

Beyond Content: Why Process Matters

The mind has great facility with “content.” This may seem obvious and uninteresting, but I wish to draw out what this means, by contrasting it with the aspect of the mind which I will refer to as “process.” In this aspect, the mind is happening - unlike the static concept that we operate with when we conceptualize it. (For starters, we can categorize the brain as content.) And my claim is that healing, when it comes to mental health, is also a process.

It is common to be overly focused on content, for modern Westerners¹. I will illustrate how, in the context of the institution of psychiatry, this content focus narrows the horizons of possibility for the attainment of true mental health, in patients and in psychiatrists alike. In doing so, I will try to show how the treatment of mental illness can be distinguished from, and contextualized within, the greater process of moving towards mental health.

By content, I mean the privileging of that which can be rendered explicitly in our consciousness; ordinary things, like objects or bits of information or thoughts or mental images. Similarly, some concepts are held in the mind easily, like the concept of linear, mechanical causation, or the materialist conception of inert matter. Take, for example, that it is easy to imagine a literal hammer, hitting a nail. (In fact, it may be hard *not* to picture it, when the reader reads these words.) These sorts of things appear almost palpable to us, and they tend to be more easily grasped over things that “aren’t things.” Consider, as examples, meaning, unity, wholism, or beauty. (These concepts are hard to picture even with concentrated effort.) These concepts are implicit; in other words, they are literally indescribable; or, they always transcend whatever category we might try to place them into. We can grapple with them, we can appreciate or reflect upon them, but we can never measure or control them. Hope itself cannot be put in a bottle and sold.

A good argument can be made for a focus on content for health scientists. Content is the kind of stuff that can be translated into knowledge, which can be put to use. So in psychiatry, treatment plans often include the recommendation for the prescription of certain named medications, which are explicitly written on paper (or in an electronic medical record system, these days) as a prescription. Psychiatric medications are understood to be things that operate through cause and effect; they are physical chemicals which are absorbed after swallowing, which then cross from the bloodstream into the brain, causing alterations to some aspects of its structure and function, at the level of individual brain cells called neurons. In many cases, medications are necessary and helpful, most obviously so in the cases of severe depression, bipolar disorder, and schizophrenia. That’s the undeniable usefulness of content.

The usefulness of content seems to justify its dissemination. Over the course of my relatively brief career thus far, I have already seen an increase of emphasis and reliance upon medication guidelines, which offer objectivity to the rational clinician, in the form of a set of “evidence-based” choices in treating their patients. In psychiatry, guidelines

are developed by international teams of scientists who have objectively conducted psychiatric research by statistically analyzing reams of population-level, externally measurable aspects of the mind, which are quantified and thus converted into data. In order to implement these guidelines, the doctor must consider the patient, who is sitting in front of them in their office (or, on their video conference call, these days), to be essentially fit into the category of patients from whom the data has been objectively extracted. When individualized - which means interpreted with sensitivity and with careful attention to the individual patient in the doctor's office - this objectivity can help a lot of people, because it facilitates the conveyance of powerful treatments to multitudes of mentally ill individuals.

This approach is incentivized in a number of ways. I have already pointed out that it is considered to be an intellectually rigorous approach, therefore it has credibility. Secondly, it is satisfying. A psychiatrist is someone who has been oriented to navigate in the complex landscape of the psyche, and their maps are constituted by population level data and the resultant guidelines as I described above. Using these these maps and other tools, a psychiatrist is empowered to determine the trajectory for illness-alleviating treatments, which they expertly recommend after conducting an assessment. They produce a report which is seen by the family physician who is looking after the regular care of the patient in question, who then looks under the heading "treatment recommendations" for the report's most high-impact content, and they are generally thankful for the expert guidance in these complex cases. The psychiatrist feel valued and they feel they are helping. And they are.

Thirdly, it literally pays. Bottom line; more consultations, more money. The psychiatrist who looks to maximize the number of consultations they can conduct is liable to see the patient through the lens of utility. But utility proceeds best through the simplification of reality; complexity only serves to confuse when rapid action is needed (in other words, a map is useful precisely *because* it is a simplified version of reality). When taken to an extreme, the relationship that emerges is one based on control and manipulation, and ultimately efficiency, which factors out the complexity and uniqueness of the patient as much as possible. Similarly, grants in psychiatric science tend to go to those who have a track record for getting *results*. So, content breeds knowledge, usefulness, credibility, satisfaction, and income.

