

No Mind is an Island¹

On ‘Mental Illness’ and the Reciprocity of Minds

Peter B. Raabe

Abstract: This essay disputes the approach to so-called ‘mental illness’ in which the individual patient is presumed to be the locus of his or her ‘disorder,’ and should therefore be treated with brain-altering drugs. My position is predicated on the conviction that no one’s mind is identical to their brain. Nor is anyone’s mind a totally isolated island in the dynamic sea of human interactions and cognitions, and should not be treated as such.

Key Words: mental illness, individual, community, drugs, philosophy.

“Truth goes through three steps: first, it’s ridiculed, then it’s violently opposed, and finally, it’s accepted as obvious.” Arthur Schopenhauer. (1788-1860)

Introduction

In 2019 the *New Yorker Magazine* ran a story about a teenaged girl who was initially diagnosed with ‘depression’ by her psychiatrist and treated with an anti-depressant medication. But her distress reappeared over time in various iterations to the point where she was diagnosed as suffering from various ‘mental illnesses,’ and prescribed a total of nineteen different medications over the course of fourteen years (Aviv 2019, 40). It’s not clear whether her psychiatrist ever took a moment to ask her what she was depressed or distressed about.

It’s not at all uncommon for a person to have this sort of experience when being treated within our current western mental healthcare system. Psychiatrist Richard Johansson puts it this way:

There are still some psychiatrists whose practice entails a nuanced understanding of human suffering. But they’re rarely found in the current insurance-based system, in which a monthly fifteen-minute medical check-up is considered adequate psychiatric care. (Johansson 2019, 3)

It's true that the mental healthcare system in North America does in fact promote therapeutic counselling and talk therapy. But in practice the number of prescriptions for psychoactive drugs given out in mental healthcare are skyrocketing.² This raises two important questions: Why are mental healthcare providers so enthusiastically employing drug treatments that disturb the brain's, and the body's chemistry; and why is treatment for so-called 'mental illnesses' almost exclusively focused on individualizing the patient? In order to answer these questions, it's necessary to first understand how the current mental healthcare system typically perceives 'the mind.'³

Mind Defined

The brain is a physical organ much like a kidney or the liver. The brain is anatomically almost identical in all human beings. It is made up of a compact tangle of fleshy tissue that can be weighed, measured, surgically divided, electrically shocked, and chemically altered. It is therefore at least an object or a thing.

On the other hand, the mind is not an organ. It is frequently claimed to *hold* 'propositional content,' or to just *be* a compendium of 'propositional attitudes' toward quasi-linguistic dispositions such as beliefs, values, fears, and hopes (Ratcliffe 8-9, 59-60). But the intangible mind is in fact a phenomenal construct of existential thoughts and feelings. It's not merely a static collection of data bits. It is a vibrant wellspring of cognitive processes, intentional stances, and self-referential narratives, all easily distinguishable from brain matter. It is what makes the person the self who it is, a complex of often contradictory musings attended by a consciousness that wonders about the meaning of its own existence. The common understanding of the word 'mind' is based on a vaguely implicit connotation—a kind of 'phantom objectivity'⁴—lacking a non-ambiguous denotation. While 'it' defines the person, there is no tangible 'it-mind' further down inside the person; no referent for it within the brain or body; no substratum of interior 'thingness.' Scientists and philosophers who mistakenly insist on a reductionist or materialist perspective of the mind—as just the organic brain—proceed as though the brain itself has beliefs, values, fears, and hopes; that its neurons make plans for the future; that its glial cells express their love to someone; that its frontal lobes chose the roses and the red white wine over the white; and so on, when in fact these are the romantic thoughts and actions of a person.

Mark Rowlands, professor of philosophy at the University of Miami, agrees with the 18th century philosopher David Hume in saying that "...to encounter your mind is to encounter your mental states and processes." There is no concrete object or thing to be found that lies beneath mental states and processes (Rowlands 9-10). While the brain can be compared to a novel with many pages of text, the mind is like the story in that book.⁵ The story can't be understood by examining the paper pages and ink marks. Like the story, the mind is someone's meaningful imaginings, evaluations, hopes, points of view, opinions, and so on which add up to that person's nature and personality.⁶ In short, the mind is nothing like the brain. When clinicians study the

brain in order to understand the mind, **they're mistakenly** studying the paper and ink marks in their efforts to understand the story.

In his book *The Mind and its Discontents* Grant Gillett, Professor of Biomedical Ethics, at the University of Otago in New Zealand, gives a practical definition of what the mind is all about. He writes,

A mental life is a narrative construct or product of the integrating activity of a **concept-using subject as a person in relation to others.... Thus, acting and relating** are the foundations of the psyche [or mind] rather than merely receiving, assembling, and connecting representations. (Gillette 138)

A common misconception is that, because the mind is contained within a brain encased inside a skull it creates an absolute separation between human minds. Another common but false belief is that, **"We leave this life the same way we enter it: totally alone"** (Crouch 13); or **"We're born alone, and we die alone."**⁷ This sentiment has been popularized on social media, in novels, in pop songs, and even in houses of worship. But **it's** clearly false. And most people will readily **agree that it's false after** realising that, at the very least, their mother must have been present at their birth! No child is born alone and none develops to maturity in isolation. In fact, there is no such thing as a solitary child; for the child to survive the **nascent 'being'** must always be the inseparable mother-and-child dyad.⁸ Total autonomy is an illusion (Eilenberger p.248). In fact, functional magnetic resonance imaging (fMRI) studies have shown that specific regions of the brains of both mother and child are **"coupled"** during positive interactions (Levy et al., 2017; Soliman 211). Most children live and grow up within the environment of a loving family, a cooperating community, and an evolving society. Unfortunately, this is not true for all children; single and multi-generational family dysfunction can engender a history of mental troubles (van Orden 152).

