

WHAT MAKES “A NEW MENTAL ILLNESS”?: THE CASES OF SOLASTALGIA AND HUBRIS SYNDROME.

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ABSTRACT: What is a “mental illness”? What is an “illness”? What does the description and classification of “mental illnesses” actually involve, and is the description of “new” mental illnesses description of actually existing entities, or the creation of them? “Solastalgia” is a neologism, invented by the Australian environmental philosopher Glenn Albrecht, to give greater meaning and clarity to psychological distress caused by environmental change (Albrecht et al 2007) The concept received some coverage in the international mass media in late 2007 (Thompson, 2007) Much of this described solastalgia as “a new concept in mental illness”, a description endorsed by Albrecht himself. The doctor and former British Foreign Secretary, Lord Owen, has coined the phrase “hubris syndrome” to describe the mindset of prime ministers and presidents whose behaviour is characterised by reckless, hubristic belief in their own rightness. This paper uses both the concept of solastalgia and the related concepts Albrecht posited of psychoterratic and somaterratic illnesses and hubris syndrome as a starting point to explore issues around the meaning of mental illness, and what it means to describe and classify mental illness. These issues illustrated tensions between natural and social philosophy, with the nature and status of psychiatry as a scientific, “value-free” enterprise or a humanistic, “value-laden” one discussed. Should “the distress caused by environmental change” be deemed a mental illness? Could it thereby included in catalogues of mental illnesses such as DSM-IV and ICD-10? The process whereby the psychiatric establishment defines and categorises mental illness is described, and as well as examining whether solastalgia and hubris syndrome meets these criteria, those criteria are compared to more critical views of psychiatry and the nature of mental illness. The approaches of Szasz, Boorse, Fulford, Canguilhem and other thinkers to issues related to mental illness are discussed. Finally it is suggested that the language of mental illness is increasingly used for rhetorical purposes, and that caution should be exercised in extending the label of illness to the phenomena of solastalgia and hubris syndrome.

KEYWORDS: Psychiatry, mental illness, philosophy of medicine, philosophy of science, Szasz, Canguilhem

INTRODUCTION: THE CASE OF SOLASTALGIA

Solastalgia is a neologism, invented by the Australian environmental philosopher Glenn Albrecht, to give greater meaning and clarity to environmentally induced distress

(Albrecht et al, 2007) Albrecht had worked for some time as an environmental activist and advocate in the Hunter Region of New South Wales. Open cut coal mining and the construction of new power stations had transformed this formerly pastoral landscape. Many area residents who were concerned about specific environmental issues contacted Albrecht to discuss these. In the course of these interactions he began to notice that a wider distress at the extent of local environmental change was evident. Influenced by various environmental thinkers (Rapport 1999) who linked man-made environmental stress leading to “land-sickness” (which, unlike other environmental stresses, did not lead to an environmental recovery) with psychic stress among the population of the particular environment, he developed the concept of solastalgia. Ethnographic studies among residents of the area identified the following themes:

Their sense of place, their identity, physical and mental health and general wellbeing were all challenged by unwelcome change. Moreover, they felt powerless to influence the outcome of the change process. From the transcript material generated from the interviews the following responses clearly resonate with the dominant components of solastalgia – the loss of ecosystem health and corresponding sense of place, threats to personal health and wellbeing and a sense of injustice and/or powerlessness. (Albrecht et al, 2007, S96)

Postulating “nostalgia” as a place-based distress, with the distress being due to absence from the loved place, Albrecht observed that “people who are still in their home environs can also experience place-based distress in the face of the lived experience of profound environmental change.” (Ibid., S96) He had also coined the concept of a “psychoterratic” illness, one in which psychological symptoms are induced by land sickness: “the people of concern are still ‘at home’, but experience a ‘homesickness’ similar to that caused by nostalgia. What these people lack is solace or comfort derived from their present relationship to ‘home’, and so, a new form of psychoterratic illness needs to be defined. The word ‘solace’ relates to both psychological and physical contexts.” (Ibid., S96) The concept received some coverage in the international mass media and in the “blogosphere” in late 2007 (Thompson 2007)

Much of this described solastalgia as “a new concept in mental illness”, a description which, while not originated by, was endorsed by Albrecht himself. A rating scale was developed which purported to provide a means of measuring Environmental Distress (Higginbotham et al, 2007.) This was an 81-point instrument, with a mix of yes-or-no statements and five-point scales. One subscale measured solastalgia, and the researchers assessed the validity of solastalgia scores in predicting other aspects of environmental distress. The overall aim of the research has been described as follows:

