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Book Review | *The Disordered Mind: An Introduction to the Philosophy of Mind and Mental Illness*

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Psychiatry is moving through a period in which its basic subject matter — namely, the experiential world of its patients — seems inaccessible and unknowable. (Schwartz and Wiggins 2004)

The crucial issue is whether psychiatric syndromes are separated from one another, and from normality, by zones of rarity or whether they are merely arbitrary loci in a multidimensional space in which variation in both symptoms and etiology is more or less continuous. (Kendell and Jablensky 2003)

A conversation and reciprocal osmosis between philosophy and psychology have thus far been, with periodically varying intensities, maintained for well over a century. Correspondingly, we rather frequently find such themes as the nature and acquisition of language, epistemology, identity, the structure of personality, culture, and distress in all its manifestations being discussed with about the same verve and conviction by members of both camps. Indeed, since the latter half of the nineteenth century, world scholarship has included theoretical models, or parts thereof, within which the boundaries between these disciplines are so obscure as to be practically nonexistent. For example, insofar as Sigmund Freud’s psychoanalytic ideas of totem and taboo, the Oedipus and the Electra complexes, thanatos, and his elegantly interlocking mechanistic structural schema of id, ego, and superego are all epiphenomenal, his personality model might be thought of as more properly belonging within the perimeters of metaphysics than within our current, experiment- and statistics-obsessed psychology. Much the same (and perhaps framed in stronger terms) might be said concerning Carl Gustav Jung’s indelible anthropological inclinations in his analytical psychology, and particularly about his focus on mythology and
dreams, and his notion of the collective unconscious, including archetypes, the shadow, and the anima and the animus.

Nor are psychodynamic paradigms the only result of this mingling of philosophy and psychology: Presuming students of intellectual history are right, the incunabula of experimental psychology — no less a hard science than chemistry or physics — can be traced back to the first psychological laboratory, established by Wilhelm Wundt, who was certain that his research equally enriched both philosophy and psychology. In view of these observations, one would be right to infer that the widening divergence between the two fields must have begun relatively recently.

Freud’s decisive impression upon psychiatry’s developmental trajectory during the former half of the twentieth century precipitated another consequential interdisciplinary mingling, this one between psychiatry and philosophy. In fact, Ludwig Binswanger’s existential approach to phenomena, intentionality, and his preoccupation with freedom, guilt, anxiety, and death, along with Karl Jaspers’ phenomenological and existential treatment of Dasein, Existenz, Transcendence, and his pointed concern with delusions, represent perhaps the most illustrative amalgams of philosophy and psychiatry. Yet, within a few years following World War II, when many were beginning to believe that these and thematically parallel syntheses were setting the foundations of an exciting new scholarship, the hairline fissures which always existed between the biological and the psychodynamic camps in psychiatry suddenly became increasingly wider. The ensuant climate of division and uncertainty, in turn, created an opportunity for some to challenge not only the propriety of coercive treatment of the mentally ill, but also the very use of neuroleptic drugs, psychiatry’s medical provenance notwithstanding. Ironically, and still worse, some of those challengers were themselves — psychiatrists.

While between the early 1960s and mid-1980s this new, antipsychiatry movement comprised texts from much of the world, those of its founders were the most frequently quoted and remained as striking as they were initially: Reinforcing his first salvo fired in an earlier paper, Thomas Szasz claimed that modern psychiatry began not by identifying “diseases by means of established methods of pathology, but by creating a new criterion of what constitutes disease” (1961/1974: 12). As such, Szasz urged, it should be in no sense a hyperbole to say that mental illness is, fundamentally, a myth (xv). At about the same time, underscoring the thesis that mental illness is not quite what we have been led to believe, R.D. Laing maintained that a schizophrenic’s actions “can be seen in at least two ways . . . as ‘signs’ of a disease . . . [or] as expressive of his existence” (1960/1969: 31). Hence, Laing counseled, we should be closer to the truth to regard what most of us would call behavioral symptoms as mere reflections of one’s interpretation of his or her cultural
environment. Lastly, locating mental illness within social hierarchies of power relations, Michel Foucault observed that the modern day mental institution, much as did the asylum centuries ago, marks “the boundary of reason and unreason” and “enjoy[s] a double power: over the violence of fury in order to contain it, and over reason itself to hold it at a distance” (1961/1988: 245). In that respect, Foucault noted, our mental health system might not improperly be said to be preoccupied with incarcerating anyone whom most of society tends to consider an Other, as did many European societies with lepers until leprosy’s virtual extinction at the end of the Middle Ages.

Jarred by these and similarly substantial objections, psychiatry embarked upon a continuing course of self-amelioration. Consequently, with the proscription of leucotomy and the deinstitutionalization of large state-supported mental hospitals in the late 1960s; with today’s much lower incidence of involuntary commitment; the invention of atypical or second generation antipsychotic drugs, which have reduced the potential for, and the effects of, tardive dyskinesia; and with the invention of neuroimaging instruments, which reveal the influence of neurotransmitters upon brain processes — psychiatry showed that it had developed into a science with conscience.

Insufficient as these revisions turned out to be in neutralizing antipsychiatry as a movement, they nevertheless contributed toward marginalizing its leaders, and therewith dissipating much of its influence. (Granted, Foucault’s voice remains relatively strong in certain philosophical circles, but that is because of his contribution to cultural genealogy and to the history of ideas, not because of his advocacy of antipsychiatry.) In fact, since the mid-1980s, antipsychiatry has been unable to cogently point to any sway outside the two spheres wherein it has consistently found sympathizers, namely, the mental health consumer/survivor movement — run largely by former patients whose diagnoses and treatment made them feel dehumanized — and the Church of Scientology. To the extent, however, that antipsychiatry virtually sprang into being as, fundamentally, an academic front, many of even these sympathizers have trained a less than trustful eye on its claims and intentions. The teleological discrepancy between these ideological parallels is also reflected in the public’s general perception of them: While antipsychiatry’s challenge of psychiatry has appeared to most of those familiar with it as intramural esotericism, the consumer/survivors’ and the Scientologists’ radicalism seems to most of those familiar with the salubrious results of psychiatric treatment, frightening. And reasonably so, for consumer/survivors and Scientologists have as their objective not to in any recognizable sense improve the mental health system, but to deracinate it.