Mind Illness

The most common message advanced by teachers, professors, doctors, and even popular actors and athletes is that psychopathologies, or so-called **'mental illnesses,'** such as **anxiety and depression, cause** suffering. But in reality, so-called **'mental illnesses'** **don't cause anything** at all. **They can't because they're not organic diseases governed by the natural or physical law of cause and effect.** Since the mind is an abstraction, and there is no corporeal **'it,'** there is no referent for **the term 'mental illness.'** **"It goes without saying that all mental illnesses are neurologically instantiated, but this says nothing about their causation"** (Fisher 41). The clinical term **'depression'** is a label applied to a combination of emotional experiences such as sadness, self-doubt, hopelessness, low self-esteem, and so on. To say that depression is a **'disease'** in the patient that **causes** sadness, self-doubt, hopelessness, and low self-esteem ignores the fact that the emotional experiences **themselves are diagnosed as 'depression.'** There is no **'disease' of depression over and above** the emotional experiences of the patient. While the public is led to believe that so-called

‘mental illnesses’ *cause* misery, the term ‘**mental illness**’ is merely a reification of misery. ‘**Mental illnesses**’ are always *about* something meaningful such as self-doubt, relationship problems, social or cultural difficulties, and other human concerns **where taking a pill won’t help**. “Life events, particularly negative events and stressors play a substantial contributory role in the development of depression from childhood through adulthood” (Hankin 252).

Depression is not the presence of psychopathology; it’s the absence of contentment. There is an enormous difference between saying “He’s suffering *from* depression”—where the depression is said to be the *cause* of the suffering—and “He’s depressed *about* something”—which acknowledges the individual’s internal narrative and underlying existential reasons for the suffering. To say that depression causes something is to claim that sadness, worry, or confusion are ‘**mind illnesses**.’ This not only disregards the common understanding of the word ‘**illness**’ as bodily malfunction or biological sickness; it’s a **misunderstanding** of the intangible nature of ‘**mind**.’ It’s meaningless to say, “She’s suffering *from* anxiety,” when she’s actually anxious *about* something. It makes no sense to say, “He’s suffering *from* schizophrenia,” when he’s confused and unsure *about* life. Or, “He’s suffering from ADHD,” when his mind simply works faster than the minds of other children.⁹

The host of a Canadian television talk show on CHEK TV in Victoria, Canada described ‘mental illness’ as, “**something that just happens to you that you have to work through, like a broken arm or a broken leg**” (July 11, 2003). So-called ‘mental illnesses’ were discussed as if it were a bodily injury. A CNN report around that same time talked about the treatment of “**diseases such as diabetes, heart disease from high cholesterol, and depression**.” Depression was again presented as analogous to a physical illness, and explained as caused by a possible chemical imbalance in the brain. In both media there was no mention that familial and social circumstances play a major role in the onset of so-called ‘**mental illnesses**’ (Hankin 136).

Furthermore, there was no mention that there is no scientific or medical evidence that a chemical imbalance in the brain causes ‘mental illness’ (Phil 90). Since there are no laboratory tests for objectively discovering a mental dysfunction, clinicians are only able to make the distinction between a normal and an ‘ill’ mind “**by intuition**” (Zachar 120). The so-called ‘**chemical imbalance in the brain**’ hypothesis has only proven to be a *reversed correlation* between depressed patients and their brain chemistry. In other words, it’s **claimed that the person’s despondency is caused by** a chemical imbalance in the brain, when in fact the reverse has been proven to be true: the **person’s despondency causes** the changes in their brain chemistry. But the physicalism of diagnostic criteria—that, for example, sees depression as a biomedical disease like cancer or diabetes but is caused by despondency—is the stance that has been adopted by professionals in the North American mental healthcare field. It is also enthusiastically endorsed and financially rewarded by the pharmaceutical industry.

The media reports that there’s now a ‘pandemic of mental illnesses.’ A *Google* search suggests that at least 10 percent of the world’s population is affected by some type of ‘**mental**

disorder; 20 percent of the afflicted are said to be children and adolescents. In the United States alone, **it's claimed that** almost half of adults (46.4 percent) or about 44 million people experience a 'mental illness' each year (*Google* Feb, 2019). If this were accurate it would mean that every American experiences seven or eight '**mind** illnesses' in their lifetime. Furthermore, these numbers are predicted to rise even higher due to the COVID-19 pandemic. And interestingly, so-called '**serious mental illnesses**,' like vaguely defined **schizophrenia**, "**are diagnosed in black people at a rate five times that of white people.**" This shows that there is clearly something wrong in the mental healthcare field (Wood 2020). According to Randolph Nesse, Research Professor of Life Sciences at Arizona State University, and Professor Emeritus, Departments of Psychiatry and Psychology, at the University of Michigan,

...carefully conducted studies find no increase in major depression rates in recent [pre-COVID] decades. It can nonetheless appear as if we are in an epidemic [of mental illnesses] because drug advertising... and publicity campaigns emphasize the prevalence of depression. (Nesse 124)

In his book *A Metapsychology of Psychopathology*, Peter Zachar, professor of psychology at Auburn University, discusses a concern even more troubling than the exponential growth in diagnosing of sadness or confusion as '**mental illnesses**' in adults. It's "the recent increase in the prescription of antipsychotic medications to agitated young children diagnosed with 'paediatric bipolar disorder'" (Zachar 164).

