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A Relational Theory of Mental Illness – Lacking Identity and Solidarity with Others

Abstract

In this paper, I aim to progress towards the philosophical goal of ascertaining what, if anything, all mental illnesses have in common, attempting to unify a large sub-set of those with a relational or interpersonal dimension. One major claim is that, if we want a promising theory of mental illness, we must go beyond the dominant western accounts of mental illness/health, which focus on traits intrinsic to a person such as pain/pleasure, lethargy/liveliness, fragmentation/integration, and falsehood/authenticity. A second major claim is that the relational facets of mental illness are plausibly understood theoretically in terms of a person's inability to identify with others or exhibit solidarity with them, relational values salient in the African philosophical tradition. I show that these two extrinsic properties explain several intuitive instances of mental illness well, including, amongst several others, being abusive, psychopathic, narcissistic, histrionic, paranoid, and phobic.

Keywords

intrinsic, extrinsic, mental health, mental illness, neurosis, philosophy of psychology, relational disorders, relational values

1. Introducing Theorisation of Mental Illness

Do all mental illnesses have something in common? More carefully, is there a single property, or a small handful of them, in virtue of which a psychological disposition counts as a disorder? Is there one feature that explains why those with abusive, psychopathic, narcissistic, histrionic, paranoid, or phobic traits warrant interventions such as therapy and medication?

It would be intellectually fascinating if there were an affirmative and explicit answer to these questions. A philosophical mind, or at least one sort, seeks unity and would be pleased upon being able to place all mental illnesses under the same conceptual heading (for non-constructivist reasons). Such insight into what is fundamental to much human life would plausibly be an instance of knowledge that is good for its own sake.

Of course, there might turn out not to be any essence to mental illness. Perhaps the most unity we will be able to establish is a family resemblance account, or we might encounter such substantial heterogeneity amongst mental illnesses that theoretical unification is altogether precluded. However, we cannot know with confidence that an essential property, or a small cluster of similar properties, does not exist unless we continue to search in earnest for one, and we will have learned much about mental illnesses in the course of doing so.

Beyond the consideration of knowledge for its own sake, if we were to establish a theory of psychological disorders, i.e., a comprehensive, basic, and fairly simple account of what they are, doing so would likely have important

practical implications. Note that it was largely through theorisation that the field of psychology came to reject the idea that homosexuality is a mental illness. Roughly, the field realised that being statistically unusual is not sufficient for a mental trait to be considered an illness, and that homosexuality cannot be easily grouped with other traits uncontroversially classified as mental illnesses, in part because of the lack of harm to self or others.[1] Debates continue about whether, e.g., attention deficit and hyperactivity "disorders", certain kinds of Asperger's "syndrome", and dysphoria consequent to socio-political oppression count as mental illnesses (or at least at which point they do). A theory well grounded on comparatively uncontroversial instances of mental illness could help resolve these more controversial matters, thereby making important differences in how people understand themselves and are treated by others.

In this paper, I do not offer a theory of mental illnesses as such, but instead try to make headway on a notable sub-set of them, some of which are these days called "relational disorders" in the literature. As many readers will know, the latest version of the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) now includes a section devoted to some mental illnesses centred on how people are disposed to interact with others. Despite the "widespread consensus that the effects of relationships and relationship events are so central to every aspect of psychopathology and clinical practice that they must be included somewhere in the diagnostic system" (Beach *et al*. 2006: 3), it has been only recently that scholarship has begun to recognise certain disorders *qua* relational. Unlike the DSM-4, the DSM-5 does include a heading "Relational Problems", but it remains cautious about them, relegating them to a part of the book titled "Other Conditions that May Be a Focus of Clinical Attention" (American Psychiatric Association 2013: 715).

Key examples of what the DSM-5 labels "relational problems" are child neglect and spousal abuse. However, in this paper, I argue that a *much* wider array of mental illnesses can be fully understood only with a relational perspective. If we want a promising theory of mental illness, then we must go beyond the dominant western accounts of mental illness/health, which focus on features intrinsic to a person such as pain/pleasure, lethargy/liveliness, fragmentation/integration, and falsehood/authenticity. For example, I contend that extrinsic or relational properties are essential to explain adequately why it is apt to describe traits such as being psychopathic, narcissistic, histrionic, paranoid, and phobic in terms of "mental illness". Although I do not contend relationality is an *exhaustive* explanation of why these are disorders, I maintain that it is *essential*, i.e., that one would be missing something vital about these conditions and many others without appealing to it.

I also in this paper advance an attractive theory of the relational dimensions of psychological disorders. I maintain, specifically, that one is more mentally ill, the more one is psychologically unable to identify with others and exhibit solidarity with them, showing that this principle captures many intuitions about why and to what degree traits such as the above count as mental illnesses. Again, my claim is not that every mental illness is nothing over and above a failure to relate in these ways. Instead, I claim that many mental illnesses cannot be fully understood without referencing such a failure. A complete theory must (partially) include an explicitly relational dimension captured by a lack of identity and solidarity, or so I argue here.

