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In Defence of the Concept of Mental Illness – FORTHCOMING 2023

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Abstract

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Abstract

Many worry about the over-medicalisation of mental illness, and some even argue that we should abandon the term mental illness altogether. Yet, this is a commonly used term in popular discourse, in policy making, and in research. In this paper I argue that if we distinguish between disease, illness, and sickness (where illness refers to the first-personal, subjective experience of the sufferer), then the concept of mental illness is a useful way of understanding a type of human experience, inasmuch as the term is (i) apt or accurate, (ii) a useful hermeneutical resource for interpreting and communicating experience, and (iii) can be a good way for at least some of us to establish a liveable personal identity within our culture.

1. 'There Is No Such Thing as Mental Illness'

There is a family of views that argues against using the term mental illness to describe distressing mental experiences such as deep sadness, anxiety, or grief.[1] This family of views includes arguments from anti-psychiatry (Szasz, 1961; Benning, 2016**)**, critical psychiatry (Double, 2019, Middleton and Moncrieff, 2019**)** and the survivor/ex-patient movement (Chamberlin, 2015; Beresford, 2019**)**, and less well-articulated versions can be encountered in the media, and in everyday discourse. Since these views are based on a disparate range of arguments (Chapman, 2023), it is best to characterise them as a family resemblance group (Wittgenstein, 1953/2009). The commonality between them

1 I will differentiate between mental illness and mental distress throughout. One can experience mental distress (e.g., grief) without experiencing mental illness. I will also use the term 'health problems' when I am not referring to illness specifically as a first-personal experience.

lies in their rejection of the concept *mental illness.* This is in stark contrast to the recent world-wide prioritisation of mental health in public health policy (WHO, 2021). According to the Global Burden of Disease study, mental illnesses are one of the largest causes of disability worldwide (Vigo *et al*., 2016; Arias *et al*., 2022). Critics are of course still in favour of reducing experiences of mental distress,[2] while believing that people's experiences are wrongly medicalised and should not be regarded as illnesses. I will here argue that we should not abandon the term *mental illness* because it is a useful way of understanding a type of human experience, inasmuch as the term is (i) apt or accurate, (ii) a useful hermeneutical resource for interpreting and communicating experience, and (iii) can be a good way for at least some of us to establish a liveable personal identity within contemporary Western social and political culture.

Over the years I have been told many times that I should not identify as someone who lives with mental illness. At first, the idea seemed to be that this was only a phase of life, that I should not medicalise adolescence. Either I was conflating the usual woes of adolescence with mental illness, or I would 'grow out of' youthful mental illness, just as I grew out of childhood car sickness. Later on, I was told that mental illness is not 'real' because it could not be identified on an MRI brain scan. Finally, some people assume that I have the same mental experiences as everyone else, only I am unwilling to deal with them like everybody else.

We could reframe these three examples as follows. Firstly, by referring to mental illness, we are over-medicalising common life experiences, such as adolescence, and confusing them with illness. Secondly, disease is something that is accessible to the (bio)medical gaze, and to the extent that mental illness is difficult to delineate from mental health and has no biomarkers, it is not a fitting subject for medicine. Thirdly, by referring to mental illness, people are looking to excuse either malingering or acting out. Under this heading, what we think of as mental illness may actually be primarily a moral problem, one of bad behaviour, or of weakness of the will. The writings of anti-psychiatrist Thomas Szasz (1961) offer examples of all three of these arguments (Chapman, 2023).

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2 Although arguably some form of emotionally distressing experiences such as disappointment or grief are important to experience (Olberding, 2023).

In this paper, I want to put forward a positive counter-argument in favour of the concept of *mental illness.* This counter-argument also responds to the kinds of objections to calling myself 'mentally ill' that I have just outlined. Ultimately, I believe that it is important that we continue to accept that mental illness experiences do exist and must be named in order to treat people justly or morally, that is to 'treat persons as persons' (Spelman, 1978), especially as a lack of recognition of their suffering is very threatening to those who suffer (Wilkinson, 2005).

My argument is that there is a phenomenon that we experience as illness-like (section 3), which is *usefully* described as illness-like within our culture (section 4) and that there are people who can benefit from identifying, either personally or socially, as someone having or living with mental illness. In order to do this, I first need to discuss how *illness* contrasts with *disease* and *sickness* (section 2).

2. Introducing the Disease / Illness / Sickness Triad

While it is frequently used in medical sociology and medical anthropology (e.g., Kleinman, 1988), the *disease* / *illness* / *sickness* triad is less frequently employed in philosophy (but see Amoretti and Lalumera, 2020, for a great example). *Disease* is a biomedical, theoretical construct that is identified by the medical gaze; *illness* is the subjective experience of lack of health; and *sickness* is the bundle of social responses and attitudes which are provided to someone who is diagnosed with a disease, or is experiencing illness (e.g., Boyd, 2000**)**. I will argue that continuing to view some mental distress as *illness* is worthwhile, as it is a phenomenological concept which describes a type of suffering from the perspective of the sufferer. By contrast, it is the contemporary notions of *disease / disorder*[3] and *sickness* that accompany experiences of mental *illness* that are the appropriate targets of common objections. In many cases, the target of mental illness critics is actually mental disorder and the accompanying sick role,

3 In the context of psychiatry, the term *disorder* is used instead of *disease*. The two are conceptually similar enough for my purposes and I will use them more or less interchangeably.

whether this is explicitly stated, as in the case of the 'Drop the Disorder' campaign (Watson, 2019), or not.

