MORAL MOODS

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ABSTRACT

In this dissertation, I argue that moods can be intentional states, that is, they can be *about* something. I make this case by exploring the moods that underlie two psychopathological diagnoses: depression and borderline personality disorder (BPD). The view that moods can be intentional is counter to dominant positions in both philosophy and medicine.

This project has three elements. First, I critically examine current medical approaches to depression and BPD. I distinguish two dominant models of medical practice and argue that many medical practitioners within both models (implicitly) deny the potential intentionality of moods. This results in a widespread medical mischaracterisation of depression and BPD.

Second, I argue that the intentional features of those moods that underlie depression and BPD can be appreciated when one assumes the role first of 'affective reconstructor' and then of 'affective interlocutor.' Affective reconstructors explore the origins of someone's mood with the aim of identifying its intentional object(s). If an intentional object is found, one can assume the role of affective interlocutor. In that role one actively engages with the mood experiencer, carefully considering whether those intentional object(s) fit appropriately with the mood.

Third, once the moods that underlie depression and BPD are seen as potentially intentional, I argue that they may be 'moral moods.' I use case studies of sufferers of depression and BPD, particularly the character of Sophie (from William Styron's novel *Sophie's Choice*) and Lilah, a composite of several patients diagnosed with BPD. I argue

that their moods are responses to moral violation. Non-intentional accounts of moods, either philosophical or medical, will fail to acknowledge the moral dimension of these moods. I argue that this is a substantial failure, both for Sophie and Lilah and also for those around them, who will miss the opportunity to fully understand their experiences.

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CHAPTER I
MOODS AS INTENTIONAL STATES

In this dissertation, I will be offering a partial analysis of mood. Within the philosophical literature there has been very little discussion of moods. Among those who have taken a position, however, the dominant position is that moods are non-intentional mental states. I will be arguing against this view. On my view, moods can be intentional, at least sometimes. In addition to their potential intentionality, moods are also a very complex phenomenon, with many different facets and variable manifestations. As a result of this complexity, I will not attempt to provide a complete account of moods. I will argue, however, that recognition of the potential intentionality of moods has several benefits. Significantly, it allows us to appreciate the moral place that moods can occupy in our lives.

1. Introduction

There are many proposals as to which affective phenomena should count as moods. Here are some suggestions: depression (gloominess), irritation (grumpiness), anxiety, cheerfulness, boredom, buoyancy, peacefulness, satisfaction, stressfulness, charmed, listless, contentment, agitation, euphoria, loneliness, reflectiveness, pensiveness, and uneasiness.[1] There is very little consensus about which of these should be included. The first two, however – depression and irritation – are almost always accepted as paradigmatic examples of moods. I

[1] This list recalls Paul Griffiths observation about emotions. He notes that any effort to list emotions results in an extraordinarily heterogeneous set of examples. He argues that there is no single identifiable psychological state captured by the folk psychological category, 'emotion.' (Griffiths 1997.)

will be focusing on these, particularly as they relate to the psychopathological diagnostic categories, depression and borderline personality disorder. I will be presenting case studies of these two diagnoses, and I will argue that both of these cases can be significantly characterised in terms of moods. I will further argue that current dominant understandings of these psychopathologies – both medical and philosophical – do not fully capture these phenomena.

Why might an examination of mood be philosophically interesting? To begin, there has been a large amount of recent philosophical interest in the emotions. But despite the many similarities between moods and emotions, relatively little attention has been paid to moods. A search of the Philosopher's Index, for example, shows 1745 matches for "emotions" as a subject, but only 32 for "moods."[2] Within psychology and psychiatry, emotions and moods are often simply conflated, with fear treated as interchangeable with anxiety or sadness interchangeable with depression. One possible reason for this confusion and relative silence with respect to moods may be because they are, in some respects, phenomenally more difficult to characterise than emotions. Despite this challenge, however, I think moods are worth exploring because they significantly affect our lives. In some respects, these effects are similar to the effects that emotions can have, but there are significant differences as well.

An additional question about my dissertation might arise about my use of cases of psychopathological diagnoses to illuminate moods, which are not in themselves seen as pathological. One reason for using psychopathological cases is that this is where the preponderance of empirical work on mood has been focused. Further, I will argue that one of the results of my account of moods (that they are sometimes intentional states) is that

[2] Search conducted on May 1, 2006. The search for "moods" as subject excluded the discussion of moods related to logic and the philosophy of language.

depression and BPD often should not be understood as pathologies that are different in kind from typical mood experiences. In fact, both depression and BPD can be seen as intentional and intelligible responses to life experiences, at least sometimes. Many diagnosed cases of depression and BPD are not well-characterised as pathological at all (at least under certain definitions of pathological). Instead, they are species of normal responses to particular (traumatic) environments.

In this chapter, I will discuss current philosophical accounts of mood. As I mentioned, although there has been relatively little philosophical exploration of mood, what exists has been strongly dominated by non-intentional accounts. This is the position that I will be arguing against. In section 2, I will explore some of the challenges that arise when characterising the intentionality of moods. In section 3, I will present some of the other features of moods that need to be kept in mind when developing an account of moods. Then, in section 4, I will discuss some intentional accounts of moods and I will explain why their analyses are inadequate. In section 5, I will focus on the work of some philosophers who have offered non-intentional theories of mood. I will argue that these theories do not adequately capture several of the significant features of moods. Finally, in section 6, I will offer a brief summary of my own view, although the full case for that position will be made only over the following chapters. In those chapters, I will show how non-intentional accounts of moods (both philosophical and medical) affect our understanding of depression and borderline personality disorder. I will argue that in both cases, the non-intentional account is mistaken. I will use these case studies to argue that moods can at least sometimes be intentional states. Further, I will argue that in virtue of their intentionality, some cases of depression and BPD can also be either intelligible or moral or both.

2. Moods and intentionality

There is a general presumption among many philosophers that the way to make the distinction between emotions and moods is that emotions are intentional, moods are not. Although there have been many philosophers of late who have enthusiastically endorsed strongly cognitive and intentional accounts of the emotions, there is very little philosophical support for a cognitive and intentional account of moods (despite the many similarities between emotions and moods). Martha Nussbaum, for example, a strong proponent of cognitive accounts of the emotions, makes comments like the following: "Philosophers, psychologists, and anthropologists generally agree that [paradigm emotions] are distinct, in important respects, from bodily appetites such as hunger and thirst, and also from objectless moods…."[3]

In many cases, this claim is considered so self-evident that it is not accompanied by an argument. It is taken as given.[4] For this to be legitimate, one would assume that the view had widespread support. But quick reflection of our folk psychology shows that this is not the case. In our folk psychology, moods are clearly understood as at least sometimes intentional. When someone says, "I feel grumpy today" we will typically ask why. Sometimes the response will be a non-intentional explanation: "I slept poorly"; "I skipped breakfast." But in other instances, the response will be intentional: "I had a fight with my husband"; "My boss criticized me unjustly." Here, the responder cites her experience with her spouse or boss not merely as having caused her mood, but serving as a kind of justification for her mood. The normative underpinning provided by such responses is a

[3] Kahan and Nussbaum March 1996.

[4] See, for example, Carroll 2003.

hallmark of intentionality. Because we sometimes take ourselves to be able to justify our moods, we must be considering moods to have intentional content. In our folk psychology, moods can sometimes be *about* something. Thus, it seems to me that persons offering a non-intentional account of mood face a burden of explaining why our folk psychological account is so misguided. This is a not a burden that I have seen philosophers who discuss mood typically acknowledge.[5]

Eric Lormand offers one of the only non-intentional accounts of moods that argues for the non-intentional position.[6] He describes three features of moods that he thinks set moods apart from emotions. These three features lead him to postulate three conditions that he thinks any account of moods has to meet. He then considers four intentional theories of moods and argues that none of them meet these conditions. Ultimately, I will argue that Lormand is mistaken – notably, of course, because he fails to consider *my* intentional account of moods. But I happen to agree in many respects with the observations Lormand makes about moods.

Lormand's first condition is linked to the intentionality of moods, and I will now discuss it at some length. Lormand observes that moods do not seem to manifest intentionality in the same way that emotions do. On his view, one is not euphoric *about* some thing in the same way that one is angry *about* some thing. This produces Lormand's first condition: the

[5] If I am able to establish that depression and irritability are sometimes intentional, my opponents might simply argue that all my success shows is that depression and irritability are sometimes not moods. I think the burden will be on my opponents to explain why depression and irritability should be ejected from the mood pantheon. Of course, I face a burden of explaining how the distinction between moods and emotions ought to be made, if at all, if not through non/intentionality.

[6] Lormand 1985. Claire Armon-Jones offers another. I will discuss her central objection to designating moods as intentional states in section 4.

"Intentionality Condition." According to Lormand, an account of moods will have to explain this at least apparent difference between moods and emotions.

I think the way to respond to the "Intentionality Condition" is to make a distinction between two kinds of intentional objects for mental states (or at least two kinds of objects that have the appearance of being intentional objects). They can either be part of or divorced from the causal history of a mental state. Objects that are part of the causal history of the state I will call occasioning intentional objects. For example, Kate may be pushed when entering the subway and become angry. The subway-pushing or subway-pusher is (at least part of) the cause of Kate's anger,[7] and is thus its occasioning intentional object. Objects divorced from the mental state's causal history I will call immediate (apparent) intentional objects. These are the objects that a preexisting affective state gets attached to. For example, Kate may enter a classroom irritated, and then focus her irritation on the chalkboard, which the previous instructor did not erase. The unerased chalkboard is the immediate (apparent) intentional object of Kate's irritation. Central to understanding moods is appreciating this phenomenon of extant moods taking on additional immediate intentional objects.

We need to keep this distinction clear, because there is a tendency when evaluating moods and emotions to compare the occasioning intentional object of an emotion with the immediate (apparent) intentional object of a mood. This results in the intentionality of emotions seeming to be more discrete and pronounced than the intentionality of moods, but

[7] It is a challenge to work out the precise details of how intentional objects enter into a causal chain that produces a mental state. This is especially the case with intentional objects where the object does not exist. I will not attempt to engage that debate here. For my purposes, all I need is the uncontroversial claim that intentional objects can constitute at least part of the cause of some mental states.

the comparison is improper.[8] It seems to me that Lormand's analysis gets off the ground by comparing the immediate (apparent) intentional objects of a case of euphoria with the occasioning intentional object of a case of anger. When we imagine the cases, we start by imagining being euphoric and think about how that euphoria extends to other immediate (apparent) objects around us – the sky is bluer, the faces of friends more pleasing, etc. than they would seem to us were we not euphoric. But then we turn to anger. And rather than imagine being angry and extending that anger to objects around us, we imagine becoming angry and the occasioning intentional object of that just-caused anger.

This is very common. In discussions of emotions, most commentators only discuss cases where the intentional object is the occasioning cause (e.g. someone is angry *at* or *about* the situation that brought the anger into existence; someone is afraid *of* the thing that caused their fear). Lormand is quite correct – there is a big difference between the objects that get taken up within an extant mood and the object that is part of the cause of an anger episode. The taken-up objects of euphoria are not as intentionally pointed as the occasioning object of anger is. This difference, however, becomes substantially less pronounced if we take cases of immediate (apparent) intentional objects of emotions.

The challenge, however, for the intentional theorist of moods, is to show that emotions, like moods, can take immediate (apparent) intentional objects. I think this is clearly the case. Consider Donald Dutton and Arthur Aron's experiment in Capilano Park.[9] They placed an attractive female interviewer in three interview sites: (a) low wooden bridge; (b) suspension bridge over a deep gorge; and (c) outdoor clearing where people who had walked over the

[8] In this dissertation, I am primarily concerned to establish that moods can have occasioning intentional objects, but this will only be accomplished in later chapters.

[9] Dutton and Aron 1974.

suspension bridge 10 minutes earlier would pass by. She asked men in each of these settings some questions, and asked them to complete a narrative. The subjects on the suspension bridge created narratives that included more sexual content than subjects in the other experiment conditions. Further, at the end of the interview, the interviewer gave the men her phone number and told them that they could call her if they wanted to know more about the experiment. The men who encountered the interviewer on the suspension bridge were considerably more likely to call that those men who were interviewed in the other experiment conditions.

It seems likely that the subjects on the suspension bridge took themselves to be experiencing sexual arousal and thought that the intentional object of this arousal was the attractive interviewer. Further, the subjects likely believed not only that their arousal was directed at the attractive interviewer, but that her presence actually created the arousal in the first place. This looks like a mistake. There is a broad acceptance that the men are in fact simply mischaracterising their fear. Their emotional state was not, in fact, caused by the attractive interviewer, but rather by being on a suspension bridge over Capilano Gorge. The occasioning intentional object of their emotional state was not the interviewer, but the Gorge. Thus their affective state is, in light of its causal and intentional history, fear – not sexual arousal.[10] Using my distinction, the interviewer is merely an immediate (apparent) intentional object which gets 'picked up' by the men's already extant emotion. On my view, as the fear arousal picks up the interviewer as an immediate (apparent) intentional object, it becomes a more complicated affective state, with elements of both fear and sexual attraction.

[10] This phenomenon of getting our emotion wrong is characterised by David Pugmire as a "factitious emotion." See Pugmire 1998.

It seems likely that the 'error' that happens on the Capilano suspension bridge is at least partly due to the novelty of the situation. Most of the time, we are unlikely to mischaracterise our emotions in such a dramatic way. But a similar kind of phenomenon can be observed in a more everyday scenario. Consider Kate, who is having a serious fight with her spouse in the car, a fight that she desperately wishes was not happening. She stops at a gas station and the attendant appears thoughtless or rude. Although she did not take herself to be angry during the fight, she now becomes angry at the attendant.

When asked, Kate might insist that her anger was only related to her experience with the attendant. She will certainly make intentional avowals with respect to the attendant. But her anger is *really* about the fight. Psychoanalytic theory has many resources for explaining what is going on in these sorts of cases, particularly by appealing to defense mechanisms. Perhaps Kate has a deep aversion to seeing herself as someone who is angry at a loved one. She thus denies that the fight with her spouse leads her to be angry. But despite her denial, her anger is still there, simmering along. She encounters the attendant before she is able to fully suppress or dismantle it. She enters that moment experiencing an anger she cannot or will not acknowledge toward an occasioning intentional object she will not admit is so situated within her emotion. Then a suitable anger object presents itself. Voilá – she is angry at the attendant. As with the Capilano Gorge case, in a sense, the attendant is the intentional object of Kate's anger, but only the immediate (apparent) intentional object. The actual occasioning intentional object is her spouse / the content of their fight / etc. To the extent that Kate denies the occasioning of her anger with the fight, she is mistaken.

I should acknowledge that another interpretive possibility with the Capilano Gorge experiment is that there is no real mistake; there are simply two separate emotions. One is

fear of the Gorge, the other is attraction to the interviewer. The men perhaps do not recognize that they are experiencing two emotions, but this is a different kind of mistake than taking themselves to be experiencing a different emotion than the one that they are actually in. With this interpretation, there is no need to posit immediate (apparent) intentional objects. There are simply two separate occasioning intentional objects to go with the two separate emotions. This seems possible to me. But I do not think this interpretation will work in the Kate case. The possibility of two separate emotions has some plausibility when there are two types of emotions involved. With Kate and the gas station attendant, however, it seems odd to claim that Kate is simultaneously experiencing two distinct tokens of anger. Consider the person in a rage who stomps around the house picking up different household items, yelling that the ugliness of each one is infuriating. It seems pretty clear that such a person does not acquire a new token of the rage emotion. Instead, she is in a rage as a result of some occasioning object and that rage takes on immediate (apparent) intentional objects as she stomps around.

When we are careful to compare only immediate (apparent) intentional objects of both moods and emotions, the difference in intentionality is considerably less pronounced. Let us return to Lormand's example of euphoria. Let is imagine that Kate is euphoric, and upon seeing an acquaintance she gleefully launches into conversation. She is euphoric about meeting up with this person, even though under other, more typical, conditions, she is only slightly fond of this acquaintance. As observers, there is a sense in which her affective state is not directed toward the acquaintance in a particularly pointed way.

But I think the Capilano Gorge experiment establishes what we already know first-hand about emotions – emotions, too, can come into existence with one intentional object and then

pick up other intentional objects along the way (and even become transformed into other emotions as this happens). It seems to me that the intentionality found between Kate's mood and the acquaintance is very similar to the intentionality found between Kate's emotion and the attendant. Here we are contrasting two cases of immediate (apparent) intentional objects, and we do not find a substantial difference between moods and emotions. A failure to appreciate this distinction between occasioning and immediate (apparent) intentional objects contributes to mischaracterising moods as always non-intentional.

Notice, however, that I label immediate intentional objects only apparently intentional. This is because I find their intentional status uncertain. There is a kind of intentionality, but it is not clear to me that an intentional object wholly divorced from a mental state's cause can truly count as an intentional object of that mental state. I am sympathetic to the view that if this were the sum of the intentionality of moods, then it is at least not intentional in the same way that an emotion can be intentional, with respect to its occasioning intentional object. I am not sure what sort of evidence or argument could establish the interviewer (in the Capilano Bridge case) or the attendant (in the case of Kate and her fight with her spouse) either as fully an intentional object or fully not an intentional object. Robert Gordon, for example, argues that something can count as an intentional object of an emotion (and by my extension, mood) only if it plays a role in the emotion's causal history.[11] He considers the example of a father coming home already angry. Upon arriving home, he discovers Junior has destroyed a role of film. According to Gordon, the father can only be said to be angry *at* Junior if Junior's actions were enough to make the father angry in the first place, without the already extant anger. But I am not sure emotions or moods can be differentiated so finely.

[11] Gordon 1987, 47-48.

Going back to the example of Kate's anger at the gas station attendant, perhaps Kate would normally become mildly angry at behaviour of the type manifested by the attendant. But if she had not been angry at her spouse, her affective response to the gas station attendant would have had some similarity to, and several marked differences from, what she actually experienced. I am not sure how to separate the two angers out. Claire Armon-Jones, conversely, explicitly rejects this causation requirement, and insists that emotional intentionality need not be linked with an emotion's causal history.[12] Because of these difficulties, I intend to remain agnostic on this question of whether or not immediate intentional objects are truly intentional.

At this point, all I have attempted to show is that both moods and emotions can take immediate (apparent) intentional objects and further that the intentionality found with respect to these objects is similar in both. But I have granted that emotions routinely have occasioning intentional objects (in addition to sometimes taking immediate (apparent) intentional objects). I have also granted that the intentionality found with occasioning intentional objects is sharper and more pronounced than that with immediate (apparent) intentional objects. Thus, if moods do not have occasioning intentional objects in the way that emotions do, then Lormand's original point will stand: theories of moods will have to explain a significant difference in intentionality between moods and emotions.

Unlike most emotions, moods routinely do not have discrete start and end points. Emotions may often be experienced as isolated phenomena. They are often intense, but also often brief, responses to specific and limited arousal conditions. Moods, however, are often less intense and more longstanding. They are less episodic and they are less often the result

[12] Armon-Jones 1991, 50-60.

of easily identifiable arousal conditions. At this point there might be a temptation to think that an often-used distinction from the philosophy of emotions literature, between formal and particular intentional objects, might map on to my distinction between occasioning and immediate intentional objects. The feature of an object / event that brings an emotion into existence is its formal object. The object / event itself is the emotion's particular object. For example, with emotions, a case of fear might have "a snake" as its particular object, and would have "threatening objects and events" as its formal object. Someone might be tempted to think that, with moods, my immediate (apparent) intentional objects are particular objects and my occasioning objects are formal objects. On this account, moods would come into existence purely in response to formal objects (depression coming about through a sense of loss, for example). This would seem to preserve the sense that moods don't really come into existence in response to particular events or objects.

This, however, would be a mistake. I think, with emotions and moods, both occasioning and immediate intentional objects are species of particular objects. I think many people feel that moods in fact do not have occasioning intentional objects. But it is my contention that there are simply differences in the way that moods and emotions are connected with occasioning intentional objects. Moods are typically not the result of exposure to discrete objects or events. I think that moods are sometimes the product of accretions of exposure to intentional objects or events – a kind of affective build-up.

This is why their occasioning intentional objects can be hard to identify. By the time we recognise that we are experiencing a mood, the objects / events that occasioned the mood are already behind us. This is in contrast with emotions where we typically experience the formation of the emotion just as we experience the occasioning intentional object. I contend

that even in cases where someone says that there is no reason for her mood state, we can often engage in a process I will call "affective reconstruction." In this process we take an apparently non-intentional mood state and go over the experiences the mood experiencer has gone through. Often, in reconstructing this history, the many small intentional objects that led to the creation of the mood will come into focus. This means that rather than a single intentional object, often there will be many intentional occasioning objects for intentional moods.

I will argue for this position more thoroughly in my later case study discussions of depression and BPD. It seems clear to me that both depression and BPD can be caused by exposure to bundles of occasioning intentional objects. But identifying these bundles requires a rich appreciation of the causal history of the mood states. Figuring out the causal history of someone's depression or irritation / depression mood blend (which underlies a case of BPD) can sometimes be complicated, and the "affective reconstruction" required can be daunting. But it is possible, often, to figure out just what intentional states led to someone's moods, even when those moods are typically designated pathological.

Throughout this dissertation, I will aim to be careful about whether or not an intentional object is occasioning or immediate. Non-intentional theorists of mood focus on immediate (apparent) intentional objects, argue that they are not, in fact, intentional objects, and then go on to claim that they have thereby shown that moods are non-intentional. I think they are not entitled to this conclusion, simply because I think they have disregarded moods' occasioning intentional object.

3. Additional important features of moods

Lormand offer two more conditions on theories of moods in addition to his "Intentionality Condition," explored in the previous section. The first of these I endorse, while I will argue against his third condition as mischaracterising the phenomenon. Lormand observes that moods are very pervasive. They seem to influence a greater range of a mood experiencer's experience than do emotions. This produces the "Pervasiveness Condition." This seems exactly right. To borrow the metaphors of other philosophers, moods typically "colour"[13] and "frame"[14] our experience in a much more global way than emotions do. (As Lormand has observed, "some of the finest philosophical poetry" has been written in an effort to characterise this global effect of moods.[15]) Another way of putting this is that moods take up many more immediate (apparent) intentional objects than emotions. Of course, emotions can extend in this way. As I argued, after the fight with her spouse, Kate takes the gas station attendant as an immediate (apparent) intentional object of her anger. But often we are able to contain our emotions, keeping them focused only on their occasioning intentional object. Moods are almost never so constrained. The mood someone experiences almost always extends over many of the experiencer's surrounding objects. Here I think Lormand is quite correct. This is one of the significant features of moods that makes them worth considering independent from emotions. Any account of moods will have to be able to accommodate this feature.

[13] Ryle 1963, 96.

[14] William Morris 1989, *Mood: The Frame of Mind*.

[15] Lormand 1985, 389.

Finally, we come to Lormand's condition on theories of moods that I think is misguided. Lormand discusses the way that moods enter into explanations of behaviour. He claims that when someone says "He kicked the dog because he was in a bad mood," they are offering a purely causal explanation. In this case, the dog-kicking is motiveless – the bad-mood dog-kicker does it for no reason. He was simply caused to do the kicking by his bad mood. This is supposed to be in contrast with emotions in explanations. In the case of an emotion being employed in an action explanation, someone might say that the dog-kicker was afraid that the dog would bite his sister, or angry that the dog bit his sister – in both cases, his emotion (fear or anger) hooks up with practical motivations (prevent the biting, punish the biting) in the explanation and leads him to kick the dog. Moods, according to Lormand, do not get employed in this way. This leads Lormand to create the "Explanation Condition." A theory of moods, on Lormand's view, has to accommodate this difference in how moods and emotions get deployed in action explanation.

Here, I do not accept even a superficial account of this distinction between moods and emotions. First, I think that Lormand gets off to a bad start with his dog-kicking example. In this culture, anyone kicking a dog has a lot of explaining to do, bad mood or no. So let us change it to door-slamming. "He slammed the door because he was in a bad mood." There is certainly a sense in which bad moods cause us to behave in all kinds of ways, including door slamming. But so do emotions. Anger certainly causes us to slam doors. We may angrily slam a door because we wish to communicate our anger to another.

But we may also have no reason, no practical motivations that produce the door-slamming. So when someone says, "I slammed the door because I was angry," we may ask why. The answer might be related to aims held by the agent, or it might simply be, "I was

just really mad." And that will be the end of it. In fact, Peter Goldie argues that "…no genuine expression of emotion is done as a means to some further end."[16] Of course, this type of explanation will not cover any action the person performs while experiencing an emotion. If a person bursts into yodeling and, when asked why, responds "I was just really mad," more explanation will be needed. Different emotions have different actions that can be explained in a final way by appeal to an emotion. Anger will typically produce actions that have some component of violence. Sadness often produces crying. Positive emotions can play out in the same way. Happiness may hook up with practical motivations and lead us to kiss a loved one. But it can just as easily cause such behaviour with no additional end in mind. No intention to kiss the loved one is needed, nor belief that some practical goal will be thereby achieved. You can simply be happy and find yourself unexpectedly, happily, pressing your lips to your sweetheart's cheek.[17]

Additionally, there is no shortage of practical motivations served by mood-induced behaviour. Anyone who has spent an afternoon with a bored teenager knows that a sigh is rarely simply *caused* by her mood. Her mood of boredom has several associated goals, notably, to be entertained. The teenager is communicating her mood and that goal and doing so in a way that is quite likely to inspire surrounding adults to respond to her. Thus, it seems to me that both moods and emotions can enter into explanations in a purely causal way, and both moods and emotions can enter into explanations as part of an account of practical motivations. So when we consider various theories of moods, I will not be holding them accountable to Lormand's "Explanation Condition."

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[16] Goldie 2000, 25.

[17] Rosalind Hursthouse makes essentially this same point in her paper, "Arational Actions." (Hursthouse 1991.)

4. Intentional theories of moods

In light of the discussion of the previous sections, I think an account of moods will have to be able to say something about their intentionality, linked both with occasioning intentional objects and immediate (apparent) intentional objects. Further, the account will have to accommodate the pervasiveness of moods. Moods also often seem to be of longer duration and lesser intensity than emotions – this, too, should find a place in a fully adequate account of moods. Lormand discusses four types of intentional accounts of moods, and I agree with him that there are serious problems with each of the intentional accounts he considers. Let me present them, and quickly run through their shortcomings.

The first two theories do not seem to really get off the ground at all, and it is not clear to me that anyone actually endorses them. First, there is what Lormand calls the Duration Theory: "Moods are simply prolonged emotions." Here the central problem is thinness. While there is something right about the central observation – most moods last longer than most emotions – it does not grapple with any other features of moods. This account makes no effort to say anything about either intentionality or pervasiveness.

Second, there is what Lormand calls the Summation Theory: "Moods are sums of conscious emotions." According to Lormand, Wayne Davis is a proponent of this position.[18] I find this the strangest account of moods. To my mind, it fails before it even gets off the ground because it so completely ignores so much of the experienced phenomenon of moods. While it is certainly the case that if one is experiencing the emotion, happiness, for example, one's mood is typically going to be positive. Conversely, if one is afraid, then one's mood is typically going to be negative. But there is no necessary connection between them. It is

[18] Davis 1981 actually argues that moods are the sums of all conscious mental states, not just emotions. But I do not think this difference matters to the criticisms I and Lormand have for Davis' analysis.

possible for someone experiencing profound depression to have a moment of happiness, without their underlying depression being eroded. Emotions and moods influence each other, but they can come into existence and persist independently.[19] Additionally, as Lormand points out, this theory cannot accommodate the "Pervasiveness Condition," which rests on the observation that the mood someone is in effects, in substantial ways, much of how she then sees the world. This causation runs opposite to the direction proposed by the "Summation Theory," which holds that moods follow already extant mental states.

Third, there is what Lormand calls the Precondition Theory: "Moods are necessary for emotions." This account has a little bit more substance as well as some actual proponents, primarily among psychologists.[20] Vincent Nowlis and Brian Parkinson et al., for example, argue that moods are pre/dispositions to have emotions.[21] William Morris and Paul Ekman argue that the main function of moods is to "alter the threshold for excitation of particular emotions."[22] Here, too, as with the "Duration Theory," I think there is a central accurate observation. Moods do seem to incline us to move more easily into emotions. In fact there are patterns to such inclinations. Being irritated can incline one to become angry, being depressed can incline one to become sad. This account, however, is surely not exhaustive.

