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The False Binary Between Biology and Behavior

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THE FALSE BINARY BETWEEN BIOLOGY AND BEHAVIOR

AWAIS AFTAB



PPP CONTINUING COMMENTARY

This article comments on the following previously published article: Moncrieff, J., “It Was the Brain Tumor That Done It!” Szasz and Wittgenstein on the Importance of Distinguishing Disease from Behavior and Implications for the Nature of Mental Disorder. *Philosophy, Psychiatry, & Psychology*, 27 (2), 169–181.

JOANNA MONCRIEFF’S PHILOSOPHICAL views on the nature of mental illness (Moncrieff, 2020) represent in many ways the enduring legacy of Thomas Szasz in philosophy of psychiatry. She articulates a defense of Szaszian thinking about disease, with connections to Wittgenstein’s philosophy, that is probably as compelling a defense as a contemporary student of philosophy is likely to find. However, Moncrieff’s eloquent arguments contain significant conceptual problems, and I will try to explain some major points of contention in this commentary.

Moncrieff, following Szasz, categorizes behaviors as either resulting from a bodily process or as self-directed behavior. In my view this distinction is a typical example of a false binary (or the logical fallacy of the excluded middle). False binaries distill a complex set of options into two mutually exclusive options. Neurological processes

and intentional, self-directed behaviors are not mutually exclusive (Bolton & Hill, 2004). There is a complex relationship between behaviors and underlying biological processes (which can include diseases). Furthermore, many psychological states and psychiatric conditions cannot adequately be described using the terms “self-directed” or “behavior.” States of mood and perceptual experiences of auditory hallucinations are strictly speaking neither “behavior” nor “self-directed”. This mischaracterization of complex psychological states and psychiatric conditions as “self-directed behaviors” creates a lot of confusion and helps nudge Moncrieff to arrive at invalid conclusions.

According to Moncrieff, Wittgenstein’s philosophy illustrates that the ‘mental’ cannot be equated with the biological since mental attributes are inherently entwined with public behavior. I agree that mental cannot be *equated with* the biological, however, that nonetheless leaves open a myriad of ways in which the biological *relates to* the mental. Consider sexual desire. Sexual desire is conscious, psychologically meaningful, and it is usually, if not always, directed at an object. While sexual desire is “mental,” it is influenced by biological factors such as the production of various hormones. Sexual desire cannot be “equated with” hormonal signaling, but hormonal signaling plays an important role, and changes in hormonal signaling underlie as well as influence the experience of sexual desire.

We do not choose to experience sexual desire; we can exert some control over it, but it is not entirely under our control, and we have little control over the object of our desires.

Moncrieff sees mental disorders as aspects of character and self-directed behaviors, but she acknowledges that they are not always rational or fully controllable, and for that reason they may not necessarily be accompanied by moral responsibility. Stating that self-directed behaviors are not always fully controllable and may not be associated with moral responsibility seems to me to be a self-defeating effort considering that one of the reasons Moncrieff is against viewing mental disorders as diseases is because it contradicts the sense of agency. It is also odd that Moncrieff allows “aspects of character” to be have a complex relationship with agency, yet she denies the same complex relationship to behaviors caused by disease processes such as brain tumors. I would argue that the relationship between behaviors and brain tumors can be just as complex.

Moncrieff uses the examples of epileptic fits, blinking, and brain tumor causing pedophilic behavior to argue that biological causation trumps other explanations of behavior. It is a mistake to lump epileptic fits with complex behavior such as pedophilia arising in the context of a brain tumor. An epileptic fit by-passes the conscious decision-making processes of our mind-brain. Neurological reflexes such as blinking also involve no conscious decision-making. Pedophilic behavior, however, is much more complicated because it does involve conscious awareness and decision-making.