Diseases are pathological processes, seen in the medical gaze and communicated through a diagnosis. It is supposed to be an objective representation of what has gone wrong with the body. In philosophy of medicine, one of the key questions is how to conceptualise disease (e.g., Bolton, 2008; Bolton & Gillett, 2019; Wakefield, 1992, 2007). *Diagnosis* is the process through which disease is identified in the individual, named, and applied to them. In the clinician-patient interaction, a key role of diagnosis is to offer an understanding of treatment options, and the likely course of the disease (Jutel, 2011). A diagnosis can validate someone's subjective illness experience publicly by relating it formally to a disease, while the lack of a diagnosis sometimes calls it into question, as in the case of chronic Lyme disease, which does not exist as a recognised disease entity (Dumes, 2020). Receiving a diagnosis of disease or disorder can also unlock sickness benefits and costs, such as access to treatment, sick pay, legitimate demands for rest, or stigma.

The prototype disease in modern medicine remains one which is diagnosable using standardised techniques, has observable biomarkers, is described through measurable deviations from the normal, and has a clear progression (Marinker, 1975). The ideal medical disease requires that a clear disease mechanism is present (Sontag, 1989) and there is a clear cause for dysfunction. This prototype already struggles with chronic illnesses which require long-term care, rather than cure. In general, modern medicine is based on what Rosenberg (2007) calls disease specificity, which is the 'notion that diseases can and should be thought of as entities existing outside the unique manifestations of illness in particular men and women' (p. 13). Medicine (at least at the theoretical level) treats the disease rather than individual symptoms or the individual person (Foucault, 2010).

Disease specificity, clear causal factors, and a known disease mechanism are all problematic for psychiatric disorders. One of the main aims for successive revisions of the Diagnostic and Statistical Manual of Mental Disorders (current edition: DSM-5-TR, APA, 2022) has been to increase inter-rater reliability for disorders between different clinicians to make sure that different psychiatrists give the same diagnosis to a patient

(Tsou, 2019). Psychiatric patients often receive multiple diagnoses, and treatment resistance is relatively common. This means that some of the benefits of diagnosis are not always available: including predictability, self-understanding, or the possibility of hope (Jutel, 2011). Psychiatric disorders are also over-determined, making causal mechanisms difficult to establish. Neither do we fully understand how psychopharmacological interventions work. These are just a few of the many reasons why critical psychologists are right to question the usefulness of psychiatric diagnoses even if the extent of psychiatric exceptionalism is frequently overstated (Chapman, 2023).

In reality, in clinical practice it is often sufficient to treat the symptoms without worrying about an accurate diagnosis. Sociologist of medicine Annemarie Jutel (2011, pp.122–3) illustrates this with a personal anecdote. She had a chronic cough, which her general practitioner couldn't diagnose, despite numerous tests over a period of months. In the end, she was given anti-inflammatory medication to ease her symptoms, which resolved her complaint immediately. She was no longer ill, even though she never received a diagnosis. At the same time, Jutel acknowledges that as her symptom (an incapacitating cough) was both easily observable and clearly undesirable, there was no danger that her illness account would be dismissed. Equally, a lack of objectively diagnosable mental disorder may not always be a problem, as long as treatment through medication and therapy is effective for many people. Problems often start when diagnosis confers problematic *sickness* costs such as stigmatisation or institutionalisation.

Sickness is the social response to illness and disease. It is the external, public mode of what happens to people when something goes wrong with their health. Individuals acquire a *sick role* (Parsons, 1975). This includes a wide range of provisions, some informal, some formal. Sending someone flowers or a 'get well' card can be seen as informal requirements of the sick role. Formal provisions include statutory sick leave and pay, and social welfare provisions for people with chronic illnesses and disabilities.

Not all aspects of *sickness* are beneficial, as has been amply demonstrated in the case of mental disorders. Treatments for mental disorders have often been punitive.

Sufferers have been subject to institutionalisation, forced medication, and even forced sterilisation and other eugenic actions. Unfortunately, this is still an ongoing problem (Saks, 2007; Newton-Holmes and Mullen, 2011; Tickle, 2023; McCurry, 2023), and one which proponents of critical psychiatry and members of the ex-patient / survivor movement are rightly campaigning against.