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[19] I should point out that this is not the criticism that Lormand uses against the "Summation Theory." Lormand rejects the "Summation Theory" because it fails to meet his "Explanation Condition." As I do not think the "Explanation Condition" should be employed, I will not discuss his analysis.

[20] Lormand claims that Martin Heidegger holds this kind of view. I am not convinced that this is the best interpretation of Heidegger. For Heidegger, moods "disclose ways of mattering" (1972, 137), which is considerably more complicated than Lormand's "Precondition Theory." (See Quentin Smith 1981 for a discussion.) I have opted, however, not to discuss Heidegger's analysis in this dissertation. Heidegger places moods at the center of his analysis of what it is to be human. Thus, understanding Heidegger's analysis of moods requires understanding his full metaphysical account of human beings and the world they inhabit. This task was beyond the scope of my project here.

[21] Nowlis 1963 and Parkinson et al. 1996.

[22] Ekman 1994, 57. See Morris 1999 for corroborating analysis.

First, we can have moods that persist for long periods of time without leading to any additional emotion. These moods are phenomenally experienced and seem occurrent, rather than dispositional. Second, sometimes the relationship between an emotion and a mood runs the other way. Moods often seem to be the 'leftovers' of an emotion, such that anxiety persists after an episode of fear. Finally, if the idea behind the "Precondition Theory" is the strong claim that experiencing a mood first is *necessary* in order to experience an emotion, it clearly fails. It would mean that for someone to become afraid of something, she would have to be in the predisposing mood. But what of waking up to a loud noise and immediately being afraid? Does this mean she was sleeping anxiously prior to the emotion? Perhaps she went through a very brief anxiousness prior to entering the full emotion state of fear? It looks like one would have to be in every mood simultaneously and constantly to account for our ability to enter into a wide range of emotions very suddenly. While there is a link between many emotion episodes and moods, the claim that moods predispose us to have emotions is not the only context in which moods are experienced. So we need some way of making sense of moods independent from emotions, which this theory cannot accommodate.

Fourth, there is what Lormand calls the Generalization Theory: "Moods are general emotions." This position is the most important intentional account that has been offered. The idea is simply that the intentional object(s) of a mood state is very general. It has been held by Anthony Kenny, [23] Robert Solomon, and, more recently, by Jose Arregui. For each of them, moods are not sharply distinguished from emotions. The central difference is simply that unlike emotions, a mood's intentional object is the whole world. Kenny, for example, writes that "…pointless depression is not objectless, and the objects of depression

[23] It is worth noting that Kenny has changed his position on moods and intentionality in later works. In *The Metaphysics of Mind* (1989, 57) he argues that moods have only inadequate intentional objects.

are the things which seem black."[24] Solomon writes that "…moods are about nothing in particular, or sometimes they are about our world as a whole."[25] Arregui claims that "…the object of moods is the world as a whole evaluated in a determinate way, that is, under a determinate description."[26]

I think Solomon, Kenny and Arregui are focusing on what might be immediate (apparent) intentional objects and setting aside concern with occasioning intentional objects. It seems clear to me that the whole world or a person's total experiences generally cannot serve as the occasioning intentional object of a mood. Instead, a mood exists and the whole world is seen in light of it. The mood feature that I think they are concerned with is the way that moods "colour" or "frame" a mood-experiencer's entire experience, as I discussed when presenting the "Pervasiveness Condition." Solomon writes that certain moods "[cast] happy glows or somber shadows."[27] Lormand rightly disparages this metaphorical characterization – more detail is needed. First, I will present Lormand's criticism of the "Generalization Theory," and explain why I am not convinced by his critique. Then I will present Claire Armon-Jones' criticism, and again argue that her analysis misses the mark. Finally, I will present my own concerns with the "Generalization Theory."

Lormand begins his criticisms of the "Generalization Theory" by arguing that it fails to meet his "Explanation Condition." As I have already argued, however, this condition is not one that theories of moods should be subjected to. In addition to this worry, Lormand argues

[24] Kenny 1963, 61.

[25] Solomon 1976, 173.

[26] Arregui 1997, 407.

[27] Solomon 1976, 173.

that the "Generalization Theory" cannot accommodate the moods' lack of "cognitive penetrability." The basic observation is that a person can change her beliefs associated with the (apparent) general intentional objects of her mood but not see any change in her actual mood state. Lormand's observation here is accurate. If Kate is depressed and takes everything around her e.g. the weather, the facial expression of others she sees, as objects of her depression, a change in those objects, even a change that results in a change in Kate's beliefs, will not end her depression. The weather could improve, people could smile, and Kate could recognise each of these alterations, but her depression will likely persist. But this is no way to draw a distinction between moods and emotions, as lack of cognitive penetrability is also a feature of many emotions. If you are home alone and hear a noise that you think is a possible intruder, you may well become afraid, call a friend and get him to come over with a baseball bat. When you then discover that the noise was an opossum rooting through leaves in your front yard, you know immediately that you do not have reason to be afraid. But your fear will not go away so quickly. You will continue to have an elevated heart rate, continue to have sweaty palms, and continue to jump at other unusual noises.

Importantly, even though you fully endorse the claim that there never was an intruder and there was only ever an opossum, you will continue to surreptitiously look in the bushes when your friend is not looking. You know there is no intruder to discover. You do not hold any representational content that continues to endorse the possibility that an intruder is present. But a simple belief change does not disengage your fear, and you will continue to manifest certain behaviour, namely, continued investigation into the possibility of a threat, even when your beliefs give you grounds for certainty that such investigations are not needed. Thus it

seems clear that recalcitrance or lack of cognitive penetrability is not a feature exclusive to moods.

Further, it should be pointed out that the phenomenon of 'recalcitrant emotions' is a standard objection to strongly cognitivist positions on the emotions. In a strong cognitivist account of the emotions, emotions just are beliefs or judgements. A theory like this will indeed have problems explaining recalcitrance. According to Lormand, under the "Generalization Theory," moods too are constituted by and reducible to beliefs and desires about the whole world. If this is the view, then it does look like moods should cease to exist once those constituting beliefs and desires cease to exist. But there is nothing in the "Generalization Theory" by itself that commits a theorist to also hold that moods are constituted by beliefs and desires regarding those general object(s).[28] Different theories of emotions handle the issue of recalcitrance differently, typically starting with not treating emotions as reducible to or equivalent with associated beliefs. I do not see why the same plurality of options that exist for intentional theorists of emotions do not also exist for theorists of moods. Thus, I am not convinced that Lormand's criticisms are decisive against the "Generalization Theory."

Claire Armon-Jones also provides criticisms of intentional theories of moods, and they are primarily directed at arguments that fit (roughly) in the "Generalization Theory" camp.[29] She discusses cases where someone describes her mood as "depressed about everything." For Armon-Jones, a mental state can only be intentional if the objects of the state can be

[28] I should acknowledge that the version of the "Generalization Theory" offered by Solomon (in his 1976 book, *The Passions*) and possibly Kenny and Arregui are open to the 'cognitive penetrability' argument Lormand gives. My point here is simply that there is nothing in the "Generalizability Theory" *per se* that requires being open to this objection.

[29] Armon-Jones 1991, 61-65.

described independently of the state itself. She insists that if the depression truly is 'about everything,' then the person "…is not depressed about any particular thing or things, which is surely a case of depression without object."[30]

Of course, often, someone who is depressed will often say, "I'm depressed about *everything*" or "*Everything* is depressing to me." But saying it does not make it so. When pressed, the depressed person can typically identify many things that they are depressed about, but more, they can identify things they are *not* depressed about. This is not actually something that Armon-Jones denies. She acknowledges that someone may say that they are "depressed about everything," when in fact she is depressed only about things related to her personal life. This kind of depression does count as intentional for Armon-Jones, since objects related to the depression sufferer's personal life can be described independently of the sufferer's depression. But she claims that most instances of depression are indeed about everything, and thus, about nothing at all. But again, as with Lormand, I think Armon-Jones is led to her position by considering only cases of a mood's immediate (apparent) intentional objects, rather than looking for a mood's occasioning intentional object. It is true that moods can end up playing a role in how a mood-experiencer perceives the 'whole world.' In such a mood, 'everything' is taken as the mood-experiencer's immediate (apparent) intentional object. But this only happens once a mood exists. It says nothing about how that mood comes to be.

Of course, I have already discussed some reservations I have with considering immediate (apparent) intentional objects intentional at all. Divorced as they are from the mood's causal history, they have a kind of borrowed intentionality that puts their intentional status in

[30] Ibid. 63.

question. Since versions of the "Generalization Theory" are focusing on immediate (apparent) intentional objects (ignoring the mood's occasioning intentionality), they are subject to these worries about the extent to which these states are fully intentional, at least in the way that emotions are intentional.

But in addition to these worries, I think the "Generalization Theory" faces another problem, related to a criterion of intentionality needed to distinguish it from causation – the possibility of misrepresentation. A state that is exclusively non-intentionally caused cannot misrepresent its cause. But an intentional state has to be able to misrepresent its intentional object. I am not sure how an intentional object like "the whole world" can be misrepresented. It seems to me that in order for misrepresentation to be possible, there needs to be a particular object that can be investigated. This concern, coupled with the worries about the specificity of the intentionality possible with immediate (apparent) intentional objects, makes me unwilling to endorse a "Generalization Theory" for moods.

5. Non-intentional theories of moods

Eric Lormand's argument in favour of non-intentionality is an argument by elimination. He provides his three "conditions of adequacy" that he thinks theories of moods must meet. He then considers four intentional accounts of moods and argues that each fails to meet at least one of the conditions. But under my analysis, one of Lormand's conditions – the "Explanation Condition" – should be completely eliminated. Further, I substantially recast his "Intentionality Condition" in light of the distinction between occasioning and immediate (apparent) intentional objects. With this new set of conditions, Lormand fails to eliminate one of the intentional accounts of moods that he presents, which means he has failed to show

that moods must be non-intentional. Of course, I have provided my own reasons why the "Generalization Theory" is inadequate. I aim to show in my remaining chapters that the intentionality of moods is not best captured by positing general intentionality, but rather can be found in a thorough exploration of the causal origins of at least some moods.

Lormand does provide a positive non-intentional account of moods. He claims that moods set the parameters of which of our intentional states (beliefs, desires, and emotions) become active. For Lormand, moods are the sieve through which intentional states pass, and different moods "catch" different intentional states, although with respect to how that mechanism works Lormand is forced to remain silent. He is sure, however, that such a sieve is not, itself, intentional. I do not actually wish to take issue with the 'sieve' proposal per se. It seems to me, as Lormand acknowledges, that making this case requires substantial empirical data tracking each of these mental states in an effort to sort them out. These data, as yet, simply do not exist. It is worth noting, however, that this proposal focuses on how moods work once they exist. This theory is an effort to grapple with Lormand's "Pervasiveness Condition." But this account does not grapple with how moods come into existence, and it seems to me that it is not incompatible with moods being intentional, particularly with respect to the possibility of having occasioning intentional objects. It seems possible that part of the mechanism of such a sieve might be linked to representations linked with such an occasioning intentional object. There is nothing in Lormand's analysis that rules this possibility out.

I think similar claims are true of other substantial theories of moods recently offered by philosophers. Laura Sizer, for example, begins presenting her theory of moods by saying: "By moods, I mean generalized, nonspecific affective states like melancholy, ennui or

ebullience."[31] Sizer's starting point basically presupposes moods' non-intentionality, which is to beg the question with which I am concerned. Her theory is computational, arguing that moods bias cognitive operations. In broad outline, it is quite similar to Lormand's view, and is concerned primarily to explain how moods affect other mental states once the mood exists (that is, to explain moods' pervasiveness). But again, this focus is on moods already in existence. It does not address how a mood state comes into existence, and is not incompatible with a mood having an occasioning intentional object. Finally, Paul Griffiths, too, simply assumes that moods are non-intentional, and then goes on to argue for an evolutionarily adaptive function fulfilled by extant moods.[32] In remaining silent about the manner in which moods arise, Griffiths' view, too, does not rule out an intentional analysis of moods with respect to occasioning intentional objects.

6. Final caveats

In making the case for moods as potentially intentional states, I will be emphasising cognitive content. Intentional objects are linked to representational content like beliefs, judgements or construals. Thus, if moods are intentional, they become candidates to be understood in ways like emotions are understood within cognitive theories. There may be a temptation to assume that I am arguing for a strong cognitive account of moods, similar perhaps to cognitive accounts of emotions offered by Robert Solomon and Martha Nussbaum, where emotions are equated with their associated beliefs. This is not at all the view I wish to propose. Moods, even intentional ones, are not reducible to beliefs or any

[31] Sizer 2000, 744.

[32] Griffiths 1997, 248-257.

other kind of exclusively cognitive events. Moods include many elements – including cognitions, feelings, physiological components, and behavioural tendencies. My emphasis on cognitions should not be taken as an effort to reduce moods to cognitions.

Recall an argument from Lormand I presented earlier against mood intentionality, due to a lack of 'cognitive penetrability' found in moods. I think Lormand's rejection of an intentional account of moods is partly due to his own endorsement of a strongly cognitive account of the emotions. Lormand worries about the lack of moods' "cognitive penetrability" – that is, you can change the beliefs associated with the apparent intentional objects of moods but not see any change in the mood state. This is true. But on my view, this lack of full cognitive penetrability only establishes that moods are not exclusively cognitive. Moods have many components and once a mood has come into existence, often the elimination of a single one of its components, e.g. its associated beliefs, will not be enough to discontinue the mood.

Lormand thinks that this lack of cognitive penetrability is a signal of mood's non-intentionality. There are several problems with this position. First, as a way to distinguish non-intentional moods from intentional emotions, it does not work, as many emotions are also cognitively impenetrable (this was my point in the earlier discussion about fear that arises as a result of the noise of an opossum in the yard). Second, there is considerable cognitive penetrability with moods. I will cover this evidence in more detail in the depression and BPD chapters, but there is strong evidence that exclusively cognitive therapies have considerable therapeutic efficacy, and even more when combined with pharmaceutical interventions.

In this light, let me say some things about the connection between moods and rationality or reasonableness. Those who are willing to consider emotions as having a cognitive element often talk about emotions being ir/rational or un/reasonable. The same is often said about moods. Kate's irritation may be declared to be reasonable or unreasonable. This ascription to emotions and moods is certainly part of our folk psychology. But I think this ascription is misleading, both in the case of emotions and moods. Let me first try to explain why I think the ascription is so common, and then I will explain how I think it can lead us astray.

First, as I mentioned earlier, when an affective state is seen to have an intentional object, it becomes identified with representational content. Thus, if moods are intentional, they become candidates to be understood in ways like emotions are understood within cognitive theories. As soon as we start talking about the beliefs that are partly constitutive of an 'anger episode' or a 'depression episode,' we invoke epistemological considerations. Is the emotion's / mood's concomitant representational content justified? If yes, then the emotion / mood is rational. If no, then the emotion / mood is irrational. Talking in terms of cognitions like beliefs opens the door to normative evaluation, captured in terms like ir/rational or un/reasonable.[33]

The worry is that terms ir/rational or un/reasonable, once attributed to emotions and moods, make emotions and moods fundamentally cognitive. But while I will argue for a cognitive feature to some moods, and I accept that emotions, too, have a cognitive feature, they certainly are not exclusively cognitive states. As I just argued, emotions and moods have many non-cognitive elements. Instances in which anger might be warranted will be

[33] This is a problem I think is found in Patricia Greenspan's work. See for example, Greenspan 2003.

considerably different from instances in which a concomitant anger-belief, like "Paul just did something unjust to me" might be warranted.

Peter Goldie has a similar worry. He argues that philosophers that take a cognitive position about the emotions end up endorsing an "add-on theory" of the emotions. They characterise the intentionality of emotions in terms of beliefs or desires or perceptions. Then, to capture the phenomenology of emotions, they "add-on" other emotion features like feelings. Goldie insists that "an adequate account of an emotion's intentionality, of its directedness towards the world outside one's body, will at the same time capture an important aspect of its phenomenology."[34] The same is true with moods and concomitant mood beliefs. Deciding whether or not someone's depression is warranted is a very different investigation from deciding whether or not someone's belief "The world is a disappointing place and I'm a disappointing person" is warranted. [35]

Although I worry about the use of assessments of ir/rationality or un/reasonableness with moods (and emotions), I do think that moods (and emotions) can be normatively evaluated. There are standards of fit that can be applied to the relationship between a mood and its object, but they are not the same standards as those applied to a belief / object pair. In many instances, these standards are not especially mysterious. When we learn of someone being in some mood, we can ask why they are in that mood. We then assess whether or not their response has adequate justificatory force. I think these standards primarily come to us from our folk psychology, although they are not easily fully specified. I will be discussing 'fit' between specific moods and their objects in my case discussions of depression and BPD.

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[34] Goldie 2002, 242.

[35] Aaron Ben Ze'ev endorses a similar position. See Ben Ze'ev 2003.

Another way to put this is the common locution that a mood either is or is not 'appropriate.' This strikes me as preferable to the assessment of a mood's reasonableness or rationality (for the reasons just discussed). I wish to point out, however, that 'appropriate' can be assessed along several dimensions. Justin D'Arms and Daniel Jacobson have argued that there are three distinct senses of 'appropriate' for emotions.[36] First, emotions can be fittingly 'appropriate,' that is, an emotion can fit with its intentional object. There is a rough fit found between negative events and negative emotions, and between positive events and positive emotions.[37] But fit is typically more finely differentiated. For example, Jessica might learn that her spouse is having an affair or that a loved one has died. For Jessica, both the affair and the death are negative events. But we think the negative emotion of jealousy fits with the affair as its intentional object, while grief fits the death as its intentional object. On the positive side, Jessica might receive both a good grade and a lovely gift. Both are positive events for Jessica. The positive emotion of pride fits with a good grade as its intentional object, while it typically would be misplaced if it took the lovely gift as its intentional object.[38] This possibility of fit between emotions and intentional objects is signaled by many adjectives. Someone may describe an object or event as 'enviable,' 'pitiable,' or 'saddening.' In those cases, the speaker is claiming that envy, pity, or sadness were among the responses that would have been fitting in response to seeing those objects or experiencing those events, even if the speaker did not herself experience those emotions.

[36] D'Arms and Jacobson 2000.

[37] There can be exceptions to this general rule.

[38] Of course there might be cases where jealousy fits with a death and pride with receipt of a lovely gift. But for this to be plausible there would need to be rather curious circumstances to make these emotion / object pairings fitting. The explanation of the circumstances would need to show how the fit arises.

Second, emotions can be prudentially 'appropriate,' that is, experiencing that emotion serves some prudential goal. Consider a case of a person whose employer treats her badly. Becoming angry at such treatment could be a fitting response. If, however, she cannot afford to quit the job or antagonize her employer, and she finds being angry without acting on that anger very uncomfortable, then her anger may be prudentially inappropriate. All things considered, we can imagine a situation where someone ought not experience anger out of prudential considerations, even though her anger might fit its intentional object.

Finally, emotions can be morally 'appropriate,' that is, they are morally appropriate to experience, all things considered. Imagine a case of a toddler hitting you intentionally (not accidentally). In general, there is good fit between being intentionally hit and becoming angry. But in this case with this particular toddler, you know that while the child did intend to hit you, she did not intend the harms that come with being hit. She is sufficiently young that she does not truly appreciate what it means to hit someone. In a case like this, even though there is a fit between you being intentionally hit and you becoming angry, if you actually become angry there is a lack of moral appropriateness in your anger. Your anger is fitting, and we may even sympathise with it. But if you experience anger, it signals your failure to appreciate the child's position, and as such is not fully morally appropriate. I believe these same distinct types of assessment can happen with moods. Moods, too, can be fittingly, prudentially and morally appropriate, as I will explore in my later chapters.

As a final point, I wish to make clear that, in addition to not believing that moods are exclusively cognitive, I also do not think that all moods or all instances of some particular mood are intentionally caused. It seems clear to me that one may become irritated exclusively as a consequence of a headache – there is no occasioning intentional object.

Further, although this irritated mood will inform how you see the world, you may well never take up any particular things in the world and have them as full-blooded intentional objects of that irritation. This does seem to establish that some moods are non-intentional.

But I would also like to point out that this feature of moods does not establish a route to a distinction between moods and emotions, as there are similar cases with emotions. Consider stubbing your toe on the small and easily overlooked stool in your kitchen when you are in a rush to get out the door and to the airport. One common response is to become angry, immediately. Those who endorse a strongly cognitivist account of emotion insist that one becomes angry *about* something. But in a case like this, what are you angry about? The strong cognitivist might insist that you are angry about stubbing your toe. But clearly your anger exists prior to any thoughts about toe-stubbing. In fact, you are more likely to be angry *at* the stool. You will almost certainly look angrily at the stool and perhaps even say some angry things in its general direction. But it is unlikely that you truly take yourself to be angry at the stool. Your anger needs an object and so you mistakenly reach out and grab one. But actually, your anger does not have an intentional object, at least not a particular intentional object – it is caused in the absence of intentionality.[39]

As I have argued, moods elude easy characterisation relative to emotions in several respects, notably with regard to their intentionality and their pervasiveness. As I have discussed, moods take up many more immediate (apparent) intentional objects than emotions typically do. They constitute our way of seeing the world much more broadly than emotions typically do. This, I think, is the primary distinction between moods and emotions. It seems

[39] Those who argue for the distinction between formal and particular objects may consider even this stool-caused anger to be intentional in a formal sense (see e.g. Prinz 2004). But I will not be concerned with formal intentional objects in this dissertation.

to me that this is a difference in degree, rather than a difference in kind. Thus it seems to me that moods are more like emotions than the non-intentional mood account acknowledges. Despite this lack of a sharp distinction between emotions and moods, however, I think the difference is striking enough that moods warrant their own exploration.

CHAPTER II
MEDICAL APPROACHES TO DEPRESSION

Depression, as I mentioned in my introductory chapter, is one of the paradigmatic instances of a mood. Additionally, depression is considered a 'mood disorder' and is currently the most commonly diagnosed psychiatric disorder. According to the experts, the prevalence of diagnosable depressive disorders in North America is staggering. Researchers estimate that North Americans have about an 18% chance, over a lifetime, of suffering a major depressive episode, and another 6.5% chance of suffering dysthymia (a chronic depressed affective state, less intense than found in major depressive disorder, that persists over years).[1] These prevalence rates are considerably higher than any clinician would have estimated early in the last century.

In the previous chapter, I argued that philosophical accounts of moods often deny that moods can be intentional. In this chapter, I will explore how medicine denies intentionality to the mood that is diagnosable depression. Given that the limits of diagnosable depression are expanding rapidly, this means that a lot of depression (broadly understood) is now or will be soon taken to be non-intentional within medical practice. This means that the mood of depression is under pressure to be seen as non-intentional from two directions, philosophical and medical.

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[1] Kessler et al. 1994. The odds for women are substantially higher: 21% and 8%, respectively. For men, it's 13% and 5%.

1. Worries about pathologisation

Why is the diagnosis and prevalence of depression on the rise? Most people believe that this is the result of a greater level of awareness about depression among both clinicians and the general public. In fact, however, the increase in the diagnosis rate is largely the result of the pathologisation of moods that would have previously been considered low moods in the normal range. (For my purposes, to pathologise a phenomenon is to subsume it under current mainstream medical practice and treat it as a medical disease.) Evidence for this claim can be found in the manual used to diagnose psychiatric disorders in North America, the *Diagnostic and Statistical Manual of Mental Disorders*. The *DSM* is the central diagnostic authority on mental disorders in North America. Currently in use is the *DSM* fourth edition, text revision, or *DSM-IV-TR*. It contains nine diagnostic symptoms of depression:

(1) depressed mood
(2) decreased pleasure in typically pleasurable activities, including sex
(3) poor appetite / weight loss or increased appetite / weight gain
(4) insomnia or hypersomnia
(5) psychomotor agitation / retardation
(6) fatigue
(7) negative self-assessment
(8) trouble concentrating / indecisiveness
(9) suicidal ideation

For a diagnosis of major depressive disorder, a patient must suffer five of the possible nine symptoms, which must include either symptom (1) or (2), and these symptoms must have been present every day, almost all day, for at least two weeks.[2] Many criteria that were used to limit which people could count as pathologically depressed in earlier editions have been either loosened or removed all together.

[2] APA 2000.

But most people, clinicians and the public more broadly, are confident that drawing a distinction between normal low mood and depression is a straightforward enterprise. Such a distinction would protect our everyday 'blue' states from being designated disease states, and, so long as this is secure, there is little aversion toward having much or most low mood pathologised. I intend to show, however, that currently there is a strong push within medical practice towards blurring the distinction. Once we understand how medical practice currently works, we can see why more and more cases of low mood that once were considered normal are now being understood as pathological instances of depression.

In sections 2 and 3 of this chapter, I will explain how the pathologising process is led by a dominant approach with current medical practice, what I will call Medical Model A. Medical Model A emphasises physiological causation and treatment. In sections 4-6, I will explore the features of Medical Model A that I think significantly explains why the diagnostic rate for depression has increased so dramatically. In section 7, I will also explore a second model of medical practice, Medical Model B, which makes room for environmental effects on physiological pathologies. Throughout the chapter, I will argue that the ultimate result of both of these current medical practices is an implicit denial of intentionality to an increasing number of instances of depression / low mood states. I will not assume that these medical models take a position with respect to the general intentionality of moods. I will argue, however, that once depression becomes subsumed by these medical models under a diagnosis, that is, once depression is seen as pathological, then it is no longer engaged with as an intentional state. This is primarily the result of the treatments associated with both of these models, which do not incorporate engagement with intentional features of the phenomena they aim to eliminate. I think this ends up being consistent with our 'folk

medicine,' in which diseases are not intentional, in both senses of 'intentional.' If you have a disease, your symptoms are not under your control, that is, they are not intended. Additionally, there is a general presumption that diseases are not intentional in the sense that I have been discussing, that is, diseases are not *about* anything. To the extent that these models purport to and are taken to provide a full account of the pathological phenomena they subsume, this clinical practice of non-engagement is tantamount to a denial that the state has an intentional component at all. I will argue that broad pathologising of low moods/ depression is a mistake. It both mischaracterises moods and potentially undermines fully morally adequate responses to the suffering encountered with depression.

Before I delve into my analysis, however, I need to explain how I will use certain terms. 'Depression' is commonly used to designate both a pathological state (linked to the medical diagnosis of depression) and a sad mood. For clarity, I will use the term 'depression' for what is commonly now considered a pathological state, as contrasted against what I will call 'normal low mood.'[3]

2. Medical Model A: The physiological version of the low mood/ depression distinction

The prototypes for medical diseases are (apparently) clear-cut pathologies like diabetes or cancer. According to Ian Hacking, in the current medical climate "the names for real illnesses have objective, individuated referents; scientific metaphysics and popular science alike demand that the referent is biochemical, neurological, organic, something that could in

[3] It might seem more natural to use the term 'sadness' here, rather than the cumbersome 'normal low mood' locution. Sadness, however, is commonly used for both emotion and mood states. I wish to remain clear that my concern is with mood.

principle be isolated in the laboratory."[4] What Hacking is describing in this quote is what is commonly referred to as the 'medical model.' The 'medical model' is the set of beliefs held by medical practitioners and educators about what a disease is, what the roles of various medical practitioners are, what the goals of treatment should be, and what counts as a cure. Because the practice of medicine in this culture is so large, there is considerable heterogeneity within the medical model. In this section, I will discuss one such model, Medical Model A. The influence of Medical Model A is substantial among the clinicians and researchers who analyse psychopathologies.

Within Medical Model A, clinicians and researchers understand diseases exclusively as physiological pathologies. For example, according to a recent volume on disease and its origins used by a variety of medical schools, "the cause of disease comprises either a [physical] event that overwhelms homeostatic mechanisms (an extrinsic cause) or one that undermines them (an intrinsic cause)."[5] These pathological events will typically manifest themselves in physiological symptoms. Different causes will result in different symptoms and the aim of diagnosis is to provide a taxonomy that aligns symptoms and causes through explication of a common physical causal mechanism. Treatment should ideally be directed at that underlying intrinsic or extrinsic pathology. On this model, mental diseases are physiologically grounded brain malfunctions that result in unpleasant psychological states.

