

See discussions, stats, and author profiles for this publication at: <http://www.researchgate.net/publication/281901523>

Moral Enhancement: Do Means Matter Morally, Reply to Christoph Bublitz

ARTICLE · AUGUST 2015

READS

3

2 AUTHORS:



Farah Focquaert

Ghent University

28 PUBLICATIONS 109 CITATIONS

SEE PROFILE



Maartje Schermer

Erasmus MC

77 PUBLICATIONS 539 CITATIONS

SEE PROFILE

Online Neuroethics Symposium on The Brains Blog

<http://philosophyofbrains.com/2015/08/25/neuroethics-symposium-on-focquaert-schermer-moral-enhancement-do-means-matter-morally.aspx>

Moral Enhancement: Do Means Matter Morally?

Reply to Christoph Bublitz

Farah Focquaert & Maartje Schermer

We would like to thank Christoph Bublitz for his interesting and in-depth comment and for the attention he draws to the control criterion within the moral enhancement debate. We agree with most of what he argues in response to our paper and will, in our future work, consider his suggestion to understand active participation as one aspect of the control criterion.

We completely agree with Bublitz when he argues that “the first effect of an intervention is a physical process in the brain. This is true for all interventions, be it talk therapy, pharmacology or brain stimulation. And as every mental state has a neuronal correlate; every alteration of the mind is inseparable from an alteration of precisely this correlate. Therefore, one cannot target the mind without targeting the brain, or change the mental state directly but the underlying neuronal state only indirectly.” This is important to highlight, and we completely agree that ‘the moral enhancement debate should be in tune with insights of philosophy of mind and not reproduce folk psychological ideas, deeply imbued with vague dualistic intuitions’. The last thing our paper aims to defend is any kind of dualistic notion of the mind-brain relation and we thank Bublitz for giving us the chance to clearly state this.

Differentiations in terms of whether the mind or the brain is the prime or direct target of an intervention are indeed ontologically meaningless. We agree that it will not help to refer to the “aims” of the intervention, as the immediate aims are the same for both active and passive intervention. Engaging in talk therapy to combat anxiety, or taking pharmaceuticals to combat anxiety, aim at the same thing: relieving an individual of his/her anxiety. Moreover, if effective, comparable (or the same) post-intervention brain alterations will be observable in terms of brain structure and functioning. When we draw a distinction between direct versus indirect and/or passive versus active, we are referring to the *process* by which the changes come about, not merely the way in which the brain exerts its effects. Talk therapy, pharmaceuticals or deep brain stimulation (e.g. for reducing anxiety) are very different processes by which the same or very similar effects (can) come about.

In our view, the ability to rationally reflect upon changes is a central part of what it means for an intervention to be active, i.e. to involve active participation on behalf of the individual undergoing the intervention. We do not argue that a person will be *unable* to reflect upon the effects of a substance (e.g. SSRIs) or stimulation (e.g. tDCS). We argue that there’s a greater likelihood that such reflection might be compromised, either due to the abruptness of the changes or due to the concealed nature of the changes. We fully agree that individuals can reflect upon changes, e.g. those caused by pharmaceuticals, and decide whether to continue or withdraw medication in light of the effects. Overall, we think that pharmaceuticals leave more room for reflection compared to interventions like deep brain stimulation. Although we consider the use of

pharmaceuticals as more passive compared to CBT, we regard pharmaceuticals as (potentially) more active compared to deep brain stimulation.

Last but certainly not least, we fully agree that *control* matters morally in case of deliberate moral enhancements, where control is understood very broadly and ought to incorporate voluntariness and prospective and retrospective endorsement of potential identity changes.

Comment on “Do Means Matter Morally?”
By Dr. Christoph Bublitz
University of Hamburg

Farah Focquaert and Martje Schermer address the question whether means to alter minds matter morally. To appreciate the significance of the topic, it might be helpful to put it in a broader perspective. Among the central controversies of neuroethics is the question whether novel means to intervene into brains and minds are qualitatively different to traditional ones, and whether this difference – if there is one – has normative ramifications. This is not only of academic interest, but stands in the background of ordinary everyday decisions. On the individual level, persons may, for instance, ask whether they should take antidepressants, or give Ritalin to their kids, or whether the desired effects could – and perhaps should – be brought about on different ways, such as more exercise or a different diet. On the collective-political level, one may ask whether a societal setup in which a percentage of the population is permanently medicated with psychoactive substances so that these persons can cope with and participate in social life might be in need of reform (e.g. a different school or employment system). Thus, broadly speaking, choosing the ways by which we influence our own and other persons’ minds is a topic of common concern and not necessarily related to neurotechnologies.

