Most of us exchange information about ourselves, our families, and our friends with others all the time. We make casual conversation with seatmates on an airplane, chat with colleagues at the workplace, send holiday letters with a summary of our family news, and have heart-to-heart conversation with our friends about the minutia of our lives. My question is how information about someone’s mental illness should be treated in our routine exchanges with one another.

On the one hand, it is widely regarded that mental illness should be regarded as any other illness: admitted openly and discussed without shame, on the model of how we treat diseases such as cancer or diabetes. If I would mention that my sister had breast cancer, why wouldn’t I mention that she was struggling with bipolar disorder, when the conversation had turned to the topic of current family crises? If I would mention that my child was being treated for diabetes, why wouldn’t I mention that he was being treated for depression? Mental illness is a genuine illness, with an identifiable physiological basis in aberrant brain chemistry. To avoid mentioning mental illness, when one would have openly mentioned some other form of illness, is to perpetuate a stigma surrounding mental illness.

On the other hand, three distinctive features of mental illness need to be considered in deciding how best to proceed with open communication about it. The first feature is shared by other socially sensitive conditions such as homosexuality and AIDS, so we may gain insight by comparing how information about these other conditions should be shared as well. The other two, however, seem distinctive to mental illness.

Reducing the Stigma of Mental Illness

First, even if we believe that mental illness is unfairly stigmatized, the ongoing existence of stigma means that we need to weigh an individual’s interest in avoiding the deleterious consequences of revealing his illness against the good to be achieved by taking one small step toward the goal of stigma reduction. Here we need to perform some weighing of clear and significant immediate harm to one individual versus diffuse and distant collective gains. This raises a host of philosophical difficulties. As with many collective action problems, such as those faced in reducing global warming, any one individual’s contribution either to solving or worsening the problem is miniscule, if not completely without any actual practical significance, whereas the costs to the individual of engaging in or refraining from the relevant behavior may be great.

We might want to distinguish here between the individual herself choosing to take the step of announcing her illness and someone else making that announcement about her. If we compare the case of mental illness to the case of homosexuality, we may have a different assessment about the individual outing herself versus being outed by others. Two plausible principles suggest giving considerable weight to this distinction. One is the principle that the person most directly affected by an act should have the greatest say over whether or not the act is performed. If she is the one who will be harmed by her outing, she is the one who should decide whether or not to make her sexual orientation public. Ditto with the revelation that one has been diagnosed with AIDS, or with the case that concerns us here, mental illness. The other is the related, but distinct, privacy-based principle that each individual is in some sense the owner of information about herself; it is hers to divulge or not to divulge as she chooses.
The Economy of the Earth
Philosophy, Law, and the Environment
Second edition

Mark Sagoff

Mark Sagoff draws on the last twenty years of debate over the foundations of environmentalism in this comprehensive revision of The Economy of the Earth. Posing questions pertinent to consumption, cost-benefit analysis, the normative implications of neo-Darwinism, the role of the natural in national history, and the centrality of the concept of place in environmental ethics, he analyzes social policy in relation to the environment, pollution, the workplace, and public safety and health. Sagoff distinguishes ethical from economic questions and explains which kinds of concepts, arguments, and processes are appropriate to each.

The second edition incorporates the increasing engagement of mainstream and evangelical religious communities with environmental protection into his argument for a democratic environmentalism not constrained by either economics or science. Sagoff’s carefully reasoned and wide-ranging arguments will infuriate economists, ecologists, and elite environmentalists equally, but the book is essential reading for anyone interested in the future of environmentalism.

—Dan Tarlock, Chicago-Kent College of Law

The first edition of The Economy of the Earth staked out a position that many felt but few had said: the most important reasons for protecting nature are moral and aesthetic, not economic and instrumental. In the second edition, massively revised and updated, Sagoff portrays the same arguments but even more clearly and eloquently. The second edition of The Economy of the Earth is as vital to debates about environmental policy as the first edition was in its time.

