



Mind-Body Causal Relationship: Inquiry into Mental Health Disorders and the Limits of Neurobiological Reductionism

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Abstract

This paper undertook a critical and exploratory inquiry into how causality in the mind-body relationship has been theorised and operationalised in contemporary mental health discourse. Unlike dominant approaches that prioritised brain-based explanations for psychological disorders, this paper interrogated the ontological and epistemic assumptions underpinning neurobiological reductionism, which is the belief that all mental phenomena can be explained purely through physical processes in the brain. Approached through the philosophy of mind, particularly (emergentism, dual-aspect monism and enactivism), the paper reframed mental disorders not as mere neurochemical malfunctions but as complex, causally layered phenomena emerging from interactions between the physical, subjective, social, and environmental domains. Methodologically, the study applied conceptual analysis, drawing from theoretical triangulation across analytic philosophy, phenomenology, and systems theory to reconstruct the mind-body problem in light of clinical realities such as treatment-resistant depression and psychosomatic disorders. The proposed framework challenged linear, one-directional causality and instead, advances a recursive, non-reductive model where mind and body are mutually influential yet ontologically distinct. The discussion engaged historical trajectories from Descartes to contemporary neuroscience, while critically reviewing diagnostic paradigms in psychiatry (e.g., DSM-5) that reflect implicit reductionist biases. The paper concluded by suggesting a shift toward pluralist explanatory models in mental health, advocating for integrative diagnostics and treatment modalities that considers both neural and experiential dimensions.

Keywords: Mind-body causality, Mental health theory, Neurobiological reductionism, Emergentism, Enactivism, Non-reductive physicalism

Introduction

The dominance of neuroscience in psychiatry has contributed significantly to the understanding of mental disorders, albeit narrowing the way such disorders are conceptualised, often treating them as isolated biological pathologies within the brain. While this has informed useful treatments such as pharmacotherapy and neurostimulation, it has also seen to a model that often fails to account for the experiential, environmental, and relational dimensions of mental suffering. For example, the persistent challenge of

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treatment-resistant depression raises questions about whether biological reductionism is sufficient to explain the lived realities of those experiencing mental illness.

Reductionist approaches in psychiatry stem from long-standing assumptions that connects mental disorders with neural malfunctions, often reducing

diagnosis and treatment to alterations in brain chemistry or structure. This framework is evident in how diagnostic criteria are constructed around observable symptoms rather than causes, with minimal reference to patients' subjective experiences. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), despite its clinical utility, remains emblematic of this stance, as it avoids theoretical models of causation altogether¹. In avoiding these theoretical commitments, it implicitly supports a biomedical orientation that treats the mind as subordinate to the brain. This leads to an ontological restriction of the complexity that mental disorders often involve.

Although neuroscience continues to make progress into correlates of mental distress, such as altered serotonin transmission in depression or reduced hippocampal volume in Post-Traumatic Stress Disorder, these findings are not sufficient to explain or resolve the full range of human psychological suffering. Kendler² on this note cautions that the overconfidence in biological explanations creates what he describes as "a potentially misleading reification of psychiatric categories". This reification not only affects clinical judgment but also fosters expectations of mechanistic solutions to problems that often have existential and social roots. If mental disorders are not merely biological, then a biologically exclusive model cannot offer a complete understanding of them.

This gap between biological findings and subjective realities demands a more comprehensive model that acknowledges the layered causality of mental disorders. This includes not only neurophysiological changes but also first-person experiences, interpersonal relations, and socio-cultural contexts. The concept of emergence, for instance, offers a useful way to understand this complexity as mental phenomena can emerge from neural processes without being reducible to them, much like liquidity emerges from water molecules without any single molecule being "wet." Searle³ argues that "consciousness is both caused by and realised in brain processes but has its ontological status". This position, while retaining a material base, preserves the autonomy of mental states as having causal efficacy in their own right.

Emergentist perspectives shift focus from a hierarchical structure where the brain unilaterally causes mental phenomena to a dynamic system in

which both mind and body co-create meaning and experience. This has practical implications for mental health care as a person living with depression may exhibit low serotonin levels, but the disorder may also arise from prolonged grief, social alienation, or existential despair. Attempting to resolve such suffering with medication alone can lead to inadequate treatment and a misunderstanding of the patient's condition. Fuchs⁴ makes a strong case for this argument by asserting that "psychopathology cannot be reduced to brain dysfunction but should be understood as a disturbance in the person's relation to the world". This approach recognises that mental illness is not just located in the brain, but in the lived body and social world.