The use of the word '**illness**' in the term '**mental illness**' is an appropriation of the term's legitimate use within the vocabulary of somatic medicine. Biomedical psychiatry has been trying for years to find support for their **alleged** 'medical model of mental illness,' **without recognizing**—or being willing to admit—that the model is faulty. Sami Timimi is a Child and Adolescent Psychiatrist and Visiting Professor at the University of Lincoln, UK. He writes the following:

The failure of decades of basic science research to reveal any specific biological or psychological marker that identifies a psychiatric diagnosis is well **recognized**...Relentlessly searching for evidence of biological correlates [to support subjective diagnoses] continues to deliver nothing scientifically or clinically useful. (Timimi 209)

In *The Textbook of Anxiety Disorders*, (Stein ed 2002) there's **an unsettling** confusion. There is a definitional obscurity, and a constant equivocation between talk of anxiety as being a biological disorder (caused by inferior genetic combinations, faulty neurochemistry, and malfunctioning brain circuitry) and anxiety being *about* something (such as worry or stress associated with problems in everyday life). In one chapter the authors claim that the medial prefrontal cortex plays a causal role in anxiety (Bremner 51), while in the next chapter the author states, "**Environmental stresses play a central role** in the expression of anxiety and in the precipitation of episodes of **mental illness**" (Hoffer 60 italics added). The tension between the two

versions of anxiety—as a biological disease and as a result of life stressors—remains unresolved throughout the entire volume. And yet Georg Northoff at the Institute of Mental Health Research at the University of Ottawa states unequivocally that while it's still unknown how and why the neuronal activities of brain tissue generates mental features "...the various psychopathological symptoms are essentially mental symptoms." There is no mention of biological brain pathology (Northoff 910).

If there really is a so-called 'epidemic of mental illnesses', what is its cause? Is there really a chemical imbalance in the brains of millions of people? This seems improbable. In fact, disturbing life situations such as a dystopian family environment, or a social situation where there is inequality, irrational communication, physical danger, and injustice can bring on a range of mental distress and suffering that are in danger of being diagnosed as 'mental disorders.' Interestingly, according to Lennart Jansson, with the Department of Clinical Medicine in Copenhagen, Denmark, historically there are approximately forty different definitions of schizophrenia (Jansson 773). Today there is still no universal consensus in psychiatry regarding the definition of schizophrenia and many other so-called 'mental illnesses,' their meaning, their causes, nor which treatment protocols clinicians should act on.

A number of psychiatrists in London were asked in an interview, "What biological or physical tests are there to support the existence of mental illnesses?" All of them stated that they knew of no medical tests which could identify a 'mental illness,' or verify such a diagnosis (CCHR). As if to demonstrate the point that the creation of 'mental illness' categories remains as much a social and cultural endeavour as a scientific process, the American Psychiatric Association (APA) solicited input from the general public. Journalist Ethan Waters explains how people were invited to "submit suggestions for deletion of existing disorders, and submit suggestions for new disorders to be added to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*. He argues that if so-called 'mental illnesses' were legitimate medical diseases such a request would make no sense (Waters 252). Furthermore, if aberrant and anti-social behaviours can theoretically be diagnosed as 'mental illnesses' then why are other aberrant and anti-social behaviours, such as religious fanaticism, money hoarding, racial discrimination, homophobia, and being a mercenary soldier, excluded from diagnostic manuals?

Families are often the most influential causal factors, but only in as much as they create the earliest learning environment that has the potential to lead to a child's troubled thinking and behaviour. A child must learn many things, such as the proper use of a common language (Wittgenstein), strategies for decision-making, emotional reactions to objects, people, and the surrounding world, the sorting of truth from error, the distinction between delusion and reality, and so on from parents and others (Ratcliffe 155-6). Rationality describes, in part, an understanding and anticipation of the thinking and behaviour of other people. The ability to predict actions and their effects, and to imagine counterfactuals (what-ifs) are essential to a healthy young mind.

A child or adolescent, who must cope with a role model whose every unpredictable action and ambiguous utterances might lead to verbal abuse or physical violence, may become mentally and emotionally ‘stuck’ or ‘frozen’ at an incredibly stressful ‘fight-or-flight’ response. Anthropologist and social scientist Gregory Bateson found that it seems likely that children who grow up in a cognitively dissonant household, where the child is unable to comprehend parental emotions, and **can’t accurately foresee** their behaviours, will develop the sort of uncertainty, confusion, fear, and severe affective and cognitive distress that can be diagnosed as ‘**schizophrenia**’ (Bateson 23). Physician Edward Bullmore points out that childhood stressors, like malnutrition, abuse, neglect, and early separation from parents, are often predictive of polyvariant mental problems that arise decades later (Bullmore 58; Rose 49).

