the suffering. And just like continued use of alcohol to dull the brain can lead to alcoholism, continued use of medication to treat mental disorder can lead to a chemical dependence and addiction. And just like using alcohol can lead to harmful side-effects such as sclerosis of the liver and high blood pressure, using psychotropic medications can lead to side-effects such as kidney failure and suicidal ideation. And furthermore, just like sobering up includes the suffering of a hangover, going off medications includes the suffering of withdrawal symptoms.

Psychotropic medications are known to alleviate some symptoms but have not been shown to cure any underlying causes, whether they are in fact organic diseases or otherwise. But the proclamation that mental disorders are biological has generated a quasi-medical environment that has produced the huge profits now being enjoyed by the many, primarily North American, pharmaceutical corporations marketing the numerous psychotropic medications.

³¹ Horwitz. p. 113.

After half a century of medical research, there is still an embarrassing lack of evidence in the form of disease-specific markers for any of the currently listed mental disorders. This is not surprising because the classification of mental disorders has no basis in medical science; it is based on the observation and evaluation of human behaviours, experiences, and actions. A person's behaviours, experiences, and actions cannot be characterized or scrutinized independent of an understanding of the beliefs, values, assumptions, and intentions underpinning them, or of the social settings in which they occur.³² Behaviours, experiences, and actions which are diagnosed as being mental disorders are not the deterministic performance of a faulty brain; they are the meaningful communications of the beliefs, values, assumptions, and intentions of a person's mind.

Propositional mental content, even that which is considered abnormal, cannot be defined in reductionist biological causal terms for the simple reason that mental content is often normative and tentative, two states that cannot be said to apply to biological causation. In other words mental propositions are often beliefs or assumptions about what ought to be, and these beliefs can be doubted—even and often within the same mind! Normative and tentative language makes no sense when applied to biological cause and effect relationships.³³ The constellation of symptoms that are labeled 'mental disorders' are not caused by underlying organic disease processes; they come from sociocultural influences that structure particular types of thinking, experiences, and behaviours into socially appropriate symptoms. The particular 'disorder' that emerges is not a discrete biological disease; it is a reification of observed symptoms, and a reflection of both sociocultural stressors and influences.

Causal factors appear to create general symptoms not specific to depression, anxiety, or other common disorders. What continues to hinder the 'discovery' of causal factors for mental disorders is the fact that one set of symptoms can be variously identified and classified as a number of

³² Barham, Peter. p. 87.

³³ For a discussion of normative mental content see the essay "Reductionism/Antireductionism" by Tim Thornton in *The Philosophy of Psychiatry*. Jennifer Radden ed. New York: Oxford UP. 2004. p. 198.

different disorders depending on the interpretive paradigm being employed by the diagnostician. In fact there is continual disagreement among professionals about which symptoms ought to be listed under what mental disorder in the diagnostic manuals. This is why there are virtually no specific etiological or causal factors currently listed for any particular non-psychotic disorder.³⁴ With this level of professional vagueness and ambiguity in the definition of specific mental disorders, with such ontological relativism, causal claims simply become meaningless if not absurd.

When talk of biological brain diseases is abandoned, and mental disorders are seen as the result of propositional problems, it is easy to see how etiological or causal factors might include living in a family with a history of variously diagnosed psychiatric disorders, the experience of early childhood trauma, troubling life situations, a weak or absent social support network, and gender.³⁵ Yes, gender is a causal factor when mental disorders are understood to be caused by stressful or traumatic life situations such as the suppression of a woman's rights and freedoms, or confusion concerning gender orientation and identity.

But the current force of the medical/biological model of mental disorders is a formidable and enduring barrier to research into their cultural, social, and personal origins. The cost of the ascendancy of biological psychiatry has been a dismissal of all but biological and genetic causal explanations, and a minimizing of the much more pervasive sources of individual suffering and distress found in an individual's daily life experiences. Psychiatrists have drifted away from discussions about problematic life situations with their patients, and are spending their time instead writing prescriptions for powerful brain-altering medications. It has been left to psychotherapists and counsellors to offer non-chemical help to those with troubled minds.

³⁴ Horwitz, p. 111.

³⁵ The 'diagnosed psychiatric disorders' are nothing more sinister than the problematic coping strategies employed by the members of a dysfunctional family.