Only partly impressed by psychiatry’s list of self-corrections, since abut the end of the twentieth century, a growing host of writers have dusted off and restructured some of
antipsychiarty’s questions and perspectives under the name of a new investigative field, the philosophy of psychiatry. Nor should the alacrity wherewith this new scholarship has installed itself as a seminal section of the philosophy of mind really surprise us, as the academic climate — and to a large degree the cultural climate — essential for its quick acceptance had been already prepared by postmodernism’s rejection of totalizing models and advocacy of semiotic analysis. Whether, then, stimulated by the opportunity to bring into existence still more conceptual amalgams, or raise doubt about, decenter, or sublate prevailing theories and practices, the new field’s contributors have discovered another, younger generation of receptive ears. While some of these contributors have aimed at presenting an objective appraisal of psychiatry’s reductive, diagnostic, and therapeutic triumphs, others have concentrated on the ethical implications that attach to the idea of mental illness, and still others attempted to create a mutually illuminating relationship between psychiatry and philosophy. Jennifer Radden, for one, puts these conceptual nodes and chiasmata into focus as follows:

Clinical practice, psychiatric theorizing and research, mental health policy, and the economics and politics of mental health care each ineluctably engage philosophical ideas. Disease, health, and disability are moral and metaphysical categories as much as they are social and legal descriptions. Conceptions of rationality, personhood, and autonomy, the preeminent philosophical ideas and ideals grounding modern-day liberal and humanistic societies such as ours, also frame our understanding of mental disorder and rationales for its social, clinical, and legal treatment. (2004: 3)

Besides reaffirming these nexuses between philosophy and psychiatry, Radden is at once identifying what she believes is a persistent need for, and promoting precisely that type of a symbiotic approach to mental health care; and, at least in principle, rightly so, since while philosophy can explicate psychiatry’s “moral and metaphysical categories” from a conceptually complementary angle, and ipso facto further sharpen psychiatry’s analysis and application, psychiatry can expand philosophy’s understanding of reason, irrationality, and human nature. In practice, though, this relationship might (not unfairly) be characterized as somewhat one-sided, for philosophy has much more to gain from psychiatry than psychiatry could ever gain from philosophy.

Radden’s same textual passages might also be interpreted as implicitly providing justifications for any attempt to establish philosophy as an authority to which psychiatry would be wise to appeal and defer when considering questions of ethics. It is, of course, true that disease, health, and disability are moral and metaphysical categories, and that “rationality, personhood, and autonomy” are seminal philosophical conceptions. It is at the same time equally true that these and related themes, taken together, were already an
important constituent of the theoretical and therapeutic frameworks of psychodynamic and existential clinicians decades before the appearance of even the first philosopher of psychiatry. Accordingly, Radden’s counsel would have served us better had it said that philosophers and mental health practitioners should borrow from each other’s findings, instead of intimating that we all might benefit from the addition of another stratum of control over the existing regulating homunculus that is psychiatry’s conscience.

Perhaps, one might retort dubiously, perhaps it would be excessive to claim that psychiatry’s conscience is in need of reinforcement. Even so, is it not the case that some of antipsychiatry’s objections remain relevant? Do not, for example, questions about the influence of values in the treatment of mental illness, and about psychiatry’s legal power, which has always been greater than its partly unscientific precepts should merit, continue to be largely undervalued? Still more, might we unqualifiedly dismiss the Szasz-inspired idea that while psychiatrists and physicians resort to similar therapeutic methodologies, insofar as they are engaged in different types of patient evaluation they ought to be seen as practicing different professions? After all, unlike physical illnesses, whose diagnoses rest on empirical, structural-functional evidence, mental disorders are diagnosed under the influence of such ethical and religious and philosophical questions as, “How does man live? and, How ought man to live?”

“Psychologists and psychiatrists,” according to Szasz, “deal with moral problems which . . . they cannot solve by medical methods” (1961/1974: 9). Underscoring this notion’s bottom line, Szasz insists that insofar as they are influenced by personal and cultural norms and values, all psychiatric evaluations and treatment must be pronounced biased, and thus scientifically and ontologically tenuous. Upon reflection, however, this claim begins rapidly to yield much of its superficial élan: We can, indeed, point to no human-independent standards that might be said to inform any therapist’s decisions; or, as David Hume puts it in his Treatise of Human Nature:

[C]an there be any difficulty in proving, that vice and virtue are not matters of fact, whose existence we can infer by reason? Take any action allow’d to be vicious: Wilful murder, for instance. Examine it in all lights, and see if you can find that matter of fact, or real existence, which you call vice. In which-ever way you take it, you find only certain passions, motives, volitions and thoughts. There is no other matter of fact in the case. (Book III, Part I, Section 1)

Yet, questions about whether we actually require intrinsic standards whereby we might justify psychiatric diagnoses, or whether all standards qua values are of equal weight, are infrequently addressed by Szasz or by his backers. To illustrate, if personal values really
reflect what we think of as important to us, then one’s impulse toward, and engagement in, behaviors that include, say, a full spectrum of devious sexual play, or uncontrolled pyromania, and, yes, even infanticide would have to be declared no less legitimate — when viewed, let us emphasize, from a moral, if not a legal, vantage point — than are preferences for, say, specific foods or drink or clothes.