Social workers tend to understand that mental problems are not generated innately, that **they’re** developed interpersonally, and that sufferers benefit more from the support of other people than from the solitary ingestion of medications. A number of international studies have concluded that the greater the inequality in economic and social resources in any society, and the more dangerous the society is, the poorer is the mental health of that society (Timimi 212). For example, “when people are displaced from work, rates of addiction and mental-health issues skyrocket” (Heller, 17). Mental health can be undercut by unemployment, homelessness, and hunger—none of which are simple chemical imbalances in the brain. And yet pharmaceutical corporations, just like their tobacco company counterparts, continue to maintain the fiction that their chemical concoctions are remedial. Their pervasive “Ask your doctor for our product” media campaign keeps their customers believing a pill is the answer to all their daily concerns.

Mind Treatments

In general medicine, bodily symptoms such as pain, fever, or a cough are recognized as informative indicators of biological problems. In psychiatry, mental symptoms such as worry, low mood, and distress are often presumed to be the problems themselves. **“In psychiatry viewing symptoms as diseases remains the norm”** (Nesse 118). So instead of searching for what might be producing worry, a low mood, or distress many clinicians instead speculate that they are the products of the **patient’s** unhealthy brain chemistry. Social psychologists have called this the “**fundamental attribution error;**” and **in the rest of medicine it’s** referred to as the “**clinician’s illusion**” (Nesse 40, 47). The Mood Disorder Society of Canada runs what they call **the “Depression Hurts”** campaign. In it they clearly imply that the symptoms are the disease. So instead of searching for what might be producing these symptoms, many bio-psychiatrists instead simply begin with the assumption that some sort of unproven chemical imbalance in the brain needs to be corrected with their favourite drugs.

In the June, 2014 *International Journal of Clinical and Health Psychology* doctors Richard Pemberton, of the University of Brighton, Brighton, UK, and Tony Wainwright, of the University of Exeter, Exeter, UK, pointed out another false causal claim:

“The contemporary assumptions concerning mental distress—for example the serotonin deficiency theory of depression—are deeply rooted in the minds of mental health professionals. The idea that depression and other diagnoses are related is **similarly strongly believed. This is similar... to the view that the earth is the centre of the universe.**” (Pemberton 218)

Diagnosing and treating a specific individual, without a consideration of their family and social environment, is as outdated as diagnosing people on the basis of phrenology. Physician and professor at Cambridge University, Edward Bullmore points out that the most significant source of major depressive disorder (MDD) is likely social stress. Major negative life events like bereavement, divorce, and loss of employment, as well as burdensome adult social roles, like caring for a dependent loved one, increases the risk of depression weeks, months, or even years later. And he suggests that psychoactive medications are best conceptualised “as inducing particular psychological states rather than **correcting chemical imbalances**” (Bullmore 58).

Psychoactive drugs **don’t cure ‘serotonin deficiencies,’** nor are they ‘**illness**’ specific. The theory is that selective serotonin reuptake inhibitors (SSRI) do something to the mental state, but that ‘something’ is not clear nor diagnosis specific. “**Although drugs marketed as ‘antipsychotic’** are often claimed to reverse a biochemical imbalance in the brains of psychotic patients, no such imbalance has been demonstrated” (Timimi 211). Physicians know that anti-psychotics are major tranquilizers, **but they’re** not advertised as such. Research has also revealed that while anti-psychotic meds are similar in effect to a large glass of strong alcohol, they generate many more unpleasant, and sometimes dangerous side effects than alcohol. Furthermore, a meta-analysis of the clinical trials done on the foremost anti-depressant drugs on the market today found that they are actually no more effective in relieving depression than placebos (Kirsch et al).

Biopsychiatry’s extensive application of drugs in an attempt to alter the brain chemistry in patients suffering from so-called ‘**mental illnesses**’ is still the ‘**gold standard**’ in treatment. *The Wall Street Journal* reports that the global antidepressants market is expected to grow from \$14.3 billion in 2019 to about \$28.6 billion in 2020-21 as mental health issues are expected to surge due to the COVID-19 pandemic (Apr 21, 2020). Today’s message is, “If you’re feeling depressed or anxious about COVID **it’s your brain’s fault.**” But a doctor can prescribe anti-depressants and anti-anxiety drugs that will help you feel better. Does this make any sense at all, **given that it’s** perfectly normal—it is absolutely *nominal*: within expected and acceptable limits—to feel upset about this life-threatening virus?

“Industry-funded advertising and professional ‘education’ promote the profit-maximizing simplistic view that all emotional disorders are brain diseases needing drug treatment” (Nesse 7). But psychopathology “**cannot be understood completely** in neurobiological or individual terms.” (Kirmayer 399)

Since the 1950's pharmaceutical corporations have pushed two problematic assumptions, both within the contemporary mental healthcare field and in the marketplace: (1) that a troubled mind can be treated in isolation, and (2) that a troubled mind must be treated indefinitely with costly brain-altering drugs. Now all they need to do is to keep their trusting customers—both doctors and their patients—believing that their products are ideal treatments for so-called **'mental illnesses.'** Their motto seems to be **'Everyone should be taking something!'** But theirs is not simply an innocent though myopic view of mental suffering. They know that **there's no money** in it for them to admit that talk therapy is a healthier alternative to psychopharmaceuticals, or that group therapy sessions offer more long-term benefits than brief chats with a medical doctor wielding a prescription pad.¹⁰ **There's simply too much** money to be made through the sale of psychotropic meds. So pharmaceutical companies use the term **"illness"** in referring to mental suffering in order to help them justify the promotion and sale of their powerful brain-dulling—and side-effect causing—prescription drugs.