Establishing this physiological underpinning also establishes the non-volitional quality of the disease in question. This is important in a variety of respects, notably because, as I mentioned earlier, there is a link within our folk medicine between disease and lack of

[4] Hacking 1998, 10.

[5] Scriver et al. 2001-2005.

responsibility.[6] On the dominant cultural view, having a medical disease confers certain privileges on the sufferer. To have a medical disease is to abdicate certain responsibilities — it is not your fault that you are unwell, and because you are unwell, you do not face the same obligations that you would otherwise have to meet. This privilege ought only to be bestowed upon those who really cannot help their condition. If a mental disease has an underpinning in physiological malfunction, then surely its symptoms are not under conscious (or unconscious) control and medical doctors are the right kind of experts to respond to it.

Sometimes, questioning the legitimacy of characterising a particular psychological phenomenon as a mental disease is intended to ensure that the phenomenon is not the product of (sub)conscious efforts by patient, physician or community at large. This is, for example, largely the motivation behind raising critical questions about the diagnosis of multiple personality disorder. There is a desire to be certain that neither sufferer nor doctor nor mass hysteria is 'making it up.' There is also a need to ensure that the unpleasant psychological state in question is not simply a normal part of being a person. This is the motivation behind questioning diseases like attention deficit disorder. Calling very active and inattentive children (typically boys) 'sick' worries many, since we think it is part of normal human variation for at least some children, notably boys, to be very active and inattentive. In additional to non-volitionality, typically diseases are considered to be pathologies that are beyond the scope of normal, or reasonable, human experience.

[6] There are, of course, exceptions to this view. Smokers with lung cancer are clearly considered to have a disease but they may still be held responsible for it. I do not believe, however, that persons who are seen to have clear cases of mental disorders are in this category. To the extent that some non-clinicians do hold persons with, say, schizophrenia, responsible for their symptomatic behaviour, I think it is because they are not seeing the phenomena exclusively as a disease.

Both low mood and current cases of diagnosed depression certainly qualify as unpleasant psychological states, but many instances seem to be states that are normal, an ordinary part of human experience. Everyone experiences a low mood sometimes, and moreover, as I mentioned in the introduction of this chapter, the prevalence of diagnosable depressive disorders in North America is staggering. I think the sheer normalcy of low mood / depressed experiences should prompt skepticism about whether or not many of these are genuinely pathological phenomena.

This idea that mental diseases are only real if they are malfunctions grounded in physiology or materially caused rests on the commitments currently held by Medical Model A. Further, Medical Model A demands that practitioners ought to aim to eliminate mental disorders by fixing those deviant physiological causes, and the elimination of physiological dysfunction is best accomplished through material, namely, pharmaceutical, intervention. As the cause of the disease is material, so too must be its cure. A common unwarranted corollary to this position is the idea that if there is a material treatment for an unpleasant psychological state, then there can be confidence that this psychological state is a mental disease. Treatment in this instance just means that the unpleasantness of the psychological state is eliminated.

It is my contention that these (implicit) beliefs are evident in the expansion of depressive diagnoses. Further, I believe that this expansion has been fueled by the advent of new anti-depressant pharmaceutical interventions. In order to establish this claim, I must first show that depressive diagnoses have in fact been expanding, and then show that there is reason to believe that availability of new drug therapies has motivated it.

3. The remarkable expansion of depressive diagnostic categories

The claim that the pathologisation of depression is expanding to encompass more 'normal' variants thereof is not one that requires much argument. Convincing evidence is found in an examination of the various editions of the *DSM*. The first edition, published in 1952, did not gain universal acceptance among either clinicians or researchers, and while the second edition, *DSM*-II, published in 1968, had more success, it also did not become the diagnostic device of choice.[7] It was the third edition, *DSM*-III (1980) that became established as the singular source of psychiatric classification for North American practitioners. Its organisers wanted it to be the central voice in American mental health diagnostic practice, and they have succeeded in making it so. A large number of specialists from a wide variety of theoretical camps were consulted during its creation, and a lot of work went into ensuring that the manual kept as neutral a face as possible on established disputes within the discipline. Its current use by everyone from Freudians to biochemists is proof of its success in this regard. The most recent editions, the revised third edition, *DSM-III-R* (1987), the fourth edition, *DSM-IV* (1994), and the text-revised fourth edition, *DSM-IV-TR* (2000), are essentially unrivalled.

A simple tally of the number of depressive diagnostic categories across the *DSM*s (these are any disorders whose primary symptom is considered to be anhedonia) will begin to demonstrate their proliferation. Where *DSM-II* had four, *DSM-III* had eight. *DSM-III-R* added another two distinctions within the *DSM-III* categories, and *DSM-IV* replaces an "and" with an "or", in order to decrease diagnostic narrowness, and builds in flexibility to time limits so that people are not arbitrarily excluded.

[7] Use of the first edition of the *DSM* was quite limited. Very few copies still exist and I was unable to gain access to one. As a result, the progression that I will trace through the *DSM*s will begin only with *DSM*-II.

Of course, it is not enough that the number of categories increases. I also need to establish that the range of behaviours or psychological states that these categories cover is expanding to encompass milder forms of the depressive experience (that many are inclined to think of as normal rather than pathological). This is abundantly clear in the move from *DSM-II* to *DSM-III*. In the *DSM-II*, there were four ways in which one's depression was considered pathological. If there was an obvious psychosocial stressor preceding the depressive episode, then the depression must be either "excessive,"[8] in which case it is an instance of 'depressive neurosis,' or it must "[impair] reality testing,"[9] which is 'psychotic depressive reaction.' If there is no obvious preceding stressor, then depression might be either 'involutional [onset late in life] melancholia,' which involves severe insomnia, or 'manic-depressive illness, depressed type,' which requires severe psychomotor retardation. Notice what these categories entail. Either the person must be obviously sadder than most other people would be, given the same life experience(s) (implying that the behaviour of 'most people' is not pathological), or it requires clear and extreme somatic symptoms, either delusions, insomnia, or obviously slowed movement and cognition.

In the *DSM-III*, no such distinction is made between depression that is or is not preceded by a clear stressor. This is because "there is no compelling evidence that once a major depressive episode has developed, its course and response to treatment are affected by whether or not its onset was associated with a stressor."[10] Instead the patient needs to have

[8] APA 1962, 40.

[9] Ibid. 38.

[10] APA 1980, 376. This passage will be relevant later. In *DSM*-III, major depressive disorder may be further specified to have psychotic features (i.e. delusions, hallucinations), be in remission, or be linked with melancholy (generally more severe).

had depressive symptoms for some minimum amount of time, and experience some minimum number of symptoms from a checklist. For a diagnosis of the umbrella category, major depressive disorder, for example, the depressive symptoms must have been present every day, almost all day, for at least two weeks, the person must be generally dysphoric, and she or he must have four symptoms from a possible eight:

(1) poor appetite / weight loss or increased appetite / weight gain
(2) insomnia or hypersomnia
(3) psychomotor agitation / retardation
(4) decreased pleasure in typically pleasurable activities, including sex
(5) fatigue
(6) negative self-assessment
(7) trouble concentrating / indecisiveness
(8) suicidal ideation

Notice what this list now permits. First, there is no longer any acknowledgement that psychosocial stressors may have normal depressive responses. Further, one need not have externally observable somatic dysfunction at all in order to qualify; having the symptoms in (4)-(7) will suffice. These four symptoms seem to fall clearly within the bounds of normal responses to stressful events, and even the two-week requirement still permits many individuals who would never have been diagnosable under *DSM-II* to now have a bona fide mental disease. *DSM-III*'s dysphoric disorder is similar. In this case, the symptoms must be largely present for a period of two years, but never be severe enough to qualify as major depressive disorder, and the individual must have three of a list of 13 symptoms, including manifestations like decreased productivity at work and pessimism about the future. Again, pathologisation is possible of symptom-profiles that never would have counted as disorders under *DSM-II*.

The same trend is seen in the move from *DSM-III* to *DSM-III-R*, although not as extreme. For example, new subcategories are provided that permit seasonal depressive symptoms to

count toward either major depressive disorder or dysthymic disorder, thus permitting the waiving of the minimum time period requirement. *DSM-IV* also continues the creation of new sub-categories, including, for example, a specification that a person mourning someone's death is a candidate for a mental disorder if their grieving lasts longer than two months. The end result is simply that more people count as pathologically depressed now than did 40, or even 10, years ago.

The obvious question is, what has fuelled this remarkable expansion? I think any assumption that this is simply the result of better diagnostic skills is too facile. Instead, I wish to argue that the primary fuel for progressively larger diagnostic categories has been the advent of exciting pharmacological responses to milder forms of depression. A pharmacological treatment is of course exactly what Medical Model A would endorse. It is the availability of a 'cure' for certain mood states – I will call this the 'response to treatment' criterion – that has led to the permissibility of designating them pathological, rather than simply as one of the normal responses humans might demonstrate. The importance of therapeutic drugs in the research of depression is acknowledged by Randolph Nesse. He writes with enthusiasm about how much researchers know about the neurotransmitters involved in depression, and is clear that this knowledge is largely a result of clinical observations of the effects of various drugs.[11]

Here is the argument that I believe practitioners within Medical Model A implicitly endorse:

1. The 'response to treatment' criterion is a suitable test of the existence of a (diagnosable) disorder.
2. Mild depression is materially treatable.

Therefore 3. Mild depression is a disorder.

[11] Nesse 1999, 895.

4. Materially (i.e. pharmacologically) treatable disorders must have material causes.
Therefore 5. Mild depression is materially caused.
6. Clinical understanding of materially-caused disorders should not focus on non-material reasons.
Therefore 7. Clinical understanding of mild depression should not focus on non-material reasons.

In section 4, I will argue that in the current medical climate, mental health practitioners do indeed consider the 'response to treatment' criterion to be grounds for its pathologisation (premise 1). In section 5, I will argue that the recent advances in pharmacological treatment of depression represent a change that mapped on to the 'response to treatment' criterion (premise 2). I take premise 4 to be fairly uncontroversial and will not devote time to establishing either its truth or that clinicians hold it to be true. In section 6, I will attempt to establish that clinicians do indeed believe that where one has a materially-caused disorder, the focus should not be on non-material reasons.

4. Medical Model A acceptance of the 'response to treatment' criterion

Before showing that the 'response to treatment' criterion has been influential in the development of depressive diagnostic categories, I must make an admission. There have been several explicit acknowledgments among clinicians that the 'response to treatment' criterion is problematic. Robert Spitzer, the psychiatrist who spearheaded the creation of *DSM-III*,[12] and some of his colleagues have overtly argued that this criterion is not one that should be employed.[13] The main concern is the criterion's circularity.[14] Clinically, a

[12] Alex Spiegel has written an interesting article in *The New Yorker* detailing the way that Robert Spitzer's vision has shaped the DSM and all psychiatric classification. (Spiegel 2005.)

[13] Zimmerman and Spitzer 1989.

[14] Frances 1994, vii.

'disorder' is typically understood as some unpleasant state X (in this case, mental state) that should (ideally) be treated. This characterisation of disorder cannot be clinically useful if what makes X a disorder in the first place is that X is treatable.

Further, reliance on a 'response to treatment' criterion contravenes the tenets of evidence-based medicine, the current dominant theoretical standpoint of North American medicine. The aim of evidence-based medicine (EBM) is to make medicine more scientific.[15] Within EBM, treatments are not generally administered until their efficacy is established, and this can only happen if the disorder being treated is well- defined prior to experimental drug trials. A therapy's success can only be measured if there is clarity about the disordered state that is to be alleviated. But despite the awareness of some practitioners that the 'response to treatment' criterion is invalid, I remain confident that it has been an unstated influence on practitioners' views about permissible diagnostic categories. I am not alone in this belief. Peter Kramer's book, *Listening to Prozac*, is an extended analysis of just this phenomenon. He worries that both clinicians and society at large "permit the material technology, medications, to define what is health and what is illness."[16]

Evidence for this claim is found, in part, in an examination of the *DSM*s, both the diagnostic entries and theoretical commitments. Making a case for the importance of treatment opportunities in determining the diagnostic categories of the *DSM*s is a little complicated. The *DSM*s do not discuss treatment, as they are intended to function strictly as diagnostic companions. Despite this silence, it is interesting to note the experience of Andrea Jacobson and William McKinney, who prepared a treatment guide to accompany the *DSM*-

[15] See e.g. Paris 2002, 130.

[16] Kramer 1993, 16.

III. They note that psychopharmacological methods bear an "…easy correspondence … to *DSM-III* categories, e.g. antidepressants to major depressive disorder."[17] I am confident that this easy correspondence is not mere good fortune or coincidence.

The *DSM-III* is the first to explicitly acknowledge the interconnectedness between treatment and diagnosis, its authours claiming that "planning a treatment program must begin with an accurate diagnostic assessment."[18] The influence of the 'response to treatment' criterion is seen in the diagnostic profile that appears only in *DSM-III-R*, for Major Depression, Melancholic type. Here, one of the possible symptoms of this disorder is "previous good response to specific and adequate somatic antidepressant therapy, e.g., tricyclics, ECT, MAOI, lithium."[19]

In a focus group with primary care physicians, Patricia Carney et al. discovered that every participant accepted that the presence of depression could be indicated by response to selective serotonin reuptake inhibitors, or SSRIs.[20] Harold Pincus, director of research for the American Psychiatric Association, said in an interview that so-called subthreshold disorders (e.g., minor depression) ought only to receive disorder labels after treatment had been shown to influence the natural history of the condition.[21] Recall, too, the earlier quote that explained why the central *DSM-II* distinction — between depression that was preceded by a stressor and depression that was not — was eliminated for *DSM-III*. It was because

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[17] Jacobson and McKinney 1982, 184.

[18] APA 1980, 1.

[19] APA 1987, 224.

[20] Carney et al. 1999, 971.

[21] Brody 1997, C2.

there was no difference in their respective responses to treatment. In the absence of treatment response, the distinction was considered to do no work.

It must be acknowledged that the 'treatment response' symptom of 'major depression, melancholic type' has been removed for *DSM-IV*. I propose that this is because, in this instance, the criterion was explicit, and there is some awareness that it is problematic. It still seems clear to me, however, in light of the evidence that I just cited – *DSM* diagnostic categories, Carney's research into clinician attitudes – that the 'response to treatment' criterion has been employed as an indicator of disorder status – sometimes explicitly, sometimes implicitly. I further believe that this acceptance has had a pervasive influence on the diagnosis of depression.

5. How the 'response to treatment' criterion relates to new treatments of depression

Now I must show that newly developed pharmacological anti-depressants were indeed different enough to spark the transformation that I am describing. The medications I have in mind are the second generation of anti-depressants, the selective serotonin reuptake inhibitors, or SSRIs. They have been a rallying point for those wanting to include less-severe instances of depression in categories of mental disorder, but their actual effects are difficult to disentangle from their hype. Irving Kirsch et al. used the "Freedom of Information Act" to access all the SSRI study results that were submitted to the Food and Drug Administration. Astonishingly, they found that SSRIs do not have a clinically-significant different effect over placebo on depression.[22] There have not yet been that many studies of SSRI treatment specifically of depression that is considered by clinicians 'sub-threshold.' Sub-threshold

[22] Kirsch et al. 2002.

depression is a case where the clinician feels that the phenomenon is the same phenomenon as found in depression proper, but the symptoms either are less severe or have existed for a shorted time, and so the patient does not qualify to be diagnosed with depression. This category is comprised of cases of what I am calling 'normal low mood.' James Barrett et al. found a difference between placebo and paroxetine for dysthymia patients, but concluded that "watchful waiting" was still the best approach with this patient population.[23] This hardly seems to warrant the level of excitement that Prozac and its brethren have elicited.

But there are two ways in which the SSRIs have been revolutionary. First, the smaller side-effect profile of the second generation of antidepressants has meant that they could be more comfortably administered to people who were suffering less. When a medication has a lot of serious, unpleasant side-effects, a physician will be restrained in giving it to people who are not that sick. But reduce the side effects, and that frees up the doctor to try it out on people who are not in particularly dire straits but who are suffering some degree of discomfort that is similar to the kind of discomfort for which the medication is indicated.

This is exactly what happened in the use of SSRIs. Standard medical practice demands that new treatments may only be used for a patient population once there is evidence that the new treatments are likely to be more effective than current treatments. In the case of SSRIs, it did not seem to matter that these medications had not been proven more effective than other alternatives in the treatment of minor depression. What was especially clinically significant was that people with apparently minor depression could, without much sacrifice, take them. In an analysis of the prescribing patterns of physicians from 1985 to 1994, Harold Pincus et al. found that psychopharmacological agents were prescribed initially to 53.5% of

[23] Barrett et al. 2001.

the depressed patients who visited a psychiatrist. This percentage rose to 70.9% by the end of the study time frame. This rise is accounted for entirely by SSRI prescriptions.[24] This means that people who would not typically have been administered pharmacotherapy were now receiving it.

The second way that SSRIs were revolutionary, in this ad hoc experimentation, is seen in the reports that started coming in from people for whom the SSRIs did work, and the reports were glowing. Patients' enthusiasm for the SSRIs and their life-transforming effects far outstripped any response to the earlier anti-depressants. This tendency is clearly seen, for example, in Debra Elfenbein's collection, *Living with Prozac*. This book was intended to be a presentation of a wide variety of personal accounts of what taking Prozac was like. There are, however, very few negative perspectives offered. Instead, most of the entries read like the testimony of people who have been saved. Janet Thacker, for example, writes that, since taking Prozac, "[i]t has been like opening the dark, dirty windows of my life and allowing myself the fresh air and freedom to be alive."[25]

I have just been arguing that recently developed pharmacological treatments for depression were in part responsible for the shaping of new diagnostic categories of depression. In opposition to this position, there are those who might argue that exemplary pharmacological responses to depression have always been available, that Prozac is nothing new. The simple truth — that emotions, mood and personality have physiological underpinnings that can be tampered with — has, of course, been known for some time. Emotions, mood and personality have been altered for quite a while through the ingestion of

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[24] Pincus et al. 1998, 530.

[25] Elfenbein 1995, 27.

drugs that now typically are called 'recreational.' Making a principled distinction between prescribed versus recreational drugs is difficult. Pharmacological treatments are often used recreationally, and persons with psychological problems who take recreational drugs — alcohol is especially common — are often considered by their doctors to be 'self-medicating.' Thus, if I am attempting to explain new diagnostic features by appealing to the new possibilities that come with SSRIs, my critics will insist that I am making a mistake.

While it is certainly likely that physiological ways of responding to depression have existed almost as long as there has been depression, I still think there are substantive differences between previous somatic intervention possibilities and the new generation of anti-depressants. The obvious one, of course, is that SSRIs, notably Prozac, were created by medical researchers for the explicit purpose of being used as a therapeutic agent.[26] But beyond their favourable situation within the network that defines mental disease, there are other differences that facilitate clinicians becoming comfortable with allowing Prozac and its ilk to guide their diagnostic efforts.

There is a potentially-invoked difference between old (e.g. bourbon) and new (e.g. Prozac) somatic treatments of depression that does not work for my purposes. It might be claimed that recreational drugs are mood-altering in a way that masks the original, pre-pathological self, whereas antidepressants, especially the SSRIs, are self-revealing. Implicit in this assertion is that SSRIs restore a natural order, whereas recreational drugs impose an unnatural one. Here, I think, empirical evidence is both relevant and fairly decisive. Often, when Prozac works, it does not just restore patients to their pre-pathological states (assuming

[26] Kramer 1993, 60-66.

that such states even exist). It restores them to a level of well-being they have never experienced before.[27] The self on Prozac is often not a self that the patient has ever met.

An overwhelming majority of mental health practitioners and philosophers are willing to grant that all mental events require brain events, in some fashion or other (although the nature of this requirement is not easy to spell out). It seems likely that this requirement is quite far-reaching. Larry Siever and William Frucht, for example, claim that "we are beginning to know, in a specific and detailed way, that personality styles as well as mental disorders have physical and chemical origins. All are rooted in the brain. In a sense, even our "selves" are grounded in the brain's biology."[28] Recreational drugs and SSRIs both work on brains. Why would the brain tampering that happens with Prozac be self-revealing, while the brain tampering of alcohol or uppers/ downers is self-altering? Certainly alcohol effects different brain events than Prozac does, but it would require much more argument to establish that the Prozac-processes are the 'self-processes', but the alcohol-processes are not. All psychological events find expression in brain events, and everything people experience, e.g. exercise, diet, emotional turmoil, effects brain physiology to some degree.

A better-motivated difference between old and new somatic treatments of depression is the aforementioned 'cleanness' of the new antidepressants, e.g. generally, no hangover, no interference in motor coordination, no withdrawal symptoms, no cravings. They are also less toxic. This means that should the depressed person attempt suicide by taking an overdose of SSRIs, they are less likely to be lethal that other medications (e.g. lithium). They also provide a stability of mood over long periods of time that few recreational drugs can match.

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[27] Kramer 1993, 126.

[28] Siever and Frucht 1997, viii.

Maintaining a steady level of a drug like alcohol, such that one's depressive symptoms are continuously alleviated over months or years, with almost no ups and downs, is essentially impossible, particularly without doing oneself serious harm in the process.[29]

Perhaps a more important difference is that while alcohol/ marijuana/ opium/ heroin/ etc. do alleviate certain symptoms of depression, primarily the psychic pain, they also interfere with the pursuit of personal and professional goals. They stunt, in certain respects, one's emotional and cognitive development. Prozac not only does not seem to interfere with the pursuit of goals and interpersonal relationships, it also seems to actually foster their development. Prozac manages to alleviate the burden of psychic pain without reducing the individual's motivation to pursue productive life projects, and often even enhances it. Thus, the rejection of recreational drugs as fruitful treatment might be said to arise because they prevent people from meeting their obligations, both to others and to themselves. With the new breed of antidepressants, however, almost the reverse is true. Initially, for the depressed person, depression interferes with their ability to form and maintain meaningful relationships. It is only in virtue of taking Prozac that they are able to resume a place within their community.

If I am right about medications being a strong influence of diagnosis of depression, then the timing of their introduction and the publication dates of the *DSM*s should correspond, and this does indeed seem to be the case. The first pharmaceutical specifically intended as an antidepressant (the tricyclic, imipramine) was introduced for general use sometime around 1959. If the tendency to pathologise that which was pharmacologically treatable had greatly

[29] One possible exception to this claim is marijuana. While the treatment profile of marijuana is rather scanty — doing research on the clinical effects of dope on human depression has been rather difficult in the present political climate — it is impressive. See e.g. Williamson and Evans 2000 for a brief overview of the literature.

influenced the creation of the *DSM-II* (published 1968), then there should have been an expansion of its depressive diagnostic relative to the *DSM-I* (published 1952). There are, however, almost no significant differences between the two manuals.[30] Although the reason for this consistency is beyond the scope of this thesis, a suggestion can be made based on the wording of the symptoms of the depressive diagnoses in the *DSM-II*. Depressive neurosis, for example, was considered to be "an excessive reaction due to an internal conflict or to an identifiable event."[31] The psychoanalytic undertones of this diagnostic category imply that the availability of pharmacological treatment would not have been tremendously important in its classification.

It is in the introduction of *DSM-III* in 1980 that the most interesting changes are seen. Imipramine gained tremendous popularity in America during the 1970's, along with a number of other antidepressants. In 1980, as I have shown, the depressive diagnostic categories greatly expanded with the publication of *DSM-III*. Few changes in antidepressant therapy happened throughout the early 1980's, and there are not many substantial changes or expansions seen in the depressive diagnostic categories in the *DSM-III-R* (published in 1987).

The introduction of the first SSRI, Prozac, happened in December, 1987, with two other important SSRIs, Zoloft and Paxil, following in 1991 and 1992, respectively.[32] In 1994, *DSM-IV* introduced 'minor depression' as an important research diagnosis. This indicates that not enough time had elapsed for clinicians to be confident that they could treat minor

[30] Wallace 1994, 38.

[31] APA 1968, 46.

[32] Pincus et al. 1998, 530.

depression with the SSRIs, but enough anecdotal reports of successful treatment had come in that they felt that minor depression should be singled out for special mention.[33] In the intervening six years, despite the still relative paucity of strong empirical evidence showing that minor depression responds consistently to antidepressants, most mental health practitioners insist that it warrants its own diagnostic category, based largely on clinical experience.[34]

In light of this evidence, this dissertation offers an empirical prediction: in *DSM-V* (currently being prepared and due to be released in 2010), minor depression will have joined the ranks of the regular diagnostic categories. Its symptom profile will emphasize anhedonia, low self-esteem, and fatigue, and its time requirements will fall somewhere between major depressive disorder (two weeks) and dysthymia (two years), with intermittent symptoms explicitly permissible.

If my analysis thus far is correct, it means that ultimately, if pharmacological intervention can 'treat' (i.e. make go away) the mood state that comes, for example, when someone is in a hopeless situation, when someone loses a spouse, or if they experience mild low mood in light of disappointing events, then these experiences will be categorised as a disorder. This claim will no doubt evoke protest, as it seems clear that such mood instances are not expressions of a disease, they are simply normal reactions to hardship, loss or disappointment. There is still a strong intuition that there is a difference in kind between normal low moods (especially if it is mild) and pathological depression (especially if it is major). On what grounds is this distinction to be made? Ultimately, I think our efforts to

[33] Pincus et al. 1992, 116.

[34] See Kramer 1993, pages 47-66, for an extended discussion of the development and introduction of antidepressants.

clear space for non-pathologisation of some cases of low mood require taking these moods as possible intentional states. Current medical practice, however, does not pursue that kind of engagement.

For the practitioner within Medical Model A, to make the distinction between mild low mood and depression, a physiological difference would need to be found between the two. If such a difference could be found, then it might serve as a barrier that could stop the encroaching tide of pathologisation. It might be possible simply to stipulate that the brain states associated with what we think of as normal low moods are themselves simply normal brain states. Although the existence of such a clear physiological distinction is being debated among researchers, thus far, none has been found. Researchers have spent considerable resources looking, but with limited success.[35] They have encountered no genetic differences, as extrapolated from twin studies,[36] no difference in brain activity,[37] and no qualitative difference in reported phenomenology.[38]

The lack of difference is especially highlighted by the two characteristics central to current medical practice: impairment of functioning and treatability. Both major depression and low mood impair functioning in similar ways, as their sufferers work less and consume more health care resources.[39] Both are also amenable to treatment by antidepressants.[40]

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[35] Vrendenburg et al. 1993.

[36] Kendler and Gardner 1998.

[37] Kumar et al. 1998.

[38] Kessler et al. 1997.

[39] Spitzer et al. 1995.

[40] See e.g. Paykel et al. 1998 and Szegedi et al. 1997.

Pharmacological treatment of low mood (that appears to be the result of some recent psychosocial stressor) has been shown to be as efficacious as treatment of major depressive disorder and dysthymia.[41]

Hope that a difference in kind between normal low mood and pathological depression would be found by rigorous empirical examination of physiology has not been borne out. Instead, it seems quite possible that there is no such difference in kind, and that many forms of depression exist along a physiological continuum, with major depression at one end, and mild low mood at the other.[42] Since both normal low mood and pathological depression are treatable by pharmacological interventions, they must have a physiological cause. In fact, as far as medical practitioners are concerned, since they are (roughly) treatable by the same drugs, they likely have (roughly) the same physiological underpinnings. In this picture, it becomes straightforward to see how the distinction between the two would become blurred – normal low mood works much like and is treatable much like many clear cases of pathological depression. It thus fits comfortably into current categories of diagnosable mental disorders.

This trend should, I believe, raise some concerns. There exists a naïve hope that 'normal' moods are easily recognisable, that psychopathology will make itself known. But recent research is establishing the details of what we have long known. *All* moods – the normal, the pathological, and everything in between – arise in conjunction with changes in brain chemistry. They all have the potential to effect functioning. In the case of depression, there are no physiological or functional markers that set the pathological states apart. And the

[41] See e.g. James et al. 1999, and Robinson et al. 2004.