Informal responses to *sickness* can be equally problematic. Someone can be required to take on a sick role whether they want to or not. People diagnosed with various diseases are often expected to behave or respond to their condition in a socially expected manner. For example, people may learn how to 'do' bipolar disorder (Martin, 2009) or ADHD (Brinkmann, 2016). A prominent negative consequence for many diagnoses is stigma,which has been well documented for mental disorders (e.g., Rusch *et al*., 2020). Efforts at eliminating stigma through popularising the idea that mental health problems have biological explanations seem to have resulted in greater unwillingness to engage with the mentally unwell, as their behaviour may now seem to be even further out of their control (Kvaale *et al*., 2013).

It is important to stress that not all parts of the disease-illness-sickness triad need to be present simultaneously (Wikman *et al*., 2005). Someone may have a disease without feeling ill, as in the case of asymptomatic Covid-19 infection (Amoretti and Lalumera, 2021). Others might experience illness in the absence of a diagnosable disease, as in the case of Jutel's bad cough (2011). In the case of mental illness, someone feeling ill and with a medical diagnosis may still be seen as undeserving of a sick role due to stereotypes or stigma (Sadowsky, 2021, p. 142). Finally, many people diagnosed with mental disorders do not experience their condition as an illness (Michalak *et al*., 2011; Thoits, 2016).

In contrast to both the third-personal 'objective' *disease* under the medical gaze and that of the social category of *sickness* as a response to health problems, *illness* (including mental illness) is internal, first-personal experience. Feeling ill spurs people on to seek out medical attention, and can lead to the diagnosis of a disease. Illness adjusts to fit the individual and their circumstances, making it more patient-centred and less alienating than disorder, as it centres individual experience rather than matching signs and symptoms to an ideal-type.

Separating the concept of illness from the concepts of medical disease / disorder and sickness is a necessary first step towards establishing why retaining the concept of *mental illness* is worthwhile. If we deny the existence of mental illness as it lacks clear biomarkers (Szasz, 1961), we are contesting the status of mental disorders as diseases. If we object to treating mental distress with medication, we are calling on aspects of the disease and sickness regimen that accompanies the illness experience. In order to rebut objections which are specifically against using the concept *mental illness* to describe our subjective experience, I will argue for three claims in the rest of this paper. Firstly, that mental illness is a relevantly illness-like experience. Secondly, that calling this experience illness is fitting within our culture. Thirdly, that identifying as someone with such as illness-experience can be beneficial rather than detrimental.

3. Experiencing Mental Illness

Based on the three-fold distinction between disease, illness ,and sickness, no matter what kind of illness we are experiencing, there is something phenomenologically 'like' to be ill, a first-personal sense of felt unease, separate from objectively having a disease or occupying a sick role socially. Our way of being-in-the-world when we are ill is different from our way of being-in-the-world when we are healthy (Leder, 1990; Toombs, 1992; Carel, 2016; Reynolds, 2022). The first aim of this paper is to argue that the term *mental illness* is apt, because there exists an experience of mental distress which is fundamentally illness-like.

How we experience the world, (perceptually, cognitively, emotionally, and so on) changes which aspects of that world are most salient to us. Even a minor illness, for example a bad cold, colours how we experience our day. By losing our sense of smell, we cease to perceive aspects of the world we might otherwise take for granted, and bad smells bother us less or not at all. Our activities become more effortful from lack of energy. We cannot concentrate, hence tasks appear harder to complete. We start sneezing, and we become aware of aspects of our environment such as the availability of tissues. Our mood is affected, minor setbacks are more unpleasant than usual.

Illness also changes how we experience our embodied selves, and what features of ourselves we hold salient (Toombs, 1992). Illness alienates us from our bodies in a

way that makes them appear not just as objects, but as malfunctioning things which impede our interactions with the world (Toombs 1992, pp.71–2). Leder (1990, p.84) writes about the 'dys-appearance' of the body. The healthy body *disappears* from our attention, we are absorbed in our activities, we move through the world easily. He calls this an ecstatic or outward-focused mode of living. By contrast, an ill body *dys-appears*, appears wrongly, draws itself to our attention to the point that we may not be able to pay attention to anything else. It forces our focus to shift inwards, towards ourselves, and spatiotemporally to the here and now. Standard pain scales track this progress from a background annoyance, through a limitation of normal activities to a complete inability to pay attention to anything other than our pain, making the slightest movement impossible. In her phenomenological study of illness, Havi Carel (2016) argues that the experience of illness involves a series of losses: loss of wholeness, loss of certainty, loss of control, loss of freedom to act, and loss of transparency. For an experience to count as illness, it also needs to be disvalued; whatever else we agree on, in itself illness is a form of suffering we would rather avoid (Chappell and Jeppsson, 2023). Suffering may at times lead to growth, but even if it does, this only gives us reason to value it instrumentally, as a means to an end.[4]