There's a **'shell game'** going on in which the health insurance companies say they won't pay for visits to a doctor unless there is first a formal *DSM* **'mental illness'** diagnosis. So, sadness is now formally diagnosed as **'depression,'** and worry becomes the **'illness of 'anxiety,'** both said to be the result of a **'chemical imbalance' in the brain.** And because there is now this formal diagnosis of **'brain illness,'** the pharmaceutical companies are happy to supply the **'anti-depressant'** and **'anti-anxiety'** drugs, to meet the insurance industry's demands. This **'game'** ensures that families and their communities are left out of any direct involvement in caring for the suffering individual. **And the patient or 'mark'** has been duped into relying on, and paying for (through their insurance premiums), largely ineffective medications in a zero-sum game. In fact, the drug manufacturers have been flooding the numerous media with messages that have habituated physicians and mental health care clinicians to routinely write prescriptions in response to sadness, worry, uncertainty, low self-esteem, and other normal human experiences.

No individual mind exists in isolation... at least not for very long. Psychologist Carl Jung explained that **it's natural and healthy for children** to become discrete, self-fashioning members of humanity. But he warned that individual isolation—which he termed individual/*ism*—can lead to serious problems of depression, anxiety, and so on (Jung 1953). And yet current mental healthcare treatment for a majority of patients proceeds on the premise of individual/*ism*: each **sufferer's mind is on its own.** Why is this? One of the reasons is because the inventors, manufacturers, and distributors of so-called psycho-pharmaceutical products profit the most when marketing their drugs primarily to the individual consumers: solo patients and their doctors.

A common assumption is that pharmaceutical corporations and physicians are merely "supplying the demand" for their medicines, when in fact those corporations are actually working daily to increase the demand and their profits by circulating media messages that target individuals. Despite readily available clinical research data showing that medications **aren't** the best treatment for so-called **'mental illnesses,'** pharmaceutical companies continue to encourage

individuals to consume their dependency-creating drugs (Rose 99-102, 116-133). This results in the social isolation and stigmatization of those who are suffering. The corporate insistence that solitary pill ingestion is necessary and sufficient treatment for controlling mental distress distracts from the need for socially inclusive discussions about the actual meaning and existential causes of mental suffering. What is forgotten or ignored is that people value not only the reduction of their symptoms but also the elimination of the causes of those symptoms. By taking pills that merely reduce some symptoms, patients and their worried families become and remain perpetual customers.

“Considering mental illness an individual chemico-biological problem has enormous benefits for capitalism... It provides an enormously lucrative market in which multinational pharmaceutical companies can peddle their pharmaceuticals” (Fisher 41). The ‘medication mentality’ in today’s modern clinics, on which much of our contemporary **“bio-mental”**¹¹ healthcare is based, disconnects the troubled person’s **mind** from the intricately interwoven fibers of their challenging life-world. (Moran 205)

Mind Re-Defined

Although normal human consciousness begins spontaneously at birth it does not evolve independently of society. Consciousness is a generative process that develops and matures by means of the cognitive affordances, intellectual opportunities, and emotional constraints and so on within the shared social world. UCLA professor of philosophy Tyler Burge writes that **“the sense in which a man is a social animal runs deeper than much mainstream philosophy of mind has acknowledged”** (Burge 477). Studying the minds of severely neglected children has shown that a trustworthy connection with parents, siblings, and others is essential for normal early development. In discussing the effects of culture on psychiatric practice Michael Ratcliffe, professor of philosophy at the University of Vienna, insists **that** **“the minimal self needs to be reconceptualized in *interpersonal terms*”** (Ratcliffe 149).

Human beings are embedded or situated within a society. They are **‘socially constructed’** because they learn inter-dependently with and from each other; they cooperate and develop by assisting one another. In their book *The Mind and the Brain: Neuroplasticity and the Power of Mental Force*, professor of psychiatry at UCLA School of medicine, Jeffrey Schwartz, and senior science writer for *Newsweek*, Sharon Begley, highlight the importance of environmental influences on the developing mind.

Our brain is marked by the life we lead, and retains the footprints of the experiences **we have had and the behaviours we have engaged in...** The [human] brain wires itself in response to signals it receives from its environment. (Schwartz 110, 117, 212)

A mind **isn't simply** an epiphenomenon of a functioning brain—like the heat radiating from a running motor—because mental activity is a phenomenon of **a person's** meaningful interactions within a social context. Epiphenomenalism implies that the mind is causally inert or idle, having no existential purpose. And without an effect on the world, there would indeed be no purpose and no personal meaning to all the active components we call **'the mind.'**

One of the most significant differences between humans and all other animals is the human ability to share **what's 'on'** the mind, and thereby to progress intellectually, logically, technologically, spiritually, and so on. Many people believe incorrectly that we experience only our own minds, when in fact what we experience is a non-mystical universal **phenomenon**. It's often ignored **that one's own cognitions** are only a small, though inseparable part of a much larger whole. If each mind were operating discretely from all others, then humanity would be doomed to re-invent the wheel with each new generation.