How well a psychoterratic syndrome such as solastalgia captures the essence of the relationship between ecosystem health, human health and control (hopelessness and powerlessness) and negative psychological outcomes. (Albrecht et al 2007, S97-8)

In discussing the results of the validation of the Environmental Distress Scale (EDS), Higginbotham et al observed that

As measured through the EDS, the concept of solastalgia appears to give clear expression, both philosophically and empirically, to the environmental dimension of human distress. This has not been achieved previously. We might further consider whether or not the experience of solastalgia is essentially the primary process underlying the EDS measurement as a whole. In other words, solastalgia may well account for most of what we have measured under the rubric of environmental distress. (Higginbotham et al, 2006, p. 252)

It should be noted that the concept of “solastalgia” has emerged from a context of thinking among environmentalists and environmental philosophers about the relationship between the “natural environment” and “psychic stability.” Albrecht has described how his thought evolved under the influence of the American environmentalist Aldo Leopold, who in the 1940s described links between environmental problems and psychic states (Leopold 1949) This tradition seems to be separate to that which has linked psychiatry and philosophy in recent years, focusing on making connections between the health of the environment and the health of individual human beings and drawing parallels between medical and ecological approaches. (Kristjanson and Hobbs, 2002)

Solastalgia was described as a “new mental illness” in the wider media coverage of the phenomenon (Thompson, 2007). As outlined above, Higginbotham et al suggested that solastalgia did underlie the environmental distress they had measured, and argued that the validation of their rating scale appeared to support viewing solastalgia as a clear expression of environmental distress. They did not take into account the process whereby psychiatry, as a medical specialty, defines and “accepts” a phenomenon as a “mental illness.” Nor did it take into account the philosophical issue of what a mental illness actually is, and whether or not solastalgia could be classed as one. This therefore allows us to review the topic with solastalgia in mind as an exemplar of a proposed “new mental illness.”

THE CASE OF HUBRIS SYNDROME

David Owen, ennobled as Lord Owen, qualified as a medical doctor and subsequently entered UK politics. Minister for Health and Foreign Secretary in Labour Governments of the 1970s, he later was a co-founder of the Social Democratic Party in the 1980s and Special Representative to Bosnia-Herzegovina in the 1990s. In recent years he has written widely on the interaction between medical illness and politics (Owen 2008a)

In these writings, he has introduced the concept of “hubris syndrome.” (Owen, 2008b), described as follows :

Hubris syndrome is associated with power, more likely to manifest itself the longer the person exercises power and the greater the power they exercise. A syndrome not to be applied to anyone with existing mental illness or brain damage. Usually symptoms abate when the person no longer exercises power. It is less likely to develop in people who retain a personal modesty, remain open to criticism, have a degree of cynicism or well developed sense of humour. Four heads of government in the last 100 years are singled out as having developed hubris syndrome: David

Lloyd George, Margaret Thatcher, George W Bush and Tony Blair. (Owen, 2008b, p. 428)

Owen describes hubris syndrome as inextricably linked with power, and indeed requiring the person to be in a position of high, if not supreme, political office. He also argues it is related to the length of time an individual is in power, and “evolves and is in a continuum with normal behaviour.” Owen suggests a checklist of thirteen symptoms, of which a “three or four should be present before any diagnosis is contemplated.” Here four of those symptoms are given:

- a narcissistic propensity to see the world primarily as an arena in which they can exercise power and seek glory rather than as a place with problems that need approaching in a pragmatic and non-self-referential manner
- a predisposition to take actions which seem likely to cast them in a good light, taken in part in order to enhance their image
- a disproportionate concern with image and presentation
- a messianic manner of talking about what they are doing and a tendency to exaltation in speech and manner (Ibid., p. 428)

Owen describes how not all politicians, even those who achieve the highest office, succumb to hubris syndrome. He discusses the careers of United States President Harry S Truman and British Prime Ministers Clement Attlee and James Callaghan as examples of twentieth century leaders untouched by hubris. In more detail, he discusses the behaviour of Lloyd George, Thatcher, Blair and George W Bush, with particular reference in the case of the latter two to their approach to the Iraq War of 2003. He argues that hubris syndrome is associated with very considerable mortality and morbidity worldwide, as leaders take major decisions, especially in relation to war and peace, recklessly. He distinguishes between hubris syndrome and personality disorders, and very firmly states his conviction that a neurochemical, neuroscientific approach is required to elucidate the causes and prevent the occurrence of hubris syndrome:

It is my hope that neuroscientists will consider hubris syndrome within the broad basis of a systems-orientated approach and examine whether prolonged leaders' stress associated with noradrenergic and dopamine systems with some predisposing factors may affect this system in ways not dissimilar to the resetting experienced by the long distance runner after a prolonged period of running. A resetting of the dopamine system might provide an explanatory hypothesis underpinning of the hubris syndrome. (Ibid., p. 432)

THE CONCEPT OF MENTAL ILLNESS: PSYCHIATRISTS AND PHILOSOPHERS

Defining what psychiatry is and what mental illnesses are can often seem a circular process. One indisputable fact is that psychiatry, as it is currently constituted, is a branch of medicine. While contemporary psychiatrists tend to aspire to practice using a “bi-

opsychosocial approach” (Clare, 1999, p. 109), their training and the structure of the vast majority of psychiatric practice fits a medical model. People present with symptoms and exhibit signs which are examined. If these symptoms and signs are deemed to provide evidence of pathology, they lead to a diagnosis of an illness. Investigations and treatments are ordered. Medications and other interventions are prescribed to treat the illness. The cessation of the symptoms and signs marks recovery from the illness. This is, on the surface, similar to how an ophthalmologist would approach cataract, or a respiratory physician chronic obstructive pulmonary disease. Dictionary definitions of psychiatry describe it as the medical specialty concerned with mental illness (Oxford English Dictionary, 2007) Psychiatry textbooks too generally gloss over the actual meaning of mental illness but assume it has a readily understood and commonly accepted meaning.

A key paper from within the psychiatric establishment on the definition of mental illness is Robins and Guze (1970) on the establishment of diagnostic validity in psychiatric illness, with regard to schizophrenia. This paper’s approach has had a strong influence on the development of DSM-IV, the American Psychiatric Association’s classification of mental illnesses which is used in clinical practice (although it was developed primarily to enable researchers to communicate with each other rather than as a clinical tool) for diagnostic purposes. Robins and Guze describe a five step method for achieving diagnostic validity in psychiatric illness is described, consisting of five phases: clinical description, laboratory study, exclusion of other disorders, follow-up study, and family study. The method was applied in this paper to patients with the diagnosis of schizophrenia, and it was shown by follow-up and family studies that poor prognosis cases can be validly separated clinically from good prognosis cases. The authors conclude that good prognosis “schizophrenia” is not mild schizophrenia, but a different illness.

“Diagnostic validity” means that a diagnosis of schizophrenia is in fact a case of schizophrenia. It differs from a related concept, reliability, which describes how well diagnoses match each other—a reliable diagnosis of schizophrenia means that other clinicians would come up with a diagnosis of schizophrenia given the same case. It is possible for a diagnostic process to be reliable but not valid, although validity implies reliability. It does not, however, address the question of what schizophrenia is.

Validity implies that one is describing an entity whose existence and nature is not disputed. It does not address fundamental questions of what this entity actually is. Solastalgia may well fit the Robins and Guze framework very well. Clinical description has already been carried out. “Laboratory investigation” is mirrored in the development of the Environmental Distress Scale. Exclusion of other disorders could, arguably, involve showing that the distress experienced by the person is due to environmental change and no other factor.

Hubris syndrome also fits this framework very well. Already clinical description and exclusion criteria are provided by Owen. Owen suggests possible avenues for laboratory study, referring to neurotransmitters. Although the rarity of hubris syndrome may make this study and follow-up studies challenging, it may be that analogues to hubris

syndrome in less eminent persons will be developed. Family studies would be more problematic, although cases such as the two Bush Presidents and the Nehru-Gandhi dynasty in India would suggest that this could be overcome. Follow-up and family studies, in any case, refer to activities psychiatric researchers undertake, and implicitly assumes that the diagnosis is an entity in itself.

And this points to the essential circularity of mainstream psychiatry's definitions of mental illness. Robins and Guze's formulation of mental illness is made up of five steps that refer entirely to medical and psychiatric activity itself. Psychiatry is the medical specialty concerned with mental illness, and mental illnesses are conditions which are the concern of psychiatry.