In the following I start by recounting the dominant western theories of mental illness and mental health (section 2), highlighting the fact that they conceive of them strictly in terms of a person's intrinsic properties, after which I argue that these are insufficient to explain why many traits are intuitively mental illnesses (section 3). Then, I draw on ideas largely from the African philosophical tradition to articulate a relational account of many mental illnesses (section 4). Unlike psychologists and value theorists in the West, those whose work is informed by sub-Saharan cultures (and in some respect by cultures in the Global South more generally) tend to prize the good of cohesion or harmony, where I provide a specific interpretation of it as the combination of identifying with others and exhibiting solidarity with them. I argue that the psychological incapacity for identity and solidarity not only captures the relational facets of many psychological disorders well, but also provides a plausible way to rank some as worse than others (section 5). I conclude by acknowledging that the relational theory is insufficient on its own to capture everything about mental illness, suggesting that a combination of relationality and rationality is particularly promising when it comes to developing a complete account (section 6).

2. Western Theories of Mental Illness

For about 100 years, Euro-American psychologists, philosophers, and the like have posited theoretical accounts of what makes a mental condition count as sick and warrant treatment.[2] While obviously unable to address them all here, what I do is to recount several of the salient theories to show that they have shared an individualist or intrapersonal orientation, in which there is no essential mention of anyone but the person with the mental illness. It is only in the following section that I argue that such an individualist orientation is insufficient to make adequate sense of why an array of conditions intuitively count as mental illnesses.

Let us begin with Sigmund Freud, who in some of his texts maintains that the point of analysis is to make the unconscious conscious (1961a [1920]: 12, 1963 [1938]: 224). The suggestion is that mental illness consists of a patient's behaviour being influenced by mental states of hers that she does not know she has. Although the aim of becoming more aware of oneself *could* involve, say, achieving cognisance of previously unacknowledged feelings about another person, it need not. Therefore, Freud's account of what health and illness *essentially* are is individualist in that they make no essential reference to a relationship between the patient and another. Furthermore, even if becoming aware of oneself did essentially include becoming aware of past relationships with others, that is not the same as actually relating to others now, on which an interpersonal or relational theory of mental health/illness focuses.

1
Some might suggest that it was upon discovering the biological cause of much homosexuality that the field changed its mind, but that is implausible. There are quite likely some biological causes of psychopathy, autism, and even alcoholism, but that has not given the field pause at classifying them as mental illnesses.

2
I acknowledge that meriting treatment by a psychologist and suffering from a mental illness are logically distinct, but treat them as more or less equivalent for the sake of this paper (at least since the former is strong evidence of the latter).

In addition, note that while it could well be that substantial "ego expansion", replacing *Id* with *Ich*, tends to *bring in its wake* an improved ability to relate to others (as one would expect), the bare idea that the point of psychotherapy is ego expansion is intrapersonal. It does not say that its ultimate point *consists of* being able to relate to others in a certain way.[3]

Similar remarks go for Freud's other major suggestion, that the therapist's goal should be to relieve patients of suffering and to help them feel pleasure without contortion, disturbance, or other symptoms (1961b [1930]: 32–33, 48; for similar recent views, see Bader 1994: 261; Fink 2010). The capacity for pain or pleasure is constituted by properties intrinsic to a person, without anything essentially relational. Of course, often one can avoid pain and obtain pleasure only upon having interacted with others, whether mothers, therapists, or lovers, in certain ways. However, that is to posit relationality as a mere *means* to the end of certain affective states internal to a person, which are themselves considered instances of either mental illness or health. By an interpersonal account, certain undesirable ways of relating with others are to be avoided for their own sake as illnesses, while certain desirable ways of relating are to be pursued as mentally healthy ends.

The same kind of individualism is characteristic of the array of psychoanalytic, psychodynamic, humanist, and self-oriented theories that were so prominent in the post-war era. Invariably the conditions advanced as the suitable aims of psychotherapy were intrapersonal, making essential reference only to the patient, and not necessarily mentioning anything about improving relationships with others as ends – even if certain kinds of engagements with a therapist were considered reliable means towards them. Consider the various familiar suggestions that the point of therapy and related psychological interventions is to enable a patient:[4]