But, a great irony takes place. This objective manner of conducting business, if taken too far, becomes one in which a certain insidious type of invalidation and stigma is perpetrated by the very group that is charged with caring for the mentally ill. What I mean by invalidation in this case is that the experience of the patient is not valued beyond its utility in implementing an outcome, and this has certain impoverishing effects on the patient, which I will explain below. Nonetheless, on the surface, this manner of conducting business may still conform to standards of practice, and the guidelines still usher in the appropriate treatment, and this whole enterprise is evidence-based. In fact, this disengaged stance fits appropriately in with how our entire modern society is more and more content-focussed. This is what I mean by insidious.

Up until this point, I have been drawing out elements that include attitude, feelings, and assumptions that the psychiatrist brings to the table (another word for this might be countertransference, in the broad sense of the term), when they are overly content-focussed. A few points of clarification are in order. Please note that all medical specialties, or anybody anywhere, for that matter, can be overly content-focussed in the manner I have been describing; this countertransference is by no means unique to psychiatrists, and it by no means applies to all psychiatrists. Neither do I wish to imply that psychiatric science should be replaced by something else, for it has many positive elements, and I am not so grandiose to claim that I have a better alternative. Finally, I will stop short of defining where the threshold lies between being content focussed to a “benign” - minimal and inevitable - degree, and what I have been calling “overly content-focussed.” I leave that as an open question.

From the patient’s perspective, there may be a particular experience associated with this countertransference. After a one-hour encounter, they are given a prescription, but in their memory, they may recall receiving little else. Subsequently, they may find that being on said psychiatric medication profoundly alters their relationship with the world, and they may feel that they are offered unsatisfactory follow-up to emotionally process what this means and how to understand their new experiences. These concerns and questions may get completely sidelined by the busy psychiatrist who is incentivized to expediently determine the trajectory of the treatment plan and move on to the next one-time consultation.

The objectivity of the psychiatrist can be experienced as “disengaged.” As such, the patient’s lived experience becomes data, summarized in a report under a subheading “history of illness.” Their experience in the room, during the course of the assessment itself, is often smoothed out by some degree of professionalism on the part of the psychiatrist (however, warmth and empathy, in this scenario, might be experienced by the patient as a strategy used to collect their data most efficiently). They may have little sense of participation, other than their playing a predefined role in a play whose script has already been written. They feel “done-to,” and they may feel resentment due to the helplessness associated with this. (This can all contribute to the complex global challenge in psychiatry with medication non-adherence in patients.)

So, we have an active “doer,” and we have a passive “done-to.” Perhaps this type of interaction helps in alleviating mental illness some cases, but what about the promotion of mental health? What about spiritual health? What about participation and presence? Meaning? Without attention paid to these implicit qualities, I would claim that there is a subtle moral impoverishment which gnaws at the root, tainting the entire enterprise.

Re-focussing on process can help. Deemphasizing utility and “just being present.” Why? *Not* because a process-orientation can be harnessed to direct a causative effect on theoretically homogenous members of a given category, linearly moving them towards precisely defined outcomes. No, not because it can be controlled. But precisely because the process-orientation involves a *release* of control, and thus the fullness of experience can manifest.

The participants can feel free to just *be*; to be existential loci of subjective experience, enlivened with autonomy and agency. And an experience of this sort can be more profoundly transformative than an externally-affixed label. This recontextualization, which is exclusively available through the process-orientation, opens one to sources of meaning that are simply not accessible from a content-focussed perspective, for example, an embodied sense that your perspective “really matters,” or a sense of coherence and significance. To clarify what I am gesturing towards, I’ll put it another way; participation in healing is ultimately more valuable than the physical piece of paper itself, with even the appropriate medication name written explicitly on it.