What does it mean for complex human behavior—characterized by awareness, intention, and conscious decision—to be caused by a brain tumor? How exactly does a brain tumor result in pedophilic behavior? It doesn't cause it in the same manner as a neurological reflex. It doesn't turn the person into an automaton. Instead, the tumor—due to the involvement of relevant biological processes—influences the desires experienced by the person: the object of sexual desire may shift, the severity of sexual desire may increase, and the influence of conscious ability to inhibit and suppress urges may be lowered. Some individuals may by default have functional configurations

of neurological mechanisms that lead sexual desire to be focused on pre-pubescent children. From Moncrieff's perspective, this is simply “an ordinary criminal case of pedophilia.” From her perspective, people with pedophilic desire demonstrate “self-directed behavior” and as having a certain sort of “character,” and should be liable to moral judgment, but if the pedophilic desires are a result of a brain tumor, then this “ceases to have the characteristics of ordinary behavior and can sensibly be described as ‘symptoms’ of a disease.” The picture that emerges from a neuroscientific understanding of human behavior is a different one, where—with or without disease processes—our desires and our inhibitions are generated and modulated in part by neurological mechanisms.

Individuals with “pedophilic disorder” have recurrent, intense sexually arousing fantasies or sexual urges involving sexual activity with a pre-pubescent child on a sustained, possibly life-long basis. Like everyone else, they do not choose the object of their sexual desire. Often, they find it distressing, horrifying and repulsive. What is the difference between pedophilic disorder and pedophilic sexual urges in the context of a brain tumor? The main difference is that the causal explanatory power for the presence for pedophilic urges in the case of a brain tumor is concentrated in the focal process of a brain tumor while the causal explanatory power for pedophilic disorder is more diffuse, and spread out over genetic, hormonal, neurobiological, and psychological factors. The focal concentration of explanatory power in the case of a brain tumor makes it possible to address it more effectively (for instance, with surgery), while the diffuse nature of causality of pedophilic disorder makes effective intervention more difficult. Both of them, however, have a complex relationship with agency and moral responsibility.

From a scientific perspective which assumes physical determinism, “autonomous behavior” is considered autonomous not because it is the result of some metaphysical free will, but rather because the behavior springs from an individual's intentions, thoughts, desires, and conscious decisions (Dennett, 2015). However, these intentions, thoughts, desires, and decisions themselves do not arise in the mind-brain *ex nihilo*. They arise from

the apparatus of the mind-brain and they are subject to a variety of biological influences. Whether these influences should be considered a “cause” can devolve into a semantic argument depending on how “cause” is defined, but these influences on autonomous behavior are a scientific reality.

Moncrieff emphasizes that “philosophers who take an ‘anti-positivist’ position have long suggested that it is important to distinguish how we understand the material world, which includes autonomous biological processes like diseases, from our understanding of human behavior.” However, there are also philosophers such as Karl Jaspers (Ghaemi, 2007) who have argued that ‘understanding’ (meaningful and comprehensible connections that are inherent in one’s personality and biography) and ‘causal explanation’ (causal connections that are mainly rooted in biology or other forms of mechanistic explanations) are not mutually exclusive, but rather both perspectives can be applied to our psychological lives and that they are complementary and necessary when it comes to psychiatric conditions, generating a need for pluralism of perspectives.

To appreciate the curious contradictions in Moncrieff’s worldview, consider her treatment of pain. She cites Wittgenstein’s famous example of how we learn to use the term ‘pain’ to describe our own experiences through learning how the term is applied to situations in which *other people* are said to be in pain. “The first person and third person use are indissolubly linked.” Despite quoting this example from Wittgenstein, Moncrieff’s view of pain subsequently in the article seems to be very different; instead of a mental state with all the complexity of first-person-third-person-indissoluble-link, pain suddenly becomes a physical sensation and a physiological state that lacks meaning. (She writes: “In other words, unlike physical sensations or physiological states, such as hunger or pain, emotions and moods, like thoughts and behavior, are usually meaningful.”) This arbitrary decision to cut off pain from the mental life is made without any philosophical justification. If pain can

be understood as both a complex meaning-laden mental state and a physiological state, then there are no reasons why other mental phenomena such as emotions cannot be.

Moncrieff’s views are tempting when one is confronted with the portrayal of mental disorders exclusively as “brain diseases,” especially when the notion implies simplistic, single causes such as neurotransmitter deficiency or excess. However, one can be skeptical about explanations that reduce psychiatric disorders to biological abnormalities, and nonetheless maintain the view that psychiatric disorders have complex causation across multiple levels, and this requires us to adopt a plurality of perspectives for a proper understanding (Ghaemi, 2004; Kendler, 2012). Moncrieff’s efforts to ‘reduce’ mental disorders to self-directed behaviors or aspects of character are as philosophically mistaken as the efforts at neurobiological reduction.

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