As outlined in the statement of the Focus & Scope of this journal, a tension between "cosmology, conceiving the cosmos as an immutable, timeless order, and history, concerned with actions, intentions, conflicts and the rise and fall of individuals and communities, has been at the core of virtually all intellectual and political oppositions throughout the history of European civilization." This tension is particularly germane to psychiatry. Psychiatrists spend much of their time trying to improve the image of psychiatry within medicine by insisting it is a scientific enterprise, characterised by the assumptions of expertise, specialist knowledge and greater objectivity that (it is assumed) are possessed in full by other medical specialties. However psychiatry, as shall be seen, is also intimately concerned with values and the concerns of the humanities. The tension between the worldviews of ethical and political philosophy on the one hand and the traditional scientific view on the other is particularly acute in psychiatry.

Any attempt at any overarching, definitive definition of what philosophy is will be even more contested than that of psychiatry. Just as with medicine and medical practice, there are very many disciplines subsumed within philosophy, and while the medical model described above is generally accepted within most medical specialties, there is no such consensus within philosophy as to what philosophers do, what "the business of philosophy" should be, or how philosophers should approach the problems that come under the heading of "philosophy." Of the many things that philosophy is, it is perhaps safest to say that philosophy questions assumptions and encourages critical thinking about things taken for granted.

The concept of "mental illness", which as we can see from the above can be considered an assumption in common usage within the psychiatric profession (and, perhaps, in wider society), has been subjected to a thoroughgoing critique from philosophers, psychiatrists, psychologists, social workers, political scientists, feminists and many other figures. This critique has taken five main approaches:

- a psychological model, as exemplified by the British psychologist Hans Eysenck, arguing that mental disorders are in fact learned abnormalities of behaviour (Eysenck 1968)
- a labelling model, as exemplified by the American sociologist Thomas Scheff, who argued that the features of mental disorder are in fact a response to the labelling of an individual as "deviant" (Scheff 1974)

- a “hidden meaning” model, postulating that the apparently irrational, harmful or meaningless behaviour associated with mental disorder is in fact meaningful. The Scottish psychiatrist R.D. Laing, for instance, argued that “madness” was a sane response to an insane society. (Laing, 1960)
- an “unconscious mind” model, influenced by psychoanalysis, which postulates that, again, the apparently irrational can be comprehended, this time with reference to the unconscious mind
- political control models—this critique of psychiatry sees it as a legitimising the social status quo and allowing those who dissent from it to be labelled mentally ill. The practice of psychiatry in the former Soviet Union exemplifies this. Another example is the feminist critiques of post-natal depression, which feminists would argue reflects society’s treatment of mothers rather than being a disease *per se*. Thus legitimate distress at the unfair structure of society is pejoratively labelled an illness. Similarly, the Franco-Algerian psychiatrist Frantz Fanon argued that psychiatry was a tool of colonial control and part of the hegemonic order of industrial capitalism.

This questioning, much of which has been posed by psychiatrists, has forced psychiatry to scrutinise its own concept of what constitutes mental illness. Many of it is more about the role of various psychological, social and political factors in the development of mental illness, rather than being an attack on the basic concept of mental illness. Other critiques have not so much been of psychiatry as a discipline or practice, but on the cultural significance of a therapeutic ethos, for instance that of Philip Rieff in “The Triumph of the Therapeutic.” (1965) For Rieff, the rise of psychotherapy and the “psychological man”—marked a turning point in human culture, being the death-knell of a Western culture whose ideals had lost their power to deeply pervade the characters of its members. In a therapeutic ethos, truths are contingent and negotiable, and commitments or faiths only survive as therapeutic devices easily discarded in the interests of therapy. For Rieff, this is a symptom of Western cultural decadence and decline.

Much of the “antipsychiatry” critique has been absorbed into mainstream psychiatric thinking and practice. Psychiatry is generally practiced in the community in a multidisciplinary, biopsychosocial fashion, and psychiatrists themselves lobby for extra resources to achieve this. Government policies enshrine the concept of patient-centred care that meets holistic needs and aim for “recovery” that goes beyond the simple alleviation of symptoms (Expert Group on Mental Health, 2006.) Compulsory treatment of those diagnosed as mentally ill is surrounded by tight regulatory control in Western societies.

