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NEUROSCIENCE CANNOT REACH EXISTENCE

A HEIDEGGERIAN CRITIQUE OF NEUROPSYCHOLOGY

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Abstract

Neuroscience is not the key to understanding human existence. The author argues that neuropsychologists have carelessly confused and conflated being (existence) and beings (neurons), a problem described by German philosopher Martin Heidegger. Heidegger explains how the perspective of modern science has made a habit of conflating being and beings, thereby abandoning human existence. This can be seen in contemporary neuropsychiatry which attempts to explain depression and other

psychological disorders in terms of neurology. Doing so obscures any understanding of psychological phenomena. The author recommends that the method of existential phenomenological hermeneutics replace the now standard method of neuroscience for understanding psychological phenomena.

Keywords: neuropsychology, Martin Heidegger, hermeneutics, neurophilosophy, existentialism.

Nevroznanost ne zmore doseči eksistence. Heideggrovska kritika nevropsihologije

Povzetek

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Nevroznanost ni poglavitni ključ za razumevanje človeške eksistence. Avtor zagovarja trditev, da so nevropsihologi nepremišljeno spremešali in združili bit (eksistenco) in bivajoče (nevrone), kar je problem, kakršnega je opisal nemški filozof Martin Heidegger. Heidegger namreč razlaga, da je s perspektivo moderne znanosti združevanje biti in bivajočega, ki spregleduje človeško eksistenco, postalo navada. To je mogoče uzreti v sodobni nevropsihiatriji, ki depresijo in druge psihološke motnje skuša pojasniti s pomočjo nevrologije. Slednje zamegljuje vsakršno razumevanje psiholoških fenomenov. Avtor predlaga, naj pri razumevanju psiholoških fenomenov metoda eksistencialne fenomenološke hermenevtike nadomesti standardno metodo nevroznanosti.

Ključne besede: nevropsihologija, Martin Heidegger, hermenevtika, nevrofilozofija, eksistencializem.

Introduction

The online reference site *Dictionary.com* has named “existentialism” the word of 2019. The website authors explain: “It captures a sense of grappling with the survival—literally and figuratively—of the planet, our loved ones, our way of life.” (cf. Holub 2019) The term has shown up in popular magazine, newspaper, and public radio headlines throughout the year, demonstrating a re-emergence of the term. From what I have gathered, it is used to refer generally to human mortality, though it has also been used to describe the imminent death of certain ethnicities, social demographics, and, at least once, the National Football League. While I am pleased to see a return of the term in general, I am unhappy to see how it has been handled by psychiatry and clinical psychology—primarily in the U. S. through the American Psychiatric Association, but also abroad.

Students and consumers of scientific literature quickly learn that psychology and other human sciences offer little in the way of help for those hoping to better understand questions of existence. (Perhaps this is why they have turned to *Dictionary.com*.) All meaning, increasingly it seems, can be traced to the nervous system. This is unsettling. Philosophers have even given a name to the unsettling realization that the mind is the brain: “neuroexistentialism” (Caruso and Flanagan 2018). Neuroexistentialism is both a name for the problem of hopelessness and the disciplinary umbrella under which such research is done—that is, neurosciences of existence. Under this new disciplinary umbrella, one finds psychologists, neuroscientists, cognitive scientists, and philosophers who demonstrate how human experiences of love, autonomy, and morality are reducible to neurological phenomena, definitively solving the problem(s) of meaning and existence. Today, I argue that neuropsychiatry and neuroexistentialism are not the solution; neuroscience and the objects it studies cannot reach existence or being (and I will focus only on the former). *Clinical psychology and psychiatry must not be replaced with applied neuroscience*. Instead, help can be found in the careful examination of human existentials, the unique structures that belong to existence. This requires the existential phenomenological hermeneutics of German philosopher Martin Heidegger

(1889–1976), which has in recent years been fruitfully applied to psychiatry (Aho 2019), health psychology (Whitehead 2019), and medicine (Aho 2018).

The problem I describe in neuroscience can be likened to an accounting mistake that sometimes occurs with double-entry bookkeeping.¹ Double-entry bookkeeping is a record-keeping term where a single entry is recorded into two separate ledgers. For example, if you borrow \$25 from a friend, then you list “minus \$25” in the *debt to be paid* ledger and “\$25” in the *cash-on-hand* ledger. Double-entry bookkeeping is helpful for tracking assets and liabilities, but it can get accountants into trouble in this scenario when a record is made in only one of the ledgers. This makes it difficult to remember what the \$25 credit *means*. It isn’t revenue in this example; it is outstanding debt.