We may look for proof that mental distress can be experienced as illness-like to the first-personal testimony of people who have experienced it, such as autobiographical accounts (e.g., Saks, 2007; Hornbacher, 2008 Redfield Jamison, 1996). We can also refer to studies in various academic disciplines such as psychology, psychiatry, sociology, anthropology, and philosophy. Since we are concerned with subjective, first-personal experiences, it makes sense to turn to phenomenology as a philosophical tradition and scientific discipline in psychiatry. Phenomenological psychiatry and phenomenology of psychopathology is the study of what it is 'like' to experience mental illness, based on a careful observation of how people describe their experiences (see Stanghellini *et al*., 2019). One problem is that most people say that it is impossible to

4 As Kate Finley reminded me, experiences such as psychosis also have aspects other than suffering, whether that is transcendental insight or escape from a bleak reality. These can be very valuable to people and form one of the bases of Mad pride. My argument here only refers to the suffering inherent in the illness experience.

accurately describe what these experiences are like (Gipps, 2022). Many mental illnesses are described particularly through this disconnection from others. But accepting that there are limits to our ability to explain if we are ill, or to sympathetically enter into the world of the mentally ill when we are healthy, does not mean that it is completely impossible to describe and comprehend the experience of mental illness (e.g., Jeppsson, 2021; Potter, 2003).

Mental illness is illness-like in that it falls under the wider family resemblance category of illness. Just as in the case of a bad cold, we slip into a different way of experiencing the world[5] through changes to ourselves rather than just our circumstances. The most prominent aspect of these changes is emotional and cognitive in nature; this is why mental illness is primarily 'mental'. This is what marks it out from other illnesses, which are also often accompanied by changes in mood or levels of concentration as a result of unpleasant bodily experiences.[6] In addition, mental illnesses are not simply experiences of unpleasant moods or odd cognitions, but also encompass sensory and somatic elements (Ratcliffe *et al*., 2013). Body-aches, fatigue, vomiting, and insomnia are common examples. Panic attacks and cases of epilepsy-like seizures are especially dramatic somatic manifestations of mental illness. Mental illness also commonly affects sensory perception, as in hallucination or derealisation (Sass *et al*., 2017). People may become strangely alienated from themselves and others. This alienation negates the usual transparency of these mundane relationships (Lysaker and Lysaker, 2008). None of these aspects of mental illness can be easily separated from each other, and the way they manifest may be to some extent culturally determined. In some cultures, as in China, the somatic symptoms of depression are of primary importance (Ryder *et al*., 2008).

How can emotions and thoughts become illness-like? Based on the phenomenological characteristics of illness I outlined above (Leder, 1990; Toombs, 1992; Carel, 2016) we would expect this to mean that our thoughts and emotions force

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5 The extent of the difference depends on the kind and severity of our illness.

6 If I am in an irritable mood because I have a bad cold, my illness experience does not centre on my irritability. Instead, it centres on a stuffy nose, a headache, fatigue, and so on. The irritability is the consequence of these, rather than the illness itself.

themselves on our attention consistently, rather than allow us to navigate the world straightforwardly. In the case of anxiety, we might not be able to distract ourselves from our worries. In the case of depression, we might need to withdraw from the world due to the force of our sadness. In the case of mania, we might be unable to resist our elation to the point of acting foolhardy. In any case, we are driven by our emotions to act in ways which we would not endorse otherwise. Mental illness is often accompanied by the loss of one's world or one's sense of self. The world might become uncanny, transformed so that we can no longer move through our environment with ease. Many people say that mental illness takes away their sense of self (Wisdom *et al*., 2008); it is profoundly alienating. Delusional beliefs and other aspects of thought can also draw themselves to our attention in an unusual way. Thoughts themselves can become thing-like. Take as an example the 'silent thought echo' (Parnas *et al*, 2005), whereby thoughts very literally seem to echo around one's head, obscuring newer thoughts. While this may not make thinking impossible, it is very annoying, making the *process* of thinking no longer transparent. Just as in other illnesses, we change in a way that transforms our life-world in alienating, limiting ways.

Mental illnesses can be acute or episodic; most people do not experience mental illness as a constant, unchanging state. Some people will experience a period of mental illness once and then fully recover. If the illness returns later in their lives, this is a new instance of illness, just as we can get other illnesses more than once, even chicken pox. Other mental illnesses are more akin to chronic illness. People may experience long periods of remission, but it is more or less guaranteed that the illness will flare up again. While many people experience milder, sub-syndromal illness in the periods in-between episodes, even this is experienced as comparative mental health. The illness experiences which map broadly onto the disease concept of bipolar disorder illustrate this point well. The term 'manic-depressive disorder' originated with Kraepelin (1921). Through years of recording patients' episodes of illness, he built up a large corpus of simple lifetime illness charts (Martin, 2009). On these charts, periods of depression and mania were marked, while periods of relative health in between were only shown through empty stretches. By contrast, contemporary studies often highlight the relatively frequent changes from baseline mood to periods of mild depression or hypomania people with

bipolar disorder are prone to, taking this to be part of the illness structure (Martin, 2009; Bonsall *et al*., 2011). Kraepelin (1921) himself wrote that there are 'slight or slightest colourings of *mood*, some of them periodic, some of them continuously morbid, which on the one hand are to be regarded as the rudiments of more severe disorders, on the other hand pass over without sharp boundary into the domain of *personal predisposition*' (p. 1, emphasis in original).

