On Self-Defeating 'Mental Viruses'

An Interdisciplinary Study in Philosophy, Psychiatry, & Mental Healthcare

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Abstract: *Mental distress and suffering are often medically diagnosed as 'mental illnesses'. But an illness is traditionally defined as a malfunction in the biological body which does not include the non-biological mind. Problems with the mind are more accurately described by intangible symptoms such as confusion, sadness, fear, and so on. These can act like organic viruses, spreading throughout the entire system to become a threat to overall mental and physical health. Psychotropic medications may help ease some of the symptoms of a 'viral-mental' infestation but they can't eliminate existential causes and real-life concerns. Unfortunately, psychiatric drugs are also known to produce various alarming physical side-effects, and withdrawal symptoms. Clinical research data shows that the best counteractive treatment for 'mental viruses' is so-called 'talk therapy', fashioned after beneficial philosophical discussions.*

1) INTRODUCTION

Khalida[1] looked embarrassed as she told me she had been expelled from university. The only child of an immigrant father, she graduated from high school near the top of her class, and was awarded a full scholarship to the most prestigious university on the west coast of Canada. She continued on to achieve an undergraduate degree with first class honours (summa cum laude), majoring in Western philosophy. To reward herself for her accomplishment she decided to take a couple of years off to earn some money, travel, and recharge her batteries before enrolling into post-graduate studies. There her intelligence shone through her passion for the study of philosophy among a ten-student cohort. She was the only female in the room, not unusual in upper-level philosophy courses. But this soon resulted in difficulties. Her professor felt that her constant disagreements with him were too much of a disruption of the group. He saw

[1] Based on an actual client case. Not the student's real name.

her as overly critical of his specialized handouts, and as a challenge to his authority over other students.

Khalida had learned to argue passionately and loudly from the years spent at home defending her youthful liberal values against the views of her conservative father. She described her father as a hard-working, stern man with an old-school mind set. She and her grandmother let him win most arguments by sheer volume.

As an under-graduate Khalida had enjoyed having arguments with her various professors and classmates. "It's fun to argue when people stick to the topic, and don't attack each other personally", she told me. Sadly, her post-graduate philosophy professor took her arguments personally. He did not hear her salient points; he noticed only what he called her "radical feminist 'let's-fix-this-world' attitude". When word about this spread on campus, and their misaligned communications threatened to become a newsworthy public spectacle, the university's administration worried that their school's shining reputation might be tarnished. So its governing body concluded that it was in the best interest of the institution's good name to temporarily suspend her enrollment, and allow her to "cool her blazing spirit".

The circumstances surrounding Khalida and her philosophy professor—as they were explained to Khalida by the head of the philosophy department—was that the professor had complained several times to the administration that she was proving to be too much of a problem for him to deal with. He claimed he had asked her politely to leave the group on several occasions but that she had stubbornly continued to attend, and was "disrupting" it with her "hair-splitting" challenges.

In some academic cultures there's an unspoken rule that students must show respect and deference to professors by never questioning, and certainly never challenging them. But in North America, especially in philosophy classes, animated arguments between professors and their students are quite common. In fact they're often cheerfully invited. But Khalida's professor was not interested in having her share with the entire group what was on her mind.

2) THE DICHOTOMY

Mark Rowlands, Professor of philosophy at the University of Miami, agrees with the 18th century Scottish philosopher David Hume when he says he's not sure the mind exists at all. "I never encounter my mind. …To encounter your mind is to encounter your mental states and processes" (Rowlands 8–9). George Berkeley, an earlier Irish

philosopher, although unsure exactly what to call it, suggested a similar perspective of ‘mind’. He wrote,

> there is something which knows or perceives [ideas], and exercises divers operations, such as willing, imagining, and remembering about them. This perceiving, active being is what I call mind, spirit, soul, or my self (Berkeley, 1 & 1, 2).

These philosophers argued that there’s no object reference or concrete ‘thing’ to be found that lies beneath cognitive states and processes. While the brain can be compared to a hard copy novel with many pages of text, the mind is like the intangible story that transcends the physical book. The story can’t be understood by examining the paper pages, or the ink marks on those pages. Like the novel, the mind is someone’s evocative imaginings, insights, and opinions which combined reveal that author’s nature, personality, and self. It has been variously identified as the psyche, consciousness, spirit, inner essence, and the soul. In short, the mind is not physical, and is nothing like the brain at all. When neuroscientists study the brain in order to understand the mind they’re mistakenly studying the book’s paper pages and ink marks in trying to understand the story.[2] But the container and the content are not the same. Those who regard the brain and the mind as identical are guilty of fictional literalism: assuming that a metaphorical construct (the mind) is an ontological reality (the brain) (see Zachar chap. 6).

