
In reading the book under review, I was reminded of a lecture I heard by a prominent psychologist. As I recall it, the main point was that pigeons are better able to recognize particular persons at certain large distances than people are able to do. Pigeons can even identify particular people in various disguises at relatively great distances when people are unable to do so. The explanation seemed fairly straightforward: pigeons have visual capabilities that exceed ours because of the makeup of their eyes. Simply put, they are better able than we to make finer discriminations at greater distances. Thus comparative anatomy and physiology helped one to understand the greater discriminatory abilities of pigeons compared to humans in certain contexts.

Patricia Churchland, along with others, has long believed and argued that understanding our neurology will enable us to understand better some of what we are, what we can and cannot do, etc. On this point, and to the extent that it applies, I think we are well advised to yield to developments here. What we must be on guard against, it seems to me, is overextension or overdevelopment of what is to be gained by such advances in such knowledge of the innards of human beings.

At her most cautious, Churchland sees neurological knowledge as being a valuable ally in understanding various human states, activities, ways of behaving, etc. At her boldest, she sees such knowledge as replacing, supplanting, improving upon, rejecting as too “folk psychological” much current putative knowledge about ourselves. And it is with respect to the bolder thesis that readers are likely to engage or disengage with a kind of passion. The more cautious view seems to me to be only good sense: if a domain of human knowledge offers additional valuable knowledge, then one would be churlish, dogmatic, unwise, imprudent, etc. to ignore, overlook, or reject same. But the bolder view has the look of a program, a commitment to a method, the potential for dogmatic insistence on prioritization of scientific knowledge above and denigration of all other knowledge, etc. Strawson, well aware that we might give both scientific and more personalized accounts or stories of others and ourselves, once remarked in his book Skepticism and Naturalism about the innuendo of inferiority of “folk psychology:”

"Each story will invoke its own explanatory connections, the one in terms of neurophysiological and anatomical laws, the other in terms of what is sometimes called, with apparently pejorative intent, “folk psychology”; i.e., the ordinary explanatory terms employed by diarists, novelists, biographers, historians, journalists and gossips, when they deliver their accounts of human behavior and experience----the terms employed by such simple folk as Shakespeare, Tolstoy, Proust and Henry James."
I wish to endorse Strawson’s caution in contrasting so adversely scientific accounts and more everyday accounts of humans and their lives.

Take mental illness, for example, and its treatment both in terms of medications and counseling/therapy. I choose this example because on the one hand some significant progress in the neurology and biology of the brain has occurred in recent decades. This progress is one huge impetus for Churchland’s work, here and elsewhere. In contrast, I think some of what is appropriately called interpersonal psychodynamics is nowhere close to being understood in neurological terms, and the likelihood that we will both be interested in determining, and able to determine, such neurological intricacies of interpersonal interactions is, I think, extremely remote. I aim to highlight these contrasts in what follows, thereby shedding light on what is and what is not helpful about neurophilosophy.

The progress we have made in recent decades in medications for such ailments as schizophrenia is impressive. We are in an era where many view mental illness as [to a significant extent? primarily? exclusively?] a matter of biology. The phrase ‘broken brains’ has come into somewhat accepted parlance, even in book titles, about such matters. Here, too, I think we are well advised to yield to developments in knowledge of brain chemistry/biology/anatomy/physiology. At the same time, overextension or overdevelopment of discoveries here can lead as well as mislead.