However, for the most thoroughgoing anti-psychiatrists, this is not enough. They favour not tighter controls on compulsory admission, but the complete abolition of the phenomenon. One of the most influential critiques is that of Szasz (Szasz, 1960). Szasz disclaims the label “antipsychiatrist” and also insists he is not a philosopher, however his work could be seen both as the quintessence of “antipsychiatry” and as having a strong influence on philosophical approaches to mental illness. Throughout his career he has

stated emphatically that illness requires the presence of a physical lesion which causes disease. With mental illnesses, there is no identifiable physical lesion. Therefore “mental illness” is a myth. This is not to say that the phenomena described as mental illnesses are not actually happening, but that they are not illness. “Mental illness” involves a value judgement, whereas the diagnosis of bodily illness does not. What has formerly been termed mental illnesses are in fact “problems of living.” This leads Szasz to a radical and continuing critique of psychiatry as a discipline (Schaeler, ed, 2004.) Other critics of psychiatry (for instance Eysenck, 1968) have argued that many, if not most, patients presenting with mental illness are in fact experiencing problems of living, but have generally conceded that some at least are experiencing a biologically based mental illness. Szasz, however, has consistently maintained what could be called a “hard” position denying the validity of mental illness and, from this position, attacking both psychiatric coercion (involuntary admission and treatment) and “psychiatric excuses” (the insanity plea) Szasz has not argued for the abolition of psychiatric practice, but that psychiatric practice should only be between two consenting adults (what he calls “contractual” psychiatry), that psychiatrists should have no powers to compel treatment or admission, and that courts deliver verdicts of either guilty or not guilty with no acceptance that insanity can be a mitigating circumstance. Over the course of his career he has compared “institutional” psychiatry (contrasted to “contractual” psychiatry) to the Inquisition, the slave trade and the Holocaust. (Szasz 2002)

Szasz has never stated that the phenomena described as mental illnesses do not exist—that people who are diagnosed with depression are not suffering from distress, or that people who are diagnosed with paranoid schizophrenia are not reporting persecution without a basis in real events. Szasz simply states that these presentations are not illnesses, and their treatment as such is not simply an intellectual error but has led to massive violations of human rights on a worldwide scale.

There have been many “pro-psychiatry” counterparts to the work of the antipsychiatrists. Kendell (1975) described the ‘biological disadvantage’ criterion of illness, based on the work of Scadding (1967), a chest physician who described a disease as ‘the sum of the abnormal phenomena displayed by a group of living organisms in association with a specified common characteristic or set of characteristics by which they differ from the norm for the species in such a way as to place them at a biological disadvantage.’ Kendell used this criterion of “biological disadvantage” to argue that, in fact, a value-free concept of illness was possible, and also that it applied to mental illness, as it shortened life expectancy and reduced reproductive advantage. Later, Kendell changed his position and came to believe that value judgements were inescapable with regard to any illness (Kendell 2002). Kendell’s original argument was directly intended as a response to Szasz and the other antipsychiatrists. So, where Szasz defined bodily illness as cellular dysfunction, Kendell defined it as a process leading to “biological disadvantage.”

Kendell and Szasz share, however, a view that defining bodily illness is uncomplicated compared to mental illness. Their debate is framed in terms of comparing mental illness to bodily illness, and arguing that mental illness is illness in so far as it is more or

less like bodily illness. Many critics of Szasz since have taken the same basic approach—for instance, that there are in fact biological pathologies associated with mental illness, or that as medical science progresses we will identify these pathologies. To which Szasz replies that, if this indeed turns out to be the case, these conditions will become bodily illnesses to be treated by bodily physicians, as Alzheimer's Disease and General Paralysis of the Insane (tertiary syphilis) did in the late nineteenth century.

Many later respondents to Szasz have argued that his concept of illness is narrow, and that bodily or purely physical illness or disease is not to be defined as simply as he suggests. Szasz himself has continued to hold to his original position, writing that "I use the terms *disease* and *illness* interchangeably" (Szasz, 2000, p. 3.) Szasz has continued to insist that bodily illness is an uncomplicated concept and mental illness an unjustifiable extension of that concept. One of his supporting references is the introductory material for pathology textbooks, which (in a way analogous to the simple definitions of mental illness that are used in psychiatry text books) generally simply state that disease is due to cellular damage. Whether the authors of these textbooks, any more than those of psychiatric textbooks, have taken a philosophical approach to the underpinnings of their specialty could perhaps be questioned.