Beliefs, values, fears, and so on are never genetically inherited, and the truth value and morality of **a person's standpoints can't be genetically determined** (Lemery 187). But humans are not autodidactic (self-educated) creatures; **there's no such thing as an autonomous, self-sufficient, self-regulating mind**. The idea of a conscious mind **that's ontologically** atomistic, and completely self-determining is a fiction. Every mind is constantly influenced and shaped by other human beings. **From birth the baby's mind is contingent because it's driven by** immediate needs and **wants**. **But the infant's** mind is also socially situated, and remotely activated. It is influenced and even controlled by contemporary customs, guided by local biases, and then swayed by internal critiques, many of which are not of its own invention.

The mind defined as the individualistic and solitary locus of consciousness in space-time is a fictional artefact that has been reiterated in academic and clinical writings so often that it has **become accepted as a fact**. The token **'mind'** is a semantic error and misnomer. It is a reductionist perspective, and an abbreviation that does an injustice to the transsomatic and transtemporal type **that 'it'** actually is. Cognitions are altered and rearranged by the organizational mechanism of the mind which automatically establishes connections, clarifications, and memories in the brain. Biased **'epistemic appearances'**—the way things seem to the individual—are shaped by socially shared opinions and cultural values.

The academic study of **'philosophy of mind'** in the singular is a misguided convention, a reductionist (monadic) perspective of the essential nature of all human mental life. It suggests that only a single mind needs to be understood in order to explain all minds. In fact, a universalized, one-size-fits-all, discussion of **'the mind'** is not a defensible account of mental activity. On the one hand it denies **the uniqueness of each person's** phenomenological experiences, and on the other it ignores the interconnectedness of all those unique minds. This is why the title **'Philosophy of Mind'** in the singular for a university course is inaccurate. The more correct title for such a course is the plural **'Philosophy of Minds'** which suggests mental multiplicity and human diversity.

a. Mind is *socially constructed*.

It should be clear by now that the mind is not a discrete ‘it,’ a solitary entity. Alex Pentland, computer science professor at MIT explains that the human mind, and normal or nominal human behavior, “is determined as much by the patterns of our culture as by rational, individual thinking” (Pentland 197). Every **person’s** mind is immersed in a shared community. **Every child’s brain is born anew, but the mind that will inhabit it** is connected to the beginning of rational human existence. Each single mind reflects the integrated minds of others with whom each person has been, is, and will be ‘**entangled.**’ Research has revealed what is being called the **brain’s “resonant mirror neuron system” in which the neurons of an individual will “reflect” and synchronize** with those of others with whom they come into social contact (Molenberghs et al., 2010). Proponents of the ‘**social construction**’ thesis see the importance of abandoning the common reductionist conviction that the individual mind develops separately and in total isolation (Soliman 210). They see the mind as constructed by multiple interrelated sources. A mind is never self-fashioned; **it’s the convergence of many; it’s a focal point** at which the knowledge and experiences of others leave a significant impression. Absolute autonomy is an illusion. The **human mind, “the intellectual faculty itself, is an evolution” (Nietzsche 15).** The human mind has evolved as a cooperatively shared phenomenon. Each of us is united with all others through the diverse means and acts of communication. Research in neuroscience is showing that there is a strong social element to cognition (Hasson et al., 2012). The Internet, smart phones, television, social media, satellites, and so on connect minds anywhere on the planet and beyond. The impact of the group **on a single consciousness has never been greater.** The expression, “It takes a community to raise a child” holds true for the mind as well. It takes a community to help develop a newborn’s mind. This is also the anti-solipsism answer to academic philosophy’s so-called “problem of other minds.” Other minds *must* exist in order for any mind to exist!

b. Mind is *socially situated*.

Since Hegel’s *Phenomenology of Spirit*, philosophical discussions about mind have been marked by a broad division of emphasis between the individual and their social environment (Burge 428). But Wittgenstein’s **philosophy of language revealed** that the mind is always socially situated. We sometimes forget or even simply deny the contributions other minds have made to our own in an effort to sustain the entrenched Western philosophical myth of the totally autonomous person (Wilson 626). We often think and behave according to *what we’ve* learned from our parents and others without realizing *that we’ve internalized* that knowledge and behaviours from them. This is what connects us on a transcendental level.

Humans are prone to the fundamental attribution error, blaming characteristics of individuals and neglecting the effects of environments and situations... [such as] being trapped in an abusive marriage or dead-end job (Nesse 115).

We may think that our opinions are exclusively our own, but this is not at all supported by findings in philosophy, anthropology, sociology, psychology, history, and so on. There is no shame in accepting the fact that each mind is merely a small thread woven into the fabric of humanity (Menary 2010).

c. Mind is *extended*.

The human mind necessarily includes the external tools that the person employs—such as a pen and notebook, a smart phone, a computer and the internet, etc.—which act as extensions of the mind. Furthermore, the human mind operates beyond the limitations of its physical environment to include the transcendental realms (Clark 1998; Vold 2010).