Thus, whether these periods of remission are experienced as illness or something else is very personal. In her autobiographical meditation on neurodiversity Antonetta (2014) identifies her experience during periods of remission as a form of neurodivergence. She recognises that her moods and emotional regulation is not how most people experience these things, but she does not believe that these constitute an illness. It may at times make her life harder, but in this she finds it more akin to neurodivergent ways of being such as living with autism, dyslexia, or dyspraxia. It is notable that she wrote her book over a period when she experienced both normality and illness. When she gets worse, she considers herself ill, and seeks medical help. It is an open question whether these in-between periods of remission which are still not 'symptom-free' are seen as mild illness or something else. This may vary from individual to individual and even for the same individual over time; someone who has experienced themselves to be mildly ill in the past may come to rethink this experience as part of how her self usually is. The opposite can happen, not just through medicalisation, but also through a change of circumstances. The burden of being different may feel more like illness when life gets harder; things are stressful and one's ability to function daily becomes more limited. A level of anxiety that one person experiences as an illness may still be an acceptable part of the normal range for someone else. Just as with pain, what is in need of treatment, unbearable, and so on cannot be clearly delineated. I will return to the idea that we need this kind of flexibility in personal illness-identity in order to treat persons as persons in section 5.

4. The Culture of Medicalisation

Since there are forms of mental distress which are relevantly illness-like, we can view the term *mental illness* as a useful hermeneutic tool, i.e, a way of explaining clearly to

others and ourselves what is happening to us. Yet it is possible that that viewing these phenomena as a form of illness is specific to our culture of Western late modernity, in which case we also need to consider the possibility that this is an undesirable aspect of our culture, which we need to eliminate. Even if calling some phenomena *mental illness* might be an apt description of the experience, we may be misusing this hermeneutic tool through applying it too broadly, or through responding to it in discriminatory ways. This misuse can be an appropriate target for ameliorative action without denying that some people can describe their distressing experience as mental *illness.*

It is commonly seen as problematic if cases of everyday sadness, grief, exclusion, poverty, and other problems of living are treated through medical interventions (e.g., Dowrick and Frances, 2013). While it is impossible to know what proportion of cases are wrongly medicalised, about 80% of psychiatric medications are prescribed without recommendation by a psychiatrist (Rose, 2019). It is a problem if primary care physicians give out these prescriptions just to be doing something to help when nothing else is available. The idea of offering talk therapy to those with such problems of living seems less problematic and more likely to prove to be beneficial, inasmuch as we seek to offer help and support to all who are suffering, even if talk therapy can also have negative effects **(**Linden and Schermuly-Haupt, 2014**)**. While we commonly alter our biochemistry to suit our needs (drinking coffee and alcohol, taking over-the-counter pain killers, and so on), taking psychopharmaceutical medicines to help with mental distress is sometimes moralised, or seen as inauthentic (Karp, 2006).

By requiring that there should be something illness-like at play, we could guard against over-medicalisation. The promotion of mental health awareness may have led to people overinterpreting their experiences of mental distress as an example of mental disorder (Foulkes and Andrews, 2023). Many disorders, such as generalised anxiety disorder, are dimensional constructs. This means that anxiety can range from ordinary worry to a crippling disorder. Just through being aware that there is such a thing as ‘anxiety disorder’ people may start to think about their feelings of anxiety as more serious, and more likely to be pathological than it is. Equally, if someone experiences the emotional impact of common events such as the end of a relationship or job loss more intensely than culturally expected, they may think of this as an emotional problem

that needs to be ‘fixed’ through professional intervention (Davis, 2020). As long as we share a common cultural understanding of what *illness* is, it is hopefully still possible to recognise when we are experiencing *illness* instead of other kinds of mental distress.

Medicalisation is also not a straightforward concept. Firstly, people turn to medicine, and indeed are required to do so by pharmaceutical regulators, for many needs which are not disease-related (Jebari, 2015; Bortolotti, 2020). A paradigm example is that of female hormonal contraception. Since hormonal contraceptives can cause side effects, and lead to long-term problems for a small proportion of women, it is good practice to monitor their use. This means we provide medical treatment inhibiting fertility, even though fertility is not a disease, illness, or sickness. Secondly, illness experience can exist in the absence of a diagnosis or even a known, recognised disease. In section two, I cited an autobiographical example from Jutel (2011), whose somatic illness was successfully treated even in the absence of a diagnosis. Thus, it is an over-simplification of the role of medicine in our culture to claim that it is necessarily a form of over-medicalisation to turn to medical practitioners to help us with emotional distress in the absence of a well-defined disorder. If pharmaceutical treatments, or even electroconvulsive therapy (Gergel, 2021) help to relieve the suffering of at least some patients, then we should not moralise the medical treatment of mental illness.