This paper ontologically and epistemologically sought to understand why psychiatry continues to assume that mental illnesses are reducible to neuronal dysfunctions, which is limiting in both explanatory power and therapeutic reach. Rather than discarding neuroscience, the goal here is to re-contextualise it within a broader theoretical and clinical framework. This includes taking seriously the contributions of dual-aspect monism, which posits that mind and body are not two substances but two aspects of a unified reality. Spinoza originally advanced this position, but contemporary thinkers such as Chalmers⁵ have revitalised it within the philosophy of mind by suggesting that "conscious experience might be a fundamental feature of the world, akin to mass or charge". Such an approach disrupts the Cartesian divide and encourages psychiatry to treat subjective experience as an ontologically legitimate domain as the study shall show.

Research Objectives

The major objectives of the paper are to:

- i. Critically examine the philosophical limitations of neurobiological reductionism in psychiatry, particularly its assumptions about mind-body causality in the diagnosis and treatment of mental disorders.
- ii. Evaluate how alternative philosophical perspectives such as emergentism, enactivism, and dual-aspect monism can provide a more holistic conceptual framework for understanding mental health conditions.
- iii. Analyse the implications of prevailing psychiatric diagnostic systems (e.g., DSM-5, RDoC) on clinical practice, especially in their

treatment of subjective experience and contextual factors.

- iv. Investigate the potential of integrative, pluralistic approaches to reshape psychiatric theory, research, and practice in ways that respect the complexity of mental disorders.
- v. Propose an epistemologically and clinically coherent model for mental health care that reconciles biological, psychological, social, and phenomenological dimensions.

Research Questions

The research questions that guided the logical trajectory of the paper are:

- i. What philosophical assumptions underpin neurobiological reductionism in psychiatry, and how do these shape diagnostic and treatment practices?
- ii. How do alternative perspectives like emergentism, enactivism, and dual-aspect monism address the limitations of reductionist models in explaining mental disorders?
- iii. In what ways do current psychiatric diagnostic systems inadequately account for subjective, relational, and sociocultural dimensions of mental illness?
- iv. What would an integrative, pluralistic framework for mental health look like, and how might it improve clinical outcomes compared to existing models?
- v. How can a reconceptualisation of mind–body causality inform the future direction of psychiatric research, policy, and therapeutic practice?

Literature Review

The literature on the mind–body relationship in psychiatry has expanded significantly in recent decades, particularly in response to the dominance of neurobiological explanations for mental disorders. Much of this critique the assumption that mental illnesses are reducible to brain dysfunctions, advocating for more integrative, multidimensional models. Neurobiological reductionism rests on the idea that mental disorders can and should be explained in terms of brain structure, function, and biochemistry. Historically, this position gained traction with the rise of biological psychiatry and the development of psychotropic drugs in the mid-20th century. However, the reduction of mental disorders

to neural dysfunction is not merely a scientific position but an ontological and epistemological commitment, as noted by Murphy⁶, who argues that many contemporary psychiatric theories “presume that brain-based causation is sufficient to explain mental phenomena”.

This assumption is strongly embedded in psychiatric training and policy, often implicitly. For example, the National Institute of Mental Health’s Research Domain Criteria (RDoC) project was founded on the goal of identifying biological markers of mental disorders, but it has faced criticism for bypassing lived experience. According to Zachar and Kendler⁷ the RDoC reflects “a commitment to ontological reductionism” that fails to acknowledge the complexity and heterogeneity of psychiatric conditions. Churchland⁸ who is a strong proponent of eliminative materialism, represents the extreme edge of this position, suggesting that mental states themselves will eventually be eliminated from scientific explanation. However, such views have remained controversial. Critics like Perring⁹ argue that attempts to eliminate the mental in favour of pure neurology “collapse under the weight of subjective suffering” noting the inescapable role of conscious experience and personal meaning in psychiatry.