Locke's characterization of the mind as a 'tabula rasa' at birth upon which collected impressions are recorded throughout life is somewhat simplistic. The impressions collected on a **child's** mind are not just **randomly gathered and stored**; **they're evaluated and compared**; **they're** sorted in terms of correlations, causal relations, meaning, truth value, ethical consistency, and so on. This activity is enabled, as Kant suggested and Chomsky and others have reaffirmed, by innate abilities within a **newborn's brain**. However, the ability to qualitatively evaluate information and judge the truth could never be learned by a mind in total isolation. It requires the participation and cooperation of a family and community of trustworthy people willing to offer their **perspectives on life's many** challenging issues. But a mind can suffer, and life can become painful not only when family and community fail to be reliable, but when the needs of the body are not adequately met (Menary 2010; Rowlands 2013).

d. Mind is *embodied*.

In the most common view of cognition the brain is often seen as a metaphorical computer in the sense that it receives inputs from the environment, retrieves internal instructions, and provides outputs that drive **the body's actions**. **But the quality of the body's nourishments**, health, gender, and so on all have a significant and lasting impact on the mind as well (Wilson 632). Contrary to the Cartesian philosophy of consciousness—in which the human being is a thinking entity separate from the body—what the mind does is deeply dependent on, and affected by the characteristics of the entire body (Eilenberger p.249; Casasanto 106-117).

The mind is always aware of both the affordances and restrictions inherent in its biological structure and chemical composition due to its size, its strength, the effects of past injuries, the limitations of age, and so on. A person's own interpretation of life events, their view of the people and the objects in any given environment, is significantly influenced by their physical characteristics. The body is not merely a puppet for the mind. It intrudes itself into the perceptive and cognitive processes. And drugs can significantly affect this relationship, especially those toxic chemicals that alter the brain's **delicate** operations.

The “I am” is the combination of a transcendent mind and a material body. The human mind does not function in isolation; the body is the connection and the intermediary between internal cognitions, and perceptions of the external world. The mind encompasses the person’s entire corporeal structure. The body is the ‘me’ of the mind that experiences the social and the natural world. Just like the mind can’t exist without the brain, likewise the mind can’t exist in the world without the body. Abstract concepts such as freedom, personal agency, even love can only be realised through the physical body. And what is done to the body—including drugging the brain—always has an impact on the mind (Durt 2017; Shapiro 2014; Fuchs 2009).

Mind Concluded

Psychological phenotyping markers have not revealed any predispositions for psychopathology or so-called ‘mental illnesses.’ Mental healthcare professionals and case workers are witness to the negative effects society can have on individual minds. And yet it’s more profitable for the pharmaceutical industry if the population continues to trust their deceptive message that sadness, fear, and confusion are caused by a chemical imbalance in individual brains, which must be treated with their drugs. They’re well aware that the value of their corporate shares depends on driving the notion that nearly everyone’s brain is chemically imbalanced.

Pharmaceutical corporations, *qua* corporations, have little, if any, interest in helping people where there is no potential for profit. Sociological research has shown the importance of focusing on problematic family dynamics and social stressors such as unemployment, poverty, crime, and addiction. This is where mental suffering is prevented or overcome (Rose 43). Unfortunately, the lure of the ‘quick fix’ that requires little effort makes the chemical solutions difficult to resist.

Mental suffering is never exclusively generated by internal cognitive or psychological mechanisms. A child raised in isolation without social interactions would develop little, if any, mental activity that would be recognizably human. Some mental healthcare workers have long understood that focusing only on the single patient in front of them amounts to ignoring the social factors at the source of their patient’s problems (Rose 50-64). Seeing the patient as detached from society amounts to blaming the victim for their own suffering. In fact, one person’s suffering is often ‘multi-mental,’ in the sense that many problematic, and perhaps dangerous, minds may be responsible for the mental distress of one individual.

This is where biopsychiatry gets it wrong, and where drug companies ultimately profit. By maintaining that the cause of mental suffering is always endogenous—originating within the individual—and then treating the person with medications that interfere with brain functioning, they intentionally ignore not only the obvious difference between biological brain material and the non-material mind, they also ignore the complex social environment of human minds. The project of developing a serological response in people—boosting the mental immune system to resist the infection of mental misery—can’t be undertaken with psychoactive medications. It

requires a proven therapy that instils the ability to think clearly **and wisely about life's many** demanding contingencies.

The most effective, Evidence Based Therapy (EBT) has been clinically demonstrated to be the discursive approach, also called **'talk therapy.'** It arguably consists largely of applied philosophy. Talk therapy has been proven to be much more effective in dealing with stressful life issues than medications, and without any of the harmful side-effects. Rational Emotive Behavior Therapy (REBT) employs the sort of discursive ethical approach and critical thinking strategies taught in most **philosophy courses.** It's now considered an Evidence-Based therapy because clinical studies have found obvious beneficial outcomes (O'Donohue 1996: 304). It follows from this that any discursive counselling based on a solid foundation of philosophy deserves to be called Evidence Based Therapy.