This may be all good and well if we accept that the kind of phenomenological experiences I described in section three should be labeled *mental illness.* But one could make the stronger objection that even though these cases of mental distress are illness-like, it is still wrong to label them *mental illness*, as this is not their most salient feature. Instead, their most salient feature may lie in spirituality, social injustice, or the kinds of suffering which we can all expect to undergo at some point, such as grief. Thus, it is possible that some distressing experiences are labelled mental illness, either by the person experiencing them or by others, because we lack the appropriate social concepts, skills, and support structures to recognise them for what they are. These types of experience may be described more fittingly using a different concept, like *problems of living* (Szasz, 1961).

Illnesses often have a spiritual dimension. Depression and ‘dark night of the soul’ (Scrutton, 2020) could both be possible explanations for a prolonged period of

mental distress. Yet, it is not necessarily the case that someone experiences *either* depression *or* a spiritual struggle. Instead, we can adopt what Scrutton (2020, p. 115) calls the 'both-and view'; that is, it is possible to experience both mental illness and spiritual struggle simultaneously. Over-spritualising mental distress can be just as problematic as over-medicalising it (Finley, 2023), especially if it discourages sufferers from seeking appropriate help. Just as it would be wrong to overinterpret 'ordinary' anxiety as an illness, it would be wrong to overinterpret mental illness as spiritual in nature, especially if it leads to contentious interpretations based on spirit-possession, or punishment for sin. These examples also show the importance of requiring hermeneutical resources which we all have common cultural access to. Illness is such a resource in our culture, but spirit-possession is not. This would make it a less useful way of understanding and communicating our suffering.

Worries about medicalising everyday emotions, especially grief, are common in philosophy of psychiatry (Wakefield *et al*., 2007; Horwitz and Wakefield, 2012; Prigerson *et al*., 2021). Other objections are concerned with social problems (e.g., Beresford, 2019): poverty, unemployment, precarious employment, bullying, and domestic abuse can all lead to a pervading sense of powerlessness and anxiety which could be mistaken for clinical depression or anxiety. Through treating the emotional responses to these problems as illness-like, we might be individualising phenomena that are in need of collective solutions. The interaction between such social ills and mental health is complex. Problems such as poverty or homelessness can be triggers for mental illness, or they can be the consequences of mental illness (Brossard and Chandler, 2022). It is impossible to generalise, we must instead listen to individual stories. Yet, even if mental illness is accompanied by other forms of distress, this does not negate its existence. Scrutton's (2020) 'both-and view' can be helpfully be applied outside of the spiritual context as well. It is possible to suffer from social ills, injustice, or discrimination, while also experiencing mental illness.

We see the same mechanism at work with somatic illnesses. People living in poverty often only have access to poor quality accommodation. This type of housing often has serious shortcomings that can lead to illness mould, damp, poor air quality due to pollution, or the use of solid fuels. Those living in such conditions are more likely to

develop asthma and other kinds of respiratory illnesses (Rocha *et al*., 2019; Simkovich *et al*., 2019). The fact that the cause of the illness lies in poor living conditions does not mean that we should not treat it medically. But neither is it a satisfactory solution to simply send the patient home with an asthma inhaler, and ignore the non-medical support and policies needed to tackle poor accommodation, poverty, and pollution.

Perinatal mental illness is an interesting contrast to worries about conflating depression with grief. New parents experience a need for physical recovery , sleep deprivation, changes in identity, worries about an increase in responsibility, cognitive problems such as memory loss andloneliness. All of these can lead to changes in mood. Yet, instead of denying that on top of these difficult experiences (which, in contrast to grief, we are discouraged from acknowledging, as new parenthood is supposed to be a period of unremitting joy), some people may also experience something more problematic and not part of a normal life-stage, we now acknowledge and indeed actively look out for perinatal mental illness. We do this even if many of these problems are due to social factors, such as lack of childcare or inadequate social networks. While we might worry that this is unwarranted medicalisation of ordinary ‘problems of living’, it is more likely that it is an overdue acknowledgement that some parents do experience mental distress after the birth of a child which goes beyond what would normally be expected. Thus, instead of arguing for a perinatal exemption from diagnoses, we can recognise that this period can be accompanied by specific kinds of mental illness, e.g., depression, anxiety, or psychosis strongly coloured by the context within which it occurs.

Intersectionality plays an important part not just in the creation of identity, but also in correctly identifying lived experiences. According to theories of intersectionality, our identities are not simply additive (Crenshaw, 1989). I do not straightforwardly share the identity ‘woman’ with a black woman, while diverging in my lived experience of race. I am not a woman and white, I am a white woman. Analogously, someone experiencing grief and depression simultaneously is not just someone who happens to have experienced a loss around the time they experienced mental illness. Instead, the two experiences colour each other fundamentally to the point that they may be hard to separate. The same goes for poverty, new parenthood, and so on. We cannot look at

someone's experience of mental illness under these circumstances without also acknowledging other aspects of their mental distress. But equally, we should not deny their experience of mental illness because it is coloured by the experience of another form of mental distress. Neither of these moves would provide appropriate recognition to the suffering of the individual. Furthermore, both circumstances need to be improved simultaneously: it is not enough to offer pills or talk therapy to those with perinatal mental illness without also helping to alleviate loneliness or offering better childcare provisions. If we fail to recognise that someone is not only anxious about unemployment or grieving for a relative, but also experiencing mental illness, we may not be able to offer them appropriate support and we may hurt their interests by not recognising them as they see themselves.