- to become more open to experience and able to apprehend reality accurately (Rogers 1961 [1957]; Becker 1971: 148–153; Miller 1981 [1979]), with illness being the inability to do so;
- to be more spontaneous, independent, free, or autonomous (Rogers 1961 [1957]; Becker 1971: 153–154; Szasz 1983: 19–54), where illness involves being slavish, say, in respect of one's emotions;
- to become unique or creative (Jung 1956 [1953]: 153–154; Storr 1992 [1960]: esp. 156–160; Kohut 1984: 44), with sickness consisting of being unable to do so;
- to feel alive or experience vigour (Winnicott 1978 [1955], 1965 [1960]; Kohut and Wolf 1990 [1978]; Miller 1981 [1979]), where sickness is a matter of lethargy or enervation;
- to develop a true or strong self (Winnicott 1978 [1955], 1965 [1960]; Kohut and Wolf 1990 [1978]; Miller 1981 [1979]; Masterson 1990; Hansell 2008: 1181), in contrast to the illness of exhibiting a false or weak self;
- to regain lost parts of the self or becoming whole (Guntrip 1971: 170; Steiner 1996: 1074–1078), where sickness consists of fragmented states of mind;
- to cope with anxiety or stressors in one's environment and to be able to rely on oneself (Rogers 1961 [1957]; Bowlby 1994 [1979]; Masterson 1990; Hansell 2008: 1181), where illness amounts to being unable to do so;

- to overcome "dysfunctions that harm the person" in the sense that they "disrupt a natural function" or "involve a breakdown in the functioning of an internal mechanism" (Wakefield 1992: 375, 376), where disorder is such a dysfunction; and
- to realise oneself, which consists of "discerning one's unique talents [...] and then working to bring them to reality" or of "purposeful engagement in life, realisation of personal talents and capacities, and enlightened self-knowledge" (Ryff 2014), with mental illness being a failure to know oneself or to develop one's particular abilities.

Of course, some of these ends *could* include relating with others in certain ways, but the point is that none of them *essentially* includes that.

Note that it would be a mistake to think that object-relations theorists count as providing "interpersonal" or "relational" theories in my sense. Sometimes they have been interpreted that way (e.g., Storr 1988: xiv, 5–7, 151; Gomez 1997: 212–222), but I suspect that such commentators are misreading object-relations theorists, in that they are failing to differentiate the claim that certain relationships are a necessary *means* to mental health, which an intrapersonal theorist can readily accept, from the claim that mental health *is* to be capable of certain relationships, which an intrapersonal theorist must reject by definition. For example, the classic object-relations theorist W. R. D. Fairbairn's characterisation of the point of psychoanalytic treatment clearly counts as "intrapersonal" or "intrinsic" in my terms, when he says that its primary aim is "to promote a maximum 'synthesis' of the structures into which the original ego has been split" (1958: 380). No reference to anyone but the patient, there. Similar remarks apply to characteristic attachment theorists such as John Bowlby, for whom the end is "well-found self-reliance" (1994 [1979]: 114, 125, 136) and attachment the means.

Once one firmly grasps the difference between the question of what the ultimate point of therapy should be and the question of how to achieve it, one sees that one can hold what I call an "intrapersonal" theory of the former, as, say, psychic integration, while holding that certain supportive relationships are a necessary means by which to realise it. Conversely, it is clear that an "interpersonal" theorist can in principle accept the notion that self-analysis is a suitable means by which to realise the final end of mental health *qua* relationality of some kind.

I do not mean to suggest that the western tradition is *utterly* devoid of relational suggestions. In fact, Wakefield's influential theory, mentioned above, was at one point reinterpreted to allow for a certain, narrow class of relational considerations (Wakefield 2006). In addition, going back some years, one sees some Jewish socialist thinkers suggesting that mental health consists of

3
Some might consider it odd to characterize self-knowledge as a final aim, since psychoanalysts often deem insight rather to be the most they can achieve in a clinical setting, without considering it to constitute mental wellness as such. However, there are certainly texts that suggest otherwise, and there is a large body of literature arguing that insight *per se* should not be considered a final aim of psychotherapy (e.g., Fink 2010).

4
See, too, most of the aims discussed in a historical overview of how psychoanalysts have conceived of the point of therapy in Sandler and Dreher (1996).

the ability to love (Fromm 1989 [1956]: esp. 16–17)[5] or that "the sicknesses of the soul are sicknesses of relationship" (Buber 1967: 150). My claim is that such relational accounts have not been *salient* for the past century of Euro-American reflection on the nature of mental health/illness, whereas the relational account I advance below is a promising correction.[6]

3. Disadvantages of Western Theories

Why should one think that the intrinsic accounts need correction? While I readily accept that some mental illnesses do have an intrapersonal dimension (cf. section 6), I believe that a number of them also or instead have an interpersonal one that intrinsic properties cannot easily capture.

To start off, consider that relationality indeed appears essential to accounting for the illness involved in neglectful or abusive behaviour of the kinds the DSM-5 describes as "relational problems" (cf. section 1). Appealing merely to properties of individual persons, such as failing to apprehend reality or exhibiting a weak self, fails to capture the illness of mistreating others.

Interlocutors will be tempted to say that such behaviour is merely a symptom of the illness and not the illness itself. I accept that this position is not implausible. However, the alternative view that the disposition towards such behaviour merits treatment is no less plausible and is arguably more so. Consider the fact that if some intrinsic feature did not tend to cause a patient to mistreat others, there would be substantially fewer grounds for therapeutic or related intervention. If so, then it is likely that part of what makes something an illness is relational.