The advent of novel technologies, however, has pushed the question into the limelight. With respect to their use, two main positions can broadly be distinguished. One camp views novel technologies with suspicion because they somehow differ from traditional ones, and this difference provides sufficient reasons to evaluate them differently. The challenge is to identify the difference and to show that it is of moral significance. Candidates are their non-naturalness (artificiality), the fact that they change the brain (rather than the mind), that they are more “direct”, or their impact on the authenticity (identity) of consumers. The contrasting position seeks to debunk these ostensible differences: In the end, all interventions alter brains and minds. Since there are no intrinsic differences between old and novel means both should be treated on par.¹ To clarify: everyone agrees that different means have different effects (e.g., strength) and side-effects. The question is whether apart from such effects, novel direct and older indirect means exhibit normatively relevant differences. Confronted with this question, most people intuitively suspect that novel technologies are indeed qualitatively different. Proponents of the parity principle deserve credit for challenging such intuitions and for having exposed several weaknesses in respective arguments, especially from bioconservative quarters. Nonetheless, some differences may still remain.

In this vein, Focquaert & Schermer argue that a morally relevant difference lies in the fact that some interventions require – or rely on – activity of affected persons, whereas persons can remain passive recipients in others. This difference in activity is normatively relevant as it relates to autonomy and identity of the person. Elsewhere, I have tried to argue in the same direction, and I concur with Focquaert & Schermer’s conclusions.² Nonetheless, I’d like to put some critical questions to them as to how the distinction between active and passive interventions should be understood and whether it tracks the normatively relevant features of interventions. I wish to

¹ Cf. Levy (2007), *Neuroethics: Challenges for the 21st Century*. Cambridge University Press.

² Bublitz/Merkel (2014), “Crimes against minds”, *Criminal Law & Philosophy* 8 (1):51-77.

note that all distinctions between interventions – mine included – are fraught with serious problems. Yet, in order to make progress we have to lay them open.

1. *Direct / Indirect*

In the debate, a distinction is usually drawn between direct and indirect interventions. Focquaert & Schermer seek to replace this distinction: The “morally relevant difference is not that between direct and indirect interventions per se, but between ... active and passive interventions”.³ Active interventions are those that require psychological or behavioral effort, whereas passive interventions bring about the desired end by themselves. Why should activity be the relevant criterion? The authors suggest that more passive interventions potentially compromise autonomy and identity of affected persons to a stronger degree than more active interventions.

Before I turn to the merits of their approach, let me briefly elaborate upon the direct / indirect distinction as presented by the authors. According to them, indirect interventions “aim to change thought patterns and behavior and thus rewire ... brain structure and functioning, whereas direct interventions aim to change brain structure and function and thereby ... thought patterns and behavior”. In short: Indirect interventions target the mind, direct interventions target the brain. Focquaert & Schermer are aware that this is a crude juxtaposition because any intervention inevitably alters both brain and mind.⁴ Nonetheless, they seemingly consider some interventions to be “more direct” than others, e.g. when they compare neurofeedback to talk therapy.⁵ In their discussion of other interventions they write, for instance, that talk therapy “directly” influences mental states and indirectly the underlying brain states, whereas DBS supposedly does vice versa.

The way the difference is presented here is metaphysically dubious and morally dangerous as it prejudices normative assessments. I even suspect Focquaert & Schermer agree with me in this point, but let me make it clear: The problem concerns the way causality runs in the picture the authors present. Apparently some causal chains primarily or directly target the mind and “thus” indirectly the brain, while others primarily or directly change the brain and “thereby” indirectly the mind. So in some way, direct interventions supposedly alter the brain in a more straightforward fashion – “more directly”. This description of the difference seems to express unfounded intuitions about the brain-mind relation. I am aware of the difficulties and technicalities of formulating more correctly at this point, but neuroethics should incorporate insights of philosophy of mind and not reproduce folk psychological ideas, deeply imbued with vague dualistic intuitions. On the physical level, all there is are causal processes that emanate from a source and end up altering brains of recipients. Somewhere along the process, mental and conscious phenomena may come in. The first effect of an intervention is a physical process in the brain. This is true for all interventions, be it talk therapy, pharmacology or brain stimulation. And as every mental state has a neuronal correlate; every alteration of the mind is inseparable from an alteration of precisely this correlate. Therefore, one cannot target the mind without targeting the brain, or change the mental state directly but the underlying neuronal state only indirectly.⁶ Both

³ Focquaert and M Schermer, “Moral Enhancement: Do Means Matter Morally?” (2015) *Neuroethics*, p2.