[42] See e.g. Angst and Merikangas 1997.

common clinical attitude that response to treatment can help to identify the pathological will be no help in this context. All moods are alterable – i.e. *treatable* – through a wide range of environmental influences (e.g. sunlight, food, alcohol, drugs). Typically, treatment is considered to be a return to a state of normalcy, but of course that idea, in this context, just goes in a circle. Once the standards for the normal and the pathological evaporate, the door is opened for pathologising what is now considered a normal low mood.

Let me now return to the Medical Model A argument I presented in section 3. I have argued that some clinicians hold the view that "the 'response to treatment' criterion is a suitable test of pathology" (premise 1). In my account of how this view has played out in the case of depression, I presented data that "mild depression is materially treatable" (premise 2) – or least evidence that clinicians take mild depression to be materially treatable. This leads to the view that "mild depression is a disorder" (premise 3) which I argued is revealed in the expanding diagnostic ranges of depression. It further seems to me that the belief that "materially (e.g. pharmacologically) treatable disorders must have material causes" (premise 4) is uncontroversial. Pharmacological treatments, in that they are material substances, act on other material substances, namely, physiological conditions. This means that any pharmacologically treatable symptom profile must have some kind of underlying physiological cause. So now, my task is to show why clinicians might also hold the view that "clinical understanding of materially-caused disorders should not focus on non-material reasons" (premise 6).

6. Medical Model A understanding of materially-caused disorders does not focus on non-material reasons

Within Medical Model A, there is a basic belief that physiological diseases are not, at least clinically, best understood or approached in terms of their intentional aspects. Before I begin this section, however, I must admit (an admission similar to the one I had to make in section 4) that many clinicians explicitly deny that they hold this view. But I think that this belief shows itself implicitly in the treatment that clinicians most commonly make available. It seems to me that if clinicians took seriously the possibility that patients' depression might be intentional, then psychotherapy that grappled with intentional features of depression would be considered part of an appropriate course of treatment. Indeed, there are several important studies that establish that the best treatment of depression includes psychotherapy and so a great deal of lip service is paid to including psychotherapy in a good treatment plan.[43]

The treatment data, however, tell a different story. Despite treatment recommendations to the contrary, exclusive pharmacotherapy is the most widely used treatment for depression.[44] In a recent survey of treatment in the United States from 1987 to 1997, outpatient treatment of patients' diagnosed with depression increased from 0.73 to 2.33 per 100 persons. Antidepressant prescriptions went up from 37.3% to 74.5%, while the proportion of patients receiving psychotherapy went *down* from 71.1% to 60.2%. Moreover, the number of patients who received their care from primary care physicians went up, which is also linked to a reduction in use of psychotherapy. [45]

[43] See e.g. Mynors-Wallis et al. 1995, Pirraglia et al. 2004, and Schulberg et al. 2002.

[44] Robinson et al. 2005.

[45] Olfson et al. 2002.

This trend may simply be a pragmatic response to a variety of clinical challenges. Joel Paris claims that psychiatrists get distracted when they try to keep track of all the physiological and psychosocial factors that may go into a particular individual's problem. Thus, he contends that "by reducing complex syndromes to target symptoms that can respond to specific drugs, we can often treat patients more effectively."[46] Historically this approach has been very successful. In the past, many unpleasant physiological phenomena have been understood in terms of reasons. For example, in the 18th century, sufferers of tuberculosis were thought to be experiencing extreme forms of nostalgia. The thought was that if someone:

> … lose[s] all hope of returning safe and sound to their beloved homes and country, they become sad, silent, listless, solitary, musing, and full of sighs and moans, and finally quite regardless of, and indifferent to, all the cares and duties of life … the body gradually pines and wastes away.[47]

As, however, the causal mechanisms of tuberculosis have become better understood, talk of "loss of hope" – or any other intentional element, for that matter – is no longer accepted as relevant to clinical responses to the disease.

A more recent example is peptic ulcers. Until very recently, peptic ulcers were thought to be brought on by stress. Not just any stress, either – it typically involved anxiety about performance, and was thought to be linked to particular cognitive styles. On my view, these environmental and personal features might have been thought of as intentional objects. Now, however, possible intentional objects for peptic ulcers are no longer taken as clinically relevant. This is in large measure due to the discovery that a bacterium plays a crucial causal role in forming peptic ulcers. Once this causal story was better understood, therapy could be

[46] Paris 2002, 134.

[47] Hudson 1983, 3.

more effectively undertaken. Intentional features for ulcers are, in this new clinical light, seen as a fiction, created to mask our actual ignorance. I believe that depression is seen in a similar light – and clinicians see themselves, in eliminating intentional talk from depression therapy, as effecting the same kind of transition as gastroenterologists have accomplished in eliminating 'intentional object' talk from treatment of peptic ulcers.

Once, depression was considered to be related to intentional objects that occasioned a mood of depression. Those occasioning intentional objects could be thought about, understood, and used to prompt changes in one's life. In fact, there are many people who consider themselves to have been successful in some of these endeavours. Now, however, according to Medical Model A, it appears that this was all a convenient fiction. Once the brain physiology is worked out, intentional objects do not do any explanatory work. For them, depression is simply all in the brain, and thinking about a mood's intentional objects is not the right way to bring someone to better brain physiology.

If the preceding analysis is on the right track, I think I have established that at least some practitioners within Medical Model A endorse the argument that I laid out in section 3 of this chapter. This means that in some clinical settings, mild intentional depression – e.g. a low mood in response to disappointing events – is implicitly seen as a disease. Additionally, this disease will be approached by some clinicians purely as expressions of brain pathology, rather than intentional, meaningful responses to life events. I think that this result is intuitively disturbing for many, but I would also like to devote some effort to spelling out some of what I think is wrong with that conception. In the next section, I will offer another (perhaps more nuanced) characterisation of the medical model, that I will call the 'reason-

inclusive medical model.' I still think, however, that this model includes too limited an understanding of depression.

7. Medical Model B: The endogenous / reactive version of the low mood / depression distinction

It is important to note that the medical model practitioner need not occupy as narrow a position as I have thus far indicated. My construal to this point has been something of a caricature. The medical model often employed clinically does not necessarily entail the elimination of reasons – this is Medical Model B. Physicians working within the medical model should not – and many do not – limit the causes of psychopathology to the central nervous system, as material causation can ultimately be seen as an infinite sequence. Every event has a cause, but so too does every cause have a cause. This means that although variance in neurotransmitter levels may be responsible for depression, something must be responsible for the neurotransmitter variance.

Any physical analysis of neurotransmitters will quickly establish their genetic link (depression has a pretty clearly established genetic pedigree).[48] Genes are expressed in environments, and these environments have tremendous influences on how genes are expressed. How, precisely, material aspects of the environment act materially on the brain is not very well-established, but many researchers are confident that answers suited to their medical model analyses will soon arise. Paul Gilbert is a proponent of the idea of interaction between environmental and physiological forces leading to depression, describing it as "a

[48] Gazzaniga 1992, 168 and Klaus Lesch 2004.

negative life event/ uncontrollable stress — biological change — negative cognitive style relationship."[49]

This really is an acknowledgement that medical model practitioners have to make. It is their contention that depression is built on a physical foundation, but it is well established that talk and behavioural therapy can make a therapeutic difference. In fact, efficacy rates for talk therapy alone or SSRIs alone are roughly the same.[50] The efficacy of talk therapy is not simply an effect of conversation or human contact, as some critics have speculated, and not every type of talk therapy is equally successful in treating depression.[51] That different types of talk therapy can do this kind of work at all points to the necessity of thinking in terms of causes beyond the brain.

Medical Model B opens the door to a commonly employed, clear and simple way to make the distinction between normal low mood and pathological depression. Normal low mood has a reason ascertainable in an analysis of the environment, whereas pathological depression does not. The less apparent or direct the environmental reason, the more pathological the case. Edwin Wallace is a proponent of this view. He writes that "psychiatrists [cannot] continue inadequately to acknowledge the impact of cultural, socioeconomic, and political ambience on process, form, and content of psychopathology … weighing cultural factors and adaptational values in local contexts is important in distinguishing psychopathology from institutionalized experience, belief, and behavior."[52] The two states arising from this

[49] Gilbert 1992, 178.

[50] Schulberg et al. 2002.

[51] APA 2000a.

[52] Wallace 1990, 68.

distinction are typically called reactive depression and endogenous depression. Endogenous depression, in this context, does not, of course, mean uncaused depression. It just means that its causes will not be the ones traditionally considered to be causes of depression, e.g. stress, tragedy, etc. They need to be investigated, but causes of endogenous depression may end up being related to diet, or viruses, or some other environmental entity unconnected to stress or emotional trauma.

Given genetic considerations, it can even be argued by these researchers that depression can be valuable. In chapter I, I presented D'Arms and Jacobson's view that emotions can be assessed for appropriateness in three different respects. Paul Griffiths adds a fourth, and argues that emotions and moods (Griffiths explicitly includes moods here) can be evaluated as appropriate or not in light of evolutionary considerations. (L. Sloman et al. and Michael Gazzaniga all argue for this claim.) This view is motivated by a commitment to considering genetic phenomena as adaptive. If human beings are genetically hardwired to become depressed, then there are likely good reasons why this is the case. Michael Gazzaniga speculates that depressed behaviour might serve to elicit certain kinds of responses from one's community, citing evidence from animal studies that depressed infant monkeys receive more attention than their non-depressed peers.[53] Sloman et al. hypothesises, also based on primate studies, that depression is a response to being a lower rank in a social hierarchy.[54] This possibility has been labeled "learned helplessness." The conjecture is that a lower-ranked animal might become depressed and this will be less likely to challenge higher-ranked animals. This tendency to be non-challenging may result in increased survival. This

[53] Gazzaniga 1992, 171.

[54] Sloman et al. 2003.

adaptive consideration, when paired with the endogenous / reactive distinction, allows us to speculate that reactive depression is depression that is doing is genetically-selected-for job (which may, in our current environment, not be adaptive), while endogenous depression indicates a problem with the depression system.

Nesse likens the treatment of neurotransmitters in isolation, as though they alone were the problem, to treating physical pain in itself without wondering about its aetiology.[55] Typically, clinicians do not advocate making someone's pain go away without trying to figure out where the pain originates (certain ubiquitous pains, e.g. headaches, serve as an obvious exception). It would be absurd to assume that pain simply arises out of dysfunction in the thalamus and treat that in isolation. Like pain, depression as a phenomenon itself can be seen as a symptom and pharmacological treatment of symptoms while ignoring higher-order causes of those symptoms is short-sighted.

Proper treatment, one that really fixes things, necessarily involves confronting the primary underlying instigators of the problem. Treating the neurotransmitters without addressing the psychosocial reasons behind their imbalance is only a stopgap measure. It is quite open to clinicians in this context to say that even if pharmacological treatment of certain instances of depression is possible, pharmacological treatment alone is not appropriate because brain chemistry is not the sole cause of the depression. Other causes, including psychosocial factors ought to be responded to. Thus, psychosocial influences can be very important in a physicalist causal analysis of depression.

But, as with the earlier physiological distinction, the endogenous/ reactive distinction supported by Medical Model B does not seem to have strong empirical support. In analyses

[55] Nesse 1999, 897.

of apparently clear cases of pathologically depressed people who did not obviously seem to be reacting to any particular negative event, researchers have found that these individuals do in fact have what looks like non-physiological origins for their depression. For example, several studies have found that apparently pathologically endogenously depressed persons have suffered greater loads of psychosocial stress over their lifetimes,[56] or that their childhood experiences were more traumatic than those of non-depressed persons.[57] Even if many depressed people have not experienced extreme stressors immediately preceding their depressive episodes, there do appear to be grounds for thinking that a great deal of depression arises in conjunction with some kind of environmental pressures. It looks like, even in cases with a large consensus that the depression is pathological, non-physiological phenomena have played a role in the creation of that person's depression.

This lack of empirical support gains additional bite when we consider the limited skills that medical practitioners appear to have in ascertaining these complicated non-physiological phenomena. That suburban housewives are disproportionately considered to suffer groundless depression is worrying, for example. It seems plausible to me that being isolated in a house with the kids all day, while one's husband goes off to work and to interact with others, might serve for some women as a source of depression. That a clinician cannot immediately see what looks like a reason does not mean that the search should be called off. The visibility of certain kinds of reasons for depression will be greatly affected by who is doing the observing.[58] Numerous feminist and cultural observations can be made about ways

[56] See e.g. Nolen-Hoeksema et al. 1999.

[57] See e.g. Lara and Klein 1999.

[58] Jacobson and McKinney 1982, 215-6.

in which aspects of the lives of women or minorities are invisible to traditional medical personnel.[59]

An alternative view might be that pathological depression is present when the sufferer herself cannot identify an environmental origin for her depression, but this, too, is a worrying criterion. Given the efficacy of psychoanalytic treatment premised on the active role of the unconscious in our mental states,[60] it seems possible that many such non-physiological forces will not necessarily be transparently accessible to the person for whom they are operant.

8. The normative element of depression

Despite these problems, I believe that there are many strengths of the reason-inclusive Medical Model B I just outlined. There may even be an inclination to suppose that the endogenous / reactive distinction eliminates the need for worries about the pathologisation of normal low mood. Some non-physiological sources for both having low moods or for being depressed have been established as relevant, and at least some normal low mood states will not be medicalised. Further, an embrace of environment-physiology interaction in treatment can be part of a richer therapeutic interaction between clinician and patient. This model accepts the evidence that a combination of medication and some kind of talk therapy is the most effective treatment for depression. In turn, this therapeutic attitude will better meet the ethical obligations that exist between clinicians and their patients.

Despite these positive aspects of this line of analysis, I wish, however, to argue that environmental sources of depression, as they are understood in the reactive/ endogenous

[59] See Nolen-Hoeksema et al. 1999 for discussion.

[60] Pancner and Jylland 1996, 144-5.

distinction, are construed non-intentionally. I believe that this approach does not engage with the potential intentional element of depression – it simply leaves it out. Suppose that good evidence could be garnered that pathological depression is indeed endogenous, not caused by typical environmental prompts for being depressed, and that which is considered a normal low mood always is always preceded by such an environmental prompt. For most medical practitioners, environment in this context is simply understood as operating as a material cause for certain brain states. A clinical interaction that places emphasis on this kind of causation will not treat sufferers of depression as suffering intentionally.

In looking beyond physiology, I am looking for intentionally-underwritten reasons for depression. The force of construing depression as a response to good reasons necessarily involves a normative element. When terrible things happen to someone, these stresses lead to depression in a normatively permissible way. The stress functions as an occasioning intentional object. Sometimes, we might want to go even further and say in some cases that there is a very compelling fit between a potential occasioning intentional objects and depression. This might mean that the person should become depressed, and a failure to do so indicates a negatively-evaluable lack.

For example, in some cases of the death of a loved one (e.g. through homicide that the survivor believes she might have prevented), we might think that a failure to manifest what would now count as pathological depression (e.g. her low mood would last longer than 2 months, it would be of great intensity, it would include beliefs about the worthlessness of life and a negative self-evaluation) would indicate that something was wrong with that person. In many situations, what is important is not that people just do become depressed, but rather that they should – or, at least, becoming depressed is an appropriate and understandable

response. George Graham writes that "were a person immune to depression in justifiably depressed circumstances, I think we should be inclined to think of him as psychologically deficient. Such an individual would either be self-deceived about his situation . . . or expressing some emotional confusion, or in some other way impaired."[61]

An important difference between material and intentionally-linked causation is highlighted by the infinity that comes with material causation. Effects have causes, but causes must have causes, which must also have causes, and so on. Reasons operating as material causes, as they do in the aforementioned description, entail further causes. But reasons in the normative sense do not; they come to an end. When someone is depressed because (in the normative sense of 'because') her dog died, there is no more explaining to do. The causal analysis is complete. And this completed, normative causal chain can then be evaluated in a very different manner than material causal chains. We can ask, "*Should* she have become depressed in those circumstances?" This question makes no sense if we are discussing materially-caused effects as such. In some cases, we can sensibly endorse her reasons, even as we strive to avoid the result. Graham believes that, "[g]ood reasons may warrant a person to be depressed, even while reason warns of its possible harmful effects."[62]

If the response that depression has received serves as a model, then it is likely that we will see broad erosion of acceptance of possible intentional accounts and normative evaluations of our affective responses. Insisting that a mechanism for determining whether or not some unpleasant affect is a disease-state is that it is pharmacologically treatable is basically to miss the point. Recent research is establishing the details of what we have long known. All affect

[61] Graham 1990, 419.

[62] Ibid., 419.

— normal, pathological, and all gradations in between — arises in conjunction with changes in physiology (e.g. neurotransmitters, brain structure, etc.). Under the approaches I have been describing, all affective responses are potential candidates for pathologisation.

These kinds of intentional causes cannot be easily integrated into either Medical Model A or B. Medicine clearly (and with many good reasons) has dedicated itself to the material/ physiological analysis of the world. Once material causes become established as the central explanatory mechanism for a particular disease, there is little impetus to investigate the possible intentional aspects of that disease. It seems to me, however, that this constitutes a substantial loss. Depression is often a response to meaningful events in its sufferers' lives. This responsiveness can only be appreciated as long as the intentional objects that bring about depression continue to have a place in its description. The placement of depression strictly in the realm of the material does violence to an important element of our understanding of affective responsiveness. I think considering and engaging with depression's intentional aspects will help us better understand and respond to the differences between pathological and normal low moods. I will argue for this position in the next chapter.

CHAPTER III
THE INTELLIGIBILITY OF DEPRESSION

In the previous chapter, I argued against two current medical models that I think implicitly deny that depression is intentional. In this chapter, I will present my positive view that moods, especially depression, are at least potentially intelligible. To see someone's depression as intelligible is to understand its potentially discrete pieces – its intentional objects, its surrounding environmental conditions, its physiological responses, its affective valence, etc. – as a unified phenomenon. A crucial element of this potential intelligibility is that depression can and often does have an intentional object. I will explain this notion of intelligibility more fully in sections 2 and 3.

Once depression's potential intelligibility becomes apparent, normative engagement becomes possible. Cases of depression can be explored by assuming the role of what I call an 'affective interlocutor.' Affective interlocution facilitates making the distinction between depression that should be pathologised and depression that should not be pathologised. Then, in section 4, I will argue that just as there are moral emotions, so too can there be moral moods. Depression's (potential) intelligibility leads to the possibility that depression can be a 'moral mood' and can play an important role in our moral lives. In the final section, I will explore some of the implications of seeing depression as potentially intentional, intelligible, and moral. That current medical approaches implicitly deny the depression can have an intentional object means that they turn a blind eye to this valuable feature of depression.

1. Why we still need to make the low mood / depression distinction

Thus far, I have considered several routes found within current medical practice for motivating the distinction between a normal state of low mood and pathological depression and have found them all wanting. There are, however, clear cases of both. On the one hand, there is the person who spends several hours unable to enjoy herself because of some new awareness she has of some negative feature of the world, who then returns to feeling cheerful. On the other hand, there is the person who spends several months in progressively worse crying jags, and finally she ends up in a comatose state, unresponsive to almost all environmental stimuli. Any substantive account of depression will have to say something about the vast differences between these two cases.

There is no denying the unique negative aspects of depression. The most obvious is, of course, the increase in morbidity due to suicide associated with depression. (There is an estimated 15% suicide risk associated with recurrent depression.[1]) But the damaging effects are more than this. First, depression is, in its very nature, negative. I believe that depression, like pain, should be paid attention to once someone suffers from it, but I do not advocate that it ought to be either sought or clung to. Persons who are depressed are also less motivated,[2] have difficulty performing some kinds of complex tasks, and have been shown to engage in self-defeating behaviour.[3] They tend to alienate the people close to them at the very hour they need them most, primarily through insecurity and excessive demands.[4] It seems

[1] Pancner and Jylland 1996, 118.

[2] Lyubomirsky et al. 1999.

[3] See e.g. Potthoff et al. 1995 and Huprich and Frisch 2004.

[4] Stice et al. 2004.

appropriate to insist that even if some degree of depression is endurable and valuable, at some point all of its sufferers rightly strive to extricate themselves from it.

Beyond these sensible reasons to resist and avoid much of the potential depression that could be experienced, there is also the simple truth that most people do not experience particularly severe depression. Even given large stress levels, most people do not think about suicide, don't have difficulty getting out of bed in the morning, and moreover, they do not have to try very hard to prevent sliding into those kinds of affective states. It seems that, whatever the deeply depressed person is experiencing, it is substantially and importantly different from what the person in the somewhat low mood is experiencing.

And so this analysis is, in a sense, right back at the beginning, except in worse shape. With the medical model there is confidence that criteria consistent with medical commitments will be found for making a distinction between pathological depression and normal low mood. These will either be found, in the case of Medical Model A, in physiology or, in the case of Medical Model B, the ability to recognize when someone's depression is groundless. It seems to me, however, that there are no such criteria. But there is still a strong intuition that a distinction has to be made.

I believe that a distinction can be made, although on slightly different lines than the proposals I have considered thus far. My proposal comes out of a commitment to grapple with the normative feature of the possible intentional causes for depression. I will argue that many – in fact, most – instances of depression are intelligible. As we explore the intelligibility of a particular case of depression, we can find insight into the appropriateness of pathologising the case and we can find guidance about how to appropriately respond.

2. Intelligibility as applied to emotions

What does it mean for something to be intelligible? Intelligibility permits a unifying kind of understanding of events that are presented separately, discretely and sequentially - it sees them as a whole. Affective states, both emotions and moods, are comprised of many elements. I think, for an affective state to be intelligible, these elements have to constitute a single whole. Because most of these pieces of a whole emotional experience are normatively evaluable, it is possible for others to engage with the emotion-experiencer about her particular emotion. I call this assuming the role of 'affective interlocutor.' Through affective interlocution, the degree of intelligibility of someone's affective state (on my view, either an emotion or mood) can be determined.

In determining whether or not an affective state is intelligible, questions of fit between aspects of the affective state are primary. (It is possible, however, to explore through affective interlocution any of the three normative axes laid out by D'Arms and Jacobson – fit, prudence, or morality.) We can ask of someone's affective state, which includes emotions and moods, whether or not the conditions that aroused it are of the right kind. We can ask whether the intentional object of a person's affective state is appropriate. As her affective state persists or fades away, we can ask whether it should do so. As the affect-experiencer responds to these questions, both she and we, her interlocutors, can learn several things. We can potentially learn about both the world and the affect-experiencer herself.

What does it mean to say that depression is intelligible? For this task, I think it will be helpful to start with a description of the intelligibility of emotions. For the sake of clarity, I will be considering an emotion's intelligibility in light of its occasioning intentional object. To begin, emotions have several components. These include affective states, physiological

elements, cognitive elements, intentional objects, and motivational tendencies. Different types of emotions have different combinations of these components. Emotions are also diachronic. They follow a pattern of coming into existence, persisting, and passing out of existence. They are aroused under certain environmental conditions. These arousal conditions reveal the intentional aspect of emotions – emotions are directed toward or are about something external to the emotion-experiencer. Once arousal happens, there is typically a set of bodily responses, both physiological and behavioural, along with an affective component (which often has a typical affective-intensity arc). There are often motivational/ behavioural consequences. And finally, the emotion fades and disappears.[5] In the majority of cases I think that we are able to link these potentially discrete emotion elements into a whole, thus rendering the emotion(s) intelligible.

There are some differences in this pattern for different emotions. Additionally, many emotions are almost always experienced along with other emotions (e.g. excitement is often joined with happiness or fear, joy often accompanies love). This can sometimes make full understanding of emotions – either our own or others' – very complicated. In the vast majority of cases, however, I think that we are able to link these potentially discrete emotion elements into a whole, thus rendering the emotion(s) intelligible.

Let us apply affective interlocution to the case of Kate. Imagine that Kate became angry because while driving she was cut off. She is angry at the other driver. The other driver's behaviour is the occasioning intentional object of her anger. Let us further imagine that we cannot understand why *that* event would lead her to be angry. One of the common fitting arousing conditions for anger is an act of being threatened. Kate perhaps could tell us about

[5] An extended discussion of these features of emotions can be found in Craig Delancey 2003.

the rules of the road and the problems that arise with cutting off other drivers. She might link her anger's intentional object (the other driver's behaviour) with the occasioning conditions of her anger and argue that by cutting her off, the other driver was essentially threatening her. She would say that through this behaviour, the other driver is an appropriate target of her anger.

As she explained, we would knit the discrete pieces – the arousing conditions, the occasioning intentional object, the intensity of the affect, its duration, the physiological and behavioural elements – of Kate's recounting into a single intelligible whole. We would appreciate the fit that exists between the many elements of Kate's emotional state. We would thereby have learned that the 'cutting-people-off' event in the world is the kind of thing that entitles one to become angry, we would see the person who engages in 'cutting-people-off' behavior as a suitable object of anger and we would consider Kate's emotional response to be intelligible. In this case, we would fundamentally be learning something about the world – that being cut off is linked in an intelligible way with becoming angry.

But now let us imagine that when we encounter Kate, she is angry about being cut off while driving more than a month earlier. She could explain about how she felt threatened by the other driver's behaviour. And we might be able to understand all of these elements. But in this case, as we began to put the pieces together – the events in the world, the elements of Kate's emotion – we would likely have a further question. Why is Kate *still* angry? And if all she could give in response were the same reasons that she provided to explain how her anger was occasioned, we might not be satisfied. While we might grant that being cut off is the kind of thing that fits with becoming angry, we might not think that it does so for very long. We would be unable to integrate the duration of Kate's anger with the other elements

of her emotion. One part of her emotion simply does not fit with the other elements. This evaluation denies that Kate's longstanding anger is fully intelligible. The initial arousal, the early responses - all of these make sense. But Kate's current anger might be baffling and remain baffling despite her efforts to explain by appealing to the threatening nature of being cut off. In a case like this, we might feel that what we learn about is Kate herself. Kate is the kind of person whose anger persists longer than it should.

3. Intelligibility as applied to moods

To make my case for the potential intelligibility of depression, I need to show that this analysis of emotions also extends to moods. As I discussed in chapter I, moods have many of the same components as emotions. They may include affective states, physiological elements, cognitive elements, and motivational tendencies. Moods, too, are diachronic. They come into existence under certain environmental conditions, they persist, and they ultimately disappear. But, as I discussed in chapter I, there are two substantial differences. First, moods almost always take immediate intentional objects, unlike most emotions. Second, moods almost always do not have a single discrete occasioning object, unlike most emotions. Instead, their arousal typically happens only gradually, in response to several occasioning intentional objects, or multiple exposures to a single occasioning intentional object. Sometimes their experiencer cannot even initially identify an occasioning intentional object. In this light, it is difficult to say that moods are intentional. If the originating events cannot be determined, it is hard to understand the mood as fully directed at any particular person or environmental conditions. This characteristic poses a challenge for my claim that moods can be intelligible.

Intelligibility, on my analysis, permits an understanding of potentially discrete affective elements as part of a whole. The intelligibility that I am concerned with is open to normative evaluation through affective interlocution. I think a central part of this understanding requires being able to identify an intentional object that causes the affective state to come into existence in the first place. I just said, however, that the eliciting conditions for moods are not easily discernible, and that sometimes even the mood experiencer cannot identify an occasioning intentional object for her mood. Ultimately, however, I think that this is simply a difference of degree. Moods may not have a single and easily identifiable eliciting event. They may be the result of several small events that have built up for the mood experiencer. These are the mood's occasioning intentional objects. Many people (maybe most of us) are not especially skilled at consciously looking back and recalling each of these small events and tracking the affective build-up those events left in their wake. But I do think this build-up can come into focus through affective reconstruction.

This reconstruction is often a key activity of supportive relationships. With someone else, we can often go back over the events of the preceding days/ weeks/ months/ or even years and recall instances that in themselves were not arousing enough to bring us into a strong emotional state. When added up, however, they can be seen as grounds for having a particular mood, that is, the mood can be seen to fit its occasioning intentional objects. Often, no one event serves as a suitable single occasioning object for a particular mood, but when these events are seen in combination, intentional objects can emerge. As this happens, the reconstruction efforts can develop into a more general engagement. The person who was acting as a reconstructive aid can become the affective interlocutor I described earlier, raising questions about the appropriateness of the different elements of the person's mood.