But, the content-focussed critic may scoff, being present seems useless (“just” being present). Mere presence might be regarded as weakness or passivity in the pejorative sense. “Being together” seems too intimate, too boundary-crossing, and as such, it offends the sensibility of medical professionalism. Furthermore, it seems risky; your sense of security is threatened; now you’ve got skin in the game.

Finally, this realm of presence seems incomprehensible, uncontrollable, irrelevant to our instrumental aims. And indeed it is all three of these things. Take, for instance, how the implicit does not lend itself to crisp articulation through language (by definition, as I stated above). Instead, my written phrases “gesture” towards what I mean, indicating to the reader a jumping off point, from which a leap might be taken. This is rather like how a metaphor is understood, or how an insight is gained (the “a-ha” moment), or how one “gets a joke.” What I am hoping to do is engender a state of mind in the reader, using my statements, but that particular state of mind is difficult to define. What I am hoping to engender has more to do with a wider recontextualization, an expansion of one’s paradigm, or a shifting of one’s view of reality. This is rather more ambitious - and diffuse, admittedly - than giving the reader a new “bit of knowledge” to acquire.

Most importantly, there is the relational moral dimension. Ultimately it is this kind of morality which places a demand on us as existential beings in a modern world, that we distinguish between content and process, and that we balance the two in an ongoing, moment-to-moment way. This is what consciousness is for. This balancing is a task that is never “complete,” rather, we are called to engage in it in a continuous manner. That is what I meant, above, when I claimed that the mind is a process.

So, if we as mental health clinicians prioritize being-with, then doing-to becomes a subsidiary tool, and “providing care” becomes actually caring. Then we participate in a deeply healing human experience, and we can feel gratitude that we have the privilege to witness a patient’s willingness to take a risk, to behold their willingness to make themselves vulnerable. And maybe we are vulnerable with them too. Now we are living in a moral world. Hope becomes possible.

People who walk through my doors often have a sense of what they need in order to heal, and I strive to pick up on cues that indicate this. Whenever possible, I strive to include these patients as collaborators in their own treatment. In the following short

story, I illustrate how Veronika intuitively knew that she needed a caring presence to be with her as she told her story, and how it was my process-orientation which revealed to me the opportunity to help make this happen for her.

And healing, when it comes from a participatory shared experience, is not adequately described as a change in the structure and function of neurons. It's not merely content. It becomes a deeply mysterious process, resonating between two bodies. It is not only being done-to. More deeply, it is that *and* it is something that transcends that; it is a beautiful and inspiring - even transformative - shared experience.

I booked Veronika for an assessment. But I goofed; I wrote our appointment time in my schedule on a particular day, and I told Veronika to come on the following day. So, from my perspective, I looked out into the empty waiting room and I thought that she was a "no-show." I was somewhat irritated.

My colleague Rachel, who works down the hall from me, coordinated the referral, which was sent by a family doctor, officially requesting a one-time psychiatric consultation. We have a nice system going, Rachel and I; Rachel's clients are told to get their family docs to send me referrals, and when I see them I am able to bill the government for the service - which benefits me, obviously - and I feel able to enhance Rachel's work with her clients - which benefits them, too. But best of all, I feel able to go deep and do good work with clients if I know they are in her capable hands. I can afford to be a bit more bold, and a bit more "experiential" in my assessments. (I probably tend to more closely match the description of the mainstream psychiatrist in those cases where the patient is not in therapy at all.)

Shaking off the irritation, I thought to myself, 'no matter.' I have piles of perennial paperwork which I would take the opportunity to catch up on.

But the next day, there was a young woman, in the waiting room. She was wearing a mask as per our clinic COVID-19 policy, and her steel-blue eyes met mine as I crossed the waiting room perpendicularly to her, and approached another patient. By that time, Veronica had been waiting for an hour. Her eyes seemed slightly moist. It dawned on me that I must have goofed, and I hesitated between the two patients, awkwardly attempting to apologize to Veronika. She murmured an impatient syllable as she stiffly exited the premises.

The following week, when we tried again, I thought to myself, 'this could go either way.' I thought, if she came in angry, her anger would be justified; I was preparing myself for whatever might come, by reminding myself about my core strategy for managing the anger of others - basically I say "yes, I know I did that, and tell me how it affected you, and tell me more, and tell me even more, ...etc." I try to not avoid or dismiss my contribution to the situation - otherwise I may come across as arrogant or insensitive.

