Enactive Psychiatry

Psychiatry is enormously complex. One of its main difficulties is to articulate the relationship between the wide assortment of factors that may cause or contribute to psychiatric disorders. Such factors range from traumatic experiences to dysfunctional neurotransmitters, existential worries, economic deprivation, social exclusion and genetic bad luck. The relevant factors and how they interact can differ not only between diagnoses but also between individuals with the same diagnosis. How should we understand and navigate such complexity? *Enactive Psychiatry* presents an integrative account of the many phenomena at play in the development and persistence of psychiatric disorders by drawing on insights from enactivism, a theory of embodied cognition. From the enactive perspective on the mind and its relation to both the body and the world, we can achieve a new understanding of the nature of psychiatric disorders and the causality involved in their development and treatment, thereby resolving psychiatry's integration problem.

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Preface

> It doesn't take more than three months of living to discover that we are all connected to each other's cruelty and to each other's kindness.
>
> Deborah Levy, *The Cost of Living*

When I first started working at a psychiatric hospital as a philosophical researcher, someone advised me to keep a diary of all the things that struck me, as a newcomer and relative outsider, before I started to take them for granted. It was good advice, but unfortunately, I didn't follow it. I do remember some quite puzzling things, though. It is one of these early puzzlements that has motivated this book.

At team meetings, when we talked with and/or about patients, we talked about how they were presently doing and feeling, how they experienced the different forms of therapy they engaged in, and we talked about their lives outside of the ward: about their family situations; their jobs or schooling and future perspectives; their housing and financial situations; their relations to their partners, family members and friends. We did not talk about brains, though. We discussed various forms of medication, their advantages and side effects and how patients felt about and reacted to them. But neurotransmitters were not part of the conversation.

At scientific meetings, however, it was the other way around: we talked mostly about brains and hardly about anything else. Most research was neuroscientific research, directed at finding the underlying mechanisms of different disorders. Similarly, if we engaged in more theoretical discussions, many of my colleagues seemed to subscribe in one form or another to the idea that psychiatric disorders are diseases of the brain.

But how were they related: patients' brains, their experiences, and all the other things we talked about? Wildly diverse things seemed to affect patients' well-being – traumatic experiences, dysfunctional neurotransmitters, existential worries, economical deprivation, social relationships, genetics – and these, moreover, seemed to influence one another: traumatic experiences, for instance, altering the brain and affecting the quality of relationships, and that in turn inducing existential concerns. For each patient, the relevant factors and how they interact may differ too. How are we to understand and navigate this mind-boggling complexity? That is the topic of this book.

In what follows I present a model that integrates the many phenomena that play a role in the development and persistence of psychiatric disorders, drawing on insights from enactivism, a form of embodied cognition. Psychiatry's integration problem can be solved if we adopt an enactive view on what the mind is and how it relates to the body and the world. From this enactive perspective we can elaborate a new understanding of the nature of psychiatric disorders and the causality involved in their development and treatment. As a philosophical work this volume does not propose any novel forms of treatment or provide analyses of specific psychiatric disorders; rather, it offers an integrative theoretical framework that helps us understand what happens in various forms of treatment (e.g. the effects of medication vs the effects of psychotherapy) and that helps relate different types of research findings (e.g. neuroscientific data and phenomenological analyses).

This book is a philosophical work, but I did not write it mainly for philosophers. First and foremost, I hope to reach all of those who are interested in better understanding psychiatric disorders: those who work in mental health care (psychologists, social workers, psychiatrists, nurses), those who do scientific research into psychiatric disorders, and those who find themselves affected by psychiatric disorders as a patient or a patient's friend or family member. To enhance the book's readability, I have tried to stay clear of all-too-technical discussions and banned most intra-philosophical

debates to the footnotes. Philosophers with an interest in psychiatry, the mind–body problem, and/or embodied cognition may, however, still find enough of it to their liking.

In the first chapter I introduce psychiatry's integration problem: the difficulty of relating the heterogeneous phenomena that may play a role in the development and persistence of psychiatric disorders. In practice, many mental health professionals work holistically in a pragmatic and eclectic way. Such pragmatic approaches often function well enough. Yet an overarching framework provides orientation, treatment rationale, a shared language for communication with all those involved and the means to explain treatment decisions to health insurers and to society at large. It also helps relate findings from different areas and types of research. To do that, such a model should give an overview of the relevant aspects involved and an account of how they are related. I propose four main aspects or dimensions of psychiatric disorders that a model should ideally take into account: the experiential, physiological, socio-cultural, and existential dimensions.

