Enactivism, Causality, and Therapy

Shaun Gallagher

Philosophy, Psychiatry, & Psychology, Volume 27, Number 1, March 2020, pp. 27-28 (Article)

Published by Johns Hopkins University Press
DOI: *https://doi.org/10.1353/ppp.2020.0002*

Enactivism, Causality, and Therapy

Shaun Gallagher

In 1937, John Dewey delivered a lecture to the College of Physicians in Saint Louis. His clear message was that in the practice of medicine it does not suffice for physicians to treat just the body, or to look to just the body for the mechanism of disease. Emphasizing the relational nature of organism-environment, he argued that the physician must treat the whole patient and must therefore consider the environment of the patient. It makes no sense, he suggested, to provide medicine to address a problem with the patient's lungs and then to send him back into the coal mine. As he put it: "We must observe and understand internal processes and their interactions from the standpoint of their interactions with what is going on outside the skin" (1937, 326).

Dewey's view of the relational nature of human existence has informed the action-oriented, affordance-based conceptions of enactivism, and this is reflected in Sanneke de Haan's essay that proposes an enactivist approach to psychiatry. Although I am in general agreement concerning the direction that de Haan takes in her article, I want to highlight two problems that are not addressed by the notion of sense-making. The first is theoretical and directly connected with the issue of integration that de Haan discusses. Specifically, it is the problem of causality. The second is practical and concerns the role of the psychiatrist.

How should we think of causality with respect to the mix of factors to which de Haan points? The fact that there is existential meaning integrated with bodily, experiential, environmental, and social factors suggests that part of the psychiatrist's task is hermeneutical. How the patient understands herself and the world and what she values in life are part of what the psychiatrist should understand. This seems to be a very different task than identifying causal factors that might lead the patient to have such attitudes. Yet, such attitudes can also be addressed therapeutically. Do they play a causal role in a similar way to neural, environmental, or social factors? de Haan (note 11) is rightly skeptical of the notion of vertical integration and the top-down, bottom-up notions of causality that come with it. Sorting out the question about causality, however, is central to solving the integration problem.

A number of theorists have highlighted the virtues of James Woodward's (2005) interventionist concept of causality in psychiatric contexts (e.g., Kendler & Campbell, 2009). I take this concept to be consistent with dynamical enactivist approaches because one can treat the arrangement of variables—bodily, experiential, environmental, social, and existential factors—as a dynamical gestalt involving reciprocal causal relations. The interventionist view stipulates that if one ma-

nipulates variable A and this results in a change in variable B, then A and B are causally related. If the various factors that form the dynamical gestalt that constitutes a person's life are causally related, then we can understand both disease and therapeutic practice in terms of causal intervention. The physical or social arrangement that makes an environment toxic can clearly be a causal factor in the disease that, above a certain threshold, may generate changes in bodily (including neural), experiential, and existential factors. Therapeutic interventions on any of these factors may result in changes that affect the whole. The challenge of therapy is to decide which strategic interventions will work best for the individual patient. Importantly, as Kendler and Campbell point out, the interventionist notion of causality puts some critical bounds on an unruly holism that would claim everything as relevant.

As de Haan points out, there are some philosophical complications about the distinction between causal and constitutive factors. In contrast to mechanistic approaches that attempt to maintain a strict distinction between etiology and mereology, that is, between diachronic causal relations and whole-part constitutive relations (e.g., Craver, 2007), enactivism understands dynamical causal relations to constitute the integrated gestalt of factors that make up the life of the patient (Gallagher, 2018; Kirchhoff, 2017).

If philosophers wrestle with different perspectives on reductionism versus holism, or mechanistic versus interventionist conceptions of causality, one might think that such debates remain well in the background in relation to the practical considerations of psychiatrists in their clinical practices. Nonetheless, these different perspectives directly impinge on psychiatric practice. On the one hand, if one takes a reductionist or mechanist view emphasizing bottom-up causality and discounting holistic effects, one may be led to an overemphasis on drug-related therapy. On the other hand, if one takes an enactivist view, the psychiatrist's job seemingly becomes much more challenging. In response to Dewey's suggestion, the physician might balk at the idea that she has to become an environmental activist or consider the patient's economic livelihood. And in response to the enactivist's emphasis on how environmental and social and existential and experiential, as well as neural and bodily factors contribute to the condition of the whole patient requiring therapy, the psychiatrist might respond that she cannot be an expert on all such factors. A pluralism in therapeutic approaches is difficult given the specialization of individual training.

One pragmatic solution may be to think of psychiatry as a team effort. At least on one model psychiatrists might, as they sometimes do, work together with some select group of other professionals—social workers, neurologists, phenomenologists, movement therapists, architects, and/or simulation engineers, depending on the situation (see Röhricht, Gallagher, Geuter, & Hutto, 2014). One would treat the person, not as a patient who presents as a solitary clinical visitor, but as someone who is part of a situation that extends into the world. Dewey defined the concept of 'situation,' not as simply the surrounding environment; rather he conceives of the situation as including the agent—it is the agent-environment taken as a unit. On this view, as de Haan notes, the emphasis is rightly put on the relational.

References

Craver, C. F. (2007). *Explaining the brain: Mechanisms and the Mosaic Unity of Neuroscience*. Oxford: Oxford University Press.

de Haan, S. (2020). An enactive approach to psychiatry. *Philosophy, Psychiatry & Psychology, 27* (1), 3–25.

Dewey, J. (1937/1991). The unity of the human being. In J.A. Boydston (Ed.), *Later Works of John Dewey*, Vol. 13 (323–337). Carbondale: Southern Illinois University Press.

Gallagher, S. (2018). New mechanisms and the enactivist concept of constitution. In M. P. Guta (Ed.) *Consciousness and the ontology of properties* (pp. 207–220). London: Routledge.

Kendler, K. S., & Campbell, J. (2009). Interventionist causal models in psychiatry: Repositioning the mind–body problem. *Psychological Medicine, 39*, 881–887.

Kirchhoff, M. D. (2017). From mutual manipulation to cognitive extension: Challenges and implications. *Phenomenology and the Cognitive Sciences, 16*, 863–878.

Röhricht, F., Gallagher, S., Geuter, U., & Hutto, D. D. (2014). Embodied cognition and body psychotherapy: The construction of new therapeutic environments. *Sensoria: A Journal of Mind, Brain & Culture 10*, 11–20.

Woodward, J. (2005). *Making things happen: A theory of causal explanation*. Oxford: Oxford University Press.