Philosophy

Byron and I talked a lot about his Catholic childhood and how his family and religious upbringing had led him to see the human body as shameful, sexuality as dirty, women as evil mainly because they were desirable, masturbation as sinful, and himself as loathsome and inferior to everyone else. Of course over the course of many sessions I suggested various alternative perspectives on these issues including different strategies for envisioning his relationship to women, which helped him to change his mental habits to some degree. But what helped him the most was the letters I encouraged him to write and 'send' into the past to his nine year old self. At first he found this assignment very difficult, afraid of making a mistake, of not writing a good enough letter, even of being ashamed of having the nine year old 'see' how pathetic he now was. But little by little he found that writing these letters gave him a sense of relief and reassurance. They allowed him to show love and affection for a little boy who had rarely experienced anything but disapproval and condemnation. He felt he was rescuing a boy whose world had abandoned him. This imaginary connection to his own painful past served to boost Byron's self esteem and self confidence to the point where he allowed me to invite a female colleague to join our discussions. Her gentleness, understanding, and patience, helped Byron to reformulate his beliefs and assumptions about himself and about women, and to accept his desires as a normal part of being human. After a number of sessions Byron informed me that his medical doctor told him he seemed to be undergoing a remarkable recovery. This prompted the doctor to take him off all his medications except the mildest anti-depressant which Byron was allowed to take at his own discretion....

The practice of conceptualizing mental distress as diseases or illness, and diagnosing it as mental disorder has raised a number of serious problems in society. The *Diagnostic and Statistical Manual of Mental Illness* (DSM) system of classification includes all behaviours and experiences clinicians encounter in their present practices. This means that for the members of the board who determine which mental disorders to add or remove from the book,

problems of ordinary life such as dealing with troublesome children and spouses, poor marriages, frustrations in careers, personal identity crises, and general unhappiness had to be reconceptualized as discrete forms of individual pathology.... Chronic dissatisfaction with life could be renamed 'dysthymia'; the distress arising from problems with spouses or lovers could be called

‘major depression’; the disturbances of troublesome children could be renamed as conduct, personality, or attention deficit disorders. ...In the absence of a valid definition of mental disorder, there is no limit to the number of discrete conditions researchers and clinicians can develop³⁶

While it is argued that a mental disorder is like a physical illness, a mental disorder is not kept to the same diagnostic guidelines as a physical illness. A mental disorder such as depression is defined much more broadly than a condition like, for example, diabetes. The diagnosing of mental disorders lacks the definitional rigor seen in all other areas of medicine and science. The most common mental disorders—depression, anxiety, phobias, obsession and compulsion, panic disorders, somatizations, and so forth—are not clear and distinct entities. They are very difficult to distinguish from one another. So why has the diagnosing of mental disorders become so popular among mental health care professionals?

Diagnostic categories originally emerged in order to raise the prestige of psychiatry by ensuring that it would be recognized as being an objective scientific and medical discipline. Diagnosing also helped “...to guarantee reimbursement from third party health insurance companies, to allow medication to be marketed, and to protect the interests of mental health researchers and professionals” whose income depended on a steady flow of patients for treatment. But diagnostic models handicap rather than help us in understanding both distress that emerges from social conditions and deviant behaviour that does not result from biological brain dysfunctions.³⁷

Today more and more therapists and counsellors avoid diagnosing and labelling their clients with the specific disorders described in the DSM. During the explosive rise in the prescription of psychotropic medications in the 1970’s and 80’s, the practitioners of so-called talk therapy—dynamic psychiatry and psychotherapy—had recognized and dismissed drug treatments as “superficial palliatives.”³⁸ They could see that while some of the apparent symptoms of suffering patients were reduced with psychotropic medications, the underlying life experiences,

³⁶ Horowitz p. 72 – 74.

³⁷ Ibid. p. 109, 81, 15.

³⁸ Ibid. p. 78.

which were the real causes of the suffering, were being disregarded. They knew that understanding the subjective experience of mental and emotional distress was critical to an appropriate treatment modality. In 1997 a formal dialogue between seven New York psychiatrists and nine "consumer-practitioners" criticized the medical model and the current quasi-biological diagnostic system as "disempowering and detrimental when used to the exclusion of other explanatory frameworks."³⁹

The psychiatric classifications of repression, sublimation, projection, and so on, have fallen out of favour, as have the supposed existence of an unconscious part of the brain that contains unresolved childhood issues which were said to control the person almost against his or her will. Likewise, the diagnostic logic behind the distinct categorization of so-called mental disorders has come under significant criticism against which its supporters have been unable to mount a defence. On the other hand research data has made it increasingly more apparent to mental health care practitioners that so-called talk therapy is undeniably effective in treating mental disorders. This talk therapy is simply philosophy under a different name.