But more than simply talking with a distressed individual, fair and effective mental healthcare requires **"a system that acknowledges the growing evidence of psychosocial causal factors in many types of mental distress"** (Pemberton 218). Dr. Sing Lee, China's pre-eminent researcher on eating disorders, insists that so-called 'mental illnesses,' do not exist independently of social and historical context. There may therefore be no true natural history [of mental illnesses], but rather a social history at a given time and place, a perspective which questions **radically the biomedical assumptions...** The only meaningful components of treatment are understanding the **patient's life** (Waters 35, 57).

Nicholas Rose, professor of sociology at King's College in London, maintains that sociology is an indispensable science when it comes to understanding 'mental ill health' (Rose viii). The experience of so-called 'mental illness' **can't** realistically be privatised in the individual, and separated from culture. So-called **'mental illnesses,'** such as anxiety, depression, and even schizophrenia, are every bit as shaped and influenced by cultural norms and expectations as are hysterical leg paralysis, the vapors, demon possession, witchcraft, and many other so-called 'mental illnesses' conjured up over the history of human 'madness' (Waters 6). Randolph Nesse, Research Professor of Life Sciences at Arizona State University, says that several years into his work teaching psychiatry he became frustrated and confused when he saw the field narrowing to the slogan, "Mental disorders are brain **diseases.**"

The phrase is great for marketing drugs, decreasing stigma, and soliciting donations, but it short-circuits clear thinking. Sometimes it's accurate, but it excludes valuable insights from behaviorism, psychoanalysis, cognitive therapy, family dynamics, public health, and social psychology. (Nesse 7)

Current trends in biological psychiatry seem to lead to a tripartite conclusion:

1. It's a form of medical malpractice to administer or prescribe toxic brain-dulling drugs in an attempt to alleviate **the mind's discontent**;
2. it's a **mistake to talk** about a so-called 'mental disorder' as existing solely in an isolated individual mind, and to ignore the fact that the vast majority of human minds are in a constant, significant, and extensively reciprocal relationships with one another; and
3. **it's clear that** in dealing with the many kinds of mental suffering—the smorgasbord of so-called 'mental illnesses'—philosophical counselling is an effective, evidence-based, and appropriate therapy.

"We need to significantly reduce our ever-increasing reliance on psychotropic medications, and instead offer redesigned psychosocial services that aim for recovery and personal agency" (Pemberton 219). And it would be wise for those services to include philosophy not only as a treatment for suffering minds, but as a means to prevent future suffering as well. As Schopenhauer might have said. "This seems obvious."

*Dr. Peter B. Raabe (Canada) is a certified philosophical counsellor and retired Associate Professor of Philosophy at the University of the Fraser Valley (UFV) in Abbotsford, Canada. He is the author of many peer-reviewed journal articles, book chapters, international conference presentations, and workshops on the theme of philosophy's role in mental healthcare, and is on the editorial boards of several international publications. He is the author of three books: *Philosophy's Role in Counseling and Psychotherapy* (Jason Aronson); *Issues in Philosophical Counseling* (Praeger); and *Philosophical Counseling: Theory and Practice*, (Praeger). He is co-editor of *Women in Philosophical Counseling* (Lexington). He is also a contributing author and editor of *Philosophical Counseling and the Unconscious* (Trivium Press).*

¹ "No man is an island entire of itself; every man is a piece of the continent, a part of the main..." From *Meditation XVII: Devotions upon Emergent Occasions*. John Donne English poet. 1572-1631.

² Over the past year, U.S. prescriptions for anti-anxiety medications such as Klonopin and Ativan jumped 10.2% from 8.8 million in March 2019 to 9.7 million in March 2020, according to a Wall Street Journal analysis of data from health-research firm IQVIA. And prescriptions for antidepressants like Lexapro and Prozac rose 9.2% from 27.2 million to 29.7 million in the same time span.

³ The problematic convention of prefacing the word "mind" with the definite article "the" is followed throughout this paper. This allows the reading of the text to flow more easily. The problem is that the use of the term "*the mind*" implies that mind is a discrete entity or a physical organ, which it is not.

⁴ This term is borrowed from Georg Lukás as quoted in *A Dictionary of Philosophical Quotations*. p. 266

⁵ The brain is often said to be the container for the mind where the container and its contents are never identical. The brain can also be compared to a USB stick, and the mind as the information on that stick.

⁶ An early-modern British philosopher, George Berkeley, (1685-1753) suggested a similar definition of 'mind.' He wrote that there is "something which knows or perceives [ideas], and exercises diverse operations, such as willing,

imagining, and remembering about them. This perceiving, active being is what I call *mind, spirit, soul, or my self*⁶ (italics in the original). From his *A Treatise Concerning the Principles of Human Knowledge*, 1 § 1,2.

⁷ This popular maxim may be a condensed version of an Orson Wells quote in which he says, “We’re born alone, we live alone, we die alone....” But he continues on by saying “...Only through our love and friendship can we create the illusion for the moment that we’re not alone.”

⁸ Or caregiver-and-child dyad.

⁹ A child may develop a ‘faster mind’ than expected in ‘normal’ development as a survival mechanism when raised in a problematic home environment.

¹⁰ For a discussion of CBT as the best treatment for depression, social phobia (SP), obsessive-compulsive disorder (OCD), panic disorder (PD), and post-traumatic stress disorder (PTSD) and many other diagnosable ‘mental illnesses’ see Rothbaum and Corey.

¹¹ This term was invented by Kayla Kinsman, one of my students, and is used with her permission.