Suppose one is a mental health professional doing an initial interview of a client/patient. How is one to distinguish, during that first interview especially, but also as one gets to know the client/patient better, between symptoms of a disorder, traits that indicate a personality, and traits that are characteristic of that person only during certain kinds of stress or only in certain kinds of stressful circumstances? Do ponderings about the origins and nature of the cosmos indicate pathology, philosophical bent, or higher education with a major in philosophy or religious studies----or, of course, some combination of these or something else? Making these distinctions is vitally important for the basics of understanding the person one is getting to know. And making the distinctions might be aided by neurological knowledge, now or in the future. At the same time, our current best methods for making such distinctions strike me as involving, and involving essentially, getting to know a person better and better. Such knowledge is at best assisted or aided by neurology and not supplanted by it. Furthermore, having made progress in making the above distinctions, one is faced with numerous questions: ought one to prescribe medication and if so which one[s] and in what doses?, how ought one to treat such a person in future meetings, i.e., sustained interpersonal interactions of the sort involved in talking therapy? These issues are not very likely to be a matter of mere neurological knowledge and this for a variety of reasons. Not knowing the person well, one doesn’t know what “works” and does not work for her/him. Moreover, one’s training is a factor in the therapeutic approaches one will rely on, as are one’s inventiveness and boldness in both implementing and departing from that training. The relevant variables are not merely physiological ones, but involve other kinds of knowledge, including not just prudential knowledge but ethical and even legal knowledge as well.

What I have written above is meant to be uncontroversial: helping another person involves both getting to know her/him in a variety of ways and with varieties of knowledge that one brings to the interaction. It also involves knowing or at least believing in some ways that one ought/ought not to treat others generally, as well as knowing/having beliefs about how one ought/ought not to treat the particular person sitting opposite one and who seeks assistance in addressing particular “problems of living.” Telling someone that her/his brain is “broken” or that her/his neurons are “misfiring” or that there are certain
chemical imbalances or deficiencies raises apprehension in patients and clients that they’re not even being understood or given empathy, no matter the truth of such assertions. A psychiatrist has told a good friend of mine that he, my friend, refuses to accept the diagnosis of mental illness that the doctor has provided. But it is also true that the doctor has refused to accept my friend’s account of both how he got into such states, of what such states amount to for him, and why he lacks certain skills in the situations life has offered him. The doctor simply urges emphatically the need for the medication and the diagnosis, telling my friend: you have a disease, “you just don’t get it.” I have suggested that my friend reply in some way like this: I have told you my life story of how I got to be where and how I am and why I have certain difficulties in living, “you just don’t get it.” I think that there is considerable merit in taking BOTH views seriously and as expressing truthful accounts and NOT insisting on the truth of one account over and against the truth of the other.

Refinements in knowledge of physiology are not likely to alter some of the issues of interpersonal dynamics, even if that knowledge might in some ways enable one to negotiate certain areas better than previously. Here I think of another psychiatrist who told me that current drugs for schizophrenia lead him to the view that he does more total or net good dispensing drugs to many more patients with monthly 10-15 minute drug maintenance interviews than his longer conversations ever did for far fewer patients. At the same time, he thinks that his patients are better off without thereby getting better, that they still face varied major personal problems more on their own than when they could discuss them at greater length with him. He spoke of a clear tradeoff here: they were better able with medication to face problems than without the medication, but now they had to face them more on their own than previously. This shows, to put it overly simply, that there is a lot to life besides the neurology of life.

Of course if use of drugs enhances therapy, then there is much to recommend such use. It is even a fact of modern medical practice that major psychiatric ailments are considerably alleviated, or rather at least their symptoms are alleviated, by modern medicines. Sometimes patients see a psychiatrist just for so-called drug maintenance visits where very little interpersonal interaction is even possible. This is partly due to the costs of other alternatives, the cost effectiveness of talking therapy vs. drug therapy [as implied by the psychiatrist’s remarks above]. This is not to mention the priority of matters other than mental health [e.g., billions and billions of dollars for military activities] chosen by legislators, other leaders, and society at large. But does anyone seriously believe that in principle drugs could replace all of therapy, that we will or would want to develop drugs that would replace what is important and valuable in person-to-person relationships? In other words, is it plausible to believe that ingestion will replace---rather than affect---social interaction? People ravaged by illnesses and/or difficulties in living need far more than medication even if and when restored to what we declare to be normalcy. They may need to learn or relearn skills never possessed or lost during bouts of illness, to change career goals, to learn how to mend broken relationships or how to put them behind one effectively, etc. I, for one, do not think we are likely to develop skills by developing new medications that will “give” skills to those lacking them. Learning has neurological components, to be sure. But there are many relevant non-neurological variables involved in learning as well.