This simply means that, on my analysis, the intelligibility of a mood – that is, whether or not its elements fit together – can be considered both in terms of its immediate (apparent) intentional objects and its occasioning intentional objects. I will start by discussing the possibility of fit between depression and immediate (apparent) objects. There is a commonly employed claim about depression that lends itself to the view that depression fails to be intelligible with respect to its immediate (apparent) intentional objects. This is the claim that depression is irrational.

Recall from the previous chapter that depression is associated with several beliefs, primarily comprised of a negative assessment of both the world and the self. Those who take depression to be irrational focus on these beliefs (independent of the other elements they are associated with through the depressed mood[6]). Then they argue that the beliefs are irrational – that is, the beliefs do not fit with their intentional objects – and thus depression as a whole is irrational. The cases they consider all involve depression already in existence and how it effects how the depression-experiencer sees the world, so they are working with immediate (apparent) intentional objects. On my account of intelligibility, a broad failure of fit between depression-linked beliefs and their objects would also mean that the depression as a whole is not fully intelligible.

Let me first point out that even if these analysts are correct that depression is irrational with respect to its associated beliefs and immediate (apparent) intentional objects, this would not establish that depression as a whole is non-intentional. For this to be the case, there would need to be the further step that depression is irrational with respect to its occasioning

[6] I argued against doing this in chapter I. I think considering any of the several elements of a mood wholly independently of the others can result in the mischaraterisation of the mood in question, in this case, depression. In order to engage with the proponents of the irrational view of depression, however, I will focus on depression's associated beliefs in this section.

intentional objects.[7] I believe, however, that the view that depression is irrational with respect to its immediate (apparent) intentional objects relative to non-depression can be rebutted in two ways. First, I will review some compelling data that persons suffering with depression are actually more rational than typically thought. Then, I will review some data that non-depressed persons are less rational than typically thought, a phenomenon I will call "cheerful denial."

As demonstrated in the current diagnostic criteria for depression listed in chapter II, depression is fundamentally associated with beliefs the sufferer holds about the world and herself. The claim that the beliefs associated with diagnosable depression fit with their objects, that is, that depression is rational, may initially appear to be highly implausible. Clearly depression sometimes qualifies as a psychopathology, and the folk psychological hallmark of psychopathology is an absence of rationality. In fact, this certainty that depression is significantly irrational is often used as possible distinguishing criterion between normal and pathological depression. The claim is that the beliefs associated with low level depression meet everyday requirements of rationality, whereas pathological variants of depressed cognitive processes are distinctly irrational. The main proponent of this view is Aaron Beck, who argues that depression as disease state is, at its core, irrational, and that it is this irrationality that permits its designation as pathological.[8] On Beck's analysis, both the beliefs that the depressed person arrives at about the world (e.g. that life is deeply unpleasant and that there is little that one can do about it) and the judgements that follow from these

[7] I should point out that people who argue that depression is irrational are not trying to establish that depression is non-intentional. But because I think that this is a consequence of their analyses, I feel that I should address their arguments.

[8] Beck 1979. Beck's substantial contributions to how depression has been understood are discussed in Graham 1990: 411-12.

beliefs (e.g. that a life so-characterised is not worth living) are arrived at irrationally. But there is evidence that, in some respects, sufferers of depression demonstrate greater rationality than non-depressed people, resulting in a phenomenon called "depressive realism."

For example, rationality is, in part, an ability to see the world as it really is, to take one's perceptions of one's surroundings and through reasoning use them to arrive at plausible characterisations about the state of the world. Interestingly, there is strong empirical evidence that demonstrates that this is precisely what people suffering from depression do. Lyn Abramson and Lauren Alloy performed a study that indicated that the problem with depression is not that its sufferers are irrational.[9] In fact, quite the opposite appears to be the case. In their study, depressed individuals seem to have a better grip on reality than their non-depressed peers. The basic form of the experiments was that depressed and non-depressed students were asked to push a button and observe a light that went on and off. Pushing the button had a greater or lesser controlling effect on the light going on or off, depending on the trial. The depressed students accurately assessed the degree of control that they had in different experimental trials, while their non-depressed counterparts both overestimated and underestimated their degree of control.

The experimenters had hypothesized that the depressed students would make lower estimates of control than the non-depressed students. This was only partly borne out. "Although the depressed students were surprisingly accurate in judging degree of [control], nondepressed students showed both illusions of control and no control depending on the

[9] Alloy and Abramson 1979. For confirming earlier results, see Golin et al. 1977.

particular experimental situation."[10] In trials where there was a low degree of control, if there was a higher rate of positive responses (e.g., the light would go on more frequently) then the non-depressed students thought that they had a higher degree of control than they actually had. When there was a lower rate of positive responses (e.g., less frequent light), the non-depressed students thought that they had a lower degree of control than they actually had.

The degree of control that the non-depressed students thought they had corresponded to how successful they thought they had been. If they thought that things had gone well, then they felt that they were in control. If they thought that things had gone poorly, they attributed this to a lack of personal control. Thus, the depressed students provided lower assessments of control than the non-depressed students in some instances, when the number of positive responses was higher. But when the number of positive responses was low, the depressed students' assessments of control were higher than the non depressed students'. Further, the experimenters had thought that the non-depressed students' assessments would be roughly correct and the depressed students would think that they had less control than they really did, and this was distinctly not the case. These results, and others like them,[11] have given rise to the label 'depressive realism,' whose proponents maintain that depression, however debilitating, is not best characterised as irrational. Depression does not seem to distort perception of how things are, certainly not to the degree previously assumed.

Not only does depression seem to be rational, there are also indications that absence of depression typically involves less than fully rational behaviour. Non-depressed people, for

[10] Alloy and Abramson 1979, 477.

[11] See, for example, Taylor and Brown 1988 for an early review of the literature.

example, tend to de-emphasise their negative attributes in times of stress, although in other contexts they acknowledge that these negative characteristics do exist.[12] They also overestimate how well-liked they are.[13] S. Taylor and J. Brown argue that it is *illusions* that maintain the well-being of non-depressed persons. As Michael Ignatieff puts it, "[i]n melancholia we are dragged beneath the flat surface of our contentment to encounter the harsher truth of life which our illusions conceal from us."[14]

I think this 'cheerful denial' feature of non-depression is further seen in animal studies used to assess the effects of anti-depressants. A common experimental protocol for assessing anti-depressant efficacy is to drop rats into basins of water from which they cannot escape. The length of time the rat keeps swimming is considered to be a measure of its 'depression' — that is, non-depressed rats will swim longer. I do not intend this discussion to be taken as an attempt to establish rat rationality. It is simply my contention that typical rat behaviour in these experiments can serve as a kind of analogue of possible human responses (this premise is of course what motivates the experiments in the first place).

Returning to the experiment, I am happy to grant that it takes a less 'depressed' rat to keep swimming. But it seems possible to argue that this is not the more 'rational' rat, at least on some accounts of rationality. To persist in swimming even in the absence of indications that swimming can accomplish anything, seems, at least in some lights, the more irrational behaviour. Of course, when the depressed rat stops swimming, she drowns. But in this experiment, all the rats drown, depressed and non-depressed alike. On some analyses of

[12] See e.g. Showers et al. 1998.

[13] See e.g. Glass et al. 1993.

[14] Ignatieff 1987, 940.

rationality, it is always irrational to do anything that does not prolong living. This strikes me as too strong. Surely at some point, giving up, even though it meant terrible consequences, would be considered rational (or at least be among the possible rational responses). In humans, after a certain point, behaviour that prolongs an extraordinarily difficult life with no prospect of improvement would be considered crazy by many (although not necessarily un-admirable).

The anti-depressant medications currently on the market are all drugs that make rats keep swimming longer.[15] I am not sure that these results should be heartening. This research reinforces the possibility that grasp of certain truths about the world goes hand in hand with depression. The rat that 'sees' the futility of its situation is inclined to give up. This provides a first glimpse of the normative role that depression plays in conjunction with rationality. In certain hopeless situations, depression may simply be among the more rational responses available.

Care must be taken, of course, to not make unwarranted assumptions about the direction of causation in any of these experiments. As Alloy and Abramson observe, "[a] crucial question is whether depression itself leads people to be "realistic" or whether realistic people are more vulnerable to depression than other people."[16] But in either instance, these studies, and others like them, indicate that the insistence that depression is irrational relative to non-depressed states and that this irrationality constitutes part of its pathology is on shaky ground.

I think what happens with the irrationality thesis is that its proponents equivocate between fitting appropriateness and prudential appropriateness. The term 'rationality,' like the term

[15] Or, in the test where they are suspended by their tails, the medications keep the rats struggling longer. See Willner 1994: 298-300, for a literature review.

[16] Alloy and Abramson 1979, 480.

'appropriate' has several meanings. The adjudication of rationality might require an assessment of fit between a belief and its object or it might require an assessment of whether or not the person should hold the belief, all things considered. There is good evidence that sufferers of depression experience some good fit between their depression-linked beliefs (e.g. the world is a negative place, I am a person deserving of negative appraisal) and the immediate (apparent) intentional objects which bolster those beliefs (e.g. assessments of the control that I have in the world, views about me held by others). Rather than a failure of fit, it is more plausible to argue that it is not prudentially appropriate to hold those beliefs and see the world in that light. Even if the depressed beliefs are accurate, it may not advance your interests to be aware that people around you do not like you very much. This is an important consideration, one worth attending to. But it should be kept distinct from the question of whether or not the depression-linked beliefs fit with their immediate intentional content.

Let us now consider the fittingness of depression with respect to its occasioning objects. For this, we will return to Kate, who is now depressed and she is not sure why. To determine whether or not Kate's depression has an occasioning intentional object, we should assume the role of affective reconstructors and ask her about her life of late. Perhaps we would learn that she started a new job recently. In her previous job, she was surrounded by a group of people who formed an enthusiastic group of supporters. In her new job, she is more isolated. Moreover, she is being given a number of significant responsibilities but she does not have the training or resources to adequately discharge them. As she recounts the difficulties she is facing, Kate slowly realises just how difficult she finds this situation and she comes to see

these features of her work environment as the occasioning intentional object of her depression.

At this point, we might shift from the role of reconstructors to affective interlocutors. We would now ask how these features of her job fit with the features of her depression. Assume that Kate's depression includes the negative appraisal about both the world and the self found among the list of current diagnostic criteria for depression. In what way do the features of this job fit with Kate thinking and feeling negatively about the world? In what way do they fit with Kate thinking and feeling negatively about herself? In her responses, she might be able to persuade us that the situation does in fact fit with the depression that she is experiencing. Her depression would become intelligible.

The intelligibility of depression can also be seen in contrast. A person who finds herself in a terrible situation, knows that things are bad, believes her own worth as a person to be compromised but does not feel depression seems to suffer from some kind of affective insensitivity. Consider for a moment the person who drinks to distract herself from depression. There are many reasons for considering this coping strategy inappropriate (e.g. impaired function, compromised dignity). On my view, however, these side effects of drinking are not the only, or even the central, problem. I think a key problem with alcoholism is that one becomes the kind of person who does not feel bad, even in bad situations. The drunk is the one who laughs inappropriately when nothing funny is going on, or who is suddenly morose for no reason.

Consider now the case of Prozac, one of the SSRIs that I discussed in the previous chapter. The person on Prozac doesn't feel bad in bad situations either. But in an important respect, the person on Prozac is in worse shape than the drinker. Insofar as the alcohol

successfully alleviates the drunk's depression, she does not feel bad because she does not see the terrible things around her. The alcohol makes her blind to her situation. When this blinding feature of the alcohol fails, and the individual remembers how dire things are, the bad feelings come rushing back in. But with Prozac, a common endorsement of the product is, "I still see my problems, they just don't bother me that much anymore."[17] This is supposed to be good, because medication should not render patients blind automatons. But on another level this feature is disturbing. The person on Prozac knows that things are bad, but the knowledge does not bring about a depressed response. Not being depressed when the truths associated with depression — that life is miserable, that one's own life is disappointing[18] — are visible, seems to potentially constitute a compromise of one's emotional intelligibility.

4. Depression as moral mood

It is now reasonably well established that at least some emotions can play an important and valuable role in our moral lives. Emotions are often either elicited by events that are moral violations or they motivate us to pursue moral behavior. I believe the same is true for some moods, notably depression. I will argue for depression's place as a moral affective state, employing several examples to motivate my position.

Jonathan Haidt claims that there are four categories of moral emotions: "the other-condemning family (contempt, anger, and disgust), the self-conscious family (shame,

[17] See for example Henry Hernandez's testimony in Elfenbein 1995, 65.

[18] The lack of emotional intelligibility assumes, of course, that the person does not have certain other beliefs that might warrant an overriding cheerfulness - e.g. "Despite the miserableness of life, there are also many offsetting, wonderful features" or "Despite the disappointments of my life, there are also many successes to be savoured." Beliefs about the afterlife might be an important source of such countervailing reasons.

embarrassment, and guilt), the other-suffering family (compassion), and the other-praising family (gratitude and elevation)."[19] Some moods can also be characterized along these moral dimensions. In the case of depression, I believe its belief and judgement components are too mixed to allow it to be placed in a single family. Typically depression incorporates both a negative view of the world and a negative view of the self. Thus, I will argue that it both falls into the other-condemning family and the self-conscious family. I will motivate this claim by considering a few examples, one a fictional character, Sophie Zawistowska from William Styron's *Sophie's Choice*,[20] and the other, the mid-twentieth century philosopher, Simone Weil.

The character of Sophie is a woman who lived in Poland during WWII. She and her two children were deported to a concentration camp. While in the camp, Sophie was presented with a choice by a camp doctor. She had to choose one of her children to be killed. If she refused, both of her children would be killed. Sophie chose her daughter to die, and her son was allowed to live. During their time in the camp, Sophie's son also died. When the camp is liberated, Sophie moves to America.[21]

The novel is set in 1947 in Brooklyn. Her description clearly meets every diagnostic criterion for depression. But it is clear that her depression is not simply the outgrowth of grief for her dead children. Sophie refuses to let go of her awareness of her own culpability in their deaths. I know that many people think that Sophie is not culpable, that the choice she was presented with was no choice at all. But Sophie does not see it that way. In those few

[19] Haidt 2003.

[20] Styron 1979.

[21] I will be presenting a greatly simplified version of Sophie's situation.

moments when faced with the choice, Sophie actually made two choices. She first chose to choose between her children and then she chose her daughter. In that moment she learned something terrible about herself – that she is the kind of person who can and will choose between her children. She did what no person may do – especially not a mother.

Sophie can neither bear the world that put her in that position, nor can she bear herself and the role she played. Many will protest that her other option – refusal to choose – would also have been a choice. I agree. My analysis does not imply that had Sophie chosen otherwise, she would have been better off. She likely would simply have had a different and no less terrible burden of guilt. But given where she is, Sophie judges herself to have committed an unforgivable sin and judges the world as intolerable. And she refuses to be consoled or to turn away from this awareness. Under this description, I think Sophie's depression clearly finds a place in both the other-condemning and the self-conscious families of moral affective responses. To me, her depression is entirely intelligible. I think there is a fit between the occasioning intentional objects of her depression and the features of her particular depression. More than intelligible, I find her depression morally admirable. There would be a kind of strength in a person who was able to overcome the tragedy that Sophie faced. But I think Sophie's unflinching gaze at the horror of her past is incredibly strong.

Most of us, I think, have no problem forgiving Sophie. Many of us do not even think that Sophie did anything that needs forgiveness. But Sophie will not relinquish what she knows – that she did an atrocious thing and the world pushed her to do it. Her depression makes clear that she rejects the cheerful denial that so many of us rely on. Her attitudes pass judgement on her own past and also on the rest of us who wish her to think differently and feel better. Had antidepressants been available to Sophie, I suspect she would have refused them. She

made an effort to go on with her life. But she never becomes persuaded that what she knows about herself and the world is not true, or that its importance fades, or that it becomes less worth attending to. In the end, Sophie kills herself.

Simone Weil provides another example of depression that I would like to examine. Although she wrote a great deal about her thoughts and feelings on a wide range of issues,[22] there is, with any actual person an opacity that we do not face when dealing with a fictional character. I will present a brief account of her life and motivations but she was, of course, considerably more complicated than my brief portrait will show.

Weil was born in Paris in 1909. She pursued studies in philosophy and had a life-long interest in resisting oppression. Simone Weil judged the world to be, in many respects, intolerable. There was plenty of evidence for this view in the world around her, notably in the First World War and the Spanish Civil War, and then finally in the Nazi atrocities she learned about during the Second World War. It seems to me that her judgement about her own worthlessness was grounded in her sense that she failed to live up to the moral example set by Christ. Like Sophie, Weil refused to let go of her awareness of these truths and her long depression was surely deeply grounded in these beliefs.

Weil and her family managed to escape from Paris as the Nazis invaded. They fled to America, but Weil viewed this as an intolerable betrayal of her country and citizens. She later went to London to work for the Free French. While there she decided to live on the official rations that were allocated to residents of Paris by the Nazi occupying force. These rations were not in fact enough to survive on. People in Paris were forced to supplement

[22] Weil 1965.

their rations with food obtained through black market channels. Weil refused to do anything similar, and she ultimately died from tuberculosis complications related to malnutrition.

5. Implications

What does these characterisations of Sophie's and Weil's depressions entail for how others ought to treat them? I will start by considering Sophie. First, I am not arguing that we should stand by and do nothing as Sophie takes her own life. But I also think that we should not respond to her as merely sick in the head.[23] If she were being treated today, according to the depression diagnostic criteria, Sophie is very sick. She would almost certainly be institutionalised. And while institutionalised, she would be the recipient of countless hours of group and individual therapy. But this therapy might or might not include the kind of engagement that I want to advocate.

I think that those around Sophie – those who take on the role of affective interlocutor – should challenge her own assessment of her worth and the worth of the world that is implicit in her depression. I would want them to try to persuade her to change her assessment of her history and her current moral status. I actually think Sophie makes a terrible mistake in thinking about her wrongdoing. I think she has an expectation that mothers protect their children, independent of circumstances. I would like Sophie's affective interlocutors to challenge that conception of motherhood. But I would also want the people around her to take seriously the possibility that first, Sophie's depression is intentional. It is indeed *about* these past events. Second, I would want them to consider the possibility that there is a good

[23] In the case of someone with Sophie's history, I do not actually believe that the medical community would simply give her some pills and send her on her way. This is, however, what happens with many people currently diagnosed with depression.

fit between the intentional objects of Sophie's depression and the specifics of the mood she is experiencing. I think the fit that exists between Sophie's depression and intentional objects constitute what might be called a good reason,[24] and not simply good reasons for *Sophie* to be depressed – they are good reasons for *anyone* to be depressed. Simultaneously, however, I would want Sophie's affective interlocutors to be open to being persuaded themselves that Sophie's affective state reflects her beliefs and values and that to give it up would cost too much. Where would this kind of engagement have led? Perhaps Sophie could have changed her affective stance. Perhaps given some more time and love and understanding, she would have been willing and able to put aside her depression to some meaningful degree.[25] But also perhaps not.

Weil's example also provides a clear example of what would now count as a diagnosable depressive disorder (with an eating disorder as well). She, like Sophie, would almost certainly be institutionalised, and subjected to a great deal of therapy. And as with Sophie, I would like to advocate that her depression ought to be considered as a potential intentional state, and an effort made to locate its occasioning intentional objects. I include Weil's example in this analysis, however, because I think we might ultimately decide to resist the assessments that undergird her depression. In particular, I think Weil's beliefs about her own worthlessness may not fully fit with any occasioning intentional objects. I suspect that it would be difficult to knit the pieces of Weil's depression – the originating conditions, her affective state, her physiological responses, her behavioural motivations – into one

[24] In general, I am avoiding talking about 'reasons' for moods to avoid over-cognitivising moods, a worry I mentioned briefly at the end of chapter I.

[25] In the novel, Sophie was surrounded by men who glamorised and fetishised her depression. Their absence might have helped a lot.

intelligible whole. I am not sure if such an assessment would result in a sense that there was actually no occasioning intentional objects, that is, that Weil's depression was not actually intentional at all. I think this would have to be determined in light of more details than I can present here.

Now we are finally in a position to see how depression's intelligibility can help in responding to the distinction – normal low mood versus pathological depression – that has been vexing us. On my analysis, the distinction should be made by considering different appropriate third-person responses. In this way, it becomes a three-fold distinction. One category is for clearly pathological cases of depression that (mostly) simply require physiological treatment. This category will likely include cases of depression that are wholly non-intentional, like those caused by medications like steroids. In some instances, a person who is administered steroids becomes quickly and deeply depressed, and discontinuation quickly reverses these symptoms. This category will also include cases of patients whose affective and physiological responses are so extreme that the affective engagement I endorse is not really possible. With these cases, the question of intentionality cannot really be addressed until some of the patient's symptoms are alleviated. The other clear category will encompass cases where response on the part of the medical community is not especially warranted, as no physiological treatment is needed. This will include cases where the person's depression is intentional, intelligible and not especially severe.

But the largest and most complicated category will be cases of depression that are at least partly intentional and intelligible and involve a moderate to extreme degree of suffering. I believe that clinicians rightly attempt to alleviate suffering. Currently there are pharmacological treatments that facilitate clinicians lifting a person's low mood without

entering into the role of affective interlocutor, without engaging with the intentional features of a person's depression at all.

Most diagnosed depression in North American is now being treated by physicians other than psychiatrists and most people so-diagnosed receive exclusively pharmacological treatment (with no talk therapy of any kind). This response from the medical community constitutes the implicit denial of the possibility of depression being intentional. This means that most current pathologising responses to depression further implicitly deny depression's intelligibility. This makes depressed individuals dependent on medical experts to tell them *how* they are. Without appeal to intelligibility, it is not open to people to insist that their way of being is appropriate or even not pathological. That which counts as painful symptom warranting treatment and investigation is up for grabs, up to and including the painfulness. I take these worrying features to be ultimately grounded in the abandonment of 'reasons' talk as related to depression.

This, of course, is what I think should not happen. On my view, while the pharmacological treatments that ease suffering should be employed with this third group, they should be accompanied by the engagement that I have described and endorsed. In practice, I believe that there are clinicians who do this, but I worry that they are becoming an increasing minority. Moreover, I believe that in the broader North American culture, there is less and less encouragement to pursue this sort of response.

Eliminating this kind of engagement raises real concerns in the context of social justice. This concern crystallises in considering the current situation of women in North America, who are twice as likely as men to experience a diagnosable depressive illness.[26] Worse still,

[26] Kessler et al. 1994.

once diagnosed, they are more likely to be prescribed pharmaceuticals than men. I am not wanting to encourage clinicians to respond more paternalistically to women and insist that they live with their depression, rather than providing them with some measure of pharmaceutical relief. Instead I want to encourage everyone, as they accept that medication can be helpful, to not thereby abandon what I consider an obligation to try to understand why so many women in this culture have this response.

As I argued earlier, when we engage with the intentional features of someone's depression, we potentially learn about the sufferer and about the world. I think close attention to intentional features of women's depression, in particular the occasioning intentional objects of that depression, will reveal that the world as it currently is, is the kind of place in which women's depression is fitting. In my account of depression as a moral mood, I characterised it as belonging to both the other-condemning family and the self-conscious family. I find the depression-informed negative appraisal of the world and negative self-appraisal that women manifest highly intelligible. The kind of devaluation that women often experience in this culture can make sense of both. I think it serves as both a fitting and morally appropriate source of a negative view of the world. I also think it serves as a fitting but morally *in*appropriate source of a negative view of the self.[27] But if depression is not seen as potentially intentional and intelligible, then it cannot be engaged with normatively, and there is no possibility to even raise these questions. The social consequences of this silence strike me as deeply worrying.

If I am right that depression is part of our repertoire of intelligible responses to the world, then its placement in a narrow medical model of disease constitutes a radical change. I am

[27] I will attempt to tease out this kind of concern a little more in my discussion of borderline personality disorder.

convinced that there ought to be protest at the thought of losing the possibility of talking intentionally about one's depression. I believe that my analysis highlights some elements of depression's value, which seems to be obscured by those who medicalise and pathologise it. They respond to depression as physiological disorder and think fundamentally in terms of physical causation. This phenomenon is exacerbated by a philosophical stance that considers moods to be non-intentional. Members of both the medical and philosophical communities are often not interested in the ways that depression sometimes functions as an intelligible response to the world. But it is only when we consider depression as an intelligible response that we can see the role it plays role in moral agency. Once this role is seen, however, I believe it becomes clear that we should not permit depression's wholesale pathologisation.

CHAPTER IV

MEDICAL APPROACHES TO BORDERLINE PERSONALITY DISORDER

As I have argued in the preceding chapters, moods are affectively charged states that can come into existence in virtue of exposure to occasioning intentional objects, typically many such objects, over an extended period of time. (Moods can also be exclusively physiologically caused, with no intentional occasioning features.) As they persist, their effects are typically far-reaching for their experiencer. Most significantly, moods take many immediate intentional objects, greatly affecting how the mood-experiencer perceives both the world and herself. The mood, its occasioning intentional object (if it has one), and its associated immediate intentional objects affect how she feels and thinks and what she is likely to do. In particular, an intentionally-laden mood can play an important role in a person's moral life. In contrast, most accounts of moods do not consider the possibly intentional *origins* of moods, and some deny that moods can have intentional features *at all*. When it comes to psychopathological states, there is further denial of intentionality, because within current dominant medical practice, a designation of being psychopathological results in treatment that implicitly denies that mental state intentionality.

Both of these pressures are brought to bear on instances of Borderline Personality Disorder. BPD is a psychopathology, and as such it is subject to non-intentional medical approaches. Further, moods constitute a significant element of the phenomenon, and so it is likely to be seen as non-intentional through that lens as well. Ultimately, I will argue that

moods – understood intentionally – can play an important role in understanding BPD, potentially explanatorily bridging the origin of the disorder and the symptoms that BPD sufferers manifest. In this chapter I will first present a very brief history of the diagnosis of BPD, along with its current diagnostic criteria. Then I will explore the clinical picture of BPD, where the significance of mood to BPD can be appreciated. Finally, I will explore the ways that BPD has been designated pathological. I will argue that, once pathologised, the phenomena associated with BPD are typically taken to be non-intentional within clinical responses. In the following chapter, I will argue that BPD can be intentional, in contrast to both dominant pathologising practice and philosophical accounts. I will go on to briefly explore how the potential intentionality of moods shows the moral significance of BPD.

1. What is BPD? The Diagnostic Picture

Borderline Personality Disorder is a relatively new diagnostic category, first appearing between 1979 and 1980. To see why BPD became a diagnostic category when it did, we need to know where the diagnosis of BPD fits in psychiatric taxonomy, as well as something about the disorder. To appreciate BPD's place in psychiatric taxonomy, we need to know a little bit of the history of psychiatric diagnoses. The label "borderline" is a leftover from Freudian terminology. Early in the twentieth century, as part of Freud's legacy, all mental illnesses were understood to fall on a continuum between neurosis and psychosis. There was, however, a sense that some people were crazy but didn't fit clearly onto a single point along the spectrum – they blended symptoms from both ends (e.g. some patients were primarily neurotic but with occasional psychotic outbursts). These patients were the original

'borderlines.'[129] The patients who were labeled 'borderline' within this schema were typically women, the patient population Freud would most likely have designated 'hysterical'.[130] In the 1950's and 60's, the 'borderline' category shifted slightly and was seen as a subtype of schizophrenia, but this was always an uneasy fit.[131] While some patients designated 'borderline' did experience hallucinations, the majority did not.[132] Additionally, 'borderline' patients perform well on reality testing tasks, [133] unlike prototypical schizophrenics.

Starting in the 1950's, mental illness was increasingly being described in behavioural terms, rather than psychological ones. Behaviour is directly observable, in a way that psychological states are not, and thus was considered more amenable to analysis through the scientific method. But with this shift from discussion of psychological phenomena to behavioural phenomena, there was a sense that some pathologies could not be reduced to a single pathological behavioural manifestation, but were instead only pathological in light of patterns of behaviour. Thus, there arose a need to explain what were seen as character traits rather than specific behaviours. Personality disorders were created in the 1970's to meet this need. They are understood as stable tendencies to act and see the world in certain pathological ways, as contrasted with more discrete episodes of crazy behaviour (associated

[129] Louw and Straker 2002.