162 In neuropsychology, double-entry bookkeeping is standard. In examining fear, for example, psychologists make an entry for a particular and concrete experience of being frightened, and another general statement about sympathetic nervous system activation (such as galvanic skin conductance). Trouble arises when psychologists forget where the entries have come from, and confuse the generalized neurological statement and concrete experience as one in the same. This has the unfortunate consequence of statements that begin with “fear is when the amygdala...” Fear cannot be understood (*Verstehen*) this way. Understanding requires an analysis of fear as fear—that is, fear as it is experienced.

In this article, the reader will find a Heideggerian critique of contemporary psychiatry. This includes a summary of Heidegger’s (2001) mid-Century critique of medicine and psychiatry, and an application of that critique to the increasingly biological and neurological descriptions of mental disorders among psychiatrists and clinical psychologists. These, the author argues, ignore that which is fundamentally amiss in mental disorder—that is, problems of existence. To that end, the article focuses, not on neuroscience writ large, but on those areas where neuroscience has been used to obscure existence.

1 The metaphor is taken from Heidegger (2001), see below.

Existential psychology

This article builds on the critique developed by many generations of existential psychologists, psychiatrists, and therapists including Binswanger (1956), Jaspers (1963), Boss (1979), Laing (1960), Frankl (2006), Fromm (1969), and others. Scholars Whitehead and Groth (2019) have recently drawn upon these figures to critique a biological approach to understanding human existence, and how it might be restored for research in humanistic psychology by recommending a shift to the humanities. They call for another counter-cultural revolution like the one that produced the existential literature and philosophy in the middle of the 20th century.

However, Whitehead, et al., do not specifically address *DSM-5*'s emphasis on the neurological and biological foundations of mental disorders. That is the focus of the present article.

Disease and illness

The distinction between disease and illness is an important one for this article. A disease is a biomedical abnormality and is represented by a pathogen. Diseases occur at the level of objective physical reality and are discovered by the tools of experimental science (e.g., microscope). An illness is the subjective and disorienting experience of falling out of one's normal routine and well-being. The reality of a virus is conferred by a bio-medical instrument or practice (tissue sample examined in the laboratory). That one feels tired and nauseated cannot be verified biomedically. These are changes to one's normal routine and signify illness.

Positive critique

This article follows Heidegger's (2001) method of positive critique:

Genuine critique is something other than criticizing in the sense of faultfinding, blaming, and complaining. Critique, as 'to distinguish,' means to allow the different as such to be seen in its difference. [...] In other words, true critique, as in this letting-be-seen, is something eminently positive. (76–77)

While readers will find a criticism of neuropsychiatry, the goal is to shine a light on what neuropsychiatry has ignored—that is, existence.

Heidegger's critique of modern science

The problem I am describing does not begin with neuropsychology, but many centuries earlier with Galileo. Before Galileo, things were what they were. An apple was an apple—something to grow, eat, and nefariously poison. A crate was a crate—something to hold apples. What Galileo saw were things—real, meaningful things—which he helped turn into objects. That is, the apple and crate in their objectivity.

164 The experiments of Galileo and, soon after him, Newton supposed that everyday things could be understood as objects—that is, in terms of measurable properties (such as mass and volume) that were acted upon by hidden forces (such as gravity and momentum). This required discarding irrelevant details about the cup such as its usefulness for holding wine or how well it fit into the cupboard. The end result is a universe where things are understood not as things but as objects. This is the platform of modern science, and its influence is not in question.

Students learn how to view things this way when they are taught the experimental method, and learn how to test the physical properties of things in their objectivity. It is unusual to encounter water bottles in terms of their melting points, but this is precisely what is accomplished with Bunsen burners. While holding the water bottle to the flame, students are not seeing the water bottle as a water bottle—that is, the manner in which they encounter the water bottle everywhere outside the laboratory. Instead, they view it as a bit of matter with measurable properties. To be fair, the precise utility of modern science is somewhat obscured in this example, but for this one may look to refrigeration, combustion engines, or the newest version of iPhone. However, even with these, their usefulness as things cannot be understood when viewed as objects. A refrigerator does not preserve meat; it can only cool the air. Preserving meat is something meaningful for which humans have used refrigeration. Modern science is a system of explanation; it cannot *use* things.