The DSM-5, while intended to offer a descriptive, symptom-based diagnostic system, has been widely critiqued for implicitly reinforcing a reductionist, biomedical approach to mental illness. Deacon¹⁰ observes that, although the DSM avoids explicitly naming causes, “its structure and language nudge practitioners toward biological explanations”. The clustering of symptoms and the lack of etiological discussion produce an illusion of neutrality, but in reality, it tends to marginalise psychosocial and existential dimensions. Horwitz and Wakefield¹¹ offer a historical critique of depression diagnoses, arguing that normal human suffering has increasingly been pathologised under DSM criteria, with insufficient attention to life context. They write that the expansion of diagnostic categories often reflects cultural values and medical convenience more than scientific rigour. Moncrieff¹² examine how psychopharmacological marketing and guideline development contribute to a “disease-centred model of care” that equates mental disorders with biochemical imbalances, despite a lack of robust causal evidence stressing that this framing narrows treatment options and delegitimises therapeutic interventions that focus on meaning-

making, social integration, or narrative repair. In response, alternative classification frameworks such as HiTOP and the Power Threat Meaning Framework have been proposed. While these alternatives vary in theoretical grounding, they generally reject simple biological causation and emphasise the need to understand symptoms as contextual responses to life circumstances. Johnstone and Boyle¹³ for instance, argue that “emotional distress is best understood as a response to power imbalances and threats, rather than as symptoms of internal dysfunction”.

Emergentism provides an influential alternative to reductionist models by holding that mental properties emerge from physical substrates but cannot be reduced to them. O'Connor and Wong¹⁴ develop this idea in terms of strong emergence, which posits that higher-level phenomena, like emotions or intentions, have real causal powers not found at the physical level. This idea has been applied to psychiatry by thinkers like Kendler¹⁵ who proposes that mental disorders arise from the interaction of multiple levels of reality, including genes, neurobiology, environment, and personal history. For Kendler, explanatory pluralism is not a vague appeal to complexity but a scientifically necessary framework advocating a model where causal influences are recognised across multiple domains and interact recursively. This view is held by Bolton and Gillett¹⁶, who apply non-reductive physicalism to clinical contexts, arguing that mental causation is real and clinically significant, even if it supervenes on physical states.

Dual-Aspect Monism (DAM) provides another philosophical framework that critiques both reductionism and Cartesian dualism. In this view, mind and body are not two separate substances but two aspects of the same underlying reality. This allows for a unified ontology while still preserving the irreducibility of mental phenomena. Chalmers¹⁷ in his argument that subjective experience, what it feels like to be in a mental state cannot be explained by physical accounts alone. This has significant implications for psychiatry such that if subjective states are fundamental, then ignoring them is not just incomplete, but an ontological mistake. DAM has been used by Gozé and Samuel¹⁸ to interpret schizophrenia not as a breakdown of the brain, but as a disruption in the alignment between the mental and physical aspects of the self. This theoretical position encourages clinicians to treat patient reports of

suffering not as epiphenomenal but as an essential diagnostic data. In practice, this opens the space for integrating narrative medicine, existential therapy, and other approaches that treat the patient as a meaning-making subject.

Enactivism, developed by Varela, Thompson, and Rosch¹⁹, shifts focus away from internal representations and toward the dynamic interaction between organisms and their environments. It challenges the idea that the brain is a closed system and argues instead that cognition is embodied, enacted, and situated. This model has gained traction in mental health through the work of phenomenological psychiatrists like Thomas Fuchs, who argues that disorders such as depression and schizophrenia involve disruptions in embodied intersubjectivity. Fuchs²⁰ explains that depression is not just a chemical state but a collapse of bodily intentionality which has to do with how the body projects itself into the world. Similarly, Gallagher and Zahavi²¹ argue that mental disorders cannot be fully understood without attending to how the person relates to time, space, others, and themselves.

Enactivism has also been applied in therapeutic contexts with the Open Dialogue approach, developed in Finland, which uses enactive principles by focusing on relational dynamics rather than individual pathology. Studies by Seikkula et al²² show that such approaches can achieve better outcomes in psychosis than traditional biomedical interventions, suggesting that healing emerges from social interaction, not just medical correction. Beyond philosophical critique, several empirical and clinical studies also challenge reductionism by stressing its failure to produce effective treatments. For example, Kirsch et al²³ analysed data from FDA-submitted trials of antidepressants and found that the difference between medication and placebo was minimal in all but the most severe cases. This suggests that subjective meaning, expectation, and therapeutic context play a far greater role in recovery than the neurobiological model admits.

Similarly, the phenomenon of treatment-resistant depression has led many psychiatrists to question whether our understanding of depression is too narrow. Ghaemi²⁴ argues that biological treatments alone fail in a large percentage of cases, not because the drugs are wrong, but because the model of depression is incomplete. In response, there has been increasing interest in integrative care models which

include psychosocial rehabilitation, culturally adapted therapies, and trauma-informed care all of which implicitly reject the notion that brain chemistry is the sole determinant of mental disorder. As such, clinical literature is beginning to reflect what the philosophical literature has long argued that mind and body cannot be separated, and neither can be privileged in explaining suffering.