[130] Kroll 1988.

[131] Crowe 2004a

[132] Links et al. 1989.

[133] Marmer and Fink 1994.

for example with depression). Borderline patients had not had a stable diagnostic home for much of the 20th century. The creation of "Personality Disorders" looked suitable.

The diagnostic category, "Borderline Personality Disorder," officially came into existence with the publication of the DSM-III in 1980. Although schizophrenia and bipolar disorder (previously known as manic depression) are both more familiar diagnoses, BPD actually has a higher prevalence rate – approximately 2% of the population is considered to suffer from BPD. (Conversely, schizophrenia's prevalence rate is between 0.2-0.4%,[134] and bipolar disorder's is about 0.7-0.9%.[135])

The *DSM* symptoms of BPD include affect lability, poor impulse control, and unstable interpersonal relationships. Here are the criteria found in the current edition:

Diagnostic criteria for 301.83 Borderline Personality Disorder:[136]

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
(3) identity disturbance: markedly and persistently unstable self-image or sense of self
(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
(7) chronic feelings of emptiness
(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of

[134] Goldner et al. 2002.

[135] Soldani et al. 2005.

[136] APA 2000.

temper, constant anger, recurrent physical fights)
(9) transient, stress-related paranoid ideation or severe dissociative symptoms

As I will explore later, and as I think these criteria demonstrate, no single mood can fully explain the phenomena associated with BPD. This is in part because BPD is a personality disorder, and the symptomatic features that comprise it are very heterogeneous. But additionally, the mood experiences characteristic of BPD are more mixed than a single mood label can capture. In the next section, I will describe the clinical presentation of BPD. Then I will argue that BPD sufferers commonly experience both irritation and depression. On my view, it is this irritation / depression blend, and the mix of intentional objects associated with it, that underwrites many cases of BPD.

2. What is BPD? The Clinical Picture

Throughout the diagnostic wanderings of the 'borderline' patient population there were a substantial number of calls for its elimination as a diagnostic category altogether (that continues now, to some extent).[137] But the move to eliminate 'borderline' was never successful. I think its stability as a pathological diagnosis, despite its instability within the diagnostic taxonomy, is linked to several of its clinical features not included in its diagnostic criteria. The main features that bolster its pathological status are: (1) therapeutic intractability; (2) the "PIA" factor; and (3) delicate self-mutilation.

First, there is its therapeutic intractability. The original borderline patients, and now patients with a BPD diagnosis, have always had one of the highest mortality rates of any patient population, largely due to successful suicide efforts (approximately 9% of BPD

[137] See Magill 2004 for a discussion of this controversy. See e.g. MacKinnon and Pies 2006 for an argument that borderline personality disorder has problems as a diagnostic construct.

patients kill themselves), but also as a result of a range of self-destructive behaviours.[138] BPD has also consistently been seen as an untreatable disorder.[139] (It should be pointed out that this reputation is not because BPD patients do not change. In fact, remission rates for BPD are substantial, or at least more substantial than many clinicians believe.[140] But these remissions are not linked with any particular therapy. They appear to be spontaneous.[141]) This has been highly frustrating for clinicians working with this patient population, but I believe that this frustration was linked to a sense of clinical intrigue. This, in turn, has ensured that clinicians continued to make space for borderline / BPD patients in their clinical practices and research programs.

Second, a further factor that has gone into borderline / BPD's stability as a pathology is due to another hidden diagnostic criterion – its sufferers are *very difficult*. Practitioners with borderline patients consistently report great difficulties working with these patients. They have consistently been seen as confrontational and distinctly not treatment-compliant. Michelle Cleary et al. found, in a survey of over 500 mental health staff, that 84% of them judged BPD patients to be more aggravating to work with than any other.[142] A former head of psychiatry at New York University put it succinctly: "Borderliners are the patients you think of as PIAs – pains in the ass."[143] This 'difficult' feature of BPD is even remarked upon

[138] Linehan et al. 2006.

[139] Livesley 2005.

[140] Zanarini Frankenburg Hennen Reich, and Silk 2005.

[141] See e.g Zanarini et al. 2003 and Sanislow and McGlashan 1998.

[142] Cleary, et al. 2002.

[143] *Medical World News*, 1983. As cited in Potter 2003.

on the web site of the National Reserve Law Officers' Association. They have a specific page about personality disorders, where George Berlow rates BPD the worst personality disorder to encounter during a traffic stop.[144]

This feature of borderline patients being PIAs is psychotherapeutically characterised as a problem of countertransference unique to BPD.[145] Countertransference technically occurs when a therapist transfers her repressed emotions onto her patient, as a result of the dynamics occurring within their therapeutic sessions. More generally, it is the sum of the emotional responses a therapist holds toward her patient. It is called *counter*transference because transference is the process by which a patient transfers her emotions (typically those she holds toward her parents) onto her therapist. Transference is actually one of the aims of many types of psychotherapy. The hope is that these patient emotions, once elicited in the safe confines of therapy, can then be productively explored. But countertransference is not an aim of psychotherapy, although it is probably unavoidable. Psychotherapists are supposed to work at managing their countertransferential experiences. There is a substantial literature discussing how BPD evokes powerful negative countertransference reactions from therapists and offering different strategies for dealing with this therapeutic challenge.[146] I think the problem of countertransference – a cleaned up way of saying that BPD patients are enraging and resented by clinicians – plays a significant role in the pathologising of BPD.

[144] Berlow 2005.

[145] Bradley and Westen 2005.

[146] See e.g. Zanarini et al. 1990, Becker 1997, or Clark 2006.

Third, sufferers of BPD deliberately hurt themselves in a number of ways, in particular through deliberate self-injury, called by some the "borderline's behavioral specialty."[147] This typically involves cutting, but burning is also common. This behaviour is often referred to as 'delicate self-mutilation.' It is seen as unique to borderline patients, and highly pathological. Whenever a clinician finds someone who has deliberately injured herself in this manner, BPD is the first diagnosis that comes to mind. Clinicians are generally very disturbed by deliberate self-injury. They see it as a highly manipulative action, a method to emotionally extort empathy and caring from those around her.[148] (Clinical disdain is, I think, mirrored in the term 'delicate self-mutilation.') Because it is so bothersome to clinicians, it receives a great deal of attention both anecdotally and in the medical literature.[149] This symptom and the attention it garners is, by itself, likely significant in ensuring that borderline phenomena are robustly viewed as pathological.

3. BPD and moods

BPD can be partly understood in light of moods.[150] In fact, I think once the possible intentionality of moods is appreciated, considering BPD in light of its mood states can be illuminating. In the case of BPD, I will argue that its central mood state is a blend of irritation and depression. Irritation is a negative mood associated with a sense of violation.

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[147] Gunderson and Ridolfi 2001, 61.

[148] Potter 2006.

[149] See Paris 2005b for a summary of this literature.

[150] I would like to acknowledge that when discussing patterns of moods (especially in the case of personality disorders like BPD) it would be very worthwhile to consider the link with temperament or character. I think it is possible that temperaments / characters are themselves intentional, in a manner very similar to the intentionality of moods. Unfortunately, however, this examination is beyond the scope of this dissertation.

Depression is a negative mood associated with a sense of low self-worth and more general disappointment. (Being a personality disorder, the phenomenon of BPD encompasses many different features, not just moods. I also think that BPD is intentional in other respects, notably in its associated beliefs and behaviour, but I will not be exploring those issues here.) Unlike depression, however, BPD is not a mood disorder, so my first responsibility is to make clear where and to what extent moods constitute BPD phenomena.

I will begin by considering the way that the *DSM* symptoms of BPD are underwritten by moods. First, I would like to note that in the *DSM-III-R*, the first criterion for BPD was: "A pervasive pattern of instability of *mood*, interpersonal relationships and self-image" (italics added).[151] In the current *DSM*, the word 'mood' has been replaced with 'affects.' For medical practitioners, 'affect' is a term that encompasses both moods and emotions. This change allows emotions to be included as central to the BPD experience, but still grants moods a place of prominence. In addition, the two moods that I think make up the core BPD mood blend, irritability and dysphoria (which I have labeled depression), are specifically named as factors in symptom 6. I think, however, this irritation / depression mood blend underlies several other listed symptoms. I will motivate this claim by appeal to a feature of moods that I discussed in chapter 1.

Recall that one of the intentional theories of moods Eric Lormand presented was the Precondition Theory, according to which moods are precursors of emotions. The feature of moods that Precondition Theories capture is characterised variously as altering the threshold for experiencing an emotion, or having a pre/disposition to experience an emotion.[152] While

[151] APA 1987.

[152] As cited earlier, see e.g. Nowlis 1963, Parkinson et al. 1996, Ekman 1994, and Morris 1999 for versions of Precondition Theories.

there are problems with this theory as a total account of moods, there is no doubt that being in one mood or another inclines us to experience certain emotions more often and more intensely. A person who is in a cheerful mood will typically become happy more easily and more intensely about something that happens. In the case of BPD, this feature of moods helps to make sense of symptom 8. Borderline patients become angry more often and more intensely. Both irritation and depression can often lead to anger outbursts. Further, in part due to their quickly entered anger experiences, BPD sufferers behave in angry ways. Thus, the mood blend produces anger outbursts which lead to impulsive and damaging behaviour, which links the irritation / depression blend to symptoms 4 and 5.

In addition, borderline patients' irritation and depression is connected with symptoms 2 and 3. These symptoms are about large vacillations in a BPD sufferer's sense of either another person or herself. She alternates between idealization and devaluation. Although it is not mentioned in the diagnostic criteria, this vacillation does not happen randomly, without prompting events. In particular, the devaluation of another person is typically the result of the BPD sufferer's becoming frustrated with or disappointed by the person over some minor slight, a further indicator of a standing mood blend of irritation and depression.[153] I also think the mood blend, especially the irritation, underlies the "PIA" feature of BPD. BPD patients are so unwelcome for clinicians (and police officers) precisely because they manifest their mood-laden sense of victimisation and disappointment so clearly.

[153] I think that the BPD sufferer's tendency to idealise others is best explained by psychoanalytic considerations. In particular, I think the defense mechanisms of 'displacement' and 'reaction formation' are significant contributors to the tendency of BPD sufferer's to idealise. (Displacement involves the redirection of feelings from one person on to another. Reaction formation occurs when a person takes herself to be experiencing feelings opposite to those she actually experiences.) This explanation, however, is less directly linked with moods, and so I will not be exploring it here. I do not think this appeal to non-mood-related considerations is a problem for my account as I am not arguing that all features of BPD can be understood by thinking primarily about moods.

In my discussion of the diagnostic and clinical features of BPD, I have tried to make the case that moods are important to BPD-associated phenomena. This case can only be indirect, as I can find no research specifically examining the link between mood and the DSM symptoms of BPD. In addition to the indirect evidence I have offered, I would also like to point out that my position that mood is significant to BPD is also borne out by a current clinical debate. There are many researchers who argue that BPD ought to be characterised as a mood disorder, rather than a personality disorder. Jerome Kroll, for example, argues that BPD is basically an atypical affective disorder, as its key diagnostic criteria as affective instability and dysphoria. [154] Additionally, there is a substantial debate about whether or not BPD ought to be considered an instance of bipolar disorder (a mood disorder).[155] While I cannot contribute to that clinical debate about diagnostic categories, this dispute confers legitimacy on my focus on mood in characterising BPD. The considerations presented above and my own clinical experience lead me to conclude that mood, in particular the blend of irritation and depression, is routine for the BPD sufferer and central to the phenomenon of BPD.

4. Nonintentional philosophical / psychological accounts of moods

Further evidence that mood is significant in BPD comes from exploring one further clinical feature of BPD in light of some theories of moods. As I mentioned in chapter 1, most current theories of moods are non-intentional. According to Lormand, positing their non-intentionality responds to the Intentionality Condition that he argued for as a constraint

[154] Kroll 1993.

[155] See Birnbaum 2004 for a summary of this debate. See Smith et al. 2004 for an argument in favour of BPD being subsumed as an instance of bipolar disorder. See Paris 2004 for a rejection of this position.

on theories of moods. Of these non-intentional accounts, most aim to explain what Lormand called the Pervasiveness Condition. The Pervasiveness Condition arises out the feature of moods whereby they influence and affect our experience very broadly. Metaphorically, when we are in a mood, it 'colours' everything we experience, typically resulting in selective attention, particularly to phenomena that reinforce the extant mood. I agree that this is a key feature of mood phenomena. Concern for this feature has influenced a number of philosophical and psychological theories of moods.

Lormand, for example, characterises moods as 'sieves' for our entire experience. For him, moods determine upon which of our intentional states (beliefs, desires and emotions) we dwell.[156] Using a computer metaphor, Paul Griffiths argues that moods are higher-order functional states that determine which lower-order states (e.g. emotions and cognitions) the person is in.[157] Laura Sizer offers a similar 'computational' theory of moods arguing that moods bias our cognitive operations.[158] Consistent with these philosophical views is the "mood congruency hypothesis," argued for by a number of psychologists, notably Gordon Bower and Matthias Siemer. They characterise moods as enhancing the processing of other affects or cognitions that are congruent with the original mood.[159]

This feature – of biases or dispositions toward certain congruent affective or cognitive states – is precisely what is observed with BPD. Consider the research performed by Lauren

[156] Lormand 1985.

[157] Griffiths 1997, 248-257.

[158] Sizer 2000.

[159] Bower 1981 and Siemer 2005.

Korfine and Jill Hooley.[160] They investigated the extent to which subjects diagnosed with BPD would show biased information processing, relative to controls. Subjects were exposed to three types of words: borderline, neutral, and positive. 'Borderline' words are words that are supposed to be especially salient to persons diagnosed with BPD, e.g. words associated with abandonment or rejection. (See symptom 1 for confirmation of the centrality of these themes with BPD.) Of course, if I am right that BPD is connected with the irritation / depression mood blend, then it should come as no surprise that abandonment and rejection are BPD themes. With each word exposure, the subjects were instructed to either remember or forget the word. While there was no difference in remembering rates for words subjects were instructed to remember, subjects diagnosed with BPD showed a significantly greater tendency to remember the borderline words they were instructed to forget. This selective attending, associated with greater recall, is just what we would expect if BPD is importantly associated with moods, and moods have the features discussed above, that is, pervasive, mood-congruent effects on how their experiencer perceives the world.

Further evidence for this analysis comes from Arnoud Arntz's lab in the Netherlands, where a team of researchers are exploring the unique cognitive and affective features of BPD. From this large research project, Sieswerda et al. have also found evidence of cognitive biases in BPD.[161] They asked subjects to play a video game. Within the game, they created scenarios that were more or less bad for the subjects' game representative. Subjects diagnosed with BPD were more likely to see their situations as negative compared with control subjects. The researchers characterised the BPD subjects as having a 'negative

[160] Korfine and Hooley, 2000.

[161] Sieswerda et al. 2005.

evaluative style.'[162] Also from the Arntz lab, Veen and Arntz exposed research subjects to film clips with different emotional themes.[163] Some of these themes were characterised as BPD themes (as with the Korfine and Hooley research, these include abandonment and rejection). Subjects diagnosed with BPD showed emotional reactions that were more extreme that control subjects.

It seems to me that the theories of moods that are responsive to the pervasiveness of moods – Lormand's 'sieve' theory, Sizer and Griffiths' computational theories, Bower and Siemer's 'mood congruency' hypothesis – capture something important about moods. Moreover, BPD sufferers routinely experience the same phenomena that these mood theories aim to explain. Their experiences are 'coloured,' 'filtered,' 'framed' and 'biased' in particular, negative, directions. The direction of bias is consistent with the mood blend of irritation / depression I have posited. I think this provides another indirect piece of evidence that moods are significant in BPD – sufferers of BPD experience what experiencers of these negative moods would experience. But of course, all of these theories just discussed take moods to be non-intentional. Given that I am arguing for an intentional account of moods, it might seem that I should not invoke these non-intentional analyses. Recall, however, from my first chapter that I argued that these theories of moods were not, in fact, incompatible with intentionality. Although their proponents start from a non-intentional position, the bulk of their analyses are consistent with the intentional position that I am arguing for. On my view, these theories are concerned to explain the way that moods take immediate (apparent) intentional objects of moods (given that these theories are non-intentional, they would surely

[162] This characterisation was endorsed earlier by v. Ceumern-Lindenstjerna et al. 2002.

[163] Veen and Arntz 2000.

resist the possibility that intentional objects are involved). The intentional account I will be offering focuses instead on occasioning intentional objects and is compatible with theories that describe the effects of moods once those moods come into existence.

5. How BPD is currently understood - The Medical Model(s)

In my discussion of depression, I explored the ways that medical practice aimed to find and keep a distinction between pathological cases of depression and non-pathological cases of normal low mood. One of my concerns was with 'diagnostic bracket creep' and the pathologisation of increasingly normal mood variants. There is some possibility that similar concerns could be raised with BPD. Today, instances of BPD-like symptoms are pathologised that previously would have been considered normal. In the 1980 and 1987 versions of the *DSM*, the diagnostic list included 8 symptoms (of which 5 must be present for a diagnosis) that could be combined to make a diagnosis of BPD. This meant that there were 93 different ways that a patient could count as having BPD. In 1997, DSM-IV the diagnostic list was increased to 9 symptoms (again, of which 5 must be present for a diagnosis). That means that there are now 151 different ways that a person can 'have' BPD.

Despite these diagnostic expansions, however, there is no concern with BPD comparable to that with depression to maintain a distinction between the normal and the pathological instances of phenomena associated with BPD. The features of BPD are overwhelmingly seen as atypical and extreme, and so there is little concern that a diagnostic category for BPD threatens to pathologise very normal human responses. (As I discussed earlier, the main clinical concern with BPD has more to do with ascertaining and improving diagnostic

validity.[164]) I find BPD is robust in its designation as a pathological state. Purely clinically, spending time with BPD patients inspires tremendous confidence that something is really unique and really wrong.

As with the depression case, however, I think there is a tendency to see BPD as non-intentional, once the designation of 'pathological' is established. Again, as with the depression case, there is nothing about a state being pathological per se that entails anything with respect to intentionality. The schizophrenic's delusions of alien mind control are no less intentional for being pathological. But as I argued in the depression case, I think that a pattern of clinical engagement that includes no acknowledgement of a disorder's intentionality and that purports fully to explicate the disorder is tantamount to an implicit denial of intentionality. In this section, I will explore medical responses to BPD, in particular in light of Medical Model A and Medical Model B, which I outlined in my analysis of depression. In the end, as with depression, I will argue that the implicit denial of intentionality associated with medicalisation is revealed through the treatment methods employed with BPD.

Let us start with Medical Model A. Recall that Medical Model A is the theoretical stance occupied by clinicians who wish to characterise disorders in exclusively physiological terms. This model does not seem to have any advocates with respect to BPD. There have been attempts to find unique physiological markers for BPD, but they have not succeeded. Neurological studies have found some differences between normal controls and people diagnosed with BPD, but the differences have been slight, the number of subjects has been small (e.g. most have a sample size, $n < 10$), and the results have been mixed. To begin,

[164] The challenge of diagnostic validity for BPD is reflected in the taxonomic wanderings. See Paris 2005a for a summary of the debate.

computed tomography (CT) scans from a while back did not find differences between BPD patients and normal controls.[165] More recently, an MRI study did find some non-statistically-significant differences, but the results were confounded by co-morbidities.[166] Johnson et al. summarise a number of imaging studies using positron emission tomography.[167] The results were largely negative, that is, there were no brain activity differences between BPD patients and normal controls.

There are differences in brain activity in the pre-frontal cortex between normal controls and BPD patients with marked aggressive tendencies. Especially aggressive BPD patients show differences in their serotonergic system. Some researchers are enthusiastic that this might be a signal of a unique form of BPD. But it is not clear that these differences are really responding to BPD-specific phenomena, as similar differences are found with non-patient populations in tasks where they are asked to imagine being aggressive.[168] With BPD patients not selected for their aggressive tendencies, Zaboli et al. found a link between BPD and a rate-limiting enzyme in the serotonergic system, but it was not large.[169]

Perhaps the biggest problem with understanding BPD within Medical Model A is the failure of pharmacological treatments for BPD. This is in marked contrast to the case of depression. Part of what has given Medical Model A a foothold with respect to depression has been the development of certain pharmacological treatments. As I argued in my

[165] Synder et al. 1983.

[166] Driessen et al. 2000.

[167] Johnson et al. 2003.

[168] See Pally 2002 for a summary and examination of this literature.

[169] Zaboli et al. 2006.

discussion of depression, there is a willingness among many clinicians to employ a 'response to treatment' criterion, whereby a phenomenon that goes away when treated is a diagnosable disorder. Further, if the treatment that works is purely physiological, then the disorder should be approached in purely physiological terms.

The 'response to treatment' criterion never really gets off the ground with BPD. There are a small number of clinical trials demonstrating some BPD symptom relief. SSRIs have some efficacy with affective lability features of BPD.[170] Antipsychotic medications that work on the dopaminergic system make some difference to symptoms of impulsiveness.[171] But the most that has happened is some mitigation of isolated symptoms, with the status of the overall disorder unaffected. Use of drug 'cocktails' (mixtures of different pharmaceutical therapies) are commonly employed with BPD, typically combining an SSRI with an antipsychotic, but there is no evidence that such combinations are effective.[172] At this point, there is no pharmaceutically obtainable remission of BPD. And even in the cases where symptom relief is obtained through administration of drugs, there are as yet no developed causal explanations for why or how they work. The only (and very recent) systematic review of pharmacologic treatments in BPD concludes that "pharmacological treatment of people with BPD is not based on good evidence from trials" and recommends that future pharmacological treatment happen exclusively within the context of randomised controlled trials, rather than happening in the clinic, as it does not.[173]

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[170] Rinne et al. 2002.

[171] Friedel, 2004.

[172] Lieb et al. 2004.

[173] Binks et al. 2006a, 2.

Despite these difficulties with employing Medical Model A, there does seem to be a genetic connection for BPD.[174] Twin studies have been done, with fairly definitive results, despite their very small sample sizes.[175] But no one argues that this genetic effect is uninfluenced by environment. This brings us to Medical Model B. Recall that Medical Model B employed the endogenous / reactive distinction with depression. Reactive depression is the result of stress or emotional trauma. Endogenous depression arises in the absence of ascertainable environmental reasons. The endogenous / reactive distinction is not employed with BPD. But I think the same kind of concerns found in Medical Model B in the case of depression – environmental effects are considered important in the development of the disorder – also arise in medical responses to BPD. Basically, there is a strong consensus that previous experiences are significant in most cases of BPD. In particular, BPD is associated with a history of childhood trauma. Childhood sexual abuse is a particularly significant factor, but emotional and physical abuse are also important.[176] Zanarini et al. demonstrate that parental neglect also contributes significantly to the development of BPD.[177] The significance of childhood abuse to the development of most cases of BPD is, to the best of my knowledge, uniformly endorsed.

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[174] Of course, it is curious that a genetic link has been found in the absence of any other physiological markers. There are a couple of possible explanations for this. One is that the twin studies themselves are flawed, likely as a result of confounding factors. If this is the source of the error, then that would mean that there is little to no genetic component of BPD. It could also be the result of our current imaging technology, which produces very coarse images. If this is the source of the error, eventually we are likely to see neurophysiological differences as the imaging technology improves.

[175] Torgerson et al., 2000.

[176] See Ogata et al. 1990 and Shearer et al. 1990 for representative analyses.

[177] Zanarini et al. 1997.

On my analysis, this history of childhood abuse constitutes an occasioning intentional object for the mood blend that underlies many cases of BPD. But, as with the depression case, there is a question whether this Medical Model B interest in environment reflects a willingness to see BPD or its underlying mood as intentional. Ghzal Zaboli et al. imply that they see environment as causal with respect to BPD, not intentional:

> Several environmental and genetic factors are considered predisposing elements… Environmental factors such as sexual abuse or situations of abandonment are proposed to induce dysfunction behaviors and psychosocial conflicts, which in turn might cause emotional dysregulation and impulsivity.[178]

On their analysis, if childhood trauma occurs to a person with the right predisposing genetic make-up, it *causes* BPD. They are not interested in this childhood trauma as a *reason* for BPD. But of course this quote alone does not establish that Medical Model B practitioners take BPD to be non-intentional, even implicitly. To make that case, we need to turn to the dominant therapies currently employed with BPD.

6. The treatment of BPD

Psychotherapy is the blanket term for all the many types of talk therapies. Two main (and perhaps opposing) camps are: psychodynamic psychoanalysis and cognitive therapies. Within each of these camps, there are multiple subtypes. Psychodynamic psychoanalysis has three main theoretical orientations: ego psychology, self psychology, and object relations. (I will not be discussing the features of each of these three orientations.) What all of these psychodynamic approaches have in common is a focus on the patient / therapist interactions. In addition, each is committed to engagement with the intentional aspects of the patient's

[178] Zaboli et al. 2006, 1-2.

problems (although this need not be exclusive). The label 'cognitive therapies' is slightly misleading as cognitive therapies have now subsumed behavioural therapies. There are many types, including pure cognitive therapy (CT), cognitive-behavioural therapy (CBT), and dialectical-behavioural therapy (DBT). What each of these therapies has in common is a commitment to the idea that the dysfunctional symptoms manifested by patients are maintained by dysfunctional beliefs (some variants of cognitive therapies also take environmental elements to be important in symptom-stabilisation). The aim of cognitive therapies is to identify and dismantle the maintaining beliefs (or change the environmental elements), with the ultimate goal of symptom elimination.[179]

Cognitive therapies are now the dominant form of psychotherapy. [180] I think this dominance is the result of a better fit between cognitive therapies and current medical models, as well as the preference health care payers have for cognitive therapies. The fit between cognitive therapies and current medical practice is no accident. It was first developed by Albert Ellis as a reaction against what he saw as the excessively humanistic and insufficiently scientific psychoanalytic therapies.[181] They have many features that make them a more scientifically-based practice.

First, cognitive therapies are clear. They are clear about the goal of treatment – make the symptoms go away. Cognitive therapies accept current mainstream medical approaches to psychopathology, and so symptoms themselves are presumed to be obvious, since the *DSM* lists them. This assumption is distinctly not found within psychoanalytic practice, which is

[179] Levenson et al. 2000.

[180] Robins et al. 1999.

[181] Ellis 1975.

not especially concerned with *DSM* criteria.[182] Cognitive therapies are also clear about length of treatment. They typically have a week-by-week plan of exercises. In the end, with their clear-cut step-by-step approach to symptom management, cognitive therapies have a much shorter course of therapy than psychodynamic therapy.

Second, the features just mentioned help cognitive therapies better meet evidence-based medicine standards, relative to psychodynamic psychoanalysis. Evidence-based medicine is the dominant overarching framework within medicine today.[183] This practice endorses a hierarchy of medical research data. Ideally, clinicians should follow the treatment options supported by the results from a systematic review of data from randomised control trials. There has, however, only been one such review of psychotherapy for BPD. Its authors concluded that there were insufficient data from which to draw conclusions.[184] Cognitive therapy, however, because it has a well-defined and shorter course of treatment, lends itself to more readily to randomised control trials than do psychoanalytic therapies. Although there have not as yet been many more studies of cognitive therapies that psychodynamic therapies, there is an expectation that such a difference will emerge in the next few years. Cognitive therapies are more easily quantified and their efficacy rates more easily measured than those of psychoanalytic treatment. The (relative) simplicity of the treatment also means that it is easier to train people to provide it. The result of all of these features has been a much greater embrace of cognitive therapies by medical schools. Currently, cognitive therapies are also dominant in psychology programs as well – more than half of the current training systems

[182] Louw and Straker 2002, 191.

[183] Mace and Moorey 2001.

[184] Binks et al. 2006b.

now have cognitive therapies as their major theoretical orientation.[185] Training to provide psychoanalysis is no longer a routine part of current medical psychiatric training. This has meant that there are now many more clinicians who are trained in providing cognitive therapies.