But, starting on this foot would set me and my agenda at a disadvantage; it would be more difficult to hold an objective perspective and play the role as the psychiatric consultant, which stereotypically is to elicit data (primarily criteria of DSM 5 psychiatric diagnoses), and synthesize it into a treatment plan, which is then formally written up in a report and sent to the consulting family doctor.

‘Well,’ I thought, ‘here goes nothing.’”

As she sat down on the couch with her mask on, I searched what portions of her face were visible. I saw only her eyes, which were dry today. But there was something in them that I found disconcerting; a certain lifelessness. And there she sat, tightly wound, somewhat contorted, even, with her arms and legs stiffly crossed. I could see the whites of her knuckles. I checked in about last week and I took ownership of my goof up, and she more or less waved it off. I could hear flatness in her voice, but I was vaguely reassured.

I started listening as she told me that she lives with her maternal grandmother who, she believes, hates her. She said she has ruminative obsessions with “the past, my flaws, and my problems.” I could not help but notice the congruence between her flat demeanour and her defeated outlook.

I learned that she had been tried on three different antidepressants, but none of them seemed to have made a difference. What did seem to make a difference, however, was starting to develop a trusting relationship with Rachel, who she had been talking to weekly for about a year, as well as recent life choices she made.

I learned about her upbringing. She grew up in a household where perfection was expected, and personal needs were to be suppressed. Her mother was ineffectual. Her father was a bully, determined to control the children. A big burly man who worked in construction, he would stalk around the house in a physically intimidating matter. She learned to shrink away from his physical presence.

He wanted the children to conquer their emotions because emotions were seen as weakness. When he would yell at them, he would stare them down, and he would force them to stare back. Apparently he thought he could teach his children to control themselves in this manner. He was right, but not in the way he thought; over the years she learned that if she popped her ears while he was yelling at her, she could ‘turn down the volume’ and escape inwardly, all the while appearing to give him what he wanted, ie emotionless unblinking eye contact. He would guilt her into keeping all this inside. She never told anyone for the longest time.

In her parents’ backyard there was a big pond. She would go out in the summer and she would swim, drink alcohol and smoke marijuana. All that she yearned to do was escape, outwardly as well as inwardly.

Her speech was precise and devoid of emotion, but she spoke eloquently, and at length. As she talked, I was empathically engaged. I was “in her shoes,” and from her vantage point, I could feel the allure of freedom, and the intoxicating escape from the numb horror of her daily life. In fact, as time went on in our assessment, I became less and less on guard, and I could empathize more and more. And perhaps it was the fact that my expectation of her anger was violated that caused me to be catapulted into an unusually connected state of mind in this patient encounter. It was a very interesting experience for me.

I heard that more recently, her father’s behaviour had become more and more unbearable. And she had a terrible experience at the beginning of the summer. She had gotten a ride home from a party by a guy who she did not know well. She was “black out” drunk and he had sex with her in the car in the front driveway. Her father’s only response to this was to tease her about it. If someone was looking for Veronika, he would say “maybe she’s in a car in the driveway.”

On and on she went. Apparently, talking was her healing impulse. But I am not paid by the government to just be a listener. Not to be taken over by her story-telling, I threw in my 10 cents, pointing out, “your father is a real piece of work.” She hardly seem to acknowledge me. She pressed on.

On and on. Feeling fed up, she and her mother decided to get away. They moved out into her maternal grandmother’s house. But when he claimed that he “found Jesus” and he promised that he had changed, sure enough, her mother moved back in with him. Her mother was caught in his trap, but Veronika refused to be caught. In fact, she decided to cut him out of her life. She was becoming more animated and more relaxed as she went.

This had just happened 6 weeks prior to our appointment. ‘Well,’ I thought to myself, ‘I could interrupt more, but she is doing a good job of catching me up to the present day.’ Her flatness was starting to be enlivened by emotionality as she continued talking. I recalled guidance I received from my psychodynamically-leaning supervisors to “go where the affect is” in therapy. (‘Affect’ represents the external indicators of internal feeling. In other words, don’t let the patient just talk about what they want, you should redirect them back towards topics which are associated with the arising emotional experiences in the therapy hour.) This helped me realize that she was probably doing what needed to be done.