⁴ *Ibid*, p6.

⁵ *Ibid*, p2.

⁶ *Ibid*, p6.

are in some – concededly mysterious – way ontologically connected, and can thus only be targeted in the same manner. Suggesting otherwise presupposes that both can be separated (substance dualism). As a consequence, differentiations in terms of whether the mind or the brain is the prime or direct target of an intervention become meaningless.

Moreover, it will not help to refer to the “aims” of an intervention. Aims are subjective (only interveners, not interventions, aim at something), and descriptions of aims merely express linguistic conventions which again inherit dualistic thinking. We may speak of aiming to change another’s “thoughts” or “feelings”, but this can only be understood as aiming to change their respective neuronal correlates as well. Likewise, a doctor can prescribe antidepressant to increase serotonin levels, but ultimately he aims at alleviating the depressive condition. Trauma therapy can target “the memory” or its over-consolidated engram. How aims are phrased does not change anything in substance.

How then can one intervention be “more direct” than another? What is the standard for directness? The “length” of the causal chain? The time it takes? Compare two interventions: Person A watches psychedelic patterns on a large screen (or virtual-reality glasses). Person B ingests a psychoactive substance that induces hallucinogenic visions. Let us suppose effects are the same – a prolonged phenomenal experience of psychedelic patterns – and ignore side-effects. Which intervention is more direct? I suspect: the perception. Once visual stimuli hit the retina, a cascade of brain processes is set into motion. The pill, however, has to undergo many chemical reactions, it has to be digested, metabolized, cross the blood-brain-barrier and modify the brain’s visual system. In many aspects, the perception appears more direct. Surely, this contravenes how the distinction is regularly understood: pharmaceuticals are direct interventions whereas perceptual stimuli are indirect one. Speaking of direct, indirect or “more direct” interventions is thus misleading and invites dubious associations.

If one wishes to maintain the distinction it has to be specified. My suggestion is to define indirect interventions as sensory stimuli, i.e. those perceived by our outward senses. This is a technical definition that neither allows for comparative forms (more or less direct), nor for distinctions between targeted mental states and their neuronal correlates. What matters in ethical evaluations is, in my account, the route that stimuli take because persons have more control over some and less over others.

The thrust of Focquaert & Schermer’s argument goes in the same direction. They suggest “that the distinction between direct and indirect interventions tracks an underlying distinction between interventions that require active involvement and effort of the person, and those that allow for the subject to remain a ‘passive recipient’.” They further hold that it is this criterion rather than the direct / indirect distinction which is normatively salient.⁷ Does the active/passive difference make sense – and is it normatively relevant?

2. *Active / Passive*

This poses the question how to understand “active” and “passive” more precisely. Focquaert & Schermer present some striking examples: Cognitive behavioral therapy (CBT) surely requires

⁷ Ibid, p7.

ongoing mental efforts whereas the effects of DBS set in without further conscious mental actions. Nonetheless, I wonder whether this observation generalizes, i.e. whether activity vs. passivity really “tracks” the direct/indirect distinction as the authors suggests, or whether it merely sometimes coincides with it. In general, applying notions such as activity and passivity or loosely related ones such as integrity or (in)stability to the mind can be problematic. For all we know, the mind-brain system is ever-changing, highly dynamic, and works on different levels. The conscious mind can be – phenomenally – passive, effortless while subconscious and brain mechanisms are nonetheless actively processing information. Thus, effects of a supposedly passive intervention such as pharmaceuticals can, I suppose, be quite dynamic and generate lots of activity – on lower levels.

Surely, one can understand – as Focquaert & Schermer seem to do – activity as consciously willed effort. But this might be too narrow to capture normatively relevant differences. Consider, for instance, a typical indirect intervention and a classic practice of moral enhancement, moral education. Suppose a state organizes nationwide screenings of a movie about the flight of Yezidis from Syria, escaping enslavement by the Islamic State and crossing over to Europe on a ‘floating coffin’, which changes many viewers’ opinions on immigration and motivates some to assist refugees. In which sense is watching a movie “active” – is a TV audience not often conceived as a paradigm case of ‘passive recipients’? Watching movies requires subconscious information processing, but hardly mental effort. Compare this to a classic indirect intervention, the effects of a psychoactive substance such as LSD which may cause a more peaceful relation to oneself and others. During such an artificially altered state of consciousness, consumers may monitor themselves to identify mental changes, engage with their altered perceptions of the world and themselves, play with their altered sensory apparatus and wonder about questions that appear in a different light. This requires conscious mental activity, which in turn seems to alter the psychological effects of the substance. Drawing distinctions between watching a movie and consuming psychoactive substances in terms of conscious mental activity does not seem warranted.