From an African and Oriental philosophical standpoint, the relationship between mind, body, and mental health is often approached through a holistic, communal ontology that challenges the individualistic and mechanistic assumptions of Western psychiatry. Kwame Gyekye²⁵ argues that in Akan thought, the human person is a composite of the *honam* (body), *okra* (life principle or soul), and *sunsum* (personality or spirit), with mental well-being emerging from the harmonious interaction of these elements within the context of community life. This worldview resists neurobiological reductionism by locating causality in mental health within a network of physical, spiritual, moral, and social relations, thereby acknowledging that disturbances in mental well-being may stem as much from social disharmony or spiritual imbalance as from physiological dysfunction. Such a perspective aligns with pluralistic and non-reductive approaches in contemporary philosophy of mind, which offers culturally grounded insights into how mind–body causality can be conceptualised in ways that integrate experiential, relational, and physical dimensions.

Theoretical Framework

This paper is guided by three key philosophical frameworks known as Emergentism, Dual-Aspect Monism, and Enactivism that challenge the assumptions of neurobiological reductionism. These frameworks do not reject the biological dimension of mental disorders, but instead seek to reframe mental phenomena as complex, in degrees and relational. Each theory supports the broader goal of this study, which is to construct a non-reductive, pluralist model of mind–body causality and mental disorder. The selection of these theories is grounded in the theoretical triangulation discussed in the methodology. Each framework contributes a different conceptual angle thus: Emergentism introduces a model of causation beyond mere aggregation; Dual-Aspect Monism challenges dualism without collapsing mind into matter; and

Enactivism offers a relational, embodied account of mental life. Together, they allow for a multidimensional understanding of mental disorders that goes beyond the explanatory limits of neurobiology.

Emergentism

Emergentism holds that mental properties emerge from but are not reducible to physical processes. This means that while the mind depends on the brain, it cannot be fully explained by referencing neural mechanisms alone. Mental phenomena are viewed as higher-order features with their causal powers, distinct from the parts from which they arise. For instance, consciousness or intentionality cannot be explained simply by describing neural firings as these phenomena exhibit characteristics like subjective meaning that cannot be derived from lower-level physical descriptions. Kim²⁶ challenges this view by arguing that emergence risks violating causal closure in the physical domain. However, other thinkers like O'Connor and Wong²⁷ defend a robust form of emergence, where mental states, once realised, can influence neural processes in return, forming a feedback loop. This concept supports the idea of recursive causality proposed in this study. Emergentism aligns with clinical cases such as treatment-resistant depression, where observable brain changes do not fully account for the experiential persistence of the disorder. It suggests that even when biological interventions address chemical imbalances, the patient's subjective world values, memories, interpersonal losses remain a central part of the illness process.

Dual-Aspect Monism

Dual-Aspect Monism (DAM) proposes that mind and body are not separate substances, as in Cartesian dualism, but two aspects of the same underlying reality. This position dates back to Baruch Spinoza, who argued that mental and physical phenomena are two attributes of one substance which is God or Nature. In contemporary terms, DAM provides a framework where mental and physical events are complementary descriptions of the same process. David Chalmers²⁸ took to this view by proposing that conscious experience is a fundamental feature of the world, not derivable from or reducible to physical facts. This suggests that subjective experience has its ontological weight, even if it arises alongside

physical processes. DAM challenges the assumption that psychiatry must choose between dualism and reductionism instead supporting a model where neural events and mental states are parallel but irreducible perspectives. In mental health practice, this framework invites a shift in how patients are approached. If symptoms are both neurobiological and experiential, then effective care requires attention to both. The framework also helps explain why subjective suffering can persist despite biological “normalisation,” and why two patients with similar brain scans may report entirely different experiences.

Enactivism

Enactivism, challenges the internalist model of cognition by asserting that mental phenomena arise through the dynamic interaction between an organism and its environment. Enactivism holds that cognition is not located solely in the brain, but is embodied, embedded, and enacted in the world. According to Varela, Thompson, and Rosch²⁹, “the mind is not in the head, but in the lived interaction between the body and the world”. This has profound implications for psychiatry as mental disorders are not simply malfunctions inside the brain but disruptions in the person's engagement with the world. Anxiety, for example, is not merely an excess of adrenaline but a changed relationship to time, space, and possibility. Depression is not just low serotonin; it is also a loss of future orientation, a changed bodily posture, and a shift in how the world appears to the sufferer.