In the second chapter, I briefly discuss the currently available models for psychiatry. They can be divided into (1) one-sided and reductionist models, (2) complementary or dualist models and (3) integrative models. Single-aspect models can offer valuable insights, but they do not help to solve the problem of integration, as they do not take into account the whole range of factors that are in play. Complementary approaches are more encompassing but fail to show how the aspects relate. Reductionist models, such as the nowadays popular neuroreductionist, view that psychiatric disorders are brain diseases, do offer an integrative perspective but oversimplify the complexity of psychiatric disorders, making them both improbable and ethically disputable. The integrative models, such as the biopsychosocial model and the network model, go a long way. The biopsychosocial model, however, insufficiently shows how the dimensions relate, and while the network model offers a helpful mathematical template, it presupposes rather than provides an

integrative theory. We still lack a framework that integrates all four dimensions in a non-reductionist manner. That is where enactivism comes in.

In Chapter 3, I outline the enactive perspective on cognition – the most rigorous of embodied and embedded approaches. Cognition is defined in terms of 'sense-making': the evaluative interaction of an organism with its environment. I explain that sense-making is essential to life, implies values, and is affective. I also urge the importance of distinguishing basic from existential sense-making and discuss its implications for our understanding of the relation between cognition, perception, and action. I explicate this enactive ontology of the mind and clarify how it differs from a more traditional approach. This will then serve as the overall background in terms of which we can start to explain the precise way in which an enactive ontology can bring together the experiential and the (neuro)physiological dimensions (Chapter 4), the socio-cultural dimension (Chapters 4 and 6), and the existential dimension (Chapters 5 and 6).

A big part of the integration problem concerns the difficulty of relating the physiological and the experiential dimensions of psychiatric disorders: body and mind. In Chapter 4, I first sketch the ways in which the mind–body problem is at stake in psychiatry and how a dualist opposition is still deeply engrained in how we conceive of both causes and treatment of psychiatric disorders. While we want to acknowledge the differences between matters physiological and psychological, we do not want to adopt the unsatisfying accounts of their relation as offered by dualism and reductionism. By taking continuity rather than opposition as its starting point, the enactive life–mind continuity thesis has the potential to offer a helpful alternative perspective on the mind–body problem. The life–mind continuity thesis argues that physiological and sense-making processes necessarily go together in the process of living. Given the fundamental dependency of living beings on interactions with their environment, they require some (basic) sense-making capacities in order to survive. The viability of the life–mind continuity thesis

depends on adopting a solid account of emergence. I discuss several conceptions and conclude that emergence is best understood in terms of fusion.

From an enactive perspective, then, the relation between physiological and experiential processes necessarily includes living beings' relations to their environment. It thus reconfigures a two-place relation (mind and body) into a three-place one (mind, body, and world) and stresses their mereological co-dependency. In other words, the physiological, experiential, and environmental/socio-cultural dimensions are all part of one person–world system. This in turn has consequences for how we conceive of the causality involved between these three dimensions. I argue that this is best understood as organisational causality. Within this organisational causality we can distinguish more global from more local processes and effects, which in turn allows us to differentiate between various causes and forms of treatment of psychiatric disorders.

I end the chapter with an evaluation of the enactive framework as elaborated so far. I conclude that even though it has much to offer in terms of an integrative view on the physiological, the experiential, and the environmental/sociocultural dimensions of psychiatric disorders, it does not yet encompass the existential dimension, which is crucial for a useful framework for psychiatry.

In Chapter 5, I introduce the existential dimension and show how it is at play in psychiatry. The existential dimension refers to our capacity to take a stance on ourselves and on our interactions with the world and others. This reflexive capacity introduces a different relation to the world, in which not only survival but also the aim to lead a good life counts. This existential dimension is an important aspect of psychiatry: patients' relation to themselves and their situation can play a constitutive and/or a modulatory role in psychiatric disorders. Besides, existential considerations come to the fore in psychiatric practice through patients' relations to their diagnoses and treatments. This does leave us with the dilemma of how to

fit the existential dimension, and the values that come along with it, into a naturalist approach to psychiatry.