Focquaert & Schermer may reply by pointing to the “room for rational reflection and deliberation” that the movie leaves. But this seems equally true for the effects of a pill. In any case, “rational reflection upon changes” is a criterion different to activity. I presume many interventions leave room for post-hoc rational reflection of changes. The presentation of the authors, however, suggests the contrary: CBT, for instance, leaves “ample room for the individual to rationally reflect upon changes brought about as the interventions continues and to withdraw from the intervention if one cannot identify with these changes, or to reject certain changes and endorse others. By contrast, when directly altering an individual’s brain functioning, subsequent changes to one’s identity cannot be deliberated on in the same gradual manner and cannot be selectively endorsed or rejected”.⁸

I am not persuaded such a “contrast” exists. Why should a person be unable to reflect upon the effects of a substance or stimulation – at least once it wears off? We do reflect upon changes, e.g. those caused by pharmaceuticals, and decide whether to continue or withdraw medication in light of effects. Why should this not be possible with psychoactive moral medications? Moral

⁸ Ibid, pages 7-8.

bioenhancements are not permanent, irreversible interventions, nor do they undermine capacities for rational reflection. Post-intervention reflection does not depend on active involvement during interventions.

The quoted passage entails the further argument that one cannot *selectively* endorse or reject alterations. Strictly speaking, one can selectively endorse or reject new properties (“I endorse X but reject Y”). One may be unable to selectively *alter* properties because direct interventions cause several effects. Effects may come in a bundle so that the only options are to take or reject all. This, however, is an empirical assumption, and pertains to a different argument. Whether an intervention has fine-tuned, specific or broad-spectrum effects depends on the precise mode of its operation. It does not track the direct or indirect distinction. Specific direct interventions are just as conceivable as broad-spectrum indirect ones. Nor does it track the active/passive criterion. Consider psychotherapy: its effects take a long time, one cannot retrospectively undo them, and it potentially alters many mental properties of a person. DBS, by contrast, can be turned off – or the voltage adjusted – in minutes. In other words: interventions may differ with respect to their specificity and unwanted side-effects which inevitably accompany desired main effects. This is true for interventions of all categories, active/passive, direct/indirect. The consequence is not that a class of intervention is preferable to another, but that the effects of some interventions are only attainable by taking side-effects upon oneself.

3. *From activity to control*

However, this should not convey the impression that activity and passivity are not of normative relevance. Just as the authors suggest that the active/passive difference tracks the normative relevant features of the direct/indirect distinction, I would like to suggest that the active/passive distinction is shorthand for – and often tracks – another criterion which ultimately matters normatively: control. As I have argued elsewhere – and the authors quote this approvingly – the abstract normative idea that should guide interventions into mind and brain is mental self-determination. A central part of it is conscious mental control.⁹ Any intervention that requires active participation or even effort is almost by definition controllable – conscious activity and control often overlap, they can refer to the same mental capacity. However, one can also control supposedly “passive” technological devices such as DBS. Insofar as the individual controls the parameters of such interventions (e.g., through the simulator), her autonomy is not undermined, even though she remains “passive” and effects set in “by themselves”. Problems with control only arise if others control such devices – and thereby functions of mind and brain – without consent of affected persons. Conversely, passive interventions may even increase control when they enable steering of mental functions which we cannot access by conscious effort or activity. Activity and control are thus not the same. The general moral relevant criterion is control, of which conscious activity is an important, but not the only or even a necessary element.

In light of control, the direct/indirect distinction which the authors seek to absolve appears meaningful. We have more control over indirect interventions, defined as those stimuli that enter our brain via our senses, than over those that alter our minds through electricity, magnetic fields or chemical changes because we lack conscious control capacities over these properties. Indirect interventions can be further subdivided in those that come to conscious awareness and others

⁹ Cf. Bublitz (2015), “Moral Enhancement and Mental Freedom”, *Journal of Applied Philosophy*.

that do not. We have more control over the former. But even if we lack conscious control over the many subconscious mechanisms that process sensory information, I suggest that the entire system has more control over the stimuli which it was shaped by evolution to process than over direct interventions. Of course, empirical assumptions come in here, and there may be exceptions. I hasten to note that we do not possess *full* control even over conscious indirect stimuli, as the emotional reactions to a heartbreaking story of refugees show. Nonetheless, control seems to be the normatively appropriate criterion to draw distinctions between different means to change minds.

Finally, I wish to note that despite these – a bit hairsplitting – objections, I concur with much in Focquaert & Schermer argument and find their contribution of the activity criterion to the debate of great importance.