Boorse (1976) has also described the distinction between illness and disease, with disease referring to dysfunction (which, Boorse argues, can be used to describe cognitive and perceptual as well as purely physical domains) and illness referring to the social consequences of disease. "Disease" is a value-free, objective entity—"illness" is a value-laden, socially determined process or consequence of disease. Boorse argues that a disease becomes an illness when it becomes incapacitating for the person experiencing it. In social terms, it must be undesirable for its bearer, "a title to special treatment" and "a valid excuse for normally criticisable behaviour" Boorse argued that the fact that mental illness is value-laden relative to physical illness was not because physical illness was value free—for the whole concept of illness is value-laden. Mental illness is seemingly more value-laden because the sciences that underlie mental illness are not as well developed as those underlying other medical specialties, but this is simply a historical factor which will be rectified over time.

Boorse's disease/illness distinction—an attempt to retain value-free evaluation of pathology while accepting the value-laden nature of diagnosis, treatment and the sick role—brings us to one of the pivotal work of the French epistemologist and physician Georges Canguilhem. Canguilhem, author of one of the key texts in the philosophy of medicine, *The Normal and the Pathological* (Canguilhem, 1989), challenged the dominant "scientific" paradigm of pathology based on statistical norms of supposed immutability, which defined boundaries on a continuum between normal and abnormal. For Canguilhem, health and disease were properties of a total organism, with health being the capacity to withstand change and to establish new norms—the ability to fall sick and recover, or normativity—and disease the lack of this capacity. Anomaly *per se* was not abnormality, and a list of symptoms and signs or deviations from a statistical norm did not define disease.

Canguilhem's work was rooted in an approach to the history of medicine that looked at the evolution of conceptual rather than factual knowledge (Horton, 1995). For Canguilhem, as for many other philosophers of science as the twentieth century progressed, the positivist view of science as based on observations made in language entirely independent of theory was untenable. The dominant positivist view of medicine reflected the influence of physiologists such as Claude Bernard, who championed an approach to understanding disease based on laboratory experimentation separated from clinical conditions. Against this, Canguilhem argues that a purely "scientific", lab-based understanding of illness divorced from clinical experience or understanding the conditions of disease is impossible—"it is first and foremost because men feel sick that a medicine exists. It is only secondarily that men know, because medicine exists, in what way they are sick." (Canguilhem, 1989, p. 229)

A further key of Canguilhem's approach was that the history of medicine had shown a gradual movement from concepts of health and disease as qualitatively different entities, to one in which there is only a quantitative difference. For Canguilhem, the pathological state is qualitatively different from health because of its implications for the organism's survival and ability to flourish. It is this factor that purely positivist accounts of sickness cannot account for, but cannot ignore. The implications of Canguilhem's writing for mental illness have been discussed by Magree. (Magree, 2002)

Arguments continue about definitions of mental illness. As outlined above, Szasz has kept very strongly to his original position over the years, in the face of all critics. However the debate has moved on to other terms. Christopher Megone, for instance, describes illness both bodily and mental as incapacitating failure of bodily or mental capacities to fulfil their functions (Megone, 2000). He traces this concept of functional impairment back to Aristotle. Fulford, meanwhile, focuses on the actual experience of illness as a basis for thinking about illness (Fulford, 1993). This is influenced by the work of the philosopher J L Austin and the sociologist David Locker (Austin, 1961 and Locker, 1981). Austin was a philosopher associated with the Linguistic Analytic move in philosophy, which emphasised examining how a concept is used in ordinary usage as a way of finding out its meaning. One of the approaches to "doing philosophy" which was seen traditionally as leading to clear thinking was to "define your terms." In other writings Fulford has discussed how the assumption that "defining your terms" is a necessary condition for clinical utility has become so prevalent within medicine has led to the belief that concepts are *only* clinically useful if they can be so clearly defined (Fulford, 2001). Austin suggested that "philosophical fieldwork"—exploration the use of concepts in everyday language and usage—may be a better means of approaching the meaning of concepts, rather than concentrating on definitions *per se*.

Austin also described the complexity of actions. Philosophers had previously tended to focus on particular aspects of action—intention, voluntariness and so on—and to unpick them by defining them. Austin focused on "the machinery of action" which involves a wide range of processes and activities—"we have to pay (some) attention to what we are doing and to take (some) care to guard against (likely) dangers; we may

need to use judgement or tact; we must exercise sufficient control over our bodily parts; and so on.” (Austin, 1961) Fulford utilises this as a way of approaching the medical concept of illness, as “action-failure.” “The machinery of action” has a wide range of elements, and this breadth gives Fulford a wide range of approaches to understanding illness experiences, both physical and mental.