The mind is the activity of the brain. It develops itself in a non-material way by not only experiencing but then also reflecting on its experiences. While we can’t exchange our brains we can easily change our minds to alter our common beliefs and values, our social ‘programming’ and its residue that has been ‘downloaded’ from previous generations. Some type of brain is universal to all sentient creatures, but the mind is the experience of dynamic thoughts and emotions—the consciousness—that defines each of us as uniquely human. The materialist position held by most empirical scientists and some philosophers—that all mental events are reducible to biological brain processes (e.g. Bell, 66–73)—naïvely implies that the brain falls in love, that the brain hopes it’s loved in return, that the brain has plans for a romantic evening, and so on. Such talk about the brain having hopes and making plans is what British philosopher Gilbert Ryle famously dubbed a ‘category error’ (Ryle, 1949). It's

[2] Two other appropriate metaphors are a printed sheet of music (Hofstadter p. 9–10), and a USB flash drive.

nonsense. It's like saying that Beethoven's fifth symphony is green. It makes it seem as though the brain is an anthropomorphic (human-like) entity that falls in love, makes plans, and so on. But it's not the brain… it's the person who loves, hopes, and makes plans. (Damasio, passim; see also Plato's *Phaedo* sec 97–98). As 20th century French existentialist Philosopher Gabriel Marcel wrote, "The moment I treat my body [or brain] as an object of scientific knowledge I banish myself to infinity" (Marcel, 12).

The self is only a biological entity when the word 'self' is used to refer to the physical body and its fleshly brain. And it's meaningless to speak of the 'contents' of the mind since the mind is not an organic protein package like the brain. The mind is not a physical 'thing' containing other things. Yet it's a common-but-misguided assumption that, because the mind and brain are believed to be identical, the mind is also vulnerable to hundreds of organic illnesses. It's not.

3) THE DISTRACTION TRAP

The clinical definitions of most of the leading 'mental illnesses', such as depression, anxiety, bipolar disorder, schizophrenia, and so on are so vague, ambiguous, and so all-inclusive that they can easily be applied to ordinary feelings and emotions (Maj et al, 150). In fact this has made it impossible to reach a professional consensus on the medical definitions, diagnoses, or treatments of most so-called 'mental illnesses'. Biological psychiatry or bio-psychiatry, which is currently North America's primary approach to diagnoses and treatment, is not just an inexact science, it's not a science at all. There are no 'mental illnesses' or 'mind diseases'. There's only mental damage and injuries suffered by living within harmful social environments.

Standard treatment for so-called 'mental illness' is based on a lack of empirical data, and a foundation of contiguous false conclusions: that the mind and brain are identical; that mental illnesses are brain disorders; that drugs should take precedence in treatments; and so on. Associate Professor of clinical psychiatry Colin Ross maintains that the field of psychiatry does not have a coherent, unified model of so-called 'mental illnesses. He says, "Psychiatry suffers from an identity disorder which it's currently trying to solve by forcing the adoption of a bio-reductionist paradigm" by defining 'being human' entirely in biological terms (Ross, 86). An ever-expanding list of so-called 'mental illnesses'—new disorders and syndromes diagnosed as 'chemical imbalances' in the brain—are voted into and out of existence by a panel of psychiatrists (Kendler, 115).

While the term ‘mental viruses’ is used in this essay as a metaphor for dynamic but troublesome thoughts and emotions, bio-psychiatrists use the term ‘mental illnesses’ and consider them brain diseases. The accurate understanding of so-called ‘mental illnesses’ is that they don’t exist. Brain pathology includes organic diseases like cancer and tumors, but there is no mind cancer and there are no mental tumors. To say that ‘mental illnesses’ are natural disease entities would be like claiming that beliefs and assumptions are illnesses, or that worry and sadness are diseases. Beliefs, assumptions, worry, and sadness are real, but they consist of abstractions; they’re a different kind of ‘real’ than the brain. To argue that the brain and the mind are one-and-the-same thing is a “conceptual abyss” that can’t be intelligibly explained (Wrathall, 9–11). And neither can the concept of ‘mental illnesses.