In addition, consider the following traits that the DSM-5 does not label "relational problems" but that are in fact sensibly described that way:

- phobic, e.g., social (fear of being humiliated), or agora (fear of being in public);
- inattentive, e.g., having poor listening skills or a tendency to interrupt;
- schizoid/avoidant, e.g., loners, doll-lovers, those who isolate themselves because of, say, fear of intimacy or rejection;
- intermittently explosive, being prone to disproportionately hostile outbursts towards others;
- histrionic, constantly seeking attention or being overly dramatic;
- borderline, seeing others as all-good or all-bad, being impulsive, having a tendency to feel betrayed/abandoned;
- psychopathic/antisocial, being unable to sympathise with others, being inclined to manipulate them;
- narcissistic, treating others merely as a means to one's sense of self-worth; and
- paranoid, experiencing delusions that others have malevolent intentions with respect to oneself.

The natural thing to say about people with these problems is: "They can't relate!". All of the conditions are straightforwardly described as involving a defect in how the patient interacts with other persons that merits psychological intervention.

Appealing to properties intrinsic to the patient to explain why these traits are forms of mental illness is indirect and implausible. For example, the reason

why those who are histrionic merit treatment is that they are, well, histrionic. There are surely intrinsic properties that cause or explain why the person is histrionic, but it is reasonable to suggest that the person merits treatment from psychologists and related practitioners in virtue of the failure of relationship.

4. A Relational Theory of Mental Illness

In the previous sections, I noted that the dominant western theories of what makes a trait one of mental illness or health have been intrinsic and argued that they, on the face of it, poorly explain why a number of intuitive mental illnesses count as such. Relational considerations seem essential to accounting fully for certain sicknesses. In this section, I appeal to ideas from the Global South, especially the African intellectual tradition, to articulate a certain way of relating that, I argue, does a better job than the purely intrinsic approaches. Instead of mental health being constituted merely by properties internal to the patient, as per much of the western tradition, I contend that it also needs to be understood in terms of harmony and related values.

As two theorists have pointed out, harmony is the "mother of all values" for most peoples beyond the West or Global North (Bell and Mo 2014), where a "harmony framework has to do with balancing, [...] aligning and smoothing" (Anedo 2012: 16). These interactive concepts, which are markedly different from characteristically western and individualist ones of autonomy, authenticity, creativity, pleasure, and liveliness, are salient in many indigenous societies in Latin America (e.g., Agostino and Dübgen 2012; Gudynas quoted in Balch 2013), East Asia (e.g., Wei and Li 2013; Li 2015), and Africa (e.g. Metz 2017).

In the following, I draw principally on the way harmony, and similar values such as communality and cohesion, have been understood by southern African adherents to *ubuntu*, the Nguni word for humanness that is often used to capture the nature of a good life. However, I interpret the *ubuntu* tradition in a way that would be of particular interest to those beyond it, particularly (but not solely) to others in the Global South. For example, whereas many indigenous sub-Saharans would prescribe harmonising with ancestors, those whose bodies have died but who continue to live in an imperceptible realm on earth, I downplay contested metaphysical claims in what follows. I focus on the value system centred on harmony and consider its implications for the mental health of human persons.

There is a maxim that southern Africans often invoke to sum up salient sub-Saharan values:

"A person is a person through other persons." (e.g., Tutu 1999: 35; Mkhize 2008: 40; Dandala 2009: 160)

Although those familiar with African cultures tend to associate certain ideas with this phrase, in plain English, it means little to someone outside the fold.

5
The claim that mental health consists of the ability to love and work is often attributed to Freud, apparently first by Erik Erikson, but it does not explicitly appear in Freud's written works (on which see Elms 2001).

6
I do not attempt to show systematically that my relational theory is an improvement over others that have been suggested; it is advanced as attractive in its own right, meriting being weighed up against, say, Wakefield's (2006) revised account in future work.

Since this paper is pitched to an English-speaking audience that transcends those who know Africa, in this section, I articulate a conception of the good life based on this maxim the meaning of which can be readily grasped, and also appreciated, by those from a variety of backgrounds. Therefore, I am not seeking to accurately *reflect* the way that a particular indigenous African people (or group of them) has understood the above maxim about values. Instead, I draw on how a variety of southern societies and particularly thinkers informed by them have understood it to *construct* a principle that can plausibly capture the nature of mental health and illness.

To begin, when southern Africans say that "a person is a person" they are not expressing a tautology. Instead, what they mean usually includes the idea that someone who is a person, in the sense of a self-aware, deliberative agent, ought to strive to become a *real* or *genuine* person, that is, someone who has exhibited virtue (e.g., Mokgoro 1998: 17; Gaie 2007: 33). Someone with substantial personhood has *ubuntu* (humanness). A true or complete person lives a genuinely human way of life, displays desirable traits that human beings are in a position to exhibit in a way nothing else in the animal, vegetable, or mineral kingdoms can.