And I was compelled; I felt a bit of a thrill, empathizing with her. I identified with aspects of her story. Also, the timing was opportune. What a privilege for me to have the opportunity to work with this person in this exciting new phase of her life. I felt the weight and responsibility to use my power in this brief interaction to really benefit her.

Another factor, I think, is that I liked her. I appreciated her ability think complexly. And I was heartened by her level of insight; she was aware that her father had defined her horizons since her first days, and how he had set in motion her tendency towards

paranoia in relationships. She did not know any better, but she had a sense something was wrong. Perhaps she knew the words “mutuality, comfort, and trust,” but her actual relationships never embodied these qualities. Most heartbreakingly for me, I think, was that I could see her compassionate recognition that he had his own horrific trauma, and that he was trying to work it out - ineffectually and with harmful consequences - on his family. But, all compassion aside, she regretted that he did not work it out in his own therapy, because she and the rest of the family had to bear the brunt of it.

So, basically, I felt that she was doing the right stuff, and I wanted to encourage her because she had a difficult journey ahead of her to heal properly.

Meanwhile, my office clock kept ticking. I started sensing that I will not cover the check boxes that I am trained to check off, so I sought a way to disrupt her story-telling and get to my agenda. I interrupted her and pointed out, “if I may say, you appear to not be showing much emotion in your eyes, and your voice is rather flat and monotonous. You are talking about all these intense parts of your life with deep feeling under the surface, I think, but the emotions you show - or lack thereof - seems to not quite fit...just an observation. Has anyone given you that feedback before?” It was a process comment, and I was hoping to pivot from that to get around to my assessment.

She acknowledged that indeed people have, and it’s because “I don’t know how to feel. I’ve been needing to tell the same story several times, before ‘something’ starts to happen.” This point marked the limit of her eloquence, however.

Something “good,” I think she meant to say. I speculated, “perhaps you also get to see the reactions of your listener, and maybe it gives you a template for how you yourself might react?... For example, I called your father ‘a piece of work’ a few minutes ago, and how did that make you feel?”

She responded, “oh, I know he’s more than a piece of work - actually he’s been an asshole for so many years,” and she started tearing up. She seemed to gain strength, and grow in stature.

This was turning out to be more therapy than assessment. Why did she speak so determinedly and persistently during our time together? My direct experience with her presented me with evidence that she felt better when her story was heard. I suspected that what she was doing was externalizing what had been heretofore implicit. She was digging up her life so that she can pull out the roots of the weeds and the gnarled trees, and replant a new self in the hope that something better will grow. She needed to feel real by being in the presence of caring listeners; this made her feel connected, and alive - and these are crucial feelings, the emotional equivalent to oxygen.

I faced a decision point, because she wasn’t going to stop talking, really. I could have grabbed the steering wheel and asked for more details about her sleep or about her overly controlled eating, but my intuition told me that the way I could do her the best

service was to stay in the moment with her. And I allowed her intuition to guide us as to what was important.

To be fair, we covered the basics of safety issues, drug use, and we did discuss some medications that might be helpful. For what it is worth, we read out the criteria for complex-PTSD together, which is not an accepted diagnostic category in DSM 5, for interesting reasons. Many of the criteria resonated with her, but certainly not all.

Noticed her choking back tears, I told her, “just so you know, you can cry here - I would not be upset, or anything, if you cry.” I tried to have her see that she has permission, she can feel her feelings, express them, and make them known to others, and not believe that she is burdening people. It’s not burdensome to be real with others, in fact, it is life-giving. I tried to explain that she does not have to believe that her grandmother hates her just because she has needs. I told her that she can rely on friends, because that’s what friends are.

For all intents and purposes, she burst into tears at this point. She said, “it’s so strange, I’ve heard forever that’s what friends are, but the way that I’ve lived is that friends are people who can just drop you as soon as you do anything wrong... I’ve been so cautious not to do anything wrong.”

