

Tyler Burge, ‘Individualism and the mental’

Excerpts from Tyler Burge, ‘Individualism and the mental’, *Midwest Studies in Philosophy* 4:73-122 (1979).

Since Hegel’s *Phenomenology of Spirit*, a broad, inarticulate division of emphasis between the individual and his social environment has marked philosophical discussions of mind. On one hand, there is the traditional concern with the individual subject of mental states and events. In the elderly Cartesian tradition, the spotlight is on what exists or transpires ‘in’ the individual—his secret cogitations, his innate cognitive structures, his private perceptions and introspections, his grasping of ideas, concepts, or forms. More evidentially oriented movements, such as behaviorism and its liberalized progeny, have highlighted the individual’s publicly observable behavior—his input–output relations and the dispositions, states, or events that mediate them. But both Cartesian and behaviorist viewpoints tend to feature the individual subject. On the other hand, there is the Hegelian preoccupation with the role of social institutions in shaping the individual and the content of his thought. This tradition has dominated the Continent since Hegel. But it has found echoes in English-speaking philosophy during this century in the form of a concentration on language. Much philosophical work on language and mind has been in the interests of Cartesian or behaviorist viewpoints that I shall term ‘individualistic’. But many of Wittgenstein’s remarks about mental representation point up a social orientation that is discernible from his flirtations with behaviorism. And more recent work on the theory of reference has provided glimpses of the role of social cooperation in determining what an individual thinks.

In many respects, of course, these emphases within philosophy—individualistic and social—are compatible. To an extent, they may be regarded simply as different currents in the turbulent stream of ideas that has washed the intellectual landscape during the last hundred and some odd years. But the role of the social environment has received considerably less clear-headed philosophical attention (though perhaps not less philosophical attention) than the role of the states, occurrences, or acts in, on, or by the individual. Philosophical discussions of social factors have tended to be obscure, evocative, metaphorical, or platitudinous, or to be bent on establishing some large thesis about the course of history and the destiny of man. There remains much room for sharp delineation. I shall offer some

considerations that stress social factors in descriptions of an individual's mental phenomena. These considerations call into question individualistic presuppositions of several traditional and modern treatments of mind...

Burge's central thought experiment is developed in three steps. For the first step, he invites us to suppose:

A given person has a large number of attitudes commonly attributed with... 'arthritis'... For example, he thinks (correctly) that he has had arthritis for years, that his arthritis in his wrists and fingers is more painful than his arthritis in his ankles, that it is better to have arthritis than cancer of the liver, that stiffening joints is a symptom of arthritis, that certain sorts of aches are characteristic of arthritis, that there are various kinds of arthritis, and so forth. In short, he has a wide range of such attitudes. In addition to these unsurprising attitudes, he thinks falsely that he has developed arthritis in the thigh.

He elaborates:

Generally competent in English, rational, and intelligent, the patient reports to his doctor his fear that his arthritis has now lodged in his thigh. The doctor replies by telling him that this cannot be so, since arthritis is specifically an inflammation of joints. Any dictionary could have told him the same. The patient is surprised, but relinquishes his view and goes on to ask what might be wrong with his thigh.

The second step of the thought experiment requires us to imagine events playing out differently. We are to imagine a "counterfactual situation", an alternative way things might have gone.

We are to conceive of a situation in which the patient proceeds from birth through the same course of physical events that he actually does, right to and including the time at which he first reports his fear to his doctor. Precisely the same things (non-intentionally described) happen to him. He has the same physiological history, the same diseases, the same internal physical occurrences. He goes through the same motions, engages in the same behavior, has the same sensory intake (physiologically described). His dispositions to respond to stimuli are explained in physical theory as the effects of the same proximate causes. All of this extends to his interaction with linguistic expressions. He says and hears the same words (word forms) at the same times he actually does. He develops the disposition to assent to 'Arthritis can occur in the thigh' and 'I have arthritis in the thigh' as a result of

the same physically described proximate causes. Such dispositions might have arisen in a number of ways. But we can suppose that in both actual and counterfactual situations, he acquires the word 'arthritis' from casual conversation or reading, and never hearing anything to prejudice him for or against applying it in the way that he does, he applies the word to an ailment in his thigh (or to ailments in the limbs of others) which seems to produce pains or other symptoms roughly similar to the disease in his hands and ankles. In both actual and counterfactual cases, the disposition is never reinforced or extinguished up until the time when he expresses himself to his doctor. We further imagine that the patient's non-intentional, phenomenal experience is the same. He has the same pains, visual fields, images, and internal verbal rehearsals. The *counterfactuality* in the supposition touches only the patient's social environment. In actual fact, 'arthritis', as used in his community, does not apply to ailments outside joints. Indeed, it fails to do so by a standard, non-technical dictionary definition. But in our imagined case, physicians, lexicographers, and informed laymen apply 'arthritis' not only to arthritis but to various other rheumatoid ailments. The standard use of the term is to be conceived to encompass the patient's actual misuse. We could imagine either that arthritis was not singled out as a family of diseases, or that some other term besides 'arthritis' was applied, though not commonly by laymen, specifically to arthritis. We may also suppose that this difference and those necessarily associated with it are the only differences between the counterfactual situation and the actual one. (Other people besides the patient will, of course, behave differently.)...

The final step, Burge tells us, can be understood as “an interpretation of the counterfactual case, or an addition to it as so far described”.

[I]n the counterfactual situation, the patient lacks some—probably *all*—of the attitudes commonly attributed with content clauses containing 'arthritis' in oblique occurrence. He lacks the occurrent thoughts or beliefs that he has arthritis in the thigh, that he has had arthritis for years, that stiffening joints and various sorts of aches are symptoms of arthritis, that his father had arthritis, and so on.

We suppose that in the counterfactual case we cannot correctly ascribe any content clause containing an oblique occurrence of the term 'arthritis'. It is hard to see how the patient could have picked up the notion of arthritis. The word 'arthritis' in the counterfactual community does not mean *arthritis*. It does not apply only to inflammations of joints. We suppose that no other

word in the patient's repertoire means *arthritis*. 'Arthritis', in the counterfactual situation, differs both in dictionary definition and in extension from 'arthritis' as we use it. Our ascriptions of content clauses to the patient (and ascriptions within his community) would not constitute attributions of the same contents we actually attribute. For counterpart expressions in the content clauses that are actually and counterfactually ascribable are not even extensionally equivalent. However we describe the patient's attitudes in the counterfactual situation, it will not be with a term or phrase extensionally equivalent with 'arthritis'. So the patient's counterfactual attitude contents differ from his actual ones.

The upshot of these reflections is that the patient's mental contents differ, while his entire physical and non-intentional mental histories, considered in isolation from their social context, remain the same. (We could have supposed that he dropped dead at the time he first expressed his fear to the doctor.) The differences seem to stem from differences 'outside' the patient considered as an isolated physical organism, causal mechanism, or seat of consciousness. The difference in his mental contents is attributable to differences in his social environment. In sum, the patient's internal qualitative experiences, his physiological states and events, his behaviorally described stimuli and responses, his dispositions to behave, and whatever sequences of states (non-intentionally described) mediated his input and output—all these remain constant, while his attitude contents differ, even in the extensions of counterpart notions. As we observed at the outset, such differences are ordinarily taken to spell differences in mental states and events.