5. **Mental Illness Identity**

So far, I have argued for two points, based on demarcating the concepts of *disease*, *illness*, and *sickness* from each other. The concept of *mental illness* is important because it is (i) an apt or accurate term, and (ii) a useful hermeneutical resource for interpreting and communicating experience. In this final section, I will argue that it can also be a good way for at least some of us to establish a liveable personal identity within contemporary Western social and political culture.

We use identities both to make sense of who we are and to help us navigate our social world. Medical diagnoses and illness experiences can lead to the adoption of both internal, personal identities and external, social identities (Jutel, 2011). While identity based on disorder diagnosis can be important to people, a different kind of identity can also be based on identifying with one's subjective experience more congruently, owning one's circumstances and taking appropriate action, from acceptance of one's troubling symptoms to seeking diagnosis, treatment, and other forms of support. Identity in this personal sense is usually incorporated into someone's personal narrative; it is something which defines us and plays some kind of role in why our life is proceeding the way it is. Illness experience can also form the basis of social identities from finding supportive groups of others with similar experiences to engaging in collective action (Jutel, 2011). Illness-identity can be important even if one believes that existing diagnoses are inappropriate, or the illness is dismissed by others, as in the case of medically

unexplained symptoms. In these cases disease-identity is simply unavailable, yet illness-identity, and the awareness of the pernicious effect of illness on our life-world remains. How should we think of the concept of identity? Appiah (2006, p. 16) writes that identity 'X will have criteria of ascription; some people identify as Xs; some people treat others as Xs; and X will have norms of identification'. Thus identities have to be things others can recognise as an identity. This recognition may result in specific behaviour towards such people and one must fulfil minimal norms in order to qualify. Someone cannot identify as a keen runner unless they go running regularly. Others may end up talking to them about running or ask advice about how to take up running themselves. This leaves open the possibility that someone who goes running just as regularly, but views this simply as an accident in their lifestyle -(maybe they have no opportunity for another form of exercise) will not identify as a runner at all, much as some people working in philosophy departments do not identify as 'real philosophers'.

Our personal identity is by necessity made up of a large range of identifications. Appiah argues that we use these identities in order to construct our lives and to make sense of our experience. Without this, we cannot pursue *eudaimonia* or the good life. Different aspects of our identity are also important at different times and in different settings. While someone is a patient in a psychiatric hospital, their identity as mentally ill is likely to dominate; but this identity may remain entirely hidden from and unimportant to their identity of being a member of a local sports team. Once we accept this variety and situatedness in our identities, it becomes clear that *mentally ill* may be one useful way for people to make sense of their experiences or seek help within our particular society. Other societies in other places and at other times might offer other concepts based on which to do this, which are not available to us living in our own society. Even in our culture, *mental illness* can be a meaningful multi-dimensional construct: ideas about medical treatment can go hand-in-hand with ideas about spiritual struggle (Finley, 2023). What is of greatest importance here is that there should be multiple ways available for people to identify, beyond a hegemonic narrative.

How can we reconcile this with the idea that one of the phenomenological features of illness is that it alienates us from ourselves? According to psychological research (Strohminger *et al*., 2017) there is widespread belief in a 'true self' or authentic

self which can be obscured by the experience of mental illness (Karp, 2006) in what is known as the problem of self/illness identity (Sadler, 2007; Dings and Glas, 2020; Jeppsson, 2022). If mental illness changes our cognitions and by extension our actions, then it becomes difficult to say what part of what we think and do is 'us' and what part is the distortion introduced by the illness. If an injury stops a keen runner from being able to run, the wish to go running remains theirs. The fact that they are not actually going running is clearly attributable to a cause outside of what they think of as their identity. Of course, if the injury curtails any future ability to go running ever again, then the keen runner will need to re-evaluate their sense of self, as they will no longer be able to identify as someone who runs regularly for pleasure. If the keen runner becomes mentally ill instead, and loses their motivation to go running, it would be much more difficult to tell whether this loss of interest was a symptom of their depression. If someone diagnosed with a severe mental disorder such as 'Sylvia' in Sheehan's *Is There No Place On Earth For Me?* (2014) becomes a devout Christian, their faith may be seen as a symptom of their illness, rather than a genuine, deeply held belief.

In the process it is easy to shift, without noticing, between two kinds of alienation. It may be true that illness makes us feel alienated, but this does not mean that our illness-identity, which signifies that we have *identified* that experience of alienation as illness, need further alienate us from the social world. Just as we should not neglect or even deny a running injury, it might be important for some to name and acknowledge their illness-experience through an illness-identity.