After more than fifty years of searching without success some genetic researchers are none-the-less still trying to locate the elusive genes they believe to be responsible for mental illnesses. But if so-called ‘mental illnesses’ were genetic pathologies then no one would ever recover from them. Yet many people do, even without medications or professional help. (Warme, 90). And contrary to common belief, twin studies have not established any genetic causes of mental suffering. (Faraone et al, 21, 33, 44). The problem is that most of today’s bio-psychiatrists are reluctant to take into account the environmental stressors of life as the cause of so-called ‘mental illnesses’. They prefer the hypothetical chemical imbalances assumption, or the genetic disposition hypothesis (Ross & Pam, Chaps. 4 & 5).[3] A genetic assessment will reveal nothing at all about the mental and emotional strain on a distraught teenager whose mother tells her she’s possessed by the devil (Ross & Pam, 246).

The attribution of distress to an individual’s genetic predisposition, abnormal brain chemistry, or so-called ‘mental illness’ is today being cautiously criticized by some mental healthcare clinicians as a ‘distraction trap’. They see it as a means for diverting attention away from desperate environmental conditions and appalling social inequalities that are widely known to cause mental suffering (Mills, 20). It shifts the focus of treatment to the consumption of pills. If it’s held that it’s totally wrong to classify mental distress, worry, suffering, confusion, and so on as brain

[3] Psychiatrist George Engel conceptualised the ‘Biopsychosocial’ model of health in 1977. It suggests that to understand a person’s condition three factors must be taken into consideration: the biological, the psychological, and the social. This model has only recently begun to gain attention in the psychiatric community (see Savulescu et al).

diseases, or even worse as so-called ‘mental illnesses’, then surely there must be a better explanation.

4) ‘VIRAL-MENTAL’ MANAGEMENT

Human beings are not made up primarily of uniquely human cells that are occasionally invaded by microbes. Our bodies are really superorganisms of cohabitating cells: fungi, bacteria, and, most numerous of all, viruses. And just like there are ‘good’ and ‘bad’ bacteria, viruses fall into the same dichotomous categories. The continual challenge is to figure out how to defeat the bad ones and encourage the good ones (Scientific American).

Today most people are familiar with computer viruses. A computer virus is loosely defined as a destructive program that, when executed, invades existing computer programs in which it replicates itself to spread damage throughout the system. And much like in the case of a computer, sometimes the human mind and heart require inspection, detection, and deletion of undesirable (mental) viruses, and ‘reprogramming’ to repair any poorly functioning mental ‘algorisms. At other times it requires a ‘reboot’, a paradigm shift, a fresh perspective away from previous influences and harmful habits of mind.

Mental viruses are typically transmitted from one person or group to another, and can cause serious damage to the ‘host’. Even a personal concern, worry, or sadness, if left unresolved, can proliferate virus-like to potentially overwhelm the entire system. Mental viruses don’t emerge randomly from a hypothetical ‘unconscious’. They’re psycho-socially generated, often in the form of potent criticisms that become rooted in the victim’s self-concept. They bleed into the victim’s thoughts and emotions, and can wear down that individual’s cognitive ‘immune system’ until the resulting ‘infection’ is diagnosable as a ‘mental illness’.

Mental viruses are corrosive, eating away at self-esteem like an acid. They often, but not always, originate in the experience of childhood criticisms, abuse, and/or neglect. They can germinate in an environment of poor personal support; they flourish in intimidating school environs, in overt misogyny at work, in sadistic racism, in immoral homophobia, in exhausting poverty, in condemnatory religious dogma, and so on. Mental viruses will often also infect the body with symptoms such as headaches, loss of appetite, weight gain, sadness, sexual dysfunction, heart problems, suicidal ideation, and so on.

No child is born with a mental virus; none inherit them genetically. But almost every person on earth is vulnerable to the catastrophic self-destruction that a ‘viral-mental infection’ can bring about. And while most biological viruses are transmitted to the host from external agents, a mental virus like, for example the sadness of ‘depression’, also often originates within the self (Ratcliffe, 96).