This can happen to humans, too. That is, humans can be viewed not as humans, but as objects (*Körper*; as behaviors, neural activity, etc.). The habitual practice of viewing humans as objects reveals itself in startling ways. Earlier this semester, a nursing student was giving a presentation about prenatal healthcare in a developmental psychology class. She was explaining the uses of hysteroscopy when a fellow student asked if hysteroscopes were painful. The student giving the presentation said no, and explained that it would be like having sex. The rest of the class nodded in solemn agreement.

In her simile, the student was comparing the penetration of a hysteroscope to that of a penis (or other sexual device) during intercourse. But the penetration of labia by the penis is only sexual intercourse in the most impersonal and objectified way. (Though this is precisely how sex was described by American psychologists William Masters and Virginia Johnson.)

This student would very likely receive a hysteroscope differently than the penis of her lover. Penal-vaginal intercourse can be viewed on many grounds of receptivity—e.g., passion, a sense of marital duty, or even violence. With passion one is inviting; with duty one is passive but willing; with violence one is resistant. Behaviorists will likely produce behavioral substitutes for each of these, though I suspect that they will not limit themselves only to behaviors. On one ledger they record a meaningful experience and, in another, a behavior. They would not, for example, say: “I was looking at behaviors today and came across a highly integrated repertoire which I have arbitrarily decided to name ‘sexual violence.’” Like modern science more generally, behaviorists begin with sex as sex, and only then move backwards by viewing sex in its objectivity as a behavior. Behaviorists use double-entry bookkeeping. They explain that everything is behavior, but they do not limit themselves to behavior in their investigations. They begin with something meaningful taken from the human world such as learning to play the piano; only then do they break it down into behaviors.

I will indulge in a final example before turning back to neuropsychiatry, though I hope readers will immediately recognize its relation: phrenology. Led by Franz Joseph Gall and others, phrenology was an attempt to tie human qualities such as benevolence, hope, and intelligence to brain regions. Though limited by religious concern and therefore unable to dive beneath the skull to

view the brain in its complicated depths, phrenologists contented themselves with a study of the skull.

The assumption behind the associationism of phrenology (and, later, the localization theory of neuropsychology) was that human qualities could be understood as measurable features of objects. For example, benevolence can be understood not on the ground of humanity, but on the ground of skull-formation—specifically that of Region 24: the knot at the front of the scalp. This is double-entry bookkeeping: one entry concerns meaningful human interaction, the other skull formation. The *nature* of benevolence cannot be ascertained by plumbing the depths of Region 24. What we find there is a surface geography of the cranium and perhaps a network of capillary beds in the flesh. But the phrenologist is not only doing phrenology but also metaphysics. By benevolence, he has in mind a particularly compassionate kind of regard for others. However, to understand this he looks not to compassionate regard as it emerges—that is, benevolence as benevolence—but to the surface of the skull and what he imagines lies beneath (i.e., the brain that is shaped to cause protrusions and indentations). This is benevolence as skull-formation.

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When neuroscientists and others mine the nervous system in an attempt to understand existence, what they are in search of has already been lost. What they find are objects—neurons, action potentials, connectomes—in their objectivity. Such works are fruitful in the investigation of neurons, action potentials, and connectomes, but are of no use if the goal is understanding human existing.

To understand human existence, we must go to where a person is at home, always wrapped up in some particular concerned regard to and inseparable from his or her world.

Heidegger's critique of psychiatry

The identification of states of being with brain states is familiar to those in the fields of psychiatry and clinical psychology. Since the third edition was published in 1980, *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which is used by clinicians to diagnose mental disorders, has used an increasingly biomedical model for explaining psychological disorders (1980).

The biomedical model has replaced the psychoanalytic drive-theory model of explanation (APA 1952; APA 1968).

The most recent iteration, *DSM-5* (APA 2013), continues down the pathway of biomedical explanation. The task-force explains: “The science of mental disorders continues to evolve. However, the last two decades since *DSM-IV* was released have seen real and durable progress in such areas as cognitive neuroscience, brain imagining, epidemiology, and genetics.” (5) They continue, “[s]uch an approach should permit a more accurate description of patient presentations and increase the validity of diagnosis (i.e., the degree to which diagnostic criteria reflect the comprehensive manifestation of an underlying psychopathological disorder)” (5). Here, we see that by “psychological disorder” the *DSM-5* task force has in mind an underlying pathogen, and diagnostic validity can be improved with advances in neuroscience, brain imaging, and so forth.