There are even some special problems raised about neurophilosophy in the therapeutic context on the matter of authority. What if physiology indicates one range of psychological states in a subject but the subject reports things differently? Will we, when will we, should we, use physiology to override self-descriptions? These issues arise both with respect to oneself and others. This seems to be a cluster of problems not at all easy to address. We generally invest persons’ self-reports of their mental states,
attitudes, motivations, etc. with a kind of strong authority, assuming that they are “normal” or at least reliable reporters in other ways. And, it is worth noting, even unreliable reporters can simultaneously deliver both some reliable and some unreliable reports. The platitude that sometimes even the paranoid person is followed or persecuted says as much by understatement. What do we do then about accepting persons’ reports, especially self-reports?

An old philosophical chestnut lurks here and arises several times in Churchland’s text. It is easier for an observer than for the subject herself to dismiss the subject’s reports as reporting "mere" appearances. Science has often urged its explanations of appearances as referring to the replacements for those appearances. I am urging that we are, and that we should continue to be, leery of doing so in a large variety of cases. It may be valuable to hold onto both the intrapersonal appearances as reported and the reality science introduces to explain them. This point is both general enough and important enough that I think it bears repeating.

More than once, Churchland raises the appearance/reality distinction, inclining it seems to me to both embrace it and to reject it ultimately by saying that the sciences enable us to get at the reality involved. On the one hand, she sees the importance of the phenomena for which we seek explanations, often scientific explanations to be sure. On the other hand, she inclines to the view that the scientific explanations can and may [simply] replace the talk, conceptualization, and concern with truth[s] about phenomena. I believe that sometimes this is the correct maneuver. I also lean toward the view sometimes this would be to identify what is distinct. Sometimes the phenomena for which we seek explanation[s] and the explanation[s] are often two things, not one, and so there is no call, license or, on this view of the matter, even temptation to say that what the explanations mention are all that there is.

My concerns about therapy/counseling and neural knowledge and even neurophilosophy stem from [a] my sympathy toward each and [b] the desire to take the best of each and develop a program incorporating these in a program of best practices for responding to needs in the mental health areas. I am especially reluctant to force an exclusive choice here. And it’s not so much that Churchland would have me do so always and everywhere as that at points in her book she treats certain issues in that manner. So excited is she by the recent discoveries and current prospects of additional discoveries that she sometimes seems to focus on the development in the scientific domain to the minimalization or exclusion of interpersonal dynamics, the appearances that are involved in them and elsewhere in the phenomena with which we all deal daily. I’m leery of that exclusive focus on science on many grounds and would hope that those who use the book as the kind of introductory text it is written to be take the time to caution readers that often there are options other than those that Churchland lays before readers. Indeed, enabling readers to see distinctions such as that between the bolder thesis and the tamer one with which I began can make Churchland’s text be useful in ways she did not intend without detracting from the usefulness that she did intend. In other words, a savvy instructor less partial to neurophilosophy than Churchland could be ingenious in illustrating where and how this new methodology can be so important and helpful while also calling attention to its limitations. This is what I have tried to do in a very brief and general way in this review.

By offering an introduction to philosophy through the lens of neurophilosophy, Churchland risks slighting various aspects of the discipline. One will not find much about multicultural issues, feminism, gender equity, etc. Nor will one find detailed treatment of some of the leading figures in the history of the discipline. If anything, there is a tendency away from these because of the great interest in recent developments, ongoing research, and future results from [Western?] science. Nonetheless, Churchland
sees herself as continuing an Aristotelian approach. So what one might do in using this text would be to combine it, in spite of its own considerable heft, with some traditional excerpts/readings, the better to highlight how some see the discipline as changing, as losing in autonomy but gaining in authority as it becomes more and more assimilated to scientific endeavor. Such assimilation has been in the air for literally centuries, perhaps millennia. Churchland’s contemporary variety of such assimilation is therefore one way to introduce students to philosophy and what remains of its autonomy in the thinking embodied in neurophilosophy. Her book repeatedly demonstrates that Churchland is both a worthy ally and a worthy opponent.

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