Enactivism also connects to phenomenology, especially in its focus on lived experience. For instance, Fuchs³⁰ describes schizophrenia not as a cognitive deficit but as a disintegration of bodily and intersubjective coherence. This expands the scope of mental health theory by drawing attention to intercorporeality, temporality, and spatiality dimensions often ignored in reductionist accounts. Enactivism supports the idea that effective intervention may sometimes involve altering a person's environment, social context, or self-narrative, rather than their neurochemistry. It validates approaches such as narrative therapy, open dialogue, and embodied practices that target meaning and interaction, not just symptoms.

Methodology

This paper adopts a non-empirical, conceptual

methodology, drawing on tools from philosophy and systems theory to interrogate the frameworks that shape current psychiatric understandings of mental illness. Given that the central aim of this research is to challenge the ontological and epistemological assumptions underlying neurobiological reductionism, the focus is not on generating new clinical data but on reconstructing foundational concepts that inform how mental disorders are diagnosed, explained, and treated. This methodological orientation is especially appropriate because many of the issues at stake such as what constitutes a mental disorder, or what counts as causation, or how subjective experience relates to brain processes are conceptual rather than empirical. They are before data in the sense that they shape how data is interpreted and which data is considered relevant in the first place.

Philosophical Inquiry and Conceptual Analysis

The study is grounded in philosophical inquiry, particularly the tradition of conceptual analysis, which involves carefully examining the meaning, coherence, and implications of the key concepts used in mental health discourse. Terms like “mind,” “mental disorder,” and “causality” are not always clearly defined in clinical settings, yet they significantly influence how clinicians and researchers think and act. The task here is to reveal and critically evaluate the hidden assumptions these terms often carry. Kendler³¹ argues that, psychiatry frequently operates on “implicitly held views about the nature of the mind and brain,” which shape both theoretical models and clinical decisions. Without clear conceptual reflection, psychiatry risks reinforcing metaphysical positions such as reductionism without acknowledging them as such. Philosophical analysis allows the study to confront these underlying positions directly and evaluate their adequacy in light of clinical realities.

This approach is not meant to replace empirical research, but to provide a clarifying lens through which both data and clinical practice can be reinterpreted in a complementary manner. For example, a reductionist might point to low serotonin levels in depressed patients as a causal explanation, while a conceptual approach would ask whether this explanation is sufficient, or whether it overlooks important experiential, environmental, and interpersonal dimensions.

Theoretical Triangulation

To deepen the analysis and support its non-reductive perspective, the study draws on a triangulation of three theoretical traditions:

- i. Analytic Philosophy which provides the logical and definitional tools needed to interrogate how reductionism is structured as an argument. It helps clarify what it means to say that one phenomenon “reduces” to another, and what ontological assumptions such claims involve.
- ii. Phenomenology focuses on the first-person, lived experience of mental illness. This perspective is particularly valuable in resisting accounts of mental disorder that reduce symptoms to measurable behaviours or neural dysfunctions. Ratcliffe³² notes that, phenomenology helps uncover “structures of experience that are central to understanding psychopathology”.
- iii. Systems Theory contributes an understanding of complex, recursive, and bidirectional causality, which is especially useful in modelling the dynamic interactions between biological, psychological, and social factors. It allows for an approach where the mind is not caused by the brain in a linear sense but emerges from a network of interacting systems.

Bringing these traditions together enables a diverse inquiry that reflects the layered and complex nature of mental illness. The triangulation is not an attempt to unify all theories into a single framework, but rather to honour the plurality of valid insights that each perspective brings to the topic.

Sources and Materials

The study relies on secondary sources, including philosophical texts, psychiatric literature, and clinical narratives. These materials are not treated as empirical data but as texts for conceptual interpretation and critical engagement. Key documents include the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), philosophical works on the mind–body problem, and phenomenological analyses of specific mental health conditions. In examining these sources, the study looks not only at what they say, but at how they say it and what assumptions they make, what models of causality they presuppose, and what they exclude or render invisible. For example, the DSM-5’s decision to avoid causal explanations may appear neutral but reinforces a biomedical orientation by privileging

symptom-based classification³³.