Philosophy has proven to be an effective means by which to 'treat' mental disorders because mental disorders are non-biological problems; they are disorders of the narrative or propositional content of the mind. Philosophy as it is applied to therapy and counselling is based on three foundational premises: mental problems are not the same as brain problems; a person's beliefs, values, desires, doubts, and assumptions can cause so-called mental problems; and good philosophical discussions can alleviate and prevent many of these problems. Mental disorders are conflicts, complications, and confusions of beliefs, values, desires, doubts, and assumptions. When philosophy is defined as an examination of the reasons we have for the values we hold as good and the beliefs we hold as true, it leaves no doubt that philosophy is perfectly suited as treatment for the more common mental disorders. But philosophy has also been demonstrated to alleviate the suffering of those who have been diagnosed with so-called 'serious' mental disorders that were once

³⁹ Blanch, Andrea et al. "Consumer-Practitioners and Psychiatrists Share Insights About Recovery and Coping." *Psychological and Social Aspects of Psychiatric Disability*. Roy Spaniol et al eds. Boston: Boston University, 1997. p. 71, 69.

considered organic brain diseases such as ‘clinical’ depression and schizophrenia. When the ontology and etiology of mental disorders is properly understood it becomes clear that philosophy may indeed be considered a ‘cure’ for mental disorder.

But it might be argued that psychotherapy, narrowly understood as based exclusively on psychology, is the best method to use when trying to help those afflicted with professionally diagnosed mental disorders. Interestingly, an examination of the description of some of the foremost approaches to psychotherapy reveals that they are all already solidly based on philosophy. In his book *Theory and Practice of Counseling and Psychotherapy* Gerald Corey, a professor of counselling and licensed psychologist, describes them this way:

Psychoanalysis is said to have “touched on *philosophy*, psychology, sociology, art, and literature...”⁴⁰ Freud and Jung were both thoroughly educated in philosophy.

“**Existential therapy** can best be described as a *philosophical approach* that influences a counsellor’s therapeutic practice.”⁴¹

Person-centred therapy is “a humanistic approach that grew out of the *philosophical* background of the existential tradition.”⁴²

Gestalt therapy is “*phenomenological* as it focuses on the client’s perception of reality. The approach is *existential* in that it is grounded on the here and now and emphasizes that each person is responsible for his or her on destiny.”

Cognitive-Behavioral Therapy (CBT) “has always been characterized by being highly rational, persuasive, interpretative, directive, and *philosophical*.” Modern day **Rational Emotive Behaviour Therapy (REBT)** is said to combine humanistic, philosophical, and behavioural therapy.⁴³ As well as being heavily influenced by the ancient philosophy of Stoicism, it owes “a *philosophical debt*” to a number of other sources that have influenced its

⁴⁰ Meissner, William W. “The Future Role of Psychoanalysis and Psychoanalytic-Oriented Therapy.” In *The Challenge to Psychoanalysis and Psychotherapy*. Stephan De Schill and Serge Lebovici eds. London: Jessica Kingsley Publishers, 1999. p. 110.

⁴¹ Corey, Gerald. *Theory and Practice of Counseling and Psychotherapy*. 5th ed. Pacific Grove: Brooks/Cole Publishing, 1996. p.170. Italics in the original.

⁴² Ibid. p. 199.

⁴³ Ibid. p. 224. Italics in the original, 318, 317.

development such as the philosophical writings of Immanuel Kant, Baruch Spinoza, Arthur Schopenhauer, Karl Popper, and Bertrand Russell.⁴⁴

Reality therapy (RT) is concerned with “teaching people more effective ways to deal with the world.... The reality therapist functions as a teacher and a model.”

Classical behaviour therapy today goes beyond mere Pavlovian behavioural conditioning and deals with a person’s emotions and meaning.

Even a predominantly psychological approach like the **Adlerian therapy** “includes identifying and exploring *mistaken goals* and *faulty assumptions*” “...it pays attention to the individual way in which people perceive their world... how the individual believes life to be.”⁴⁵ This is undeniably an application of philosophical inquiry.

Each of the methods in ‘talk therapy’ is deeply indebted to philosophy. None of them resemble anything like a biomedical or pharmaceutical approach to organic brain disease, yet all of these ‘talk therapies’ are said to be successful in treating individuals suffering from diagnosable mental disorders. The reason for the successes of talk therapies lies in the fact that they employ philosophical discussions in the treatment of mental disorders. Philosophy is more than just a casual discussion of beliefs, values, desires, doubts, and assumptions; it is a legitimate approach to the treatment of mental disorders properly understood. The use of philosophy in talk therapy—philosophical counselling—has proven to be an effective treatment and even a ‘cure’ for most of the so-called mental disorders said to exist in our society today.

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⁴⁴ Dryden, Windy. *Reasons and Therapeutic Change*. London: Whurr, 1991. p. 4.

⁴⁵ *Ibid.* 264, 273, 285, 139, 135. Italics in the original.

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