The work of Locker on those features of experiences that people identify as marking out these experiences as illnesses helped suggest this approach. Four relevant features were identified—the experience is negatively evaluated, has a certain intensity and duration, is not “done to or happens to” the person undergoing it, and is not “done by the person” themselves.

Fulford has built on Austin and Locker’s work to describe the importance of “action failure” in defining illness. At first sight, “action failure” does not seem too different from the “dysfunction” of Boorse’s thought. Action and function are closely related, but are also more distinct than one might think. Individual people (as agents) perform actions; particular physiological systems or body parts function. Fulford uses this distinction to draw a parallel with the distinction between the patient’s experience of illness and a doctor’s knowledge of illness. Fulford has described a “full field” model of mental illness. Going beyond purely medical models, focusing on disease and *failure of function*, it combines the social, value-based concept of illness with corresponding *failure of action*.

To the objection that unpleasant experiences such as pain or psychological distress are often involved in illness experiences (and that these do not immediately obviously fit into the concept of action failure, Fulford replies that pain is integral to “the machinery of action”, as is psychological distress, and therefore action-failure analysis can be applied.

SOLASTALGIA AND HUBRIS SYNDROME CONSIDERED THROUGH THE PRISM OF THE CONTESTING DEFINITIONS OF MENTAL ILLNESS

Analogies can be drawn between solastalgia and post-traumatic stress disorder. Post traumatic stress disorder is a contested diagnosis within psychiatry. Many argue that it is simply a new name for a condition described by Homer (Shay 1995) and recognised by military physicians and psychiatrists under a variety of names (Shepherd 1994). Others argue that it has been “invented” for political reasons (Summerfield 1999) and reflects the subjugation of psychiatry to socio-political imperatives. Uniquely among conditions described in both DSM-IV and ICD, in its definition the cause is specified. Solastalgia would share this quality. Indeed, online commentators from the environmental movement have criticised Albrecht for the perceived narrowness of the focus and his adoption of a medical model of harm induced by environmental change.

It is of course invidious to try and predict what individual thinkers might “make of” solastalgia and Albrecht’s contention that it is a “new mental illness,” or of Owen’s identification of hubris syndrome as potentially causing more death and disability than any other illness worldwide. However, it seems reasonable to assume that Thomas Szasz

would dismiss the idea of both being “new mental illnesses” because he views mental illness itself as a myth. The problem of adjusting to an environment made strange around one is a “problem of living”; and the problem of leaders growing out of control is a political one. The use of the concept of disease in these two settings is simply an error.

Using Boorse’s framework to analyse these entities also leads to interesting considerations. One of Boorse’s initial arguments in his 1975 paper is that what gives rise to ambiguity and difficulty with mental illness is the “territorial ambitions” it has. Psychiatry is laying claim to more of life’s problems, leading to a “medicalisation of morals.” This, rather than basic definitional issues of what is a mental illness, leads to problems. In a sense Boorse partly agrees with Szasz about “problems of living” being the root of at least some “mental illnesses”—the difference being that Szasz would deem all mental illnesses so. This would suggest that Boorse would be sympathetic to the view that the concept of solastalgia and hubris syndrome represents medicalisation of the moral fault of man-made environmental change and of overweening power. Boorse’s 1975 argument came in two parts—by positing disease as dysfunction, it preserved a value-free status for medical and psychiatric practice and decision making, while by describing the social components of illness, it acknowledged the degree to which social practices and behaviours within a social context define illness. In the case of solastalgia, what “dysfunction” may be said to underlie the “disease process?” It is not clear, although perhaps the development of psychological assessments of Environmental Distress may aim at identifying specific thought processes. It is noteworthy that Albrecht and colleagues do not propose a “treatment” for solastalgia, but propose further research. It is not suggested that the interviewees’ reactions are in any way pathological, or that other reactions and emotions are more appropriate or more “functional.”

Canguilhemian notions of illness as a loss of normativity, a loss of the ability to adapt, are consonant with solastalgia’s emphasis on the distress caused by change. Canguilhem’s other emphasis on an understanding of disease that must move beyond the laboratory and detached “scientific” considerations to the setting where distress is experienced is also echoed in the solastalgia literature. Yet the use of a rating scale, with the inevitable emphasis on scores and purported norms, suggests an approach ultimately very different from that of Canguilhem.