—Dale Jamieson, Director of Environmental Studies, New York University

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Considering only the individual’s own self-disclosure, both pragmatic and moral reasons encourage the open sharing of information about mental illness. Kay Redfield Jamison writes in her memoir, An Unquiet Mind, about her lifelong journey through manic-depression: “I have no idea what the long-term effects of discussing such issues so openly will be on my personal and professional life, but, whatever the consequences, they are bound to be better than continuing to be silent. I am tired of hiding, tired of misspent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide.” Here Jamison herself voices the relief that comes from being able to refuse to hide information about her medical condition. Looking beyond the pragmatic to the moral, Richard Mohr has argued that gays who hide their homosexuality from public view, to avoid social condemnation of who they are, cooperate with the forces that maintain that condemnation; closeted gays help to maintain social norms that assault their own individual dignity. Thus Mohr, controversially, endorses “outing” of gays. There is no right to contribute to the maintenance of oppressive social norms. For Mohr, then, the same reasons that require closeted gays to reveal their true identity also license others to expose that identity as well. The normative difference attaching to first-person and third-person revelations disappears.
Turning to the privacy-based privileging of each person’s choice of whether or not to reveal certain information about himself, it isn’t clear that each of us does have an exclusive claim to be owner of such information. Where our lives intertwine, our stories become intertwined as well. If it is a fact about my child or husband or brother that he has schizophrenia, it is equally a fact about me that I am the mother or wife or sister of someone with schizophrenia. Imagine what conversation would be like if I responded to every question about a family member or friend with the evasive comment: “You’ll have to ask him about that.” Certainly, absent someone’s explicit request to keep some item of information secret, there seems no general obligation not to share general facts about our associates. When such a special request is granted, one has moral reasons to keep the promise made. But should such a request be granted in the first place? While it might seem that one would have stronger reasons to grant such a request for confidentiality to intimates than to casual acquaintances, I believe that the opposite is true. I have no particular reason to share information about casual acquaintances—though I might feel that honoring a request of confidentiality in some cases is tantamount to complicity in maintaining the relevant stigma. But with intimates, it places too great a burden on me not to be able to discuss their illness openly, to be forced to forgo the relief of being able to share my struggle with supportive or similarly situated listeners.

So far, then, I have considered a first reason why disclosing information about mental illness is problematic (harm or embarrassment to the mentally ill individual) a reason shared with the disclosure of information about any wrongly stigmatized condition, and concluded that this reason generally isn’t weighty enough to tell against disclosure.

Why Mental Illness Is Special

My second set of considerations appeals to ways in which mental illness poses special issues absent from AIDS or homosexuality. Unlike the stigma attaching to, e.g., AIDS, a diagnosis of mental illness more sweepingly and persuasively affects how a person’s entire identity is viewed, so that all the person’s behaviors may come to be interpreted through the lens or label of the illness.

Some stigmatizing conditions are arguably of no genuine importance in themselves in determining how we should relate to the individual in question, but acquire importance given social conditions and prejudices that might better be resisted.

Consider a diagnosis of AIDS. While there have been publicized cases of mass hysteria over the enrollment of an HIV-positive student in a public school, such a reaction is completely unwarranted. The only real issue involving someone’s HIV-positive diagnosis concerns easily contained risks to others of contact with their blood through shared needles, sexual activity, and so forth, risks that can be handled through simple and generally applicable safety procedures. People often do react to AIDS differently if they believe that it is “blameless” AIDS contracted through a blood transfusion, or by a child in the womb, versus “guilty” AIDS contracted through homosexual sex or through intravenous drug use. The latter background information is often used, wrongly, to ground a more sweeping judgment of the person. But properly speaking, knowledge of a diagnosis of AIDS just provides a reason to give someone additional sympathy and support for the long medical journey on which he is embarking. While homosexuality seems to involve someone’s identity much more than AIDS does—most of us think our sexual orientation is a fairly central fact about us—someone’s sexual orientation should make no difference to how I treat him, unless I am looking for a sexual partner and am trying to determine someone’s eligibility given my own sexual orientation. Put another way, my knowledge that someone has AIDS, or is gay, generally does not benefit me in any appreciable way, nor does my knowledge that someone has AIDS, or is gay, generally benefit that person in any appreciable way.

Mental illness does seem different here. It would be too huge of a topic to look at our long and tortured history of response to people who are mentally “different.” Clearly at various times people have been judged to be mentally ill (or depending on the times, satanically possessed) for behaviors that were merely socially deviant; sometimes such “deviance” was morally preferable to compliance with prevailing norms that were sexist, racist, and conformist. Some would argue that our current diagnosing of mental illness is just a way to label social deviance, that we all fall somewhere on a spectrum of “normal” to “abnormal” depending on the norm in question. Someone who believes this would reject the opening premise of my discussion, that mental illness is an illness like any other, and would argue instead that mental illness is not an illness at all.

I believe that careful professional diagnoses of mental illness do tend to identify a variety of conditions that have serious negative implications for one’s ability to survive and meet basic human needs.
as well as to interact with others within our society. Most relevant for my purposes, many behaviors caused by mental illness are arguably morally problematic, or would be rightly assessed as indicating a character flaw if observers did not instead understand these behaviors as symptoms or products of mental illness. We view a low-achieving student who has missed turning in the last two assignments as lazy and immature; then we learn that the student suffers from incapacitating depression, and we retract our earlier assessment of her character. We view a friend’s excessive spending as crassly materialistic, only to discover that it is an expression of bipolar mania. Another’s persistent and unwarranted suspicions would seem to indicate a moral failing until we discover that he is schizophrenic. In each case, moral judgment is undermined, replaced by a compassionate understanding.