Depression is an ‘umbrella term’ for unwelcome cognitions and emotions, a cluster of symptoms such as sadness, hopelessness, regret, guilt, shame, despair, and so on. The term ‘depression’ does not refer to a disease that *causes* sadness, hopelessness, regret, etc. Simply living a human life can cause the thoughts and emotions that can cause mental viruses, classifiable under a ‘mental illness’ label. Depression often initially manifests internally as a small but burdensome self-doubt that, given enough gestation time, can grow exponentially into self-effacing self-criticism and other self-damaging mental processes. And although it’s not actually a communicable disease, when a mental virus is diagnosed as the so-called ‘mental illness’ of depression in one member of a family it can have an adverse effect on every single family member. It can create multiple self-criticism viruses in the caring individuals, as well as self-guilt for not having done enough for the suffering loved one. It can ultimately destroy the entire family unit.

Mental misery was at one time dealt with by means of compassionate person-to-person discussions. But today’s bio-psychiatrists often simply renew prescriptions for brain-dulling psychotropic agents. Psychoactive medications only impair normal brain and mind functioning, and are in fact incapable of defeating any virulent ‘mental viruses’.

5) ‘IN-VALID’ INDIVIDUALS

For more than fifty years the bio-psychiatric establishment has propagated the erroneous claim that anxiety, depression, schizophrenia, and so on are known to be brain diseases. And yet there are no scientific findings that verify this claim (Whitaker, 358). The lack of empirical data exposes conventional bio-psychiatry as a pseudo-science, leaving it as nothing more than a persistent ideology. Modern catalogue-style ‘psychodiagnosing’, and the abundance of psychiatric medications encourage doctors to stop noticing the disturbing realities of human existence. Professor of psychiatry and past president of the Canadian Psychoanalytic Society, Gordon Warme laments that, “very few modern psychiatrists attend seriously to the legitimate riches of what

[their] patients say" (Warme, 116). A 'mental illness' diagnosis victimizes and destroys an individual's self-esteem by relegating them to the realm of the non-valid or 'in-valid' individual. The mental healthcare establishment has led patients to believe that psychodiagnosing and "pharma-centric" (Mills 8) treatments for so-called 'mental illnesses' are appropriate because they supposedly follow a conventional medical model.

6) 'PSYCHOPHARMATOPIA'

The legitimate medical model involves three steps: (1) valid laboratory tests that empirically identify distinct biological disorders and suggest their origins; (2) diagnoses that classify the symptoms consistently across most cultures; and (3) treatment protocols that have been empirically proven to be effective. But in standard *mental* healthcare a diagnosis ('2') is given without validation from any laboratory tests ('1') because there simply are no medical tests that indicate 'mental illnesses'. Then ('3') a treatment protocol is followed which often differs substantially from one clinician to the next (see Campbell).

The so-called 'psychometrics' in mental healthcare used to classify suffering individuals are unsophisticated questionnaires. Clinicians must rely on patient accuracy and truthfulness, and then subjectively *interpret* the answers patients give on those forms. This can lead to a wide disparity of conflicting diagnoses. According to Professor of psychology, Peter Zachar, since there are no laboratory tests for 'mental illnesses' clinicians must literally resort to "using their intuitions" to identify and medicate a supposedly diseased mind (Zachar, 120).

Just like the so-called 'science' of diagnosing and treating 'mental illnesses' is in reality not a science at all, bio-psychiatry is not a *medical* science at all because there are no empirical tests supporting it. There's simply "no convincing evidence that psychiatric disorders or symptoms are caused by a chemical imbalance" in the brain, nor that any psychiatric potion could correct such a chemical imbalance (Mills, 19). It's just impossible to eradicate mental viruses successfully with medications because biochemical formulas are only effective within biological tissues, while 'mental illnesses' and mental viruses are non-biological metaphors.

Every psychoactive prescription medication will come with at least one, if not many adverse side-effects (see Breggin). Some of them exacerbate the very suffering they were meant to relieve, causing symptoms so serious that they are in turn

diagnosed as ‘iatrogenic’ illnesses: sicknesses caused by the initial treatment itself. Unfortunately, no pill will help a patient struggling with existential difficulties: make an ethical decision, sort out a relationship difficulty, or discover meaning in life. There may be some symptomatic relief, but the life situations that have turned into predicaments, and the medication’s brain-dulling, mind-obstructing side-effects remain. This can escalate into a chronic condition in which potentially hazardous psychiatric medications lead the trusting patient to the utopian belief in the powers of those chemical remedies: the belief in ‘psychopharmatopia’.