It is, possibly, because of this absence of intrinsic criteria that human beings have evolved a moral consciousness, or *synderesis*, as the Scholastics taught, which reveals and directs us to the types of values we ought to adopt and nurture or reject and punish for the purpose of cultural as well as personal self-preservation. It is precisely because from an early age we recognize the drives and actions which tend to be injurious to our fellow citizens, that any one would practically invariably meet with dark-browed stares — from antipsychiatrists, ethical relativists, and anarchists as well as from the general public — upon conceding that he or she is actively pursuing any of the values in the first group. But if, as I say, antipsychiatrists themselves would readily base their disapproval of these behaviors on the widespread grasp of right and wrong — what could possibly arouse their suspicion concerning any qualified therapist’s seemingly impartial diagnosis of what obviously passes for abnormal behavior? What, indeed, when that diagnosis is grounded in the same conceptually instinctive foundation?

Personal safety, most of us might in accord with this instinctive moral sense aver, should by itself be sufficient to vindicate compulsory commitment of psychiatrically ill persons. Tim Thornton, on the other hand, of the Institute for Philosophy, Diversity and Mental Health, University of Central Lancashire, United Kingdom, gives the impression that he is wholly unaware of any such likely consensus when he points out:

> Mental health care is the only area of medicine where fully conscious adult patients of normal intelligence can be treated against their will. Especially against a general increase in the emphasis on the rights and voices of patients or service users (or subjects), this aspect of mental health care calls for justification. Just what is it, if anything, about mental illness that can sometimes justify such coercive treatment? Given also that the values in play in mental health care seem to be more divergent than in other areas of physical medicine, how are value judgements [*sic*] best understood? (2007: 2-3)

Thornton is incorrect on at least two counts: First, mental health is hardly “the only area of medicine” where adult patients can be treated mandatorily. Could it be that at the time he wrote these observations, Thornton had never heard that probably every nation in the world has established laws concerning the isolation and quarantine of physically, non-mentally ill
patients? Had he perfunctorily turned to, for example, the Center for Disease Control and Prevention website, he would have read that “[i]slolation and quarantine are public health practices used to stop or limit the spread of disease”; in fact, no less than “[t]wenty U.S. Quarantine Stations, located at ports of entry and land border crossings, use these public health practices” as a means to “limit the introduction of infectious diseases into the United States and to prevent their spread” http://www.cdc.gov/quarantine.

Second, Thornton’s implicit point that compulsory admission of mental patients to state institutions requires a special type of justification becomes moot and superfluous in the light of our foregoing fact. Undoubtedly most of us would have met the opponents of coercive treatment with little more than nods of agreement had the typical psychiatrically ill person been someone who, let us imagine, routinely conversed with angels, cavorted with fairies and pixies, or followed moral advice he daily received from his neighbor’s dog — but, importantly, presented no danger to anyone. Most of us would have equally likely declared imposed treatment of even potentially dangerous individuals indefensible had they functioned in an environment wherein their behavior could in no wise threaten anyone’s welfare. On the other hand, in view of every society’s originary right and task to defend its residents in the best manner it knows how — or, as Cicero formulates the point in his Treatise on Laws, “Salus populi suprema lex esto” (Book III) — it appears indispensable that we promptly isolate and treat all individuals who because of their illnesses have revealed a tendency to harm their fellow citizens.

Alas, self-evident social principles such as this must still be defended, if no longer from the moral superiority and wagging fingers of antipsychiatrists, then certainly from the liberalism and political correctness of the philosophers of psychiatry. Insofar as antipsychiatry has already taken its rightful place in the museum of intellectual oddities next to such exhibits of failed counter-theories as anti-relativism, and pseudo-scientific curiosities as orgone energy and phrenology, any endeavor nowadays to attenuate it still further would be redundant. Insofar, however, as we might assume just as antipathetic a stance toward philosophers of psychiatry who would pass themselves off as psychiatry’s moral guides, we might better grasp and analyze the elements of some of their defining claims by examining them through George Graham’s The Disordered Mind (second edition) as if through a magnifying glass. In what follows, then, I attempt to show that at least some of Graham’s more seminal inferences and assertions are resting on misleading or questionable considerations, though, granted, others might not have necessarily agreed with my selection of excerpts. To take into account as much of Graham’s discussion as we might within this text’s scope and medium, in each of the consecutively numbered blocks I, first, paraphrase several conceptually pregnant passages, and then present my analysis of each block immediately thereafter.
In the Preface to it, Graham writes that his book narrates two parallel “tales”: The first tale deals with “mental illness or disorder,” including “mental disorder’s reality, sources, [and] causes,” while the second “assumes that no sound and sensible philosophy of mind can be construed without attending to the topic of mental illness and to human vulnerability to mental illness.” Taken together, these “tales compose one story” (xiii). Graham might have brought his point into somewhat sharper focus had he said that his project is a synthesis of two related aims, namely, (i) to provide a mainly philosophical explanation of psychopathology instead of a neurological one, and (ii) insofar as they are impediments to our attaining the good life, to consider the nature and effects of mental disorders from an Aristotelian platform.

My rephrasing of Graham’s intention is important, since a philosophical treatment of mental disorders not only implicitly appeals for a reduction in our reliance on drugs, but also shifts our understanding of mental disorders from a brain-based problem to a question of ethics and subjective assessments. Graham, in effect, affirms these points when he cautions us that although mental disorders might be rightly characterized as “impairments” of rationality, we need not necessarily take them as posts whereby we might demarcate the perimeters of basic human psychology. Not rationality, therefore, but the traits and dispositions which reinforce our ability to prosper as human beings, including making choices, intellectual and emotional commitment, and intentionality, should decide what is and what is not psychologically significant.