Just as one might say that a jalopy is "not a *real* car" (Gaie 2007: 33), so southern Africans often say of those who lack *ubuntu* that they "are not a person" (Gaie 2007: 32; Dandala 2009: 260–261) or that they are even "animals" (Pearce 1990: 147; Bhengu 1996: 27; Letseka 2000: 186). That does not mean that the wicked are literally not human beings, viz., no longer deserving of moral treatment such as observing their human rights, but instead connotes the metaphorical point that these individuals utterly fail to exhibit human excellence and have instead actualised their lower, base nature (Gyekye 2010).

So far, southern African ethics is sounding *eudaemonist*, instructing an individual to realise herself or at least the valuable aspects of herself. However, what makes the view distinct from Greek or otherwise western eudaemonism is the characteristically African understanding of what that essentially involves. The second clause tells people how to become real persons and exhibit *ubuntu*, namely, "through other persons". Typically this means by entering into community with others or seeking to live harmoniously with them. It is well known that African ethics is characteristically communitarian. Still, this element is often left vague or is construed crudely, as the collective taking precedence over the individual. As should become clear below, a sub-Saharan value system can really be put to work as an account of how to live well and be attractive for giving due weight to individual interests, once one is clear about what it means to enter into community or to live harmoniously.

To spell out what relating communally or harmoniously plausibly involves, I start from representative comments from southern Africans about it:

- Yvonne Mokgoro, a former South African Constitutional Court Justice, says of an *ubuntu* ethic that "harmony is achieved through close and sympathetic social relations within the group" (1998: 17).
- Desmond Tutu, renowned former chair of South Africa's Truth and Reconciliation Commission, remarks of indigenous Africans: "We say, 'a person is a person through other people'. It is not 'I think therefore I am'. It says rather: 'I am human because I belong.' I participate, I share [...]. Harmony, friendliness, community are great goods. Social harmony is for us the *summum bonum* – the greatest good." (1999: 35)

- Gessler Muxe Nkondo, who has had positions of leadership on South Africa's National Heritage Council, says that "*ubuntu* advocates [...] express commitment to the good of the community in which their identities were formed, and a need to experience their lives as bound up in that of their community" (2007: 91).
- Nhlanhla Mkhize, an academic psychologist who has applied *ubuntu* to conceptions of the self, remarks that "personhood is defined in relation to the community [...]. A sense of community exists if people are mutually responsive to one another's needs [...]. [O]ne attains the complements associated with full or mature selfhood through participation in a community of similarly constituted selves [...]. To be is to belong and to participate" (2008: 39, 40)
- Mluleki Mnyaka and Mokgethi Motlhabi, two theologians based in South Africa, say this of *ubuntu*: "Individuals consider themselves integral parts of the whole community. A person is socialised to think of himself, or herself, as inextricably bound to others [...]. *Ubuntu* ethics can be termed anti-egoistic as it discourages people from seeking their own good without regard for, or to the detriment of, others and the community." (2009: 69, 71–72)

These construals about what it is to commune or live harmoniously with others suggest two recurrent themes (initially distinguished and analysed in Metz 2007). On the one hand, there is what I call "identity", a matter of being close, participating, experiencing life as bound up with others, belonging, and considering oneself integral to the group. On the other hand, one finds reference to being sympathetic, sharing, being committed to others, responding to others' needs, and acting for others' good, which I label "solidarity".

More carefully, it is revealing to understand identifying with another (or being close, belonging, etc.) to be the combination of exhibiting certain psychological attitudes of "we-ness" and cooperative behaviour. The psychological attitudes include a tendency to think of oneself in relation to the other and to refer to oneself as a "we" (rather than an "I"), a disposition to feel pride or shame in what the other or one's relation does, and, at a higher level of intensity, an emotional appreciation of the other's nature and value. The cooperative behaviours include being transparent about the terms of interaction, allowing others to make voluntary choices, acting based on trust, adopting common goals, and, at the extreme end, choosing for the reason that "this is who we are".

Exhibiting solidarity with another (or acting for others' good, etc.) is similarly construed as the combination of exhibiting certain psychological attitudes and engaging in helpful behaviour. Here, the attitudes are ones positively oriented toward the other's good, centrally understood as meeting their needs, and include an empathetic awareness of the other's condition and a sympathetic emotional reaction to this awareness. And the actions are not merely those likely to be beneficial, that is, to be objectively good for the other person, but also are ones done consequent to certain motives, say, for the sake of making the other better off or even a better person.

These specifications of what it is to commune or harmonise with others can ground a fairly rich, attractive, and useable African conception of the good life. Bringing things together, here are some concrete and revealing interpretations of "a person is a person through other persons": one should become a real person, which is a matter of identifying with others and exhibiting sol-

idarity with them; or an agent ought to live a genuinely human way of life (exhibit *ubuntu*), which she can do if and only if she honours relationships of sharing a way of life with others and caring for their quality of life.