Methodological Scope and Justification

It is important to acknowledge that this methodology has limitations. It does not generate new empirical findings, nor does it test hypotheses through clinical trials or statistical analysis. Its contribution lies in providing a theoretical and conceptual foundation upon which more integrated models of mental health can be built. Some by reason of their orientation may criticise this approach as too abstract or detached from practice. However, that is mitigated by grounding the analysis in real clinical challenges, such as treatment-resistant depression and psychosomatic disorders, and by engaging with contemporary psychiatric texts and discourse.

It is along this line that Stanghellini and Fuchs³⁴ observes that, mental disorders involve both “natural and lived aspects of human life,” and understanding them requires both empirical and philosophical inquiry. This paper offers the latter, aiming to clarify the conceptual terrain so that future clinical research and practice can operate with greater philosophical precision and openness. In all, this methodology reflects the spirit of explanatory pluralism, not as a vague call for inclusivity, but as a methodologically grounded position that respects the complexity of mental disorders. Rather than offering a single alternative theory, the study provides a conceptual platform from which more integrative, ethically sensitive, and ontologically coherent models can emerge.

Findings

The core findings of this inquiry challenge the major narrative in contemporary psychiatry that mental illness can be understood and treated primarily through neurobiological mechanisms. Through conceptual triangulation involving philosophy of mind, systems theory, and phenomenological critique, this study identifies five key findings that brings to the fore the limitations of neurobiological reductionism and propose a pluralistic, recursive model of mind–body causality. Each finding emerges from the convergence of theoretical analysis and observable clinical inconsistencies, such as the persistence of symptoms despite pharmacological intervention, the problem of diagnostic oversimplification, and the disconnection between treatment modalities and subjective realities.

i. Unidirectional Causal Non-Explanation

One of the most significant findings from this conceptual inquiry is that mental disorders cannot be explained using a linear, bottom-up biological model. Reductionist approaches assume that causality flows unidirectionally from brain states to mental states with low serotonin levels causing depression, overactive dopamine systems causing psychosis, and so on. However, this model consistently fails to capture the causal entanglement between subjective experience and neural patterns. Philosophically, this reflects a rejection of causal monism in favour of recursive causality where causes and effects are bidirectional and contextually co-constituted. A depressed person's negative thought patterns not only result from altered brain chemistry but may, in turn, reinforce or even alter the neural structure itself. Such mutual feedback has been documented in studies on neuroplasticity, where cognitive interventions and even social experiences can lead to observable brain changes³⁵.

Kendler³⁶ supports this in his critique of biological reductionism, stating that "although psychiatric illness is ultimately biological in a weak sense, the optimal level for understanding and intervention often lies elsewhere". This view goes against the belief that meaningful psychiatric intervention must be directed at the brain, affirming instead that multiple levels of explanation and causation can coexist, none reducible to the other.

ii. Diagnostic Categories

A second key finding concerns the conceptual inadequacy of current psychiatric diagnostic systems, particularly the DSM-5. Although DSM classifications are presented as atheoretical, this inquiry reveals that they indirectly reinforce a biomedical model, framing mental disorders as discrete, biologically driven conditions. The problem is not that diagnostic labels are entirely useless, they often offer clinical utility and facilitate treatment access. However, they function as if grounded in clear causal mechanisms. Conditions like depression, anxiety, or schizophrenia often present with heterogeneous symptoms, inconsistent biological markers, and variable responses to treatment. Yet DSM-5 categories treat them as uniform syndromes, which inadvertently obscures psychosocial, existential, and cultural contributors.

Johnstone and Boyle³⁷ argue that diagnoses often serve to "locate the problem within the individual,

rather than in their relationships or social circumstances". This finding affirms the need for integrative diagnostics approaches that include both objective classification and subjective narrative meaning. Without such pluralism, psychiatry risks projecting concepts that do not reflect the lived complexity of patients' distress.

iii. Subjective Causal Experience

Another critical finding of this inquiry is that subjective, first-person experience is not epiphenomenal but is a genuine domain of causality in mental illness. While biological psychiatry often views subjective states as symptoms arising from deeper, material causes, this paper particularly through engagement with dual-aspect monism and enactivism suggests that subjective life is itself part of the causal matrix. In depression, for instance, it is not only neurotransmitters that matter, but how the individual experiences loss, failure, or hopelessness which are experiences that shape perception. Fuchs³⁸ notes that, mental disorders like depression are "not merely brain states but disruptions in a person's relationship to the world". To this end, mental disorders are best understood as affective, cognitive and social patterns, not isolated dysfunctions of brain chemistry. This challenge the current hierarchy in mental health care, where biological explanations are often treated as more legitimate than experiential ones. The findings here support the idea that any adequate explanation of mental illness must begin with and include the patient's subjective, embodied, and intersubjective world.

iv. Treatment-Resistant Disorders

An important striking empirical support for the arguments in this paper comes from clinical phenomena such as treatment-resistant depression (TRD). Despite multiple classes of antidepressants, brain stimulation methods, and biochemical hypotheses, a significant proportion of patients show no meaningful response to biological interventions³⁹. These cases underscore that mental disorders are not simply chemical imbalances, but deeply meaning laden conditions that demand broader therapeutic engagement.