1. To illustrate humankind’s intrinsic “vulnerability to instability or distress,” in the first part of his Chapter 1, Graham asks us to consider a “brief thought experiment”: Presuming we were, collectively speaking, Mother Nature, and, prior to humankind’s appearance, we wished to “build the sort of mind that will help us as human beings to engage with life on the planet” (2). Of the various ideas of the sort of mind we might build, let us narrow our choices to only two, “a stable and an unstable mind” (3). The stable mind is distinguished by order, “purity of heart and soundness of reason”; it is “free of regret and self-doubt”; it “never loses control of itself”; and it is “the object of single-minded dedication and intelligent direction.” Conversely, the unstable mind is disordered, and has “conflicting motives, impulses, and inhibitions as well as biases of thought and impediments to reason.” Neither does it “accept the negative consequences of its actions and frequently is conflicted or befuddled about just what is desirable.”

Eventually, Graham writes, Mother Nature’s efforts brought forth a “mind that is both stable and unstable . . . orderly and disorderly, content and discontent, facing life’s vicissitudes but also seeking refuge from them.” Accordingly, while “the most unstable or discordant
individual is not without some small slice or sliver of stability,” even “the most stable is not without a shadow of instability” (3).

**Analysis:** Graham’s description of the human mind as Mother Nature’s synthesis of a stable part and an unstable part seems to be implying that both of them are equally good. After all, if Mother Nature herself saw the unstable part as important (and maybe even serviceable) enough to inextricably attach to the stable one, then might we not be misleading ourselves to reflexively prefer one to the other? Such a perspective, let us remember, is not without an historical precedent; indeed, in a multifaceted attempt to undermine the accepted primacy of the stable part, during the first half of the twentieth century — inspired by, *inter alios*, Edgar Allan Poe, Charles Baudelaire, and Georges Bataille — largely French associations of writers and artists, including Dadaists and Surrealists, went so far as to privilege nonsense and irrationality over reason and logic.

Whether he intended to do so or not, Graham’s emphasis of the human mind as stable and unstable has effectively masked another, more significant fact, namely, that this is a decidedly uneven mixture — with the stable part consistently prevailing in any normal actor’s decision-making process and social interaction. This, in turn, draws our attention to the following observation Graham *should* have made: Insofar as she has everywhere circumscribed the unstable part’s influence over us, Mother Nature herself has expressed a preference for, and has predisposed us to desire and nurture, the stable part. As to the question of why, in that case, she has allowed the unstable part to exist at all, we could not but infer either (i) that Mother Nature must be an imperfect creator, or (ii) that, as explained by the pre-Socratic law of the unity of opposites, she has, for the purpose of change and contrast, willfully created every existent with its own counterpart. Since, irrespective of whether either or neither of these might be true, the unstable part promises to be with us for as long as we are around, we might relate to it as we normally relate to any somatic illness, as a condition that we would do well to reduce in frequency and intensity as much and as soon as possible.

Our universal partiality for the stable part of the human mind is not, we must add, a mere preference, but an existential *sine qua non*. Devoid as human beings are of most of the instincts that have in certain ways made non-human existence easier, one need not be a sufferer or a Buddhist adherent to recognize human life as, in its full scope, a decidedly difficult experience. Relatively few of us are thus taken aback when, as Nietzsche quotes him in *The Birth of Tragedy*, we hear the wise Silenus deploring that the “greatest good” for humans would have been not to be born at all, to be *nothing*, while the second best, to die soon (Section 3). But if human life is difficult even now, the built-in ancillaries and *accouterments* of our social contexts created by our stable part notwithstanding, then life as
we know it would, surely, have been impossible within any social contexts created by our unstable part. Accordingly, instead of wondering what sort of mind we might have decided to put together, Graham would have proposed a better question had he inquired: Had we been better builders than Mother Nature, would we have decided to include so much as a whit of instability in that creation?

2. “When a person is mentally ill,” Graham observes in the latter half of Chapter 1, “there is necessarily something wrong or undesirable with their condition” (8). This, however, he cautions, should not be perfunctorily seen as indicating that the norms for mental illness must be neurological. To illustrate, let us imagine that “Alice’s grief and depression over the death of her husband and her disappointment with his adulterous behavior is so enduring and intense that she becomes a victim of insomnia, weight loss, and an inability to properly care for her children” (9). But her incapacity to curb these effects “does not mean that her brain is not functioning as it should relative to biological norms. She is not functioning well or as she should or wishes, to be sure, but her neural processes may be . . . in proper working order nonetheless” (8). “Alice’s depression,” Graham proposes, “is best understood by deploying two general sorts of vocabularies or causal-explanatory languages . . . If Alice did not believe that her husband was dead or if she was not disappointed in his adulterous behavior, she would not be psychologically disturbed or upset” (9-10). In a word, Graham rejects the “broken brain conception of a mental disorder” as an adequate account of the problem, for “if a disorder is mental, then human psychology (and not just neurobiology and neurochemistry) is part of its causal explanatory foundations” (8).

Describing himself as “tempted” to call his theory either the “twin theory” or “the truncated or impaired reason-responsiveness theory,” Graham decides that, “in the end,” he has “no name for it” (10). More importantly, he looks upon his book as promoting at least two “big” theses, namely, “a theory of mental disorder that does not relinquish the theory to, but deploys, brain science,” and “metaphysical realism about mental disorder.” Metaphysical realists, within whose ranks he includes himself, are those who believe that “mental disorders truly or objectively exist. They are real. By contrast: Those who assert that no condition of a person should ever be thought of as a mental disorder are mental disorder anti-realists. Mental disorders are not real. They don’t exist” (11-12).