I advance this interpretation on the grounds that it makes sense of intuitively attractive ways of life. For a key example, consider that the desirable form of a family consists of relationships in which people identify with and exhibit solidarity towards each other, as above. Roughly speaking, nearly all readers would like family members to enjoy a sense of togetherness with each other, participate with one another on trustworthy and evenhanded terms, strive to help one another, and do so for one another's sake. These forms of interaction are also characteristic of friendships, or, even more broadly, friendliness (cf. Aristotle), as well as of desirable relationships between members of an academic department, a choir, and a sportsteam. It is plausible to suggest that the more people sustain and enrich such ways of relating, the better people they are, or at least the better their lives.

Conversely, those who have difficulty relating in the above ways are missing something, and, when it is by virtue of their state of mind, it is plausibly mental health that they are lacking. Consider those discordant individuals whom Africans would describe as "not persons" or as "animals"; they are people who are not disposed to identify with others or exhibit solidarity with them. That is, they are at a minimum alienated from others and indifferent towards their good, or, worse, they are divisive and full of ill will. They are roughly those who: instead of thinking of themselves as part of a "we" with other people, tend to think in terms of "me versus you"; instead of coordinating with other people, seek to subordinate them; instead of doing what is likely to help others, harm them, perhaps recklessly or negligently; and instead of sympathising with others and acting for their sake, lack compassion and are selfish. Surely the reader does not think that such people would be ideal spouses, parents, or co-workers. Such unharmonious individuals exhibit undesirable traits, and, as I argue in the next section, mental illnesses.

5. Advantages of the Relational Theory

Here I return to the counterexamples I posed to the characteristically western theories of the nature of mental health/illness. Recall that I maintained that quite a number of intuitive mental illnesses have an irreducible relational dimension to them, one that is implausibly explained in terms of intrinsic features such as a lack of autonomy, authenticity, creativity, pleasure, or liveliness. I now argue that one can do better upon conceiving mental illness in terms of lacking the disposition to harmonise with others and tending towards discordance, as construed above.

I analysed harmony in terms of two distinct ways of relating, namely, identifying with others and exhibiting solidarity towards them, where I suggested that a person is not as much of a person as he could and should be, insofar as his mind renders him unable to relate in those two ways. Below I contend that some mental illnesses involve a notable inability to relate in one of these ways, while others involve a comparable inability to relate in both ways.

Consider, first, those conditions in which a patient is reasonably described as having a mental illness substantially in virtue of having difficulty identifying with others:

- phobic, e.g., social (fear of being humiliated), or agora (fear of being in public);
- inattentive, e.g., having poor listening skills or a tendency to interrupt;
- schizoid/avoidant, e.g., loners, doll-lovers, those who isolate themselves because of, say, fear of intimacy or rejection; and
- intermittently explosive, being prone to disproportionately hostile outbursts towards others.

Of course, those who suffer from these traits are somewhat less inclined to help others because of them; unjustified expressions of rage are hardly good for those who are the object of it, while avoiding others – even if wanting to engage with them (as per the phobic) – means being in a poor position to help them. So, some solidarity is admittedly lacking. However, what stands out about the above four conditions is that they involve psychological and behavioural distance from people, i.e., a failure to forge an identity with others. For all four, those who have them have real difficulty cultivating a sense of togetherness, let alone participating with others based on trust and voluntariness.

Next, think about those conditions in which a patient is reasonably described as having a mental illness substantially in virtue of having difficulty exhibiting solidarity with others:

- histrionic, constantly seeking attention or being overly dramatic; and
- borderline, seeing others as all-good or all-bad, being impulsive, having a tendency to feel betrayed/abandoned.

Admittedly, those who suffer from these traits are somewhat less able to engage in cooperative projects, at least ones that last, but what is salient about them is the patients' focus on their own needs to the detriment of the needs of those around them. Patients with these conditions characteristically fail to sympathise with others and instead do what they at some level expect will make themselves feel better, even when that is not good for others. Often, the inability to feel good enough and to know that others believe one is good enough leads to excessive self-concern and hence a reduced inclination to care for others. Recall I am glad to accept that traits such as a lack of self-esteem count as forms of mental illness; my point is that when they lead to giving undue weight to one's interests at the expense of others, there is an additional problem that merits intervention.

Finally, consider the remaining conditions, in which a patient is reasonably described as having a mental illness substantially in virtue of having comparable degrees of difficulty both identifying with others and exhibiting solidarity with them:

- psychopathic/antisocial, being unable to sympathise with others, being inclined to manipulate them;
- narcissistic, treating others merely as a means to one's sense of self-worth; and
- paranoid, experiencing delusions that others have malevolent intentions with respect to oneself.