These features of cognitive therapies, especially offering shorter courses of therapy and having more clinicians trained in their provision, make cognitive therapies cheaper and easier to implement. This, in turn, means that health care providers prefer them. Some critics have focused on the United States, taking the dominance of cognitive therapies to be a product of managed care corporations. But other types of health care providers, e.g. Canada's single-payer system also has a strong preference for the less-expensive therapy, and has emphasised cognitive therapies over psychodynamic therapies.[186] Some critics have lamented this emphasis on the bottom line, but I do not see why health care providers should not aspire to spend as little money as possible to provide good care. These features of cognitive therapies also often reduce the time and money that patients must provide, which also seems like a benefit. Further, the transparency of cognitive therapies has lead to standardisation of treatment and credentialing, both of which likely serve patient interests.[187]

The current guidelines for the treatment of BPD offered by the American Psychiatric Association recommend either psychodynamic psychoanalysis or psychotherapy (supplemented with some pharmacological treatments, depending on the patient's symptom profile). According to their summary, both psychodynamic psychoanalysis and cognitive

[185] Levenson et al., 2000.

[186] Paris 1998.

[187] Peter Panzarino 2000 concurs with this assessment.

therapies have roughly equal amounts of evidence to support their use, although neither has anything approaching definitive evidence of efficacy.[188] Despite the paucity of evidence favouring cognitive therapies over psychoanalytic therapies for BPD, the preference of medically-grounded clinicians for cognitive therapies is made clear by John Oldham. Oldham is actually the author of the APA treatment guidelines that advocate the use of either psychoanalysis or cognitive therapies. But in his most recent paper, he argues for a hierarchy of treatment.[189] First, the therapist should respond to suicidal and self-mutilating behaviours. Second, she should deal with behaviours that lead to serious interruptions in the continuation of therapy. Third, she should pay attention to non-suicidal symptoms linked with depression, substance abuse, panic or anxiety and dissociation. According to Oldham, each of these problems should be targeted from a purely behaviour-management perspective. Once all this is complete, then the therapist can move on to consider more psychodynamically-significant symptoms. This hierarchy prioritises cognitive therapies.

Michael Stone endorses a very similar treatment hierarchy.[190] He argues that the evidence indicates that cognitive therapies (in conjunction with appropriate pharmacological treatments) should be pursued first, to deal with some of the thornier symptoms of BPD that appear not to benefit from more psychoanalytic approaches. But he does not have any data to back up this treatment ranking. In both Oldham and Stone's accounts, they make room for psychoanalytic, intentional therapeutic engagement. It only comes, however, after most of the symptoms of BPD have been eliminated through cognitive therapies. Although they are

[188] APA 2001. These are still the guidelines in use today.

[189] Oldham 2006.

[190] Stone 2006.

not explicit about it, Oldham and Stone ultimately only support psychodynamic approaches for patients who would no longer be diagnosable with BPD.

DBT is an interesting case of a cognitive treatment that has garnered a large amount of positive clinical attention (over psychoanalytic treatment), even in the absence of solid evidence of efficacy. The use of DBT over the last 15 years has been based on a single study. It purported to show that DBT reduces suicidal behaviour, a particularly troubling BPD symptom for clinicians. This does seem to have been the case at the 6 month mark in treatment, but that effect seemed to go away by month 12.[191] A more recent, and slightly larger study, showed a slight improvement in suicidal behaviour after12 months of DBT, relative to other forms of psychotherapy, but there are a number of confounding factors.[192] This is not especially heartening, so it is curious that DBT has been greeted with such enthusiasm.

I think the answer is because DBT not only has specific protocols for patients, but also for therapists employing the therapy. In particular, DBT emphasises therapists setting boundaries with BPD patients. Within DBT, patient threats of suicide result in less access to the therapist, rather than more, as is traditional with other forms of psychotherapy.[193] I think this therapeutic accommodation makes it very attractive to therapists, independent of

[191] Linehan et al. 1991.

[192] Linehan et al. 2006.

[193] Linehan 1993.

considerations of efficacy.[194] As a final nail in the psychodynamic coffin, DBT is now the treatment of choice for BPD under managed care.[195]

Given that the features emphasized by the *DSM* criteria are primarily affective and behavioural, this preference for cognitive therapies might come as a surprise. One should keep in mind, however, that because it aims to be a diagnostic tool that can be used based on easily observable symptoms, the *DSM* very rarely includes cognitive features in its diagnostic profile. (Recall that even with depression, no cognitive symptoms are included in the symptom list.) Clinically, though, there are many cognitive elements found in BPD, just as there are with depression.[196] I touched on some cognitive elements of BPD earlier, in my discussion of the cognitive biases associated with BPD.

But in addition to these biases, BPD is also linked with what clinicians call "assumptions." Arntz et al. have identified 20 stable assumptions linked with BPD.[197] They are:

1. I will always be alone.
2. There is no one who really cares about me, who will be available to help me, and whom I can fall back on.
3. If others really get to know me, they will find me rejectable and will not be able to love me; and they will leave me.
4. I can't manage it by myself, I need someone I can fall back on.
5. I have to adapt my needs to other people's wishes, otherwise they will leave me or attack me.
6. I have no control of myself.

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[194] Bot 1997.

[195] Tyrer 2002, 116. See also Cigna Healthcare Coverage Position 2005.

[196] These cognitive features are a relatively recently recognized phenomenon. In the 1990 edition of their now classic textbook, *Cognitive Therapy for Personality Disorders*, Aaron Beck and Arthur Freeman argued that BPD was unique among personality disorders, as it did not include stable cognitive features (Beck Freeman and associates 1990). For them, this meant that BPD was not a candidate for the cognitive therapies now dominant. I assume this will not be the stance they adopt in the next edition of the book. As the evidence has mounted that BPD does include stable cognitive elements, Aaron Beck is now part of a team doing research using cognitive therapy with borderline patients. See e.g. Wenzel et al. 2006.

[197] Arntz et al. 1999.

7. I can't discipline myself.
8. I don't really know what I want.
9. I need to have complete control of my feelings otherwise things go completely wrong.
10. I am an evil person and I need to be punished for it.
11. If someone fails to keep a promise, that person can no longer be trusted.
12. I will never get what I want.
13. If I trust someone, I run a great risk of getting hurt or disappointed.
14. My feelings and opinions are unfounded.
15. If you comply with someone's request, you run the risk of losing yourself.
16. If you refuse someone's request, you run the risk of losing that person.
17. Other people are evil and abuse you.
18. I'm powerless and vulnerable and I can't protect myself.
19. If other people really get to know me they will find me rejectable.
20. Other people are not willing or helpful.

James Pretzer characterises the core characteristic BPD beliefs as: (1) the world is malevolent and dangerous; (2) they [the BPD sufferers] are powerless and vulnerable; and (3) they view themselves as unacceptable.[198, 199] Although mood was not explored in conjunction with identifying these assumptions, it seems clear to me that these are just the sorts of assumptions that one would expect to accompany a mood blend of irritation and depression that I have argued is characteristic of BPD.

It might appear that if Medical Model B endorses cognitive therapies for BPD and cognitive therapies focus on assumptions like those above, then BPD must be seen as intentional. These assumptions include clearly-intentional beliefs about a range of issues, particularly about the BPD sufferer herself. Derek Bolton takes this position, and argues that this new preeminence of cognitive therapies is very positive because it relies on the idea that intentional mental states can themselves be causal.[200] In the case of BPD, cognitive therapies

[198] Pretzer 1990.

[199] It is worth noting that the moods associated with BPD are not reducible to this assumption set. Arntz et al. 1999 found that the assumption set and the intensity with which its elements were endorsed did not vary over mood-alteration conditions (p. 551).

[200] Bolton 2004.

focus on the associated beliefs (e.g. I will always be alone) and explore the way that belief causally hooks up with unpleasant symptoms of BPD (e.g. a patient flying into a rage when her lover cancels a date). The hope is that dismantling the belief about always being alone will lead to fewer rages about cancelled appointments. As I just discussed, there is reason for this hope, although it is still only a hope, and not established as effective. Bolton characterises the history of psychiatry as a battle between psychoanalysts, understanders of narratives, and physiologists, explainers of causes. He sees cognitive therapies as bridging the gap between these two approaches, which he lauds. Given my interest in preserving the importance of intentionality, on Bolton's analysis, I should be an enthusiastic proponent of cognitive therapies.

7. How cognitive therapies implicitly deny intentionality

In some respects, I am pleased with the advent of cognitive therapies. Cognitive therapies have been clear about the objectives of therapy, clear about what therapy entails, and there has been a concerted effort to determine whether or not these objectives are met. I think this is a tremendous virtue, as patients should be able to know before entering therapy what they are getting into, and clinicians should aspire to provide their patients with treatment that actually meets patient goals. Psychoanalysis has not provided patients with this kind of information. But I do not believe that cognitive therapy actually does integrate the intentional into its practice. The basic premise of cognitive therapies includes intentional states, but closer examination of the details of the treatment reveal very little, if any, engagement with these intentional features.

Practitioners of cognitive therapies aim to make symptoms go away. That is the goal of cognitive therapies. And if cognitive therapists identify assumptions or feelings that stabilise the symptoms, then those assumptions and feelings should be eliminated. This elimination is aimed for, independent of considerations of the appropriateness of those assumptions and feelings. This is particularly the case with the possibility of appropriateness of fit between the assumptions / feelings and the intentional object(s). When I look at the list of assumptions Arntz et al. developed, it seems possible to me that it might be highly fitting for some people to hold those assumptions. As we know, most sufferers of BPD have had terrible past experiences of the world. Most of their earliest experiences include a variety of types of abuse. Further, it seems potentially fitting for patients to hold those assumptions in the mood-laden manner that I have described – a blend of irritation and depression. Given that sort of past experience, it seems highly presumptuous to me to insist that someone ought to abandon her assumption, say, that "If I trust someone, I run a great risk of getting hurt or disappointed" (number 13). I also think it would be presumptuous to ask such a patient to give up feelings of irritation and depression that are part of that assumption. But the possible fittingness of a BPD sufferer's assumptions and associated moods is not engaged with as part of cognitive therapies.

Consider the most common therapy for BPD: dialectical behavior therapy, or DBT. The focus in DBT is primarily occurrent. It is not part of DBT to discuss any of the historical traumatic events that might constitute occasioning intentional objects for her assumptions or moods. Patients are encouraged to pay attention (practice "mindfulness") to their thoughts / feelings. They should attempt to notice connections between these thoughts / feelings and their symptomatic behaviour. As they become more skilled at identifying these connections,

they should practice breaking those connections. How do therapists help their patients do this? Not by arguing with the assumption holder or presenting counter-evidence. Instead, there are a number of efforts to show the assumption holder that continuing to hold and endorse the BPD assumptions and feelings is not helpful to her. Her life goals are not advanced by holding that belief. If the BPD sufferer ceases to endorse her BPD assumptions and feelings, she will be better able to minimise her symptomatic behaviour. This is an argument from prudence, not an argument from truth. This is, of course, a powerful consideration, but it does not constitute intentional engagement.

Once this is appreciated, one can see that, within cognitive therapies for BPD (part of the Medical Model B perspective), the assumptions associated with BPD are not engaged with intentionally. Of course, the assumptions themselves (and, on my view, their associated moods) are intentional. This is not how clinicians within Medical Model B see the assumptions and moods associated with BPD. They are not grappled with through their intentional content, but instead are tackled through cognitive / affective / behaviour modification. On my view, childhood trauma constitutes the occasioning intentional object of the moods (and broader cognitive states) that end up being seen as the symptoms of BPD. But within mainstream medical practice, those cognitions / affects/ and behaviour are seen, at most, as a causal byproduct of that childhood trauma.

For non-psychoanalytic clinicians that wish to engage with the historical experiences of BPD sufferers, they now will actually avoid diagnosing the patient with BPD, precisely because current understandings of BPD do not consider this history significant with respect to treatment. Instead, they will diagnose the person with post-traumatic stress disorder, or

PTSD.[201] The diagnostic criteria and the dominant accepted treatment for PTSD more commonly make room for intentional analyses. I think this pattern of treatment (and reactive diagnosing) shows that, under the current dominant medical understanding of BPD, what I have called Medical Model B, BPD is a non-intentional state.

Before moving on to my positive case for BPD and its associated mood's intentionality, I need to acknowledge a problem for the intentionality proponent. Above, I discussed several reasons for the dominance of cognitive therapies. But one reason I cannot ignore is that cognitive therapies are now used because of the significant failures of traditional psychoanalytic therapies. For each positive reason I provided in favour of cognitive therapies, psychoanalytic approaches have a corresponding negative reason – they have not been part of studies that lend themselves to efficacy assessments, they are not transparent about either length of therapy or therapeutic goals, and they do not accept or work with the constraints of medical systems especially with respect to financial issues.

Given my analysis of cognitive therapies, psychoanalytic therapies are the only therapies that consistently take psychopathologies like BPD and their associated moods to be intentional states. (Cognitive therapies could incorporate these kinds of considerations, but typically do not.) Within psychoanalysis, therapist and patient consider the intentional origins of a patient's affective states and encourage the patient to think about and understand those origins, as well as their personal significance. If the single therapy that consistently takes BPD to be intentional does not work to eliminate the symptoms of BPD (which I grant are terrible for the BPD sufferer, as well as those around her), does that not mean that BPD should be approached as a non-intentional state?

[201] Becker 2000.

First of all, it should be pointed out that psychoanalytic approaches have not been shown *in*effective with BPD. There still remains the possibility that psychoanalytic techniques will be shown to work with BPD symptoms. Further, the problems I just cited with respect to psychoanalysis are not problems with intentional engagement, but more pragmatic. It is possible that adjustments could be made, such that psychotherapy could spell out goals of treatment and treatment length, and greater efforts at meeting financial constraints could be pursued.[202] But even if this does not work, the failure of psychoanalysis to lead to the elimination of BPD symptoms does not establish that BPD is largely a non-intentional phenomenon.

As I discussed in chapter 1, moods are extraordinarily complicated. Although I am primarily interested in considering their intentional aspects, that is not the total of what a mood consists in. This is even more true in the case of a personality disorder like BPD, which incorporates much more than just moods. It may turn out that once a set of BPD symptoms has come into existence to be diagnosed, reducing or eliminating those symptoms cannot be accomplished through attention to the intentional features.[203] The various cognitive and affective barriers, along with physiology and behaviour may converge, so that intentional analyses cannot change how the person thinks / feels / and acts with respect to the disorder. But this does not establish that intentional features do not exist. In fact, it does not even establish that focus on those intentional aspects is meaningless. In the next chapter, I

[202] John Gunderson and Glen Gabbard 1999 recognise these pragmatic problems with psychoanalysis, and argue that there is an obligation to respond to them.

[203] Lucia Imbesi 2002 argues that personality factors make insight (the core therapeutic method of psychoanalysis) impossible for some BPD patients.

will explore what I think can be gained through intentional analyses of BPD, even in instances where those analyses do not result in symptom elimination.

CHAPTER V

THE MORAL DIMENSION OF BORDERLINE PERSONALITY DISORDER

One of my strongest complaints against the non-intentional analyses of moods currently on offer is the thinness of their characterisations of moods. I will aim to avoid this tendency in my exploration of BPD. In my case study, I will explore what is gained by considering the mood states of BPD intentional. I think this approach provides a rich explanatory force. I will argue that a non-intentional account does not have the resources for the same kind of insight. Thus, my argument for the intentionality of a BPD-associated mood blend will be a kind of 'argument to the best explanation.' I hope to show how attractive the intentional account is, given that the non-intentional accounts leave so much unexplained.

I. A case of BPD

Consider Lilah,[1] a woman in her 30's who has been diagnosed with BPD and who meets almost all of the diagnostic criteria for BPD. She has had many intimate relationships with men. A common pattern in those relationships is a beginning period of intense infatuation. On three occasions, she has gotten married within a month or less of meeting her partner. But several months into the relationship, things sour. They begin fighting. Lilah finds all of his behaviour intolerable. He sometimes comes home later than he said he would, or he will

[1] I will be adapting a case provided Sidney Ornduff 2005.

fail to phone her when she expected a call. In these instances, Lilah flies into a rage. Sometimes she acts out this rage by damaging property. More commonly, Lilah responds to her rage by locking herself in the bathroom and cutting herself. In addition to the more dramatic moments described above, Lilah is almost always unpleasant to be with. It is hard to pinpoint exactly what she does that is so aggravating, but she is a person that most people wish to avoid. She routinely takes herself to be irritated about most of the things in front of her, e.g. the volume of the television, the failure of her husband to phone about his brief lateness, and the draft in the room. She escalates her distress in these situations by violently berating herself for her failings.

Lilah has been compelled to accept therapy because of a suicide attempt. She claims that she tried to kill herself because she has recently had new memories surface. At her latest gynecological exam, her physician told her that she had genital scarring consistent with having been abused. While considering this possibility, Lilah had several flashes of images of being violently vaginally penetrated by her father as a toddler. She also has memories of her mother watching as her father exposed his penis to Lilah. She has been very distraught about these memories. Lilah has had very little contact with her father. In the past he physically abused Lilah's mother, and he left her and her mother before she started school. She has only seen him once since then. He returned to the family home on the morning of her graduation from high school and climbed into bed with Lilah, ignoring her protests. Lilah's relationship with her mother has also been difficult. They fight often but are in regular contact.

If Lilah enters a course of dialectical behavioral therapy, there will be no discussion of these childhood experiences or the newly-surfaced memories qua memories. Instead, the

therapist will begin by giving Lilah exercises to help her identify which feelings and thoughts accompany her symptoms, particularly her suicidal behaviour and thoughts, along with her self-harm behaviours. If Lilah begins to experience suicidal ideation, she will attempt to observe what was going on when she started down that internal path. Were there particular environmental factors that acted as a trigger? Then, as she identifies patterns in thoughts / feelings/ behaviours, she will attempt to dismantle those that lead to her suicidal and self-harm thoughts and behaviours. Let us assume that Lilah succeeds at all these tasks. She figures out her environmental triggers and her feeling and thought patterns. She comes to master them so thoroughly that her symptoms truly do go away – she no longer has thoughts of suicide, she no longer cuts herself, she is able to enjoy her relationships and maintain her job. I think there is still a substantial gap in Lilah's understanding of herself that is worth exploring. I think this gap could be at least partly addressed through considering the intentional aspect of her feelings.

2. Intentional analysis with immediate (apparent) intentional objects

What might an intentional analysis offer Lilah? One of the advantages of considering a phenomenon intentionally is that a normative evaluation is possible. With emotions, recall that D'Arms and Jacobson identify three axes along which emotions (assuming that emotions are intentional) can be assessed for appropriateness: fit, prudence, and morality. There is also a fourth axis added by Griffiths – evolutionary fitness. I think that the same four evaluative axes exist for moods, in cases where those moods are intentional. Further, in light of my distinction between occasioning and immediate intentional objects of moods (and emotions), some instances of moods will have two sets of mood-object relationships to be

evaluated. Lilah's mood that I most wish to explore is her irritation / depression mood blend (that I argued in the previous chapter is a unique marker of BPD). In this section, I will consider the case of the immediate (apparent) intentional objects of Lilah's mood.

I will start by exploring whether or not Lilah's mood blend is fittingly appropriate in light of its immediate (apparent) intentional objects, e.g. husband lateness, television volume and draft. In considering Lilah's intense reactions to these objects, the intentional account immediately runs into difficulties. The objects of Lilah's irritation are so ubiquitous and nondescript and Lilah's mood is so strongly negative that it is not plausible to observers that the TV, husband lateness and draft are true intentional objects of her irritation / depression. Some might not think they can count as intentional objects of her mood at all.[2]

From the outside, it seems clear that Lilah's irritation / depression mood blend is considerably more longstanding than her exposure to the objects she cites as the objects of her mood.[3] Her extant mood appears to be 'directed at' or 'about' everything, rather than any particular thing. This is the feature of moods whereby they become attached to many different immediate (apparent) intentional objects, and demonstrates Lormand's Pervasiveness condition. Everything Lilah comes into contact with gets processed through her mood. This global quality of her mood, such that it is about everything, reinforces the sense that her mood in fact is about nothing – that is, her mood appears non-intentional. Thus, although we began this section intending to pursue an intentional account of Lilah's mood, problems of fit lead us quickly to a non-intentional account.

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[2] I argued earlier that it is precisely this difficulty that lends nonintentional accounts of moods their plausibility. In chapter 1, I argued that there were good reasons to deny true intentionality to the relationship between moods and their immediate (apparent) intentional objects. I will not revisit that issue here.

[3] Notice that implicit in this approach there is an insistence that a true intentional object be linked with the affective state's occasioning.

This non-intentional account gives fuel to the particular pathologising efforts found in the current dominant medical models. As observers, since we fail to identify an intentional relationship that makes sense of Lilah's mood, we begin looking for non-intentional causes. The primary causal explanation that will likely be appealed to is Lilah's BPD. The disorder causes her to be irritated and depressed. Lilah's mood is now understood as a symptom of her BPD. In fact, we will no longer consider Lilah to be primarily expressing a mood at all. Instead, her affective state will be looked at symptomatically, and characterised as "affective lability" (one of the prime symptoms of BPD). Once this pathologising move has been made, explaining Lilah's affective state will be taken up by medical practitioners. Within Medical Model B, there will be a willingness to characterise Lilah's pathological mood blend of irritation and depression as a causal response to childhood abuse. But for treatment purposes, engaging with or even acknowledging the causal history is not important. What is important is to make her symptoms – her affective lability – go away. And the dominant view now is that this goal is best accomplished through cognitive / behavioural interventions.

It is, however, possible to resist this exclusively non-intentional pathway. The non-intentional path argues that the relationship between Lilah's mood blend and the immediate (apparent) intentional objects is so tenuous that it is implausible to see it as intentional at all. I would argue that in fact it is an intentional relationship where the failure of fit is only partial. There are cases where a mood's failure to fit an object is so pronounced that it can plausibly be claimed that there is a complete absence of an intentional relationship. This is when a mood so grossly misrepresents the purported object of the mood that it appears to fail to represent the object at all. If someone claimed that she was irritated about her husband's sincere expression of love, in most cases we would simply say that her mood was not about

the love expression at all.[4] This is not the case with Lilah's mood. Clearly, Lilah's mood is very much like the mood that might often be linked with too-loud-TVs or late husbands. A loud TV or a tardy spouse is often the prompt of irritation. The main problem in the fit between Lilah's mood to its immediate objects is its intensity. In part, Lilah's mood represents the draft and television volume, which are indeed bad, as worse than they actually are. But her mood is still representing the draft and the television volume.

Of course, Lilah's mood is a more complicated mood blend of irritation and depression. Lilah's mood blend represents the television volume and a draft as somehow connected with a depressed sense of negative self-evaluation. This might seem, to some, to be a case of total misrepresentation. It is hard to see how these objects could fit at all with depression. In most cases, however, the depression follows on the heels of the irritation element, and is in fact more a response to the irritation. That is, Lilah first has an intense flare-up of her irritation in response to something like the television or her husband. Then, in taking herself to be feeling the wrong thing in being irritated so intensely, her depression is activated. Thus, her total mood state actually has as its immediate (apparent) intentional objects both the television / draft / husband lateness and other components of the mood itself. I do not think, however, it is accurate to say that Lilah experiences two distinct moods. The various mood elements merge and reinforce each other, such that they constitute a single mood experience.

Here, as with the irritation element of her mood state, there is a basic fit between mood and immediate (apparent) intentional object. If someone takes herself to have done something wrong that she could have and should have avoided, some amount of depression

[4] Of course there could be a case where context could explain that the irritation was truly about the love-expression. But in most cases, it will be more plausible to deny an intentional relationship between the mood and love-expression.

might be fitting. But again, as with the irritation component, there is a problem of intensity. Lilah's depression is more pronounced than her transgression warrants. This pattern of excessively intense mood states might be where part of Lilah's pathology might be located.

In addition to considering these questions of fit, it is also possible to evaluate the prudential appropriateness of Lilah's mood in light of its immediate (apparent) intentional objects. Here it seems clear that Lilah's mood fails to be prudential. Feeling this way – intensely and volatile-ly irritated / depressed – does not advance the interests of Lilah (or anyone else, probably). It hurts her in many ways to feel that way about those features of her environment and her own mental states. The mood states themselves are intensely negative. Sometimes the mood is so bad that it leads Lilah to cut herself. Additionally, these moods lead her to behaviour that alienates others e.g. yelling, physical violence. Of course this failure of prudentiality is also a marker of pathology. This is the primary concern of cognitive therapies like DBT. They focus on alleviating the harms associated with this lack of prudence, and put aside entirely consideration of potential intentional objects. They take the view that Lilah's mood blend manifests such an extreme lack of prudence that it would be nonsensical to attempt to understand it intentionally. I would like to reiterate, however, that there is nothing in pathologising itself that requires a non-intentional position. That Lilah's mood blend may reflect a pathological lack on a prudential level does not establish a lack of intentionality.

Then there is the moral appropriateness question. Again, it seems clear that Lilah's mood – evaluated in terms of its relationship with the TV, her spouse and the draft – is not morally appropriate. In responding to her husband's lateness with such an intense negative affective experience, she does wrong to both herself and him. In most cases, while observers might

grant that her husband's lateness fits with a slight amount of moral disapprobation,[5] it is not seen as moral warrant for the violent berating to which Lilah subjects him. Lilah's violence against herself – the 'delicate self-mutilation'- in response to the situation of her husband's tardiness and her follow up to it is also, I think, clearly morally inappropriate. Although Lilah's behaviour toward her husband is truly wrong, self-cutting is not a morally appropriate response to perpetrating this bad behaviour.[6]

Finally, there is the issue of appropriateness of BPD's associated mood blend in light of evolutionary considerations. To my knowledge, there are no empirical investigations that determine whether BPD in general results in diminished reproductive fitness, but it seems plausible that it does. The romantic relationships of BPD sufferers are more stressful and have more crises than those of persons without BPD.[7] Sufferers of BPD also have problems with academic performance[8] and vocational success.[9] In one of the largest studies of the BPD functioning, persons diagnosed with BPD received a mean score of 38.9 on the Global Assessment of Functioning Scale (out of a total possible score of 100).[10] This score indicates "serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood."[11] They experience a higher

[5] The degree of moral disapprobation that this lateness warrants will, of course, be context dependent.

[6] It seems unlikely to me that self-cutting can ever be morally appropriate. Even in cases where Lilah does something very bad, such that she deserves punishment, it is hard to imagine anyone endorsing self-cutting as the right kind of punishment.

[7] Daley et al. 2000.

[8] Bagge et al. 2004.

[9] Zanarini Frankenburg Reich Hennen and Silk 2005.

[10] Zanarini et al. 2006.

[11] APA 2000b, 32.

incidence of alcohol abuse, and have greater problems associated with that alcohol abuse.[12] They also are more likely to experience chronic illnesses and engage in more health-threatening behaviour like smoking.[13] Of course, there is also the simple fact that BPD is linked with higher mortality rates within childbearing years[14] – this difference alone is enough to make the case that BPD has negative effects on evolutionary fitness.

But in addition to this general issue of evolutionary fitness of BPD as a whole, there is the question of the evolutionary fitness of BPD's mood blend – in light of its immediate (apparent) intentional objects. This is an empirical issue for which there are no definitive data. It does seem to me, however, that the data found in the preceding paragraph make it unlikely that evolutionary fitness could be seen to be enhanced from this perspective. People typically think of BPD in terms of its immediate (apparent) intentional objects – Lilah's response to the television volume garners a great deal of attention. This attention is overwhelmingly negative for the BPD sufferer herself. It seems likely to me that the mood blend of irritation and depression, understood in terms of its immediate (apparent) intentional objects, is a significant contributor to the many psychosocial problems BPD sufferers experience. I suspect that these problems decrease evolutionary fitness.

So – Lilah's mood fails to be appropriate on any of the four evaluative measures we have. It seems possible that the manner in which Lilah's mood is not appropriate in any of these dimensions is a reflection of pathological processes. Although I have argued that it is possible to see Lilah's mood blend as intentional, if we consider only the immediate

[12] Stepp et al. 2005.

[13] Frankenburg and Zanarini 2004.

[14] APA 2001.