Furthermore, dosages must be repeatedly increased as the human body naturally adapts, developing a tolerance to the drugs consumed. Then the attempt to withdraw from an unbearable psychiatric medication can become a painful dilemma (see Carey & Gebeloff). Zachar argues that it’s dangerous to take psychiatric medications to alleviate undesirable human emotions because the capacity to tolerate sadness—a major component of depression—(and other negative emotions) is an important psychological ability which contributes to the development of compassion and empathy (Zachar, 156).

It’s a sad state of affairs that the impotent struggle for emotional tranquillity amid a fractured social reality is being catalogued by ‘experts’ under numerous newly-minted ‘mental illness’ labels. Broken hearts are called ‘chemical imbalances’, while tortured minds have been biologically diagnosed as ‘serotonin deficiencies’. Family relationship difficulties are obscured with anti-anxiety pills, while failed personal relationships are soothed with antidepressants that are no more effective than placebos (Kirsch). The past six decades has seen well-meaning mental healthcare counsellors and therapists increasingly controlled by the corporate doctrine of psychopharmacotherapy: the misguided, patented procedural protocols for the treatment of the unknown causes of so-called ‘comorbid mental illnesses’. This ironic treatment scheme clearly demands a shift to something more effective and less harmful to the patient.

A careful review of many years of clinical research data has shown that the best treatment for mental suffering is not psychiatric drugs but rather any of the many forms of ‘talk therapy’ that are fashioned after beneficial philosophical discourse: the “active employment of reason” (Collins, 25; see also Davidson; Simpson; March; Hembree; Cahill; Rothbaum). Moreover, a dose of philosophy generates no negative side-effects, and does not leave the patient to deal with agonizing withdrawal symptoms. Epicurus said, “We must not make a pretense of doing philosophy, but really do it; for what we need is not the semblance of health but real health” (Inwood

et al, 39). Genuine mental health requires the avoidance and/or defeat of mental viruses, not with chemical remedies but with remedial philosophy.

7) ANTI-VIRAL REASONING

The early philosophers were very clear about what they thought philosophy was meant to do. The early philosopher Seneca lived around the beginning of the Christian era (1 CE–65 CE). In his *Letter to Lucilius* he wrote that what philosophy holds out to humanity is counsel. Epicurus (341 BC–270 BC) stated emphatically, "Empty is the argument of the philosopher which does not relieve any human suffering" (Inwood et al, 99). The Stoic slave and philosopher, Epictetus (55 AD–135 AD) famously said, "It's not events that disturb people, it's their judgements concerning them".

But the upset people who have come to me for counselling have often been troubled by difficult or distressing life circumstances which seemed to be caused by fate or 'the gods' because they felt beyond human control. My clients often had great difficulty making rational judgements concerning their troublesome life situations because they were confused by their pain, incapable of deciding what to do next. Of course many of their difficulties also originated in their own beliefs about events in their lives, due to subtle fallacies in their reasoning. A fallacy is an informal error in logic that's often implicated in generating troublesome mental viruses (see Appendix).

The world of philosophy offers many tools other than good logic to assist in reasoning. There are ethical theories and moral cases to learn from; there are philosophical critiques of civil law, science, religion, and philosophy itself; there are perspectives on reality (metaphysics); there's inquiry into knowledge and assumptions (epistemology); there are in-depth explorations into human rights and feminism; lately there has been increased scrutiny of questionable justifications for war, and so on.

Mental viruses can make a person *self-doubting*: "I probably won't be able to understand this essay"; *lacking self-confidence*: I won't take the lead in the project if someone else wants it; *self-defeating*: "I'm not even going to try because I'll probably just mess things up anyway"; *self-censoring*: "I shouldn't speak because I'm not as smart as the others"; *self-denying*: "I don't deserve the praise; any dummy could do what I did"; *self-distrusting*: "I'll probably forget their names even if I write them all down"; *self-excluding*: "I would volunteer if I had anything good to contribute, but I

don’t”; *self-effacing*: “I don’t deserve to be loved”; *self-harming*: “I deserve my addiction to drugs”; *self-hating*: “I wish I was someone else”; *self-sabotaging*: “I don’t expect things to get better”; *self-shaming*: “I’m too fat because I have no self-control”; *self-isolating*: “no one would want to marry me”; *self-tormenting*: “all of these mental viruses are probably true of me”; and often *self-medicating*: “if I take this drink/pill I’m sure I’ll feel much better about myself”. Worst of all are the various noxious combinations.