**Analysis:** By referring to himself as a metaphysical realist concerning mental illness, Graham virtually ensures that no one would mistake him for an antipsychiatrist. At the same time, he perplexes us with his unlikely claim that Alice’s depression-caused incapacity to manage her various everyday activities “does not mean that her brain is not functioning as it should relative to biological norms. She is not functioning well . . . but her neural processes may be . . . in proper working order nonetheless.” Contingent upon how we interpret his
description, we might accept or reject Graham’s claim that Alice’s brain as still “functioning as it should relative to biological norms.” On the one hand, the brain’s structures discharge their biological duties even at the nadir of one’s depression: The hypothalamus continues to control its owner’s temperature and metabolic rate, the occipital lobes still interpret his or her visual sensory impulses, and the pituitary gland remains as the endocrine system’s director. On the other hand, Graham depicts Alice as suffering from a unipolar disorder, a condition which can cause actual (and by no means insignificant) constitutional, and corresponding behavioral, changes: Accordingly, if she went untreated for, say, several months, an eventual PET scan image would likely reveal not only a conspicuously decreased activity in her brain, but also a palpable shrinkage in its hippocampus and prefrontal cortex, an enlargement in its ventricles, and, still more, either an enlargement or a reduction in its corpus callosum. Alice’s neural processes, therefore, could be hardly thought of as being in “proper working order.”

Even so, Graham’s averment that Alice’s depression might be best understood “by deploying two general sorts of vocabularies or causal-explanatory languages” appears to be on target. Psychotherapy sessions could not only contribute to our understanding of some of the antecedents of her depression, but also prove most effective in its treatment: Once we begin pharmacological treatment or, as a last resort, electroconvulsive therapy, cognitive therapy helps the patient to recognize negative or “catastrophic” opinions and to regain a sense of control and satisfaction in life by replacing them with more positive or constructive ones. Regaining such a sense is extremely significant, since well after remission of depression, some patients still (and frequently) report subterranean feelings of guilt, anger, and helplessness. From Graham’s angle, regaining that sense of control would fulfill a cardinal “criterion” in his understanding of what constitutes “the proper treatment of mental disorders,” which is to “help people to maintain or recover their dignity and self-respect” (14).

3. Graham’s discussion, in Chapter 2, of what is “mental about a mental disorder” (29) is, he points out, based on what “philosophy of mind says is the mental: states or conditions of persons (and of other creatures) that are conscious as well as states or conditions possessed of Intentionality.” Thus, while, say, a “brick is unaware of itself . . . all sorts of things (including us ourselves) appear to us persons in all sorts of different and distinct ways” (31). “Intentionality,” Graham writes, “if perhaps not as dramatically vivid as consciousness, is just as central to mindedness or to our being minded or having a perspective.” “The mind’s intentionality or aboutness is underived. It inheres in or is intrinsic to it” (33). In support of his insistence that consciousness and intentionality are crucial to grasping the role of the mental in mental disorder, Graham draws our attention to Jennifer Church who “in discussing the conscious Intentional states distinctive of depressed people, quotes a remark
of a forlorn character in a movie . . . Everything in the world, the character says, is getting ‘meaner and grayer’ ” (33). Graham continues:

An explanation of what it is like to be depressed, Church observes, ‘must take account of correspondence between what is . . . felt and what is . . . perceived’ (175). ‘The felt qualities of [a] depressed state . . . are the perceived qualities of the objects around’ the depressed person (Church 2003: 176). Depression is the state; grayness and meanness appear in the world outside the depressed person. To feel depressed is (in part) to perceive the world as mean and gray. (34)

At least two examples, the English novelist Virginia Woolf and Alice, the same character we have already met, Graham is convinced, should illuminate the veracity of these considerations. Woolf — who committed suicide by drowning while in the grips of a third depressive breakdown, during which she had begun to hear voices — according Graham, dedicated to a life defining goal, writing, “persists in intense and challenging efforts to achieve it, but simultaneously fears or believes that the likelihood of success is negligible or slim-to-none.” She might have thus felt “trapped or intractably stymied, helpless or impotent” (27). Alice, Graham thinks, is probably suffering from a similar sense of helplessness: “Why does she perceive herself to be helpless?” “Her grief and disappointment (in her husband’s behavior) may have strengthened her expectation of negative results for other commitments or behavior.” “It is, in particular, in attitudes of a self-referential or self-interpretive nature that people experience themselves as helpless or as personally overwhelmed and therein may become depressed” (42).

So, to his own question, “how does mentality (Intentionality and consciousness) figure in mental disorder?” (35), Graham answers that in his opinion “mental disorders are produced by a mixture of mental and brute mechanical factors. In mental disorders both mentality and neurobiology/neurochemistry partially incapacitate or ‘gum up’ the operation of (basic faculties) mind and behavior” (43). “For example: Perhaps lowered serotonin does not as such cause depression directly or on its own, but permits hopeless attitudes and beliefs in one’s own helplessness to get stuck in a person’s stream of consciousness and to produce depression” (43).

Analysis: His consideration of mental disorder from a philosophical vantage point notwithstanding, Graham’s employment of Franz Brentano’s concept of Intentionality adds, I dare say, nothing of any practical value either to his immediate or to his general discussion; on the contrary, the concept appears to be at best superfluous, and at worst, confusing. In fact, the mental dispositions to which the term Intentionality refers could have been more effectively described by such terms as perception, or interpretation, or judgment:
To the extent that mental states like fears or hopes or beliefs are all about, or directed at, something, none of them could occur apart from the subject’s interpretation and judgment of the intentional object, and this irrespective of the latter’s ontological or existential status. Accordingly, while it might be true that, as Graham (à la Brentano and his Scholastic predecessors) maintains, Intentionality distinguishes mental from physical phenomena — insofar as each of the terms I have suggested equally performs the same function, he would have rendered his discussion much more accessible had he replaced Intentionality with any one of them.