But, our time was almost out. I wanted to summarize the diagnosis and treatment plan for her, as I strive to do transparently for all patients at the end of our consultation time. It was not a standard psychiatric interview, and I accepted that. Instead of a precise mechanical analogy (“you bring your car to the mechanic, they diagnose that your carburetor is shot, and they offer a solution of changing your carburetor”), I told her that we were going to deemphasize the diagnosis and simply focus on what she obviously needs in her life; real feeling and secure relationships.

She asked, “but - I can’t feel, what am I supposed to do? How am I supposed to feel?” She seemed desperate. It’s like she was saying “I’ve opened myself up here, now what do I do with this?” I was proud of her, touched that she was willing to show a level of self-prioritization that I imagined would be difficult for her. Perhaps she was getting anxious at the end of the hour - a moment that therapists know well - and apparently she judged me as safe enough, so her “doorknob comment” was to ask to have her needs met.

I felt I did not want to let her down after this risk she took. I could have written a medication name on a piece of paper and called it a day. But that would have subverted everything we had talked about prior to that moment.

I thought fast. I had to rely on my intuition and on my own embodied experience to respond to her, not on anything I learned in my psychiatric training explicitly. She didn’t need a prescription or a reading reference, she needed a human connection in that moment. I felt some anxiety myself; could I give her what she needs? But in a deep sense, what she needed was right in front of us.

With haltering confidence I said, "Tell me, something seems different about you now, compared to when when you first walked in - how do you feel right now?"

She paused for a moment and looked away, and she was able to respond, "well, I feel...better."

I felt a bit better myself, hearing that. So, I leaned forward in my chair and, gathering more confidence, I pointed at her with a sharp right index, and with narrowing eyes I said, "yes, but...how do you *know* that?"

"Well I guess I feel a bit of a sense of relief..." I waved my hand gently, indicating that I wanted more.

She moved her hand also, up along her midline, and said, "Maybe now there's a bit of lightness in my chest?" liltng her voice at the end of her sentence, as if it were a question. She was imploring, asking for something?

We were cooking with gas now. I said, "Ok, that's good! And if you ask me, that feeling is something you can trust: it's real. See?" She was listening with rapt attention.

I shifted my position in my chair, and tilted my head slightly back - "But, now - please tell me something else...what's the experience you're having on the... bottom of your left foot?"

She paused again, slightly longer this time. Cocking her head, she said, "well, yeah - I mean, I can obviously feel the bottom of my left foot," she responded somewhat awkwardly, but with a dawning understanding that, prior to that moment, she had not been aware of any feeling there at all.

My punch line: "So you see, feeling is simply available to you, and that's the mystery of the mind, isn't it? The miracle of consciousness is that, simply by intending to, you can direct your attention and bring things into the light of consciousness. They were unconscious, dissociated, but now you are aware of them." She was wide-eyed with wonder. "There you go; you can learn to start feeling more, you can practice it, simply by doing it, on purpose. And this is something you can start to work with more, perhaps with Rachel in your ongoing counselling, and maybe you can let it play out in safe and secure relationships, and like everything, your mastery will develop over time - just practice it."

She was now crying tears of joy. "I can't believe it, this is way better than getting a diagnosis or having medications prescribed - *you've given me hope!*" She looked out into me deeply for a powerful moment, a connecting link drawn from her eyes, behind her mask, into my eyes, behind mine. Suddenly I was close to tears, and I was surprised by the intensity and beauty and freshness of this human connection. Our "assessment" was completed. And reality was shifted, if ever so slightly.

Notably, I have no scientific data to confirm that what I did was efficacious, and I cannot use the authority of a nationally approved set of guidelines to objectively claim the correctness of how I related to this individual. Rather, it was my embodied implicit knowing, my socialized common sense, and my learnings from a tradition of wise therapist healers, that had me select a positive therapeutic interaction as a priority over a psychiatric intervention. Healing, here, was not some population-level data-driven justification of the implementation of treatment guidelines; the “provision of care” as the terminology goes. This was actually caring. And it was not primarily through the power of authority, and the cold detachment of the white coat. It was by means of them, and by moving beyond them, that she and I were able to be-with each other as the priority, and together we witnessed the wave of hope and aliveness upon which she was carried out my office door.