Philosophy applied as an anti-viral agent can dispel self-damaging thoughts and feelings. Philosophical knowledge and associated reasoning strategies can reduce self-doubt by raising the self-confidence-generating knowledge that one’s own decision-making is logical, ethical, and reasonable. It encourages self-reflection and self-monitoring to ensure that one’s actions and words are self-initiated and self-willed. This leads to self-respect, self-acceptance, self-reliance, and ultimately self-care. Philosophical discussions create not only improved self-mastery and thereby self-control, they reduce the self-defeating urge to self-diagnose and self-medicate. And the only ‘side-effects’ are self-sufficiency, self-improvement, and self-acceptance.

Getting rid of a mental virus that grows into a diagnosable ‘mental illness’ such as depression is no easy task. It may require a significant alteration of the problematic personal beliefs, desires, fears, values, and so on that drive thoughts and behaviors. It demands willpower and courage to undertake a careful critique and modification of the entrenched thinking habits that generate the descending spiral of negative thinking (Kendler, 176–77).

The elements of the mental virus often diagnosed as ‘anxiety’ are stressors that can generate still more stressors in a self-perpetuating vicious circle. But far from a so-called ‘mental illness’ anxiety is a self-protecting fear response to a perceived threat that can escalate until it’s so debilitating it becomes an impairment to the humans it evolved to protect (Fábrega 81–2).

The human mind plagued by a viral infestation can be helped to develop new mental defence systems. This can include discussions with a philosophically-trained counsellor. The suffering individual can learn critical and creative thinking strategies, new perspectives on previously held troublesome assumptions and values, and an honest self-appraisal of one’s familiar impulsive responses to situations.

And just like a consultation with a medical doctor is not a social visit, a discussion with a philosophically trained counsellor isn't just a casual conversation. And neither is it simply a logical deconstruction of thoughts and feelings, a sharing of clever ancient aphorisms, or a quick cliché fix. A discussion with a philosophically trained counsellor is therapeutic in that the suffering individual is listened to, cared for, and cared about. The one in distress senses the empathy of a fellow human being who tries their best to sincerely understand the experiential origins of their sadness, their worry, or their confusion. There's a compassionate connection—a caring partnership; a comforting professional friendship—that relieves the gloomy sense of loneliness and isolation that can arise in the chilling environment of a clinical diagnosis and the bitter reality of psychiatric drug treatments. Once this has been achieved the path to solving disturbing logical conundrums or distressing existential issues becomes far less forbidding. Now the opportunity exists for the philosopher to share expert knowledge of logic for use in good decision-making, quote memorable passages from iconic ancient and modern texts, and perhaps come up with alternative points of view or helpful advice that will assist the patient or client in overcoming their mental viruses.

In her book *Pathological Anxiety* Professor of psychiatry Barbara Rothbaum reminds her readers that emotional processing requires "the presence of information that disconfirms the erroneous elements" that are causing the despair. Compassionate listening is essential; but knowledgeable advice-giving is also helpful. She cites the example of grieving mothers who had lost their babies to sudden infant death syndrome. Those who were able to share their loss with a supportive social network overcame their grief far sooner than did mothers who had no one to talk with (Rothbaum 7, 13). A compassionate conversation can do what psychiatric classifications and psychiatric medications are never able to do.

> Bio-psychiatry, despite its loud claims has never identified any physiological disorder in its patients—and never will. Depression can't be diagnosed by measuring the amount of serotonin in a synaptic cleft; it's diagnosed by talking [with] the person about his way of life and his personal sense of himself (Warme, 101).

Biological psychiatry has not made a single discovery of significant clinical relevance in the past fifty years, despite hundreds of millions of dollars spent on research (Ross, 116). Besides inventing many new 'mental illnesses', and brewing up

more harsh bio-chemical merchandise every year as part of their business model, bio-psychiatry has accomplished very little in its treatment of so-called ‘mental illnesses’, and especially in terms of preventing them.