Using Fulford’s “full field” model of mental illness, which incorporates both a “value-laden” pole of failure-of-action/illness and a “value free” or “factual” failure-of-function/disease pole, we again hit the difficulty of which, if any, failure of function is being described. There is a similarity between the approaches of Locker and Albrecht in terms of their use of interviews to discover themes in subjective experience. Using the four features identified by Locker, clearly the experiences described by Albrecht’s interviewees are negatively evaluated. They have an ongoing duration and intensity. The experience is not “done by the person experiencing it.” The “sense of injustice and powerlessness” described by Albrecht et al in their paper as characteristic of solastalgia reinforces this. However, one could observe that that the experience could be said to be due to the actions of another—for instance the mining companies. Using this approach, solastalgia

describes distress rather than disease.

As for hubris syndrome, Owen suggests neurochemical imbalances that may underly the phenomenon. These are very much suggestions, however, without any definite suggestions as to what neurological circuitry is involved, for instance. Owen also writes that

Hubris syndrome is not yet a diagnostic category of accepted mental illness but it probably stems from a set of genetically codetermined predisposed personality traits. To the psychiatrist any potential new syndrome is likely to be an interaction between genes and environment or nature and nurture. Early biology and upbringing provide the basis of personality which can then be expressed, or not, depends on constraints or opportunities. (Owen, 2008b, p. 431)

While this statement is accurate, it is also extremely generalised and does not point to which aspects of “early biology and upbringing” might contribute to later hubris syndrome.

Owen locates hubris syndrome as stemming from personality traits. The implications of Canguilhem’s thinking on the normal and the pathological for the diagnosis of personality disorders has been discussed by Buchanan (2007), in particular intolerance of “the inconsistencies of the environment.” Buchanan suggests that “one testable hypothesis arising from Canguilhem’s work is that a failure actively to adapt to one’s surroundings represents the final common pathway by which narcissistic, borderline, schizoid, or other traits prevent someone from achieving his or her potential in a range of social and occupational spheres.” Owen describes a rigidity and unwillingness to reverse decisions as being among the criteria for hubris syndrome.

The distress experienced by Albrecht’s interview subjects is real. Is what they are having a “new mental illness”? While there is clearly some journalistic hyperbole at play here, and in their published papers Albrecht and his co-authors are careful to emphasise the preliminary nature of their work, solastalgia serves as a good example of how the concept of “mental illness” is discussed in the public domain. Albrecht is describing a psychological phenomenon and making a link with environmental change.

From the philosophical point of view, solastalgia is extremely broadly defined and seems synonymous with distress due to environmental changes. Albrecht et al powerfully illustrate the distress of their interviewees, but have not shown this is distress to be a mental illness. The weakness of Robins and Guze’s model of defining mental illness is illustrated by this. Essentially it depends on consensus and the acceptance of a phenomenon as an illness by the body of psychiatrists. Solastalgia, especially since the creation of a relevant and reliable rating scale, may in fact suit this definition more readily than any definition rooted in more philosophical rigour.

Similarly Owen provides a checklist of “symptoms” of hubris syndrome. Unlike what is the case with solastalgia, there is no evidence that the individuals purportedly “suffering from” hubris syndrome are experiencing any distress. The threat is more to society in general. Using Locker’s framework, the experience is not negatively evaluated by the person, or experienced as necessarily inflicted from outside on the person. Furthermore

there a sense of powerlessness is not (though possibly one of injustice is) associated with the experience. Overall, then, what Owen is described is not pathological for individual but for wider society.

CONCLUSIONS

One could surmise that one of the motivations for developing the concept of solastalgia is to try and quantify the immediate health costs due to environmental change and further influence the arguments about environmental policy (a particular issue in Australia, which has a strong mining lobby) in the context of often rancorous debate, rather than to identify a new mental illness per se. Similarly, Owen's identification of hubris syndrome can be seen as a plea for rule by cabinet and parliament rather than individuals, for oversight over leaders and for mechanisms to avoid the isolation and insularity that can accompany great power.

The language of psychiatry, as seen with Robins and Guze's approach to defining schizophrenia as an entity, tends to circularity. Mental illness is treated by psychiatrists, and who are psychiatrists? They treat mental illness. This allows the language of psychiatry to be adopted as a form of rhetoric. What both Albrecht and Owen have identified are serious social problems, ones which in different ways can affect the continuance of human life on this planet. Both raise issues that are worthy of consideration by any thinking person. The rhetoric of mental illness, which of course is related to the rhetoric of illness and disease overall, is a powerful tool to raise awareness and to agitate for change. However we should be cautious of identifying new mental illnesses based purely on the laudable motivations of those who expound them.

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