Yet, as Peter Strawson has so famously argued in “Freedom and Resentment,” the switch from the moral attitude that holds a person responsible for how she acts, to a therapeutic or clinical attitude that excuses the person because of her diminished capacity for moral responsibility, also involves our coming to see the person as less of a person. There is something condescending about our very reluctance to hold someone morally accountable for her behavior. “She couldn’t help it” both excuses and diminishes the person. The excuse has a tendency to swallow up the person, so

Do we have any reason to privilege a person’s own self-representation? Our principle might be that each of us decides how to present ourselves to the world.

that the person is identified only through the lens of her illness; in the eyes of others, she becomes her illness. So while awareness that someone has a mental illness can serve the positive function of enabling others to be more compassionate and less harshly judgmental, it can also serve the negative function of excluding the person from full-fledged membership in the moral community.

Finally, the third relevant feature of mental illness is that that the affected individual often rejects the diagnosis, although others around her view her as mentally ill. This raises the question of how much weight to give to an individual’s own self-assessment versus the assessment of others. For bipolar mania, for example, one frequently given indicator of the disease is precisely “denial that anything is wrong.” People with paranoid schizophrenia likewise often do not view themselves as mentally ill, but view those around them as hostile and conspiratorial. A clinically depressed person may view herself as merely responding appropriately to the dismal condition of the world. Here first-person and third-person assessments come apart completely. If I make mention of such a person’s mental illness, I am attributing to her a condition that she, perhaps emphatically, denies.

I earlier considered the question of whether we are permitted to reveal information about someone that the other person prefers to keep private. There I suggested that one reason not to respect a preference for privacy is when that preference problematically contributes to the maintenance of oppressive stigmas. In the current case, the mentally ill person cannot be accused of being complicit in maintaining a climate of oppression, for he does not see himself as having the oppressively stigmatized condition in the first place. So that reason for challenging his preferred self-description does not apply. Instead the issue seems to be that he has a false or mistaken assessment of himself, while others have a true and accurate assessment. Is there any reason to protect a person in his mistaken self-identification?

Put another way, do we have any reason to privilege a person’s own self-representation? Our principle might be that each of us gets to decide how to present ourselves to the world, and others should respect that decision. There seems something right about this—consider our typical deference to persons’ self-reports of their own ethnic identity—but also something that is far too extreme. To use the clichéd example of the mentally ill person who thinks he is Napoleon, certainly the rest of us do not have to treat him as if he were Napoleon. But here it also doesn’t seem necessary for one of us to point out to the rest that the man is deluded: the rest of us are going to find this out for ourselves soon enough.

This leads me back to my opening contextualizing of the discussion: most of us share information about ourselves, and about our families and friends, with others all the time. I asked then if any special restrictions should be placed on the sharing of information about mental illness. At first I was drawn to the view that information about mental illness should be treated just as any other kind of information about any other kind of illness. Now that I have considered some of the special features of mental illness, I am less sure. It is vitally important to be able to share our stories with others, including stories that involve our loved ones. However, given the sensitive nature of information about mental illness, we may need to ask: why are we sharing this information? To what end? Because of the real implications for the person with mental illness, we need more weighty reasons than the mere encouragement to share our stories, or the benefits of stigma-reduction, to talk openly about the illness. Here, in closing, are some guidelines:
1. When talking to a person who is unlikely ever to meet or have any first-hand interaction with the person with mental illness, openness remains an important value. Here stigma reduction seems paramount, as there are only negligible countervailing factors. Every time someone speaks openly about his own mental illness, or the mental illness of his friends and family, the shroud of secrecy surrounding mental illness is to that small degree lifted. Some of this stigma reduction can be accomplished by discussing mental illness without giving any identifying features of the person being discussed. However, stigma reduction is greatest, I believe, when one does give mental illness a face, when it is my sister, or my husband, or my child, who is ill, not some nameless, faceless other.

2. When talking to others who know the ill individual, if their interactions with him are fairly few and casual, he should be allowed to present himself to them as he chooses. There is no compelling reason why it should be my project to go around challenging someone else’s self-representation, to be the dis-penser to the world of information about him. However, questions about his behavior, should they arise, should be answered honestly.

3. With intimates, such as close friends and immediate family, a number of factors need to be balanced: possible harm to these associates from the ill person’s behavior (physical risk, financial risk, emotional pain), harm to the ill person himself from his interactions with them because of their uninformed response to him (strained and broken relationships), the value of an increase in compassion for him versus the disvalue of a decrease in respect for him.

4. The hardest case, in my view, is when one parent has to decide how much to reveal to his children about his assessment of the other parent’s mental health. Here I think the most important consideration is the children’s psychological well-being, that they feel as safe and secure as possible given the instabilities in their family, and also that love and respect for all parties are preserved. Age-appropriate knowledge about mental illness can be beneficial. As the children get older, and are able to handle a more nuanced presentation of the situation, it seems respectful for the parent who is discussing the other person’s mental state to acknowledge the other parent’s different perspective. This helps to preserve the balance between love and respect. In the end, the most I can conclude is that there are no easy answers here. Tolstoy opened Anna Karenina with the famous claim that every unhappy family is unhappy in its own way. Every family and friend of someone struggling with mental illness may have to deal with how to share information about this struggle in his or her own way, as well.

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