Patients with these traits and those like them are easily able neither to share a way of life with others nor to care for their quality of life. They are saliently discordant along both dimensions. Of course, we could add here the DSM-5 "relational problems" of child neglect and spousal abuse.

Besides providing a prima facie attractive account of why various traits warrant psychological intervention, the relational appeal to harmony also plausibly entails that some mental illnesses are worse than others. To start, notice that those who have difficulty identifying with others and exhibiting solidarity with them are worse off than those who cannot relate in just one of these ways. I submit that those who are moderately psychopathic, paranoid, or abusive are intuitively more in need of treatment than those who are, say, moderately avoidant or histrionic.

However, while severe impairments to both ways of relating harmoniously are worse than a severe impairment to only one, it could be that a severe impairment to one is worse than minor to moderate impairments to both. For example, consider a patient who has difficulty with both identity and solidarity but not to a substantial degree, say, someone who is mildly inattentive, compared to a patient who has substantial difficulty with identity but not with solidarity, perhaps one who is phobic. The latter is in greater need of help than the former.

A further distinction concerns the extent to which a given way of harmonising can be impaired. On the one hand, identity or solidarity could be relatively absent and their opposites, of division and ill will, could be substantially present. Here, the psychopath or antisocial individual looms large, where there is often manipulation of others and injury caused to them. On the other hand, identity or solidarity could be absent without the presence of their opposites. Roughly, an individual might fail to coordinate with others and not subordinate them, and he might further fail to help others and not harm them. A good example is someone who is a loner to such a degree that they simply do not engage with others at all, neither positively nor negatively. Those alienated from and indifferent towards others merit treatment, but not as much as those who are actively discordant.

The fact that the relational theory grounds an intuitive approach to ranking the severity of mental illnesses or the need for treatment is further evidence in its favour. Before closing, consider some additional implications of the appeal to *ubuntu* regarding how to conduct psychotherapy or otherwise undertake a psychological intervention. Supposing that at least one major aim of a therapist should be to help their patients to become real people or exhibit humanness, where that means being capable of harmonious relationships with other persons, we might be led to reconceive therapy in certain ways.

For one, such an approach means that a therapist should not be concerned only with a patient's *happiness*, but also her *excellence*. One should strive to help a patient become a person who is not merely *better off*, but also a *better person*. Such is the implication of a broad *eudaemonist* approach, which prescribes tempering the inclination of a therapist invariably to do what is good for a patient in the light of a concern to facilitate her becoming a good person.

For another, if the relational understanding of what (at least largely) constitutes the human good is true, then a therapist should be concerned not solely with a patient's orientation towards himself, but also with his relationships and for their own sake in a certain sense. Being able to relate harmoniously with the therapist or with others in a patient's life should be considered not merely a *means* towards mental health, but also (at least partly) constitutive of it as an *end*. Where a patient becomes better able to listen and to set aside their own needs for those of others, that is where (some of) the personal growth is, even if one can expect it to have further desirable ramifications for a patient's life.

6. Conclusion: Integrating Relationality and Rationality

Recall that I have not been suggesting that all mental illnesses have a relational dimension or even that a given mental illness can be exhaustively understood in relational terms. My claim has been the more moderate one that a complete understanding of the nature of mental illness is implausible without relationality. In particular, my claim is that the inability to identify with others or exhibit solidarity with them is essential to mental illness without being exhaustive. I briefly conclude by suggesting some ways forward in search of a comprehensive theory, if the analysis in this paper is approximately true.

I have addressed eleven traits that are uncontroversial instances of mental illness, and advanced a principle, informed by characteristically African notions of harmonious relationship, meant to explain in virtue of what they count. It is worth considering whether the list can plausibly be extended. My strong suspicion is that a lack of identity and solidarity also accounts to some real degree for respects in which the following merit treatment: addiction; alcoholism; stuttering; Tourette's; autism; Asperger's; oppositional defiant disorder; and sexual problems. People with these problems also have difficulty relating in harmonious ways with others.

However, there are, to be sure, some conditions meriting treatment that are not relational in a salient way. Depression, dementia, eating disorders, and body dysmorphia seem primarily to be mental illnesses in virtue of how the patient is affected, apart from her interaction with others. It is, of course, the case that these conditions can affect a person's relationships, e.g., if one is depressed, one is unlikely to do much with or for others, while body dysmorphia can inhibit one from participating with them. The current point is that these relational considerations hardly exhaust the nature of these problems and do not even capture much of them.