The enactive approach is a naturalist approach, but so far, it has neglected the existential dimension. In Chapter 6, I discuss how the enactive approach can be enriched by adopting this existential dimension. This requires reconsidering (1) sense-making as existential sense-making, (2) values as existential values and (3) environments as sociocultural worlds. I explain existential sense-making, how it differs from basic sense-making and whether this amounts to a 'cognitive gap'. Turning to values, I distinguish between valences (i.e. basic values) and values (i.e. existential values). I discuss three main theories on the relation between values and naturalism – a subjectivist, an objectivist, and an evolutionary perspective – and show that each has its drawbacks. Following the enactive ontology as developed in Chapter 3, I propose a relational view on values as relational realities, which avoids the pitfalls of objectivist, subjectivist, and evolutionary theories and allows values to be incorporated within a naturalist approach. With the capacity for stance-taking, the environment we live in becomes a world imbued with existential meaning and values. The development of this capacity is itself dependent upon and supported by being part of a sociocultural community with specific socio-cultural practices. The existential dimension has thus reconfigured the organism–environment system into a person–world system that integrates all four dimensions we started out with.

With this enriched enactive perspective in place, we can now turn to the implications of this view for how we understand the nature (Chapter 7), causes, and treatment (Chapter 8) of psychiatric disorders. I argue that psychiatric disorders are structurally disordered patterns of sense-making. Generally, the way in which the person makes sense of her world is biased in a specific direction: the world appears overly threatening, or meaningless, or overly meaningful, or chaotic. The person's sense-making is not appropriate or insufficiently attuned to her situation. She will find it difficult to adjust her sense-making to

the situation at hand, and this difficulty in adjusting and attuning typically results in overly rigid patterns of interactions. Psychiatric disorders thus pertain to persons in interaction with their world. I discuss what makes them *psychiatric* rather than somatic disorders and what makes them *disorders* rather than cases of normal sense-making. I then illustrate disordered patterns of sense-making by looking at patients' changed experience of the world. The activity of sense-making discloses the world as a field of relevant affordances, and consequently, disordered sense-making discloses an altered field of relevant affordances. I end the chapter by discussing some conceptual consequences of the enactive view on psychiatric disorders. This shows that an enactive approach dissolves several conceptual dichotomies that stem from the (implicit) adoption of the dichotomous mind–world topology that enactivism challenges.

In the final chapter, I discuss what an enactive approach implies with regard to the causes and treatment of psychiatric disorders. Much research in psychiatry is devoted to finding the 'underlying' causes or mechanisms of specific disorders. From an enactive complex systems perspective, however, this is a problematic metaphor, as it encourages the adoption of a vertical hierarchy in which symptoms are taken as signs at the surface for what is going wrong underneath – which is typically taken to refer to (neuro)physiological processes. In contrast, following the integrative enactive view, none of the four dimensions is more fundamental than any of the other, since they refer to different excerpts of one and the same system. Nothing underlies disordered patterns of sense-making: the pattern itself is all there is to it. The enactive adoption of a complex dynamical systems view further implies that causes are only causes in a specific context, thus nuancing the notion of originary causes. The initiating factors of psychiatric problems may, moreover, not be the same as their maintaining factors. Finally, the complexity of the system means that for different patients, their problems will probably have different developmental trajectories. To navigate this complexity, personalised network models could be used, using the four dimensions as the major

groupings of relevant factors. These network models can then be personalised, with regard to both the specific factors to be included and the nature of their influences.

With regard to treatment, taking an encompassing perspective on the entire person–world system may at first sight seem too complex to be workable. However, the complexity of the system also implies that there are many routes to change. An enactive approach does not a priori exclude any type of treatment. This does not mean that anything goes, however. Personalised network models show how different treatments have different effects and how one and the same treatment results in different outcomes for different patients. The enactive focus on the person in interaction with her world implies the relevance of the role of patients' environments. Part of treatment may consist in finding an appropriate *niche* for this person to flourish. Besides, from an enactive view, abilities themselves have an interactional character, and different settings can thus affect our abilities. Psychotherapy can be regarded as prasticing sense-making in a helpful setting, making it a practice of participatory sense-making.

By the end of the book, I hope to have shown that an enactive view on the mind and its relation to both body and world provides a valuable new understanding of psychiatry's old problems. While this view may at first seem more complex, in the end, it offers a clarity and unification that are otherwise hard to come by.

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