Bio-medicalization has its dissidents. *DSM-5* has been repeatedly criticized for its medicalization and somatization of psychological disorders. American philosopher of medicine Kevin Aho (2019) has explained that this has led to a “growing dependence on biological explanations which tend to downplay socio-historical factors” (3). Peter Kinderman, British psychologist and former president of the British Psychological Association’s division for clinical psychology, recommends that a psychosocial model replace the medical model (Kinderman 2014; Kinderman, Allsopp, and Cooke 2017). He suggests, for example, that “an effective way to reduce rates of mental health problems might be to reduce inequality in society” (2014, 39). In an open letter to *DSM-5* task force, Division 32 of the American Psychological Association provides four specific examples of how the newer biomedically validated diagnostic criteria have actually lowered diagnostic thresholds, making it easier to receive a diagnosis (Kamens, Elkins, and Robbins 2017). In some cases, exclusionary criteria have been removed (such as the bereavement exclusion for depression of Major Depressive Disorder). In others, diagnostic requirements have been reduced (such as with the number of symptoms required for the diagnosis of adult attention-deficit hyperactivity disorder, ADHD).

Clinicians, for example, explain how depression is caused by a serotonin deficiency the way that scurvy is caused by a Vitamin C deficiency. By replacing

the deficient chemical, both disorders can be corrected. Vitamin C deficiency *explains* the organic imbalance, but cannot help us understand scurvy *as it is experienced* by a sick person. She is not merely lethargic, but unable to exist in the ways she had previously. A talented athlete will experience lethargy in a manner that is quite different from an unemployed couch potato. When citrus fruit is prescribed to and consumed by a scurvy patient, it is the Vitamin C deficiency that is corrected. It is a nutritional problem with a nutritional solution.

168 It is different with depression. The nature of depression can only be understood in the context of being depressed and is diagnosed this way. If a stay-at-home dad doubts the worthwhile nature of his responsibilities and begins to resent his kids, then this could be interpreted as a symptom of depression. In order to understand this, we must remain with being depressed *as* being depressed. However, the neuropsychiatrist who argues that dad is his brain must limit him or herself only to the brain. He or she explains how there is no resentment or children; there is only brain activity (serotonin reuptakes, amygdala, and autonomic nervous system activity). SSRIs do not target relationships with children; they target neurochemicals. Indeed, even “targeting” is an anthropomorphism which neuropsychiatrists should be careful to avoid. This is the position that has become popular among psychiatrists and clinical psychologists who view depression as a neurochemical imbalance.

This is not how psychological disorders work. Psychological disorders are diagnoses based on groups of reported subjective experiences (symptoms) and observable behavior (signs). To include some symptoms (such as embarrassment and pain) and exclude others (such as fatigue or hunger) in a disorder is a matter of *DSM* task-force debate and a committee vote and has nothing to do with biomedical discovery. In the 1920s, *Treponema pallidum* was discovered on post-mortem pathological investigation in the brains of psychiatric patients who had been diagnosed with hysteria and other advanced psychoses. When living patients were treated with Penicillin, along with the bacterial infection the hysterical symptoms dissipated. Penicillin is not a technique of behavioral modification; it cannot treat behavior. Penicillin is a biomedical agent and treats bacterial infections. The treatment of syphilis is likely to result in greater ease with social interactions from polite and unselfconscious conversation to sexual intercourse, but this does not make Penicillin an aphrodisiac.

If the nature of mental disorders such as depression is neurochemical, then the resentment of children would be irrelevant. But this is not how clinicians talk. They explain that SSRIs restore to fathers the joys of fatherhood. This is doublespeak or, as Heidegger (2001) has described it, double-entry bookkeeping.

The confusion of being and brain states was a recurring theme in *Zollikon Seminars*—a series of lectures and conversations between Heidegger and a roomful of Swiss psychiatrists. Heidegger explains,

When [...] the assertion is made that brain research is a fundamental science for our knowledge of the human being, this assertion implies that the true and real relationship among human beings is a correlation among brain processes. Indeed, it implies that in brain research itself all that happens is that one brain, as the saying goes, “informs” another brain in a specific way, and nothing more. Then, when one is not engaged in research during semester vacation, the aesthetic appreciation of the statue of a god in the Acropolis museum is nothing more than the encounter of the brain processes of the beholder with the product of another brain process, that is, the representation of the statue. Nevertheless, if during the vacation one assures oneself that one does not mean it that way, then one lives by double- or triple-entry bookkeeping. (2001, 95)

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Thinking is not neurological activity

My calculator does not think through a math problem. We wouldn't say that the calculator is thinking, even when it takes a moment before producing a sum and we can imagine digital neurons metabolizing glycogen. In cognitive science, however, we find the reverse occurring. Humans are said to compute sums the way calculators do. This is not thinking as thinking, but thinking as calculation and computation. When thinking is equated with computation, we have already vacated thought as it is sometimes (though certainly not always) occupied by human beings. It is no surprise neuroscientists have taken the next step and have transduced cognitive computation into brain activity. Its

familiarity to human being has already been lost. Thinking is a peculiarly human way of relating to problems of living. In order to understand it, it must be viewed as thinking (Heidegger 1976).