Instead, Graham intensifies our collective conceptual indigestion by presenting us with no more lucid a depiction of Intentionality when he claims that it “inheres in or is intrinsic” to the mind, than does Brentano when he writes, “Every mental phenomenon includes something as object within itself” (1874/1995: 68). Since neither author really attempts to clearly explain this curious idea, we are left questioning whether they are: (i) advocating an immanentism of some sort, which would imply that the intentional object might be located inside the subject’s head, or (ii) claiming that if the intentional object is part of the mental act, then it must be, essentially, a sort of duplicate of the object. If so, whenever I think about my house, I am not actually thinking about the building itself, but about a part of my thinking act. Aside from these difficulties, it remains perplexing why, for as consequential a notion as Graham makes Intentionality seem, it is hardly so much as mentioned outside the several pages wherein it appears in Chapter 2.

My claim that Graham’s employment of Brentano’s Intentionality might well have been replaced with either perception or interpretation without in the slightest redirecting or detracting from his discussion, appears to be implicitly supported by Graham himself when he approvingly formulates Church’s characterization of depression as, “To feel depressed is (in part) to perceive the world as mean and gray.” To be fair, however, we must concede that whether Graham ought or ought not to have made any such change is, ultimately, a question of lesser importance vis-à-vis (a) his treatment of depression as a monolithic phenomenon, and (b) the role he assigns to Intentionality qua perception as a partial cause of the helplessness he sees in Woolf’s and in Alice’s respective behaviors.

(a) As a clinical syndrome, depression might be described as a state of conscious psychic suffering, comprised of lowered mood-tone, frequently accompanied by feelings of guilt, with difficulty in reasoning, and diminution of psycho-motor and even organic activity. Grayness and feelings of emptiness and meaninglessness, therefore, do indeed prevail in practically every depressed individual’s social and physical contexts. The fact, however, that dejection might be superimposed upon any nosologic entity, which would render Woolf’s and Alice’s forms of depression similar in quality and severity, should in no respect
preclude or question attempts to distinguish between them thus: Insofar as at the time of her suicide Woolf was just beginning to experience auditory hallucinations, her depression would have to be appraised as the culmination of developing psychotic antecedents. On the other hand, insofar as Alice experienced no notable psychological hardships until her husband’s death and (subsequent) discovery of his marital infidelity, her depression would have to be evaluated as being of the neurotic sort. When, then, Graham writes that “[t]he symptoms of Woolf’s particular disorder consisted, in part, of a complex set of conscious experiences of self and world” (27), he is, basically, referring to the symptoms of a psychiatric, or medical, illness, and not a disorder whose character is determined either by a faulty or by a catastrophic interpretation of reality.

Of course, Woolf’s “complex set of conscious experiences of self and world” did, as Graham says, likely contribute to the increasing intensity of her illness in its incipient stage. Having conceded that, we might here rhetorically inquire: Precisely why ought we to regard Graham’s point as an informative observation, instead of a platitude? After all, what functioning individual’s psychological status has not been, in part, determined by such a “complex” of conscious experiences? To proceed further, however — let us grant that both Woolf and Alice could well be seen as feeling helpless, and that both could be effectively treated with the correct antidepressant medication. Having said that, we must insist that this is also the point beyond which these cases diverge. Specifically, whereas Woolf’s depression is physiogenetic, which indicates that its origins could be traced to some impairment in her cerebral processes, Alice’s depression is clearly psychogenetic, which indicates that its origins could be traced to problems in her mental or emotional self, and not to any detectable somatic antecedents. In contrast to Woolf’s depression, that of Alice is, fundamentally, reactive, or a condition that is frequently caused by an important loss experienced by the depressed person, yet not accompanied by malignant symptoms like delusions, hallucinations, suicidal ruminations, or stupor.

(b) Graham would have done better had he, in the light of Woolf’s and Alice’s examples, not only distinguished between psychotic and neurotic forms of depression, but also emphasized the significance of each depressed person’s perception of his or her degree or intensity of helplessness. Such an emphasis is critical to understanding the decisions behind the existing spectrum of depression-precipitated behaviors. Such an emphasis is, proximal to Graham’s discussion, also critical to understanding our two — grosso modo diagnosed — characters’ strikingly different courses of action. While most degrees of depression can render even daily or routinely performed activities appear hollow, futile, Sisyphean, it is, principally, self-appraisals of complete helplessness that tend to compel fully functioning individuals to suspend their activities practically to the level of a hibernating animal. Though, in other words, it is true that most degrees of depression can variously deplete
one’s appetite for life, persons who tend to appraise themselves as only partly helpless remain quite capable of beginning and maintaining a specific plan or activity.

To the extent that Woolf and Alice has each asserted her will by declining to seek psychiatric assistance, each of their individually reached decisions deserves to be looked upon as a considered, deliberate method of directly dealing with her perceived condition. Keeping in mind that she was, previously, repeatedly successfully treated by the British mental health system, we might characterize Woolf’s behavior as perhaps prematurely escapist. (In fact, more cynical individuals might espy other, not necessarily depression-related factors in her decision to do away with herself.) Nevertheless, her behavior in the days preceding her final act, including her writing a suicide note and filling her pockets with stones just before walking into the River Ouse, shows that she was quite capable of at once lucid thought and initiative. Accordingly, we must infer that during that period, Woolf thought of herself as eventually becoming helpless, and not as being, in Graham’s dramatic description, “trapped or intractably stymied, helpless or impotent.”