Kendler⁴⁰, writes that attempts to locate a "single, privileged level of analysis" for psychiatric disorders are both scientifically and clinically misplaced. Findings here support the value of non-biological modalities such as existential therapy, trauma-informed care, and narrative approaches not as

complementary, but as co-primary treatments. These modalities engage the patient as a meaning-making subject, not just a malfunctioning brain. Without integrating these into mainstream care, psychiatry risks ignoring the very elements that make healing possible.

v. Philosophical Models

Finally, this inquiry finds that philosophical models of mind–body relations are not merely critical tools, but productive frameworks for constructing new causal logics. While much of the literature critiques biological reductionism, fewer studies offer a reconstruction. The synthesis of emergentism, dual-aspect monism, and enactivism presented here offers a positive ontological model that understands the mind–body relation as non-reductive; meaning, mental states are not "nothing but" brain states; recursive which hold that causal influence flows both up and down the system; Context-sensitive where meaning arises through embodied interaction with the world. These findings challenge the frequent clinical binary between "psychological" and "biological" disorders. The theoretical approach used here dissolves this distinction, showing that every mental disorder is both, but not in a way that collapses one into the other. Instead, these frameworks produce a middle space where interdisciplinary treatment, diagnosis, and integrative theory become possible. This way, philosophy is not peripheral to psychiatry but central to its renewal.

Discussion

Neurobiological Reductionism Epistemic Limits

The work of Kirsch et al⁴¹ which analysed data submitted to the U.S. Food and Drug Administration (FDA) for the approval of antidepressants, demonstrates how antidepressants offer only marginal benefit over placebo, especially in cases that are not classified as extremely severe. This undermines the biomedical claim that brain chemistry is the primary cause of depression. The implication is that biological causation cannot be straightforwardly assumed, even when pharmacological interventions are involved. Kirsch et al⁴² note that, the small drug to placebo difference is "attributable to decreased responsiveness to placebo among very severely depressed patients, rather than to increased responsiveness to medication. A reductionist model that centres on neurotransmitters or receptor malfunctions not only oversimplifies the

causal network of mental illness but does so by selectively prioritising what is measurable over what is meaningful. This evidentiary narrowing reflects a metaphysical bias, not scientific necessity.

Diagnostic Formalism

The DSM-5 functions as more than a neutral classificatory scheme as it implicitly legitimises the reductionist project. Its structural foundation in syndromic categorisation ignores personal history, sociocultural context, and lived experience, which are not merely incidental features but essential to understanding the onset and course of mental illness. This mechanistic bias is reinforced in diagnostic language, which tends to obscure causal complexity by invoking categories that imply ontological fixity. Johnstone and Boyle⁴³ aptly call attention to how such frameworks serve the interests of the psychiatric institution more than the people it claims to help.

Enactivism and the Lived Body

Drawing from enactivist theory, this inquiry reframes the mind–body relationship as a dynamic, relational process, not a linear interaction between two distinct substances. Rather than viewing the mind as residing "in" the brain, the findings encourage us to see mental processes as embodied, arising from and through engagement with the world with concrete implications for treatment. Depression, as discussed by Fuchs⁴⁴, is not merely a neurochemical state but an altered way of being-in-the-world. His concept of "existential disconnection" helps explain why pharmacological treatments often fail to reach the core of a patient's suffering but treat the symptoms without reintegrating the person into their relational and affective world.

Causal Pluralism and Systems Integration

Perhaps the most significant implication of the findings is the call for a pluralistic model of causality in psychiatry. The standard hierarchy where biological explanations are treated as superior to psychological or social ones fails to capture the recursive, multidimensional nature of mental disorders. Emergentist theories suggest that higher-level properties (like consciousness or affect) cannot be fully explained by their lower-level substrates, even if they are dependent on them. The mind, in this view, is irreducibly emergent, a phenomenon that arises from the body but operates according to its logics. Kendler⁴⁵ supports this perspective, proposing a model that recognises no single privileged level of explanation. This pluralism extends to treatment as

well as a person with depression may require medication, but also psychotherapy, community support, lifestyle changes, and existential engagement. Causation is not located in one place, but is distributed across multiple domains such as biological, affective, social, and historical.