8) ‘IMMUNO-PHILOTHERAPY’

When it comes to physical health, there’s a relatively new movement in our society toward the *prevention* of illnesses. People are learning how to eat healthier foods, participate in regular physical activity, drink less alcohol, stop smoking, get adequate amounts of sleep, and so on. This development has driven many individuals to seek information and treatment from those health care professionals who practice preventive medicine. Their focus is on education as a proactive means of avoiding health difficulties in the first place, instead of only remediating the symptoms of already existing conditions. After all, prevention is the best protection. This same preventive approach applies to caring for the mind. Upon request philosophically trained counsellors are happy to share with their clients their specialized philosophical knowledge. This informal education promotes the client’s autonomy and helps them avoid a prolonged dependence on a practitioner. Philosophical knowledge can act as a catalyst to accelerate the personal immune response against many, if not all mental viruses.

If good reasoning is learned early in life then the individual is much less likely to be led into the kind of mental despair that can be diagnosed as ‘mental illnesses’. In an essay in the *Journal of Mental Health Counseling* Professor of psychology Mark Kiselica and Counselling Psychologist Christine Look points out that

> preventive counseling has been a defining characteristic of mental health counseling throughout the history of the profession. Yet a review of the literature suggests that prevention has rarely been emphasized in the training process or in the practice of mental health counseling (Kiselica).

There have been very few deliberate attempts made to teach philosophy in the public sphere as a preventive measure against so-called ‘mental illnesses’. It’s impossible to stimulate a serological response in people, boosting their mental immune system, with medications. It requires a proven therapy that instils the ability

to think clearly and wisely about life's many demanding trials and tribulations. Developing good reasoning abilities in primary school pupils is one such preemptive endeavour that can help the young deal with contingent life stressors, avoid mental viruses, and ultimately escape a future diagnosis of 'mental illness' and its associated troublesome drug treatments.

9) CONCLUSION

When Khalida first came to see me she was visibly distressed. Her passionate participation in academic philosophical discussions had been absurdly misinterpreted by her professor as being disrespectful rebellion. She told me she had tried to talk with him after class on a number of occasions, but he dismissed her like a nuisance, or some kind of threat. The university administration had simply sided with her professor on principle, and had eventually asked security to escort her off the campus.

"You know, I've read a ton of philosophy books on my own", she explained. "Socrates said, 'Philosophy begins with wondering'. So I told the professor that I was wondering about his interpretation of *Phaedo*. He said that in *Phaedo* Plato claimed that the 'realm of the Forms' is spiritual. But I don't see it that way at all. I read Plato as speaking metaphysically or ontologically or even epistemologically… not theologically. Plato was a philosopher, not a priest".

"Yes, I know", I said teasingly.

"I was just trying to explain this to him. But he became very annoyed with me, and upset, like I'd done something wrong. I guess maybe I did, but I'm not exactly sure what. I just wanted to get his opinion about what I think Plato meant".

"That seems fair to me", I said seriously.

"I know. Right? Ok… Well, I did get a bit loud when he didn't even want to hear what I had to say. But I never attacked him or anything. I just got a bit loud, that's all".

"I'm sure you weren't a real threat to him".

"No way! I always tried to remember what you taught us the first day of class", she said, "that philosophy's not a combat sport, or a battle like Althusser said it was. A good argument is always a 'win-win' situation. If the other person's right and I'm wrong that's OK because then I'll have learned something from him; and if I'm right and the other person's wrong then that's OK too because he might have learned

something from me. But this professor doesn’t see it that way. He thinks if he admits he’s wrong and I’m right then he’s a loser”.

“Well, I hate to say this, but sometimes you have to do what’s required by the university and by the professors if you want them to give you that degree. What I mean is that sometimes you have to ‘play the game’, and do no more than what’s expected of you”.

“Sure, but… I didn’t… I wasn’t … Oh, I see what you mean”.

I told Khalida that at one time I had a very enthusiastic young male student in one of my classes. I explained to him that I appreciated his intensity and his passion for philosophy. But because he was so over-eager and outspoken I asked him to please tone it down a bit to allow other students in the class a chance to speak. I told him if he agreed to this I would make him my ‘go-to’ person: I would ask his opinion whenever none of the other students raised a hand. He was very happy with this arrangement, and it worked out really well for everyone concerned. So I suggested to Khalida that perhaps she could designate herself to be the ‘go-to’ person in her group by not always being the first to speak up.