What, then, one might inquire, about Alice’s condition? Ought not we interpret her continuing languishment in bed as a reflection of her feeling, or of appraising herself as being, helpless? It is, indeed, possible, as Graham says, that in the wake of her husband’s infidelity and death, Alice’s “expectation of negative results for other commitments or behavior” has increased, and that she feels overwhelmed and stripped of initiative. Yet, we could not, on the basis of the available evidence, advance such a point with complete confidence; for insofar as Graham reveals no information concerning any previous bouts with depression she might have experienced, his description of the case must be seen as incomplete. In fact, that information could be used as a standard against which we might determine whether Alice tends to respond to emotional situations with depressive, but only temporary, inactivity. Even if we discovered that this is her first helpless reaction, we could still not infer whether this will turn out to be a long-lasting state or a grieving but, again, only temporary process that any normal person would go through when faced with a similar circumstance. In a word, we could no less validly maintain that Alice has appraised her condition as something she simply has to live through than does Graham when he claims that she perceives herself as helpless.

From Graham’s angle, Woolf and Alice would have to be diagnosed as suffering from a mental disorder, since their respective mixtures of “mental and brute mechanical factors,” that is, their “mentality and neurobiology/neurochemistry partially incapacitate or ‘gum up’ the operation of (basic faculties) mind and behavior.” This explanation of mental illness sounds plausible indeed, which would indicate that, in order to thrive and prosper again, Alice should some day begin to seek psychological as well as psychiatric help. As we have
seen, however, Graham wishes to ascribe virtually as much causative influence to mentality as he does to neurobiology and neurochemistry. When he observes that perhaps lowered amounts of serotonin do not in and of themselves cause depression, but permit hopeless beliefs to “get stuck in a person’s stream of consciousness,” he is implying that treating the depressed individual psychotherapeutically should produce no less success than if he or she were treated pharmacologically. But this is hardly ever the case, since while a depressed person may or may not at all get better with psychotherapy, he or she rarely if ever fails to get better with pharmacological therapy. The same results would occur had we discovered that nothing but hopeless beliefs cause the lowering of serotonin levels in the brain, as seems likely in Alice’s case. My point could be phrased as something of a mental health theorem thus: More disorders meet with more success when they are treated psychiatrically than when they are treated psychotherapeutically.

4. Near the end of his book’s Chapter 4, Graham turns to a defining concern of his, “the respect-for-persons argument,” whose spirit he repeatedly and variously formulates thus: “Characterizing a person as the subject of a mental disorder is a form of disrespect or an indignity to them as a person” (93). To put this unease of his into focus, Graham proposes “something hypothetical and imaginary”: Suppose a psychiatrist discovers that some university students are so “dramatically and unhappily concerned with grades” that they engage not only in such a “needlessly redundant activity” as “repeating class note reviews on too numerous occasions,” but also in “imprudent and reckless behavior” like “pulling ‘all-nighters’ which cause sleep deprived students to do poorly on tests and to risk somatic ill-health.” The same psychiatrist’s research has, moreover, determined that the students’ “states of grade anxiety are accompanied by statistically abnormal activity in the verbally dominant left hemisphere of the brain.” Suppose, Graham’s illustration continues, our psychiatrist has managed to become a part of the “team composing the DSM-5 and argues that disturbances and behaviors distinctive of grade hyper-concern deserve their own classificatory status in DSM-5.” This discovery, the psychiatrist urges, might be included in the DSM as a “special sort of disorder” under the name of “Grade Obsessive Disorder,” or GOD (93).

At least one argument that could be mounted against the inclusion of GOD as a disorder, Graham proposes, is his “Respect for Persons Criticism.” In the light of this “Criticism,” unlike, for example, dogs, which frequently must be trained not to chew on rugs, “people should be treated as capable of being reasoned with about their conduct” (94). Thus, “[i]f a person were, say, to obsessively chew on a rug, we should not aim to train them. We should help them to modify their own behavior and to become better at reasoning about how to behave.” And rightly so, Graham holds, to the extent that some “people have unusual preferences, unshared by others, or imprudent desires, harmful to themselves (wishing to
chew on rugs, for example). But an unusual or imprudent desire just is another desire or preference. There is no good reason for believing that it needs to be ‘cured’ by classifying a person as mentally ill” (94). Labeling anyone as “disordered also allows psychiatrists and other mental health professionals to assume a position of unwarranted judgmental authority.” “In brief,” therefore, Graham concludes, “labeling and involuntary treatment is morally inconsistent with human dignity, with respect for persons” (95).

**Analysis:** As if their anachronistic tenor were not perplexing enough, Graham’s remarks in this section seem overwrought and self-contradictory. It is certainly true that the students in his GOD example must not be, as he says, compelled by anyone into any sort of therapy. But, indeed, we might inquire with a reflexively pronounced grimace of incredulity, how many individuals who merely behave in ritualistic ways, are nowadays — or were even a century ago — exposed to unwelcome treatment? Nor, if requested to do so, would he, I dare say, be able to name any. As well intentioned, then, as this part of his discussion might be, Graham, let us concede, is no more insightful or absorbing than anyone who would seriously set out to prove that labeling people ugly and performing involuntary cosmetic plastic surgery to improve their appearance is “morally inconsistent with human dignity.” In a word, we need be no more concerned with the incidence of involuntary treatment of obsessive-compulsive individuals than we should be about ugly individuals being given forcible plastic surgery.