William James (1904) proposed a related approach when he argued that there is no such thing as consciousness. He explained that what we have instead are functions of experience (*gerunds*) which have been objectified into various categories (*verbs and nouns*). Instead of thinking, we think thoughts; instead of seeing, we see sights; and so on. He proposed that we begin by taking the entire undifferentiated event of experience as our starting point. He called this radical empiricism. It is in this spirit that I turn to the existential phenomenological hermeneutics of Heidegger.

Human existence

170 For Heidegger, an analysis of being cannot begin anywhere but being (or existence). This does not require a special laboratory, vocabulary, or mental preparation. It requires only that we meet people where they are existing. To understand being (or existence), Heidegger instructs his readers of *Being and Time* and his class of psychiatrists at the Burghölzli hospital to begin with simple, average, and everyday examples.

We understand that a human is always in a world (Heidegger's being-in-the-world). This world is not the heavenly body that rotates on its axis, but the familiar space and things in and through which you and I live. It is impossible to exist without world; the world is the open invitation to be—a bed inviting you to rest or desk inviting you to work. It is only in such a worldly context that “difficulty waiting one’s turn” can be understood. Symptoms cannot be objectified without losing their intentional quality. Psychological disorders must be understood in context (Aho 2019) and on a case-by-case basis as problems of existing. For this, I recommend an existential-phenomenological hermeneutic case study method which I have described elsewhere.²

2 Article under review.

What this means for psychiatry and clinical psychology

The American Psychiatric Association (APA) currently lists a dizzying number of psychological disorders in its nearly 1,000-page manual (APA 2013; if one counts the appendices published online, the page number exceeds 1,000). The manual describes the signs and symptoms that define psychological disorders, as well as their recommended courses of treatment.

Since *DSM-III*, published in 1980 (APA 1980), the APA has remained committed to a neutral, biological understanding of psychological disorders (Aho 2018; Aho 2008). While the APA has abandoned the medical term “disease,” it remains clear that “disorder” is a euphemism for “disease.” However, as they are defined in *DSM-5* (APA 2013), the most widely used diagnostic manual in the world, psychological disorders are not diseases.

Diseases are visible to the tools of medical science such as blood tests and brain images, and they are defined in these terms. Gonorrhea is diagnosed not by the subjective experience of painful urination, but by laboratory analysis from a bacterial culture. Painful urination is a symptom of the disease, but should not be confused with the signs of the disease itself. It doesn't matter how many gonorrhea symptoms I have; if the bacterial cultures—the diagnostic sign of gonorrhea—come back negative, then gonorrhea is not my affliction. When physicians treat patients for gonorrhea, they do not practice double-entry bookkeeping.

It is different with psychological disorders which combine, confuse, and conflate signs and symptoms. Psychiatrists and clinical psychologists count the number of signs and symptoms and, if they exceed a certain predetermined threshold (and the clinician is inclined to believe the patient), then a diagnosis is made. For example, attention-deficit hyperactivity disorder (ADHD) may be diagnosed if an adult has experienced at least five out of nine symptoms. One of the symptoms is “has trouble waiting his or her turn.” As of this writing, there is no neurological test for ADHD. However, this does not keep psychiatrists and clinical psychologists from recommending a treatment which targets the patient's neurochemistry. We may suppose this ADHD *pharmakon* targets the patient's patience. We can be certain that if ADHD is ever discovered in the brain, then like neurosyphilis it will cease to be a psychological disorder and

become a brain disease. The treatment will not be directed at impatience or distraction, but the brain. It is worth noting that ADHD and other disorders are not discovered the way that neurosyphilis was discovered; disorders are invented.³

In his recent interview on National Public Radio (NPR 2019), former National Institute of Mental Health director (2002–2015) and psychiatrist Tom Insel urges medical providers to begin using the term brain disorders instead of mental (i.e., psychological) disorders. He explains how it is not necessary to understand, for example, the precise neural fabric of schizophrenia in order to begin thinking about it as a disease. Insel predicts that doing so will allow psychiatrists and clinical psychologists—now brain-disease-specialists—to make diagnoses years before the condition begins to affect the lives of the brain-disease-sufferers. Insel uses the examples of Alzheimer’s Disease and Huntington’s Disease to demonstrate how changes to the brain often predate psychological patterns by several years. Here we see that by disorder Insel means “disease.”