The danger is that too much will be attributed to the illness and, especially in the case of chronic conditions, that one's identity will be subsumed under that of the mental patient. Mental illness is often seen as engulfing: a kind of identity that goes beyond the identity accompanying most other illnesses. If we wrongly define our mental distress as mental illness, we might be guilty of disowning aspects of ourselves which we dislike, distancing ourselves from our problems, and giving up a significant part of our agency as a result. This worry is amplified by the problem of stigma. 'Mentally ill' is a marked identity. Someone with mental illness stands out against the unmarked, sane, and rational majority (Goffman, 1990; Zerubavel 2018). People with mental illness often face the problem of being identified by others in a way which makes the wrong attribute

seem salient (Whiteley, 2023). Elyn Saks (2007, p. 255) worries that while ‘a woman with cancer isn’t Cancer Woman’, she might be seen as ‘primarily a schizophrenic’.

Yet, these processes are not necessary ones. Maggie Thoits (2011, 2016) identifies a range of responses to a diagnosis of serious mental disorder.[7] Some people may be subsumed under their illness-identity. Others embrace and shape this identity actively, seeking to overcome stigma through pride in their identity and maybe even activism. Yet others choose to deny or renounce their diagnosis. Thoits wonders if the engulfing identity is a result of the way in which we think about or ask questions of the mentally ill. Studies of people with mental illness frequently ask whether their subjects are in employment or in education, but rarely look beyond these common ways of measuring success, such as having a satisfying family life.

Reconciling our illness-identity with other aspects of who we are may be especially difficult if these different identities diverge in ways which can seem radical. Elyn Saks (2007, p. 263) writes about her difficulty of reconciling successful ‘Professor Saks’ with ‘the Lady of the Charts’ hospitalised with schizophrenia. Many of these contradictions rely on common prejudices: assumptions such as that it is not possible to be professionally successful, happily married, or a good mother if someone lives with mental illness. This leads us back to the negative social *sick role, characterised by stigma,* that people with mental illness often experience. If this is the case, it is better to eliminate the stigma, rather than to deny people the opportunity to describe their suffering as illness, or identify as mentally ill, if this feels appropriate to them. This might require us to turn towards what Winder (2023) calls unspoiling a spoiled identity; creating alternative narratives around what people with that identity can be. This means working towards changing the common interpretation of an identity: recasting mental illness as more intelligible, with valuable qualities such as being able to see the world through a different lens (Garson, 2023), or writing memoirs like Saks’s in order to show that mental illness-identity, intelligence, and success are not incompatible.

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7 Thoughtful sociological studies are conducted with people who have been diagnosed with a disease. While I argue that disease is not identical to illness, for my purposes I believe I can use these studies to think about responses to stigma and identity-engulfment.

All this has three important implications. Firstly, for those who do not identify as mentally ill (e.g., Michalak *et al*., 2011), other forms of identity should be available which take into account their experiences. In the last few decades, two prominent examples of this have emerged: the neurodiversity paradigm (Chapman, 2020) and Mad identity (Beresford 2019, Rashed 2019). Both of these take a strength rather than deficit-based approach to mental difference. Secondly, no one should be forced into adopting or embodying a fixed or sealed identity against their will (Ahmed, 2014, p. 55). Finally, identities are intersectional and mixed so that it should be possible to adopt both a Mad identity and an illness-identity. My experience is illness-like, and it is important for me personally not to lose sight of or deny the suffering inherent in my mental illness. Yet, I also currently identify as a Mad philosopher, someone who claims to be part of a community of people who experience a wide variety of mental difference and distress. My illness-identity is primarily personal, my Mad identity is primarily social and political.

6. **Conclusion**

I have argued that the phenomenology of *mental illness* is such that it can be accommodated under the broader, family resemblance category of *illness*, and that we can turn to first-personal, subjective accounts to confirm this. If this is right, then the concept of *mental illness* is apt. It is also a culturally useful hermeneutic tool which we can use to explain what is wrong with us, and to seek help from others. Mental illness frequently co-occurs with other problems of living, whether grief or poverty, but this does not negate its existence. Finally, we need not be afraid that mental illness identity will be engulfing and that it can be one of the many identities we adopt at various times in our lives.

We need our identity to reflect our experience of the world, and the way our life is going. Our identity should also allow us to be understood by others (Bergqvist, 2021). Thus, our identities are positions from which recognition claims can be made about who we are, what our needs are, and how others can treat us as persons. Crucially, by identifying our experience of mental distress as an *illness*, we are putting forward a claim towards a particular caring, affective kind of relationship with others. When I

identify my suffering as illness-like, I wish to lay claim to a caring interpersonal relationship, instead of one which negates my experience and my deliberations on my experience by telling me that I have misunderstood the nature of my suffering. It is through responding to such claims that others can offer recognition towards us in illness and treat us as the persons we want to be treated as.

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