The Clinical and Ethical Stakes

Philosophy as seen is not merely abstract speculation but a vital contributor to clinical clarity. Concepts like dual-aspect monism or recursive causality are not theoretical luxuries but shape how clinicians perceive patients and how systems allocate resources. As such, a bad philosophy can lead to bad care. By contrast, integrative, relational frameworks enable more holistic engagement with patients aligning with newer models like the Power Threat Meaning Framework (PTMF), which reject medicalised understandings of distress in favour of contextual and narrative ones. These models emphasise agency, meaning-making, and societal context, addressing precisely the dimensions ignored by a narrow focus on the brain. The discussion supports the central thesis of this paper which is that mental disorders are not merely brain disorders, but embodied, socially mediated, historically situated experiences. This does not mean abandoning biology, but re-situating it within a broader epistemic ecology.

Conclusion and Recommendations

This study set out to interrogate the limitations of neurobiological reductionism in explaining and treating mental health disorders, through a conceptual inquiry into the nature of mind-body causality. From philosophical traditions such as emergentism, enactivism, and dual-aspect monism, it has shown that the prevailing psychiatric frameworks dominated by diagnostic formalism and neurocentric explanatory models are epistemologically narrow and clinically inadequate. Mental disorders are not reducible to isolated brain dysfunctions, nor are they adequately captured by symptom-based diagnostic criteria that ignore the relational, historical, and subjective dimensions of experience. Rather, mental health disturbances emerge from complex interactions between neural substrates, embodied affectivity, environmental contexts, and lived narratives. This complexity demands a pluralistic model of causality which is one that resists linear, one-directional explanations and instead

accommodates the mix of biology, meaning, and context.

Philosophically, this conclusion rests on rejecting the dichotomy between the mental and the physical as separate or hierarchical. Through dual-aspect monism, it has been affirmed that the ontological parity of mental and physical processes is distinct yet co-constituted aspects of the same reality. Emergentist thinking further underlines that mental states, while grounded in biology, exhibit properties and causal powers that cannot be reduced to their neural correlates. Meanwhile, enactivism shifts the explanatory emphasis from internal representations to embodied action in a world that gives rise to meaning, struggle, and healing. Clinically, this has major implications because the persistence of treatment-resistant depression, the over-medicalisation of ordinary distress, and the marginalisation of social context in diagnosis are all symptoms of a conceptual framework that has become too narrow whose reconstruction is not merely an academic task but a practical necessity for more humane, effective, and ethically sound mental health care.

Recommendations

In light of these conclusions, the following recommendations are offered for psychiatry, clinical practice, and mental health policy:

i. Adopt Integrative Diagnostic Frameworks

Psychiatry should move away from mono-dimensional diagnostic models like the DSM-5 and RDoC that rely exclusively on symptom clusters or hypothetical biological markers. Instead, practitioners and institutions should adopt integrative frameworks such as: The Power Threat Meaning Framework (PTMF) focuses on life context, relational dynamics, and personal meaning. Narrative diagnostic models that consider the patient's lived experience and sense-making, not just observed symptoms is a welcome idea.

ii. Reform Psychiatric Training

The epistemic bias toward biology in psychiatric education reinforces reductionist habits. To this end, medical and psychological curricula should be redesigned to include core readings and seminars in Philosophy of mind, psychiatry, phenomenology and hermeneutics.

iii. Reconceptualise Treatment Models

Treatment modalities must reflect the recursive and

emergent nature of mind–body processes for trauma-informed care, Open Dialogue, and existential therapies. Somatic-based therapies (e.g., sensorimotor psychotherapy, dance/movement therapy) should be incorporated into treatment plans, especially for trauma-related disorders.

iv. *Transdisciplinary Research on Mind–Body Causality*

Mental health research should no longer be polarised into biomedical versus psychosocial domains. Funding and institutional support should be directed toward transdisciplinary collaborations involving neuroscience, systems biology, philosophy, ethics, anthropology and sociology

v. *Revise Public Mental Health Policies*

Governments and international health bodies should revise public mental health policies to explicitly include: Poverty, housing, and education as key mental health indicators.

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