(apparent) intentional objects available, her irritation / depression often appears to be unintelligible. We cannot knit the pieces of Lilah's mood into a single, coherent phenomenon. The immediate (apparent) intentional object often does not appear to be a fully fitting object, particularly in light of the affective intensity. The behaviour that accompanies her mood blend is almost incomprehensible. At this point, it is not clear that the intentional analysis has brought us any new appreciation of Lilah's situation and it has not provided any insight into her pathology either.

3. Intentional analysis with occasioning intentional objects

I think that the advantages of an intentional analysis only appear when we consider Lilah's mood blend in light of its occasioning cause. With BPD, intelligibility is often only conferred when earlier events from the person's history are considered. In many cases of BPD, the occasioning cause of the typical mood blend of irritation / depression is the childhood abuse that most experiencers of BPD have undergone. In the largest study about BPD sufferers' childhood experiences, Mary Zanarini et al. found that just over 60% of their BPD-diagnosed subject pool reported childhood sexual abuse, just under 60% reported childhood physical abuse, and over 90% reported abuse that included emotional, verbal, and neglectful abuse.[15] These rates are considerably higher than rates found in populations of both normal controls and patients with other psychiatric diagnoses. More recently, in another relatively large study, Mary Zanarini et al. found that severity of abuse correlated with severity of BPD symptoms.[16] I think these data give us a starting point for examining the

[15] Zanarini et al. 1997.

[16] Zanarini et al. 2002.

intentionality of BPD's associated mood state. As with cases of depression, to determine whether a particular case of BPD has an occasioning intentional object and whether a case is intelligible, affective reconstruction and interlocution will be required.

In many cases of moods, the mood-experiencer is uncertain what the occasioning cause of her mood is. This is where the process of affective reconstruction comes in. Typically, one would begin by asking about the mood-experiencer's recent life events. In one sense, Lilah's affective reconstruction is simple. She is especially irritated / depressed right now because of her recent uncovering of memories of abuse. But Lilah has a lifetime of complicated and unintelligible (with respect to their immediate objects) mood states that need explaining. If the memories are veridical, then we might be able to say that the incidences of abuse are the long-standing occasioning intentional objects of Lilah's longstanding mood blend.

But in fact, we face a challenging question with respect to this potential occasioning intentional object. Lilah does not actually know if she was sexually abused by her father as a child. Whether or not the sexual abuse actually happened makes a tremendous difference. If she was abused in the way she is now remembering, then it is possible that her mood is a response to this abuse as occasioning intentional object. This in turn will effect how Lilah understands her childhood and herself as an adult. The 'memories' that are distressing Lilah and pushed her into therapy are actually suspect with respect to veridicality. They do not seem to have the attributes of typical childhood memory – they are too precise. Given that they came only after an authority-figure (her gynecologist) suggested that perhaps she had been raped, it is possible that they are the result of suggestion.[17]

[17] Ornduff 2005.

To decide whether or not the abuse actually happened, we would have to pursue a very difficult form of affective reconstruction. Childhood abuse does not typically leave evidence like many other traumatic life events. Although Lilah has genital scarring, there is no way to determine with certainty from the scars alone what caused them. It is further unlikely that Lilah will be able to find any physical items that would establish with any certainty whether or not the events occurred. The best way to settle this question probably would be to ask her father and mother, but this may be too difficult a task for Lilah to take on. Further, both her father and mother have reason to lie if the abuse did happen as Lilah remembers it. Lilah will have to think about what sorts of reasons she has for taking her recent mental images to be memories. She and her affective reconstructor and interlocutor should consider the possibility that those images reflect something other than memories. Perhaps they are imaginings, metaphorical images for what she takes her father (and mother) to have done to her. Perhaps not.

From the standpoint of therapies that do engage with a patient's history like, for example, standard psychoanalysis, this process of reconstruction and interlocution is fairly controversial. Psychotherapists typically do not challenge the veridicality or appropriateness of a patient's presentation of her history or how she feels. Nancy Potter argues that, especially with patients diagnosed with BPD, therapists have a moral obligation to refrain from imposing their own views.[18] Instead, she thinks that therapists must allow the patient's own understanding of her history and her symptomatic behaviour to guide the therapeutic interactions.

[18] Potter 2003.

I do not wish to part too substantially from Potter's position. I concur that respect for the patient on the part of the therapist is necessary, and part of respecting someone requires taking her assessment of her own life seriously. With BPD patients especially, since they have likely been accorded very little authority over their own lives, it is important, in Potter's words, to give their own analyses "uptake." But I am not convinced that respect entails endorsing someone's description of their own history, if there are reasons for thinking that their description is mistaken.

In the case of Lilah, mistakes might occur in two respects. First, she might mistake wholly or partly imagined mental images to be veridical memories. Second, she might take her affective state and her symptomatic behaviour to be appropriate in some respect – fit, prudence, morality – in instances where they are not appropriate. In both senses, I think respecting Lilah includes the possibility of telling her about these possible errors. Depending on the reasons her reconstructor / interlocutor has for thinking Lilah is mistaken, the reconstructor / interlocutor will have varying degrees of warrant to press Lilah to consider the possibility of error. With respect to the memory / imaginings question, it will be difficult to know how much to press. Although Lilah's memories are somewhat suspect, a reconstructor / interlocutor will almost never have grounds for anything approaching certainty, one way or another. But whether or not Lilah was truly abused in the way she newly 'remembers' is important. I think we owe Lilah some assistance with considering the possibility that what she now takes to be memories might not be. In this regard, I am partly following Ian Hacking's analysis of dissociative identity disorder (often known as multiple personality disorder).[19] He argues that therapists do their patients a serious disservice by taking their

[19] Hacking 1998.

accounts of abuse as always and absolutely veridical. With the errors associated with the appropriateness of Lilah's affective state and symptomatic behaviour, a reconstructor / interlocutor will often be on firmer ground. For example if Lilah takes her self-harm behaviour to be either fitting or morally appropriate, she is wrong. Challenging these assessments is part of what we owe her when we engage with her.

My analysis, however, leaves open the possibility that affective reconstruction and interlocution will not comprise an entire therapeutic engagement. At the moment, there are no therapies that practice reconstruction and interlocution in the way that I have described them, although I do think that many clinicians incorporate some elements thereof into their practice.[20] This means that the clinical effects of such interactions have not been documented. Challenging affective reconstruction and interlocution could only be cautiously introduced into a therapeutic relationship. Data would need to be collected about the consequences of this challenging. Therapists rightly strive to aid their patients. With sufferers of BPD, this surely means attempting to alleviate some of their distress. It is possible that affective reconstruction and interlocution would not be helpful in alleviating distress, especially in the short term. I think that this is a relevant factor to consider before pursuing affective reconstruction and interlocution. These kinds of considerations are often involved in friendship, which is where I think affective reconstruction and interlocution are typically practiced. A good friend will often challenge someone's assessments of what has happened to them and which of their responses are appropriate. But these challenges will

[20] Potter, personal communication.

often only be raised after the friend has provided non-challenging support. Similar judgements are appropriate within a therapeutic relationship.[21]

Within current medical and implicitly non-intentional accounts of moods, none of this makes any difference. Whether or not Lilah was sexually abused by her father will not affect her course of DBT. There, her only concern would be to change her behaviour right now. But this means that this therapy will not help Lilah to know if she is a person who experiences her mood blend in response to sexual abuse, or in response to some other kind of event. This would tell Lilah something fundamental about who she is. People who are abused in the way that Lilah remembers being abused – sexual penetration, boundary violation, not being defended and protected, being abandoned – respond in different ways. If Lilah was abused, then she might come to believe that her mood states are a result of this experience. She would have reason to think that she is the kind of person for whom irritation and depression arise as a result of that kind of abuse. The BPD assumptions that she holds were likely informed by those abuse experiences. In this scenario, the child she was learned many lessons as a result of that abuse. The abuse taught her that she was not valuable. It also taught her that the world was unjust. But – if she was not abused, then her longstanding mood blend is not the result of that experience. In which case, she developed her mood, gained those assumptions, and learned those lessons through some other route. And this would reveal something else about her. All of this is part of Lilah developing a full appreciation of her own history and as a consequence, an appreciation of the child she was and the woman she has become.

[21] I do not wish to suggest here that friendship and therapy are the same kind of relationship. Therapists will face many different constraints than a friend.

As I discussed with regard to depression, one of the benefits of an intentional analysis is that it opens the door to considering whether or not the mood phenomenon is intelligible. At the point when Lilah decides if she was or was not abused in the way she has recently remembered, then the affective interlocution can begin. We can start asking whether Lilah's irritation / depression fits with her experiences. If she was abused in the way I described above, the answer is probably yes. In this case, we might feel that we have an intelligible case of irritation / depression. Moreover, the intelligibility we gain in considering Lilah's occasioning intentional objects – the paternal abuse and maternal neglect – also help to confer greater intelligibility on at least some elements of Lilah's mood with respect to its immediate objects. Recall that Lilah regularly has problems with her relationships with her male partners / husbands. That she responds 'disproportionately' in response to her husband coming home late without calling becomes more intelligible if we consider that Lilah has experienced profound abuse and neglect. She 'overreacts' to not-very-bad behaviour in the present which bears some resemblance to the very-bad behaviour she experienced in the past. In the past she was abused, not only sexually but also with neglect and abandonment. Lateness might feel, to a person with these experiences, like a kind of abandonment. When we considered Lilah's response to her husband's lateness in isolation from her past, we had a failure of complete intelligibility. We can now come much closer to finding that complete intelligibility.

On the other hand, if Lilah was not in fact abused in the way she remembers, then we probably need to continue with our reconstruction. In that case, we still have no occasioning intentional object to help explain the origins of her mood blend. We also need to explain why she has memories that likely are not veridical. The origin of the non-veridical memories

may well be helpful in reconstructing the true occasioning intentional objects of her mood. It should be acknowledged that Lilah may never truly know whether or not her memories are accurate. This is particularly distressing, especially for someone who suffers additionally with BPD. But even this great uncertainty tells her something about who she is.

Appreciating the intentional origin of Lilah's mood blend of irritation and depression can also help in making her 'delicate self mutilation' more intelligible. This requires uniting three phenomena: the occasioning intentional object, the mood blend, and the self-injuring behaviour. First I will discuss the fit between the mood blend and the behaviour. To understand how these elements fit together, an affective interlocutor must appreciate that the BPD-associated mood blend is extraordinarily painful to experience. In fact, Carolyn Zittel Conklin and Drew Westen found that community samples of BPD sufferers are primarily identifiable by their intense affective distress which they characterised as dysphoria, even though this is not one of the DSM criteria for BPD's diagnosis.[22] Unlike pure depression, the negative feeling BPD sufferers experience is not dampening of motivation for action. Instead, the irritation provides substantial fuel for acting out. What motivates self-harm? Milton Brown et al. found the main reasons for self-injury among BPD sufferers is to provide affective relief and for self-punishment.[23] These results are consistent with my own view that a strong depressed self-evaluation coupled with an irritated impulse to harm the object of negative evaluation leads quite intelligibly to self-harm behaviours.

For many BPD sufferers, in moments when the irritation / depression blend are particularly triggered, cutting can be an extraordinary release. The irritation component of

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[22] Zittel Conklin and Westen 2005.

[23] Brown et al. 2002.

the mood demands action, lashing out. The depression component insists on a negative self-evaluation. These elements merge to create a strong compulsion to self-harm. On their own view, it is fitting that they should be cut and they experience pleasure, or at least lifting of affective distress, when that cutting happens. Most sufferers of BPD report that they do not actually experience pain when they cut (or hurt) themselves.[24] Moreover, those who do not experience pain are more likely to report more severe childhood sexual abuse.[25] It looks like BPD sufferers experience such intense affective distress that the physical pain of cutting or burning distracts them from their affective pain, thereby providing relief.

How does child abuse lead to a mood that is so painful to experience and is alleviated by self-injury? It is worth pointing out that the child abuse that leads to severe manifestations of BPD, including self-harm behaviours, is not 'merely' sexual abuse or physical abuse in isolation over a brief period of time. The physical and sexual abuse typically persists over an extended period of childhood, and it is almost always accompanied by serious neglect.[26] It seems that this abuse combination is what confers a fit between the occasioning object, the mood blend and the resulting behaviour of self-harm. People who have been abused in this way as children generally take themselves to have been given a powerful piece of evidence that they are not valuable. This kind of abuse is also linked with a loss of a sense of control over both their own bodies and their experience more broadly. The body is seen as a particular locus of badness and needing punishment.

[24] Bohus et al. 2000.

[25] Russ et al. 1993.

[26] Zananrini et al. 2002.

In light of these effects of the BPD abuse combination, let me provide a possible interpretation of self-injury in BPD. In the minds of the abused, that the abuse happened signals that they were not good, not worthy of love, and not worthy of protection. This becomes compounded when the child is neglected in addition to being actively harmed. In Lilah's case, if she was abused, it likely left her with feelings and assumptions like these, which combined with her experiences of neglect and abandonment. When her husband comes home late, this experience fits with her more general sense that people are unreliable and likely to abandon her. When Lilah's mood then flares into rage, she also likely reexperiences feeling a terrifying lack of control. Much as Lilah frightens those around her when she expresses how she feels, she is likely experiencing even greater fear herself, *of* herself.[27] When she cuts herself, a sense of control and balance is restored to her. Being cut suits her own mood-laden self-assessment – is appropriately fitting – and puts her in charge of what is happening to her. These experiences in turn lead her to feel better. This is an incomplete way of understanding some of the features of BPD, and it is only one possible explanation of many. It is, however, an example of the type of explanation that is available to us if we are willing to see BPD moods as intentional.

When abuse is very bad and is accompanied by a significant lack of compensating affection, mood states like those found in BPD are an intelligible response. I believe that this sense of being unworthy is not a belief that can be stripped away from the mood state. The abuse sufferer takes herself to be unworthy in a depressed / irritated way. There are many

[27] Fear might actually be a significant and underappreciated component of BPD. Recall in the depression chapters that I discussed the phenomenon of 'depressive realism,' whereby depressed people have greater insight than nondepressed people, about some range of phenomena. There is no similar feature of BPD. BPD sufferers do not manifest greater insight about BPD-related feelings and events. There is perhaps one exception – recognition of the facial expression of fear. One study found that BPD sufferers were significantly better than normal controls at recognising fear expressions (Wagner and Linehan, 1999).

senses in which someone could consider herself unworthy – she could find it exclusively enraging, with no elements of depression. It is likely that a person with this response to abuse would not end up cutting herself. In a case like that, she might not be a sufferer of BPD.

This characterisation of delicate self-mutilation also allows us to see the moral dimension of the BPD mood state. The mood blend, and the behaviour it leads to, is distinctly morally-valenced. A BPD sufferer takes herself to be doing a morally praise-worthy thing when she cuts herself. In part, the BPD's position that self-harm is a good thing to do links with immediate objects (e.g. Lilah feels she was wrong to yell about the television, she should be punished). But it gains its force through its links with occasioning objects (e.g. Lilah feels she is fundamentally deserving of punishment, because her badness is so pronounced that she was an object of abuse). When we evaluate this mood and it's associated self-harm, we disagree with the BPD-sufferer's assessment. We think she is wrong to consider cutting a virtuous act. But it is clear that this moral element is present in many cases of BPD self-harm. Self-harm in these cases is not morally appropriate, but it is morally valenced.

Of course, there are also the prudential considerations. For observers, this is a straightforward assessment. The moods, assumptions, and behaviours of BPD are rarely prudentially fitting, whether they are considered in light of their occasioning or immediate objects. If the mood blend was clearly directed at the occasioning intentional object, that is, the abuse or abuser, then perhaps the BPD sufferer would experience some relief. But instead, the BPD mood blend is overwhelmingly focused on immediate (apparent) intentional objects and the BPD sufferer typically has very little insight into its occasioning intentional objects. Thus, it seems that the interests of the BPD sufferers are almost always harmed by

symptomatic BPD behaviour. It is not clear to me whether or not BPD sufferers generally take their behaviour to be as obviously imprudent as their observers. It seems possible that they might endorse their behaviour more often than observers. In most of those cases, however, I (and most of us, I think) would likely take them to be mistaken. Finally, too, there is the question of evolutionary fitness between the BPD mood-blend and the occasioning intentional object of child abuse. This is again an empirical issue, but it seems likely that there is a diminished fitness associated with almost all BPD-specific phenomena.

Perhaps the most notable aspect of the paradigmatic BPD mood in light of its occasioning intentional object is that most observers think the BPD sufferer mislocates her lashing out. She yells at her husband for lateness. She cuts herself out of a rage- and depression-laden self-loathing. She and her husband should not be the targets of her affective distress. Instead, we would want her abusers to be on the receiving end of her negative affective states. In that case, for observers, there would be a full intelligibility, a full fit of mood with occasioning intentional objects across all evaluative axes. To the extent that this mislocation happens, the BPD mood blend is not fully intelligible. But even this mislocation can be better understood in light of its occasioning intentional object. Abuse by parents or caregivers is difficult to accept. Affective denial of these experiences has a fair degree of fit. It seems to me that the intentional analysis I just offered brings us closer to understanding a significant set of issues underlying cases of BPD.

4. A feminist interpretation of BPD

In this section, I will argue that the pathologising of BPD combined with a failure to appreciate the intentional components of BPD should be resisted, in particular out of

concerns with gender inequity. Of those diagnosed with BPD, more than 75% are women. This is a striking difference in diagnosis rates for a psychiatric diagnosis.[28] Moreover, among BPD sufferers, women are more likely than men to engage in self-mutilation.[29] There are several possible explanations for this gender asymmetry. One is that women's physiology makes them more likely to suffer from BPD (e.g. some clinicians argue that BPD is a form of premenstrual disorder). Another hypothesis for the gender asymmetry is that men's BPD goes unrecognized (e.g. men's BPD is masked by substance abuse).[30]

Both of these hypotheses are consistent with Medical Model B, and both do not require seeing BPD as an intentional response to its sufferers' experiences. The results of research into these hypotheses, however, have been unsatisfying. I contend that if more women experience BPD-symptoms than men, then we have an obligation to think about what this might mean about the conditions of women's lives. In particular, I believe that another possible explanation – that women's affective states are more likely to fit the BPD profile than men's – is underexplored. This greater fit happens in two respects. One, women's mood expressions are more likely to be seen as fitting the BPD symptom profile. Two, it is possible that women are given more reasons to manifest BPD symptoms. It is only by seeing BPD as an intentional response to the world that these concerns can come into focus.

In the previous case discussion, I argued that there were insights available if BPD phenomena were considered in light of intentional moods. In particular, I argued that we are better able to understand Lilah's symptomatic behaviour. By considering her mood blend as

[28] Skodol and Bender 2003.

[29] Starr 2005.

[30] Johnson et al. 2003.

potentially intentional, rather than seeing it exclusively in terms of her diagnosis, her affective states can be appreciated as having some elements of fit. But Lilah's analysis is a microscopic one. I only discussed a single patient, and the insights available were primarily with respect to her life and experience. I would now like to explore the possibility of pursuing a macroscopic analysis, particularly in light of the moral appropriateness of the BPD mood blend.

In my analysis, I take my inspiration from Marilyn Frye, who argues that oppression can neither be seen nor understood through fine-grained analysis of individual phenomena.[31] Frye offers an analogy of the birdcage – close inspection of individual wires cannot explain why a caged bird does not simply fly away. It is only by backing up and seeing the systematic relationship between all the wires that can make sense of the bird's immobility. I think it is profitable to back up and look at the symptomatic behaviours of BPD in a larger context. As feminists have observed, communities in different places over different times have been extraordinarily creative in managing difficult women – often by creating roles in which the woman's difficult-ness is pathologised. The diagnosis of 'hysteria' seems a strong candidate for this type of interpretation.[32] I believe that BPD is serving this same type of function now.

First, let us consider how women's mood experiences are more likely to be seen as fitting the BPD symptom profile. In the previous chapter, I argued that one of the ways that BPD was associated with moods was linked with the BPD sufferer's experience of anger. BPD sufferers are quick to anger, which I think indicates an underlying mood that predisposes the

[31] Frye 1983, 1-16.

[32] Allison and Roberts 1994.

person to become angry more quickly and intensely. This quickness to anger is important in the diagnosis of BPD. Let us return to the symptoms of BPD. Symptom (8) of the *DSM* diagnostic criteria reads, in part: "*inappropriate*, intense anger"[33] (emphasis added).[34] Symptom (8) is the only place where a normative evaluation appears in a symptom. I have argued that Medical Model B superficially acknowledges intentional states as part of BPD. This is evidence of that acknowledgement.

But even though that acknowledgement can be found, the cognitive therapies endorsed by Medical Model B do not actually engage with those intentional features. I think this symptom makes that non-engagement very clear. I think this judgement of inappropriateness is similar to the position I described earlier that takes people from a starting intentional position about BPD moods over to a non-intentional position. Earlier I talked about how there is often such a total lack of fit between a BPD sufferer's mood blend and its immediate (apparent) intentional objects that most people end up feeling that there is, in fact, not intentional relationship at all. I think that is what is being indicated here. The BPD sufferer's anger is so inappropriate that it does not really make sense to treat it as intentional.

This is consistent with an analysis of anger offered by Frye.[35] In the philosophical literature on the emotions, anger is one of the paradigmatic intentional states. Anger is always about something. To take anger seriously as anger – in Frye's terminology, to give anger 'uptake' – is to acknowledge that it bears an intentional relationship to something.

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[33] APA 2000.

[34] They use the term 'anger' which is a paradigmatic emotion term. But in the clinical literature, very little care is taken to ensure that moods and emotions are clearly distinguished. In this case, I think they mean both anger as an emotion and as a more diffuse and encompassing affective state better characterised as a mood. In part, I take them to be referring to the same phenomenon that I am identifying with the term 'irritation.'

[35] Frye 1983, 84-94.

Frye argues that in this society women's anger is not given uptake. In a sense, women's anger *doesn't even exist*. It is just noise. When a woman gets angry, rather than engage with the intentional relationship that comprises it (e.g. by asking what she is angry about), a common response is to see the anger as an indicator of who the woman is (e.g. she is such a bitch).

The clinical process of diagnosing BPD I think makes this point. When women respond affectively the way BPD sufferers do, they can not really be in an intentional affective state – anger being understood in a normative sense, requiring a relationship with an intentional object. Women who act like they are that angry are not really angry, with an attendant genuine intentional object. Instead, their anger is not about anything, it is simply the (exclusively physiologically caused) symptom of a disease. Both the pathologising impulse and the non-intentional accounts of mood work in concert here to disengage with potential objects of women's irritation.

Now let us consider the possibility that women are given more reasons than men to manifest BPD symptoms. For Lilah, her mood, including its associated assumptions, leads to a fit between her sense of who she is and cutting. Cutting is what should happen to Lilah, on Lilah's own view. This fit is what allows her to experience tremendous affective relief when she cuts herself. That she has this experience may not be very intelligible to many people. Even if we are willing to see Lilah's mood state as intentional, if we keep our analysis on the microscopic level, we may simply take this facet of Lilah and chalk it up to her pathology.

But one of the things that is available with an intentional relationship is the possibility for others to learn something about the world, particularly if we consider that intentional relationship macroscopically. From someone's depressed response, we outsiders can learn

that the experience is depressing, even if we do not, ourselves, experience depression in response to the same situation. For example, in virtue of learning about the many graduate students who experience depression while in graduate school, someone might learn that being a graduate student is depressing, even if she herself did not have that experience. The case for learning this lesson mounts as there are more instances of people who have experienced graduate school in that way.

With BPD, one of the main lessons we might learn is that abusing and neglecting a child ends up providing a fit for that child herself to engage in self-injury. This appears to be especially the case for girls. That for many girls, there is a fit between that kind of abuse and the very particular mood blend of irritation / depression that is part of BPD. This in turn leads to adult women who experience pleasure and relief at hurting themselves. In the earlier analysis of Lilah's case, there was nothing gender specific. The explanation I offered could as easily be extended to a male sufferer of BPD. The gender-biased pattern of diagnosis and suffering, however, gives us reason to think that this earlier explanation might not be the end of the story. Perhaps there are additional components related to the place of girls in this society that combine with the occasioning intentional object of the abuse to provide a special kind of fit with the feelings Lilah experiences. This is a different kind of insight from the possibility that child abuse non-intentionally causes affective lability and impulsivity, which are symptoms of a disease, which makes people engage in self-harm behaviours.[36]

This fit-based insight is not available if we only consider individual cases of BPD, explaining them in terms of pathology. It is also not available if we adopt a non-intentional framework for thinking about BPD. Many BPD sufferers are unable to articulate an

[36] This is probably the dominant Medical Model B account of BPD, although there is still considerable debate. See Links et al. 2000 for a discussion.

occasioning intentional object for their mood. Affective reconstruction is not a typical component of current responses to BPD. Thus, their BPD appears to *not* have any meaning. The aim of cognitive therapies is to simply make the BPD symptoms go away. If I am right, however, the intentional facet of BPD's underlying cause is (sometimes) being ignored. In addition, the failure to appreciate BPD symptoms both intentionally and macroscopically means losing a particular impetus to address potential underlying inequality.

One possible objection to the analysis I just offered is that a purely causal analysis could give us the same results. Simply put, child abuse (under certain conditions) *causes* BPD. This causal connection would lend itself equally well to the macroscopic analysis I was discussing. The details would need to be filled in why women are primarily affected by this consequence of child abuse. One possibility is that more women than men are abused in the particular way associated with BPD. Another possibility is that women have a relevant physiological difference, such that child abuse is more likely to cause BPD in them. Or it could be that the socialisation of females provides the right sort of predisposing attributes, such that childhood abuse of a female is more likely to result in BPD. Empirical research would be used to determine which of these is correct (and of course it is possible that some combination of these possibilities is at work). Child abuse, particularly the kind reported by BPD sufferers, clearly warrants moral disapprobation. It is wrong in itself. And if it causes BPD (among other problems) then it's wrong on consequentialist grounds too. What is added through an intentional analysis at the macroscopic level?

I think there is a difference between seeing BPD purely as a negative causal consequence of abuse (and possibly gender pressures), and seeing it as an intentional, fitting consequence of abuse (and possibly gender pressures). This difference, I think, is similar to the difference

at the individual level (which I just discussed with the case of Lilah). If the moods associated with BPD are an intentional part of a response to child abuse, we can ask normative questions about its appearance. I am most interested in two of the four possible normative evaluations: (1) the appropriateness of the fit between the mood blend in BPD and its occasioning objects; and (2) the moral status of the relationship between the mood blend in BPD and its occasioning objects. Does the mood blend of irritation and depression fit with a particular form of childhood trauma? Should people feel that way in response to child abuse? Do women in particular have reason to respond in BPD-like ways to being abused? I am torn in my responses to these questions. Prudentially, the answer is clearly, "no." It is not helpful to a victim of abuse to respond to being abused by flying into rages years later. It certainly does not help a victim to respond to being abused by cutting her own arms and legs so systematically that later, clinicians are unable to draw blood normally because of the large build-up of scar tissue. It is heartbreaking to see people who have already suffered so much add so considerably to that suffering.

But what about fit? In some cases of BPD, is there a fit between the occasioning intentional object – child abuse – and the mood blend irritation / depression? Here I think the answer is yes. Recall from the previous chapter the assumptions associated with BPD. I think it is crucial to appreciate – at a macroscopic level – that people in general, but girls in particular, will learn from being abused that the world is malicious, and that they are worthless. They will come to feel a devastating mixture of irritation and depression, where the only way to mitigate these feelings is to live a life where they oscillate between lashing out at others and lashing out at themselves. 'Delicate self-mutilation' is a female symptom. Men are already a minority of those diagnosed with BPD. They are an even greater minority

in manifesting the symptom of self-harm. We could offer a causal explanation. Girls are the kinds of creatures who are more easily caused to do that to themselves. Or we could think about it intentionally and ask whether girls have more warrant to cut themselves. I want to take the causal story seriously, particularly to the extent that it is helpful in alleviating painful symptoms of BPD. But I do not want those considerations to be the end of our investigation. The non-intentional view of the affects of BPD sufferers, especially female sufferers, means that we will not be learning anything meaning-laden about women's lives in considering their BPD symptoms.

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