Notes:

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I have drawn upon several authors in developing my thinking around the distinction between “process” and “content,” notably the following:

John Vervaeke is a University of Toronto-Based cognitive scientist who studies consciousness. He believes that a crisis of meaning which is taking hold of the modern West. In his youtube videos, in particular a 50 hour series entitled “Awakening from the Meaning Crisis,” he lectures eloquently about the axial age, which saw the emergence of 2-world religious understandings arise around the world independently in a similar time frame (for example, Confucianism and Buddhism in the East). In the West, there was Socrates, or Plato with his notion of the Forms. Of course, Christianity, which has further shaped the consciousness of the modern West, entrenched Platonism into Western thought. Vervaeke flags Cartesian dualism as a major problem (because it thwarts the development of a unified psychological theory, and it contributes to the meaning crisis) which arises downstream from a 2-world understanding. To address this, he looks closely at phenomenological aspects of consciousness, and he has been exploring “adjectival qualia” (for example, the redness of an apple), which maps well onto my notion of “content-focus,” versus “adverbial qualia” (for example, consider “demonstrative indexicality”, ie, the intuition of the “hereness” and “nowness” of the apple), which maps well onto my notion of “process-orientation.”

Charles Taylor, Canadian philosopher, has described a societal shift in what he calls the social imaginary, in his book “A Secular Age.” By social imaginary, he is referring to the social conditions for belief, specifically with an eye towards faith-based beliefs. He denies the validity of the “subtraction hypothesis,” which states that removing God from our lives was an inevitable and logical conclusion, an achievement, which we were inexorably “progressing” towards throughout the development of civilization. He points out that the result of secularization has not been a homogenous and relentless reduction in belief in God across the board. Rather, with the rise of the modern culture of authenticity, there have been an incredible number of variants of spirituality, with counter movements (for example, we see the rise of atheism, as well as the rise of religious fundamentalism), and counter-reactions to those, etc, leading to a what he calls the “supernova effect.” Basically, there been an explosion in the variants of belief and unbelief, with all shades in between, and we can see that the two orientations can operate simultaneously and dynamically in a single individual’s life. He further states that there is a “ratcheting effect,” in that once society has progressed past a certain threshold in the social imaginary, it is impossible to return society to a previous set of conditions for belief the way it operated in an earlier iteration of the society. I am aided by Taylors broad notion of unbelief (which he calls the “immanent frame”) to develop my thinking around “content-focus” and similarly, his broad notion of belief (which he calls the “transcendent frame”) aids me in clarifying my thinking around “process-orientation.”

Iain McGilchrist, Scottish psychiatrist and English scholar, explicates his clarifying theory, which deals with the distinction between the 2 types of consciousness mediated by the right hemisphere of the brain versus the left, in his book "The Master and His Emissary." The hemispheres are differentiated but evolution appears to have utilized differentiation in this case for the sake of the greater unity consisting of the individual (in fact, all multicellular organisms with even primitive nervous systems exemplify important differences between their left and right sides). He tracks the shift of a balanced state between the two hemispheres in historical cultures, and shows how multiple times in history this balance has tended to shift to a preponderance of left hemispheric consciousness (this can be shown to be the case at the end of the Golden Age in Greece, and in the downfall of the Roman Empire). Modern society, now, is demonstrating features of a collective shift to the left hemisphere preferentially over the right, and this is reinforced by the construction of a particularly modern urban/technological environment, social structure, and economic structure that renders left-brain consciousness as congruent with our surroundings and lifestyle. This makes right brain consciousness difficult to take seriously for moderns; it is an easily disavowed part of the lived experience. He would also say that this represents a ratcheting effect. Related, he would say that we are collectively operating as if we have right brain deficits in modern society (he points out 3 measurable signs of this in school-age children, being the measurable decrease in the capacity for sustained, vigilant attention, decreased facility with facial expression and recognition, and decreased empathy, all of which are primarily right brain capacities). I map left brain mediated consciousness to "content-focus" and that of the right brain to "process-orientation."



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