But I reminded her that no two professors are alike. Some professors appreciate students who challenge their assumptions, while others become defensive and even vindictive when a student, especially a skeptical female student, is too eager in class. Those are the professors who insist on students ‘knowing their place’. Unfortunately, in Khalida’s case, the professor ordered her to leave his class, which was not only an embarrassment for her, but must have been a terrible blow to her self-confidence. After that she struggled with the self-defeating belief that there might be something seriously wrong with her as a student, as a woman, and as a person. And that negative self-assessment became a painful virus in her mind that led her to contacting me through my website.

Unfortunately, before Khalida had ever come to see me the school psychiatrist had already diagnosed her as suffering from clinical depression, anxiety, and paranoia. And the (understandable) frustration she presented in his office had led him to conclude that she might also be on the schizoaffective disorder spectrum. He had put her on anti-depressants and anti-anxiety medications which made her feel “loopy”, with a strange sense of disconnection, as though her very nature was being compromised. So after a few weeks she had decided to stop taking them, but continued to self-medicate with sleeping pills.

After hearing Khalida’s story I told her I totally agreed with her when she said she had been treated unfairly. I saw her self-blame as being unfounded because her

professor was simply wrong to take such a suppressive attitude toward an obviously well-read and engaged student. But I suggested that perhaps she could offer an apology to her professor and the university so that they would permit her to resume her studies. This would not be an admission of guilt; it would simply be 'playing the game' to ensure her academic survival by adapting to the reality of what seemed to be an unfair misogynistic situation.

Khalida and I came to the agreement that there's something unethical about an educational institution that reprimands a keen student's passionate involvement in classroom discussions. It's ludicrous that the university had defined her sincere inquiries as unacceptable behaviour while they tolerated her professor's condescending ego and defensive attitude. I assured Khalida that in her case it was the professor and the school system that were the problem, not her enthusiasm. She smiled with relief, grateful for what I was saying.

Khalida's self-doubt and self-recrimination had acted like a malignant mental virus that grew exponentially, gaining the strength to mutate into severe self-criticism. In effect what she had been doing was wrongly castigating herself for her love of philosophy. After only a few counselling sessions, and a number of lively discussions about our philosophical differences, we found that we had successfully eliminated most of her troubling mental viruses. She decided to send a letter of apology to her professor, and a copy of it along with her reapplication form to the university. She was subsequently allowed to continue her studies with a different professor, and without an assessment of any academic penalties.

APPENDIX

A fallacy is the informal logic term for a reasoning error that has the potential to develop into a self-defeating mental virus. These are some of the more common fallacies:

- *faulty analogy* [an invalid comparison] (“Depression is a serious medical disease just like diabetes or cancer”.)
- *false cause* [an incorrect causal claim] (“A mental illness is a genetic disorder”.)
- *slippery slope* [an unfounded prediction of terrible consequences] (“If you don’t take your schizophrenia medications every day your condition will get progressively worse”.)
- *hasty conclusion* [an assumption based on too little evidence] (“Your headache is probably a brain tumor”.)
- *bandwagon* [the belief that what others do must be right or good] (“All my friends take anti-depressant medications to feel better, so I should probably take them too”.)
- *appeal to tradition* [What was done in the past must be continued] (“Electroshock therapy was used in the past, so there’s no reason why we can’t use it today”.)
- *either/or* [only two possible options are mentioned when others may be available]
  (A mental illness is either a genetic disorder or a chemical imbalance in the brain”.)
- *begging the question* [Is it true that…?] (“Being sad is a mental illness”.)
- *improper appeal to authority* (“Google says schizophrenia is a chronic illness”.) [Google is not an authority]. Or “They say…”. [The word “they” is often given as an authority.]
- *ambiguity* [When a word can have several different meanings {stuff}] (“I’ve seen him take stuff to make himself feel better”.)
- *vagueness* [Unclear meaning] (“Sadness can be sort of like a mental illness”.)

- *two wrongs don't make a right* ("If one pill doesn't help you feel better you may want to take several".) [This can also involve an appeal to revenge.]
- *is-ought* [Just because this is the way it's done doesn't make it right] ("In bio-psychiatry the diagnosis is usually followed by taking medications. So that's what you should do".)
- *irrelevant reason* [The reason given does not support the conclusion] ("I'm not sure I should go to work today; I've been diagnosed with a mental illness".)
- *questionable definition* [Words are sometimes given strange meanings] ("A mental illness is when the brain lacks certain chemicals".)
- *hasty generalization* [from one to many] ("My friend had a mental breakdown from social media, so I know it can cause teens to have a mental breakdown".)

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