172 Insel’s reasons for doing so are uncompromisingly optimistic. Just as mortality rates for leukemia, AIDS, and cardiac disease have fallen precipitously since the nineties, he anticipates mental health professionals will soon be able to rein in the 47,000 deaths by suicide which occur each year, and 30% of all medical disabilities for which neuropsychiatric disorders are evidently responsible.

If psychological disorders are brain diseases, then the comparison to leukemia, AIDS, and cardiac disease is an obvious one. But cardiac disease, a natural process, does not a kill a person the way that a depressed person takes his or her own life, an act of will. For Insel, and the APA more generally, choosing to end your life is caused by psychological disorder the way that maternal genetics have caused the red (now gray) in my beard. Just as my beard cannot grow red without the genes for red hair, a person cannot attempt to take his or her life (successfully or unsuccessfully) without first being depressed (for a more detailed discussion of the medicalization of auto-homicide into suicide see: Szasz 2003).

3 Article under review.

Heart-attacks follow cardiovascular problems, and treating them requires knowledge of these systems. Suicide is the decision that death is preferable to life, and it requires knowledge of life and death—that is, it requires an understanding of human existence. Rather than predicting the probability of becoming depressed or anxious by scrutinizing brain-scans which are irrelevant to the diagnosis of each, mental health professionals could begin examining psychological disorders the way they are defined—that is, as problems of living (Aho 2019). Better still would be to avoid limiting the problems of living to those which have received the APA's rubber stamp (Stolorow 2018).

Every psychological disorder has a variety of possible symptoms, each describing a slight if problematic variation on living. Remember: the disorders are synonymous with their signs and symptoms. Trouble waiting my turn (in ADHD) does not occur without horizons of meaning. These would be a more appropriate place to start. While I routinely rattle the plastic push-bar of my shopping cart or distractedly thumb through the pop-culture magazines while waiting my turn in the grocery store check-out aisle, I can remember a time when I was not presenting at least three symptoms of ADHD. I was doing landscaping for the summer and my employer asked me to run an errand for him. In the context of my workday, I had no trouble waiting my turn; I would have waited in that air-conditioned line all afternoon if I had to. The wait interfered only with the tasks of mowing a dozen more lawns and blowing pine-needles from porches. It occurred in familiar world, and it is only within the context of this world that impatience (or its resolution) can be understood.

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Conclusion

DSM-5 has been criticized for its medicalization of subjective symptoms—that is, the assumption that psychological disorders are brain disorders despite lack of evidence (Aho 2018; Aho 2008; Frances 2013; Kamens, Elkins, and Robbins 2017; Kinderman, Allsopp, and Cooke 2017). If psychiatrists and clinical psychologists are serious about understanding psychological disorders, then they must take them as psychological disorders without combining, confusing, or conflating them with brain activity. The same goes for the study of psychological morality, ethics, and aesthetics. Reducing these to brain

activity ignores their distinctive natures. In order to understand psychological phenomena—among others, thinking, emotion, relationships, development, and therapy—psychologists must take these as psychological phenomena. In doing so, one quickly sees that a second ledger is hardly necessary.

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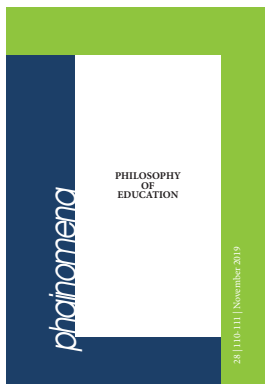
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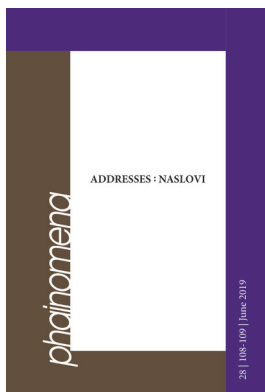


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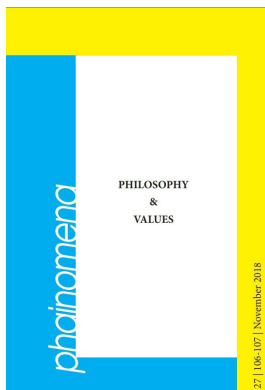
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