This point begs the question of which intrinsic feature is most promising as essential to mental health/illness. My hunch is that the category of intelligent deliberation and action is more comprehensive than long-standing appeals to a strong self, liveliness, creativity, or the like (see Metz 2013: 413–415), so that it is the combination of relationality and rationality that is necessary and sufficient. However, that case would require quite a sustained discussion elsewhere, as would the possibility that a firmer distinction must be drawn between what is a mental illness or even what would be good for a patient, on the one hand, and what merits treatment, on the other (Wakefield 1988; Metz 2016; Bortolotti 2020).[7]

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Thaddeus Metz

Relacijska teorija mentalnog zdravlja – manjkanje identifikacije ili solidarnosti s drugima

Sažetak

U radu težim napredovati do filozofijskog cilja utvrđivanja što, ako išta, sve mentalne bolesti imaju zajedničko, pri čemu pokušavam objediniti velik podskup onih s relacijskom ili interpersonalnom dimenzijom. Jedna je glavna tvrdnja ta da, želimo li obećavajuću teoriju mentalne bolesti, moramo ići onkraj dominantnog zapadnog pogleda na mentalnu bolest / mentalno zdravlje koje se usmjerava na karakteristike intrinzične za osobu, kao što su bol / užitak, letargija / životnost, fragmentacija / integracija i lažnost / autentičnost. Druga je glavna tvrdnja ta da su relacijski aspekti mentalne bolesti teorijski plauzibilno razumljivi u smislu nemogućnosti osobe da se identificira s drugima ili pokazuje s njima suosjećanje, što su istaknute relacijske vrijednosti u afričkoj filozofijskoj tradiciji. Pokazujem da ova dva ekstrinzična svojstva dobro objašnjavaju nekoliko intuitivnih oblika mentalnih bolesti, uključujući, među ostalim, bivanje nasilnim, psihopatskim, narcističkim, teatralnim, paranoidnim i fobičnim.

Ključne riječi

intrinzično, ekstrinzično, mentalno zdravlje, mentalna bolest, neuroza, filozofija psihologije, relacijski poremećaji, relacijske vrijednosti

Thaddeus Metz

Relationale Theorie der mentalen Gesundheit – mangelnde Identifikation oder Solidarität mit Anderen

Zusammenfassung

In meiner Arbeit trachte ich danach, zum philosophischen Ziel der Feststellung fortzuschreiten, was, wenn überhaupt, alle mentalen Erkrankungen gemeinsam haben, wobei ich versuche, eine große Untergruppe jener mit einer relationalen oder interpersonellen Dimension zusammenzubringen. Die eine Hauptbehauptung lautet, dass wir, wenn wir eine verheißungsvolle Theorie der mentalen Krankheit ausbauen wollen, jenseits der vorherrschenden westlichen Sichtweise der mentalen Krankheit / mentalen Gesundheit gehen müssen, welche sich auf die dem Menschen intrinsische Merkmale fokussiert, wie Schmerz / Vergnügen, Lethargie / Lebensfülle, Fragmentation / Integration sowie Unechtheit / Authentizität. Die andere Hauptbehauptung ist, dass relationale Aspekte von mentalen Erkrankungen theoretisch plausibel begreiflich sind, im Sinne vom Unvermögen einer Person, sich mit Anderen zu identifizieren oder Mitgefühl für sie zu zeigen, was herausragende relationale Werte in der afrikanischen philosophischen Tradition darstellt. Ich zeige auf, dass diese beiden extrinsischen Eigenschaften etliche intuitive Formen von mentalen Erkrankungen treffend erklären, darunter unter anderem gewalttätige, psychopathische, narzisstische, theatralische, paranoide und phobische Zustände.

Schlüsselwörter

intrinsisch, extrinsisch, mentale Gesundheit, mentale Krankheit, Neurose, Philosophie der Psychologie, relationale Störungen, relationale Werte

Thaddeus Metz

La théorie relationnelle de la santé mentale – un défaut d'identification ou de solidarité avec les autres

Résumé

Dans ce travail je m'applique à établir, jusqu'à atteindre l'objectif philosophique, tout ce qu'ont les maladies mentales en commun, si quelque chose en commun ont-elles, par quoi je tente d'unifier un grand nombre de sous-ensembles avec une dimension relationnelle ou interpersonnelle. L'une des principales affirmations est d'établir que, si l'on souhaite une théorie prometteuse des maladies mentales, on doit aller au-delà du regard que l'Occident pose sur les maladies mentales / la santé mentale, et qui se concentre sur les caractéristiques intrinsèques de la personne, à savoir la douleur / le plaisir, la léthargie / la vitalité, la fragmentation / l'intégration et la simulation / l'authenticité. L'autre affirmation principale est celle qui consiste à démontrer que les aspects relationnels de la maladie mentale sont théoriquement plausibles et compréhensibles dans le sens d'une impossibilité de la personne à s'identifier avec les autres ou à leur montrer de l'empathie, qui sont les valeurs relationnelles mises en avant dans la tradition africaine philosophique. Je montre que ces deux propriétés extrinsèques expliquent de manière exhaustive un grand nombre de formes intuitives des maladies mentales, y compris, et entre autres, le fait d'être violent, psychopathe, narcissique, théâtral, paranoïaque et phobique.

Mots-clés

intrinsèque, extrinsèque, santé mentale, maladie mentale, névrose, philosophie de la psychologie, troubles relationnelles, valeurs relationnelles