Besides, it is unlikely that many would see the GOD students’ obsessive reviewing and compulsive reshuffling of their notes as any real disorder; on the contrary, probably most of us would conclude that they are either plodders, who must persevere in order to successfully complete a task, or conscientious future professionals, who in the face of persistently rising college tuitions and a shrinking job market have no choice but to excel in their academic studies. Before diagnosing them as obsessive-compulsive, therefore, Graham’s psychiatrist ought to, first, establish whether the statistically abnormal activity in the students’ left hemisphere of the brain is the cause or the result of their scholastic travails: If the abnormality is the cause, then further research should be recommended to determine whether, besides neurological, this is an inherent and possibly lethal anomaly; if, on the other hand, the abnormality is the result, then still further research would have to be done to determine whether the abnormality is a transitory or a life-long, and lethal, condition. Whether one or the other, then, the abnormality in question sounds like a more serious neurological condition than Graham’s description seems to convey.

Individuals who have been correctly evaluated as obsessive-compulsive are widely perceived as abnormal and as behaving unusually — because they are, and because they do. So, it is surprising that as a self-proclaimed metaphysical realist, or one who believes that
“mental disorders truly or objectively exist,” Graham has decided not to recognize the behaviors he does describe, apart from the GOD students’ endeavors, as disordered. In fact, his antipsychiatric assertion that any behavior — yes, even chewing on rugs — however “unusual or imprudent” it might be, is just “another desire or preference,” and therefore requires no “cure,” is patently misleading. His petitio principii-based fear that any clinical diagnosis practically invariably translates into a human dignity violation is the sort of straitjacketing claim that only an antipsychiatrist would hold dear. Let us be clear here: When characterizing someone as being in the grips of a disorder, most of us have no wish either to insult or — as Graham approvingly quotes Foucault (95) — to “judge” for the purpose of removing him or her from society, but (i) to communicate the existence of a difficult, simultaneously fruitless and uncomfortable condition, and (ii) to imply that, if asked to do so, we might provide assistance to the individual in question.

Would we, as a society, really detract from an obsessed individual’s dignity if we informed him or her that his or her condition could be alleviated with cognitive therapy or with antidepressants, just in case he or she decided to take advantage of those options? On the contrary, we would be not only shirking our salus populi responsibility, but also detracting from that individual’s dignity if we did not familiarize him or her with those options; if anything, we would be implicitly pointing to that citizen as being of lesser importance in contrast to those who have been helped by those options.

The foregoing consideration brings us to still another problem, this one precipitated by Graham’s concern that diagnosis is cultural and legal destiny: When he proposes that if one were obsessively chewing on a rug, “we should not aim to train them,” but only “help them to modify their own behavior and to become better at reasoning about how to behave,” he, conveniently, declines to inform us how we might go about doing that. How, indeed, would we or Graham “reason” with someone who neither asks for assistance nor considers his or her behavior as extraordinary, let alone bizarre? Even if Graham were to no more than modify that sort of behavior, would Graham not have to, first, acknowledge and inform the actor that he or she is indeed in the grips of a disorder, and by doing so unavoidably insult his or her dignity? Still more, why would Graham attempt to reason with the actor if, by his own reckoning, even the most “unusual or imprudent desire just is another desire or preference”? To the extent that Graham wishes people to prosper, he would have no choice but (i) to impress upon the actor that his or her behavior is of the sort that tends to diminish the natural quality of human life, and that (ii) he or she is in need of assistance whether he or she knows it or not. He would have no choice but to (gently, I suppose, yet firmly) propose that chewing on rugs or engaging in coprophagia and necrophilia could not rightly be thought of as mere desires and preferences, but as behaviors that are potentially dangerous to the actor’s own existence and unquestionably noxious to social life at large.
The sort of lumbering conceptual gymnastics that Graham has shown us here may be encountered in other sections of his book. Limited in scope as it is, my analysis of at least some of his claims never either aimed at or succeeded in refuting his rather lengthy treatment of the character and social and legal difficulties that attach to mental disorders. My hope is that I have at least drawn attention to some of the questionable claims and inferences in *The Disordered Mind*, and, by extension, to the philosophy of psychiatry. As for the latter, if Graham and Thornton and Radden correctly reflect its letter and spirit, then we might, in contrast to the advocates of antipsychiatry, think of the philosophers of psychiatry as a growing chorus of not only younger, but also somewhat softer voices — yet a chorus singing a nevertheless old, not to say banal, tune.

Moreover, in the light of the scholarship’s invariably challenging attitude, a large part of which remains firmly footed in antipsychiatry, the danger is not insignificant that some of its (especially emerging) contributors would glom onto its defining theses, and — as tend to do most of those who have not independently derived an idea — without much critical analysis advance them as truisms. We have already emphasized that these theses are at least partly true, as, for example, that stigma attached to the mentally ill is a historical fact; that the role of values in the diagnosis and treatment of mental disorders has been frequently ignored or misunderstood; and that the cultural and political power psychiatry has wielded since virtually its inception has been consistently greater than its partly unscientific precepts would merit. At the same time, some of these concerns are not what they might appear to be at first blush: It is, for one, no longer as persuasive to claim that the stigma which attached to the *insane* decades ago is just as intense today; indeed, anyone who would still challenge psychiatry on that point is merely mounting a straw man argument.

As the philosophy of psychiatry grows, it is my hope that its advocates will exhibit restraint in their critical analysis of psychiatry. While it is true that in the past, and today, mental health workers have occasionally and for various reasons caused a “black eye” to both clinical psychology and psychiatry, their behavior should not be emphasized as any more of a sufficient reason to censure these fields *qua* professions, than would, let us say, malpractice by doctors and by nurses be sufficient of a reason to question or restrict the medical profession as a whole. To do so would cast doubt not only upon its practitioners, but also upon what serviceable knowledge we have accumulated about psychopathology. In a word, to cast psychiatry in a questionable light would be to deflect not only the social, but also the personal benefits of its treatment.
References


Centers for Disease Control and Prevention: [http://www.cdc.gov/quarantine](http://www.cdc.gov/quarantine)


