The neglect of volition

SCOTT HENDERSON

Volition is defined in the *Shorter Oxford English Dictionary* as 'the action of consciously willing or resolving; the exercise of the will', while the latter is 'the power of choice in regard to action'. In his *Enquiry Concerning Human Understanding*, David Hume said that by liberty, 'we can only mean a power of acting or not acting, according to the determinations of the will' (Hume, 1777). Recent developments in neuroscience and molecular genetics have a bearing on our understanding of volition, will and choice and their relevance to clinical practice. This calls for further examination of the ancient polemic between free will and determinism, as considered by St Augustine. Watson (1982) has provided a valuable examination of this complicated field. Determinism holds that behaviour is not free but is dictated by a chain of causation. It denies the reality of choice because of physical, neurobiological or theological forces. Clinical psychiatry accepts that the will can be impaired in many mental disorders, whereby the capacity to choose can be compromised. Individuals in such cases may then be considered not responsible for their behaviour. Some concession to determinism is thereby made, in that some of a person's behaviour is attributed to the mental disorder. As brain function comes to be increasingly understood, it is possible that abnormal behaviour will be attributed less to the person's power of choice in regard to action, and more to abnormalities of brain function or genotype. These advances have led to what Dennett, in his influential book *Freedom Evolves*, has called 'the spectre of creeping exculpation' (Dennett, 2003). This editorial considers the place of volition and responsibility in the practice of contemporary clinical psychiatry. It was prompted by experiences in an acute in-patient unit, where disruptive behaviour by very unwell people is commonplace.

WHEN ARE PEOPLE NOT RESPONSIBLE FOR THEIR BEHAVIOUR?

In the forensic context, Lord Mackay of Clashfern has set out three questions to be asked when considering the case of a person who has committed a criminal act (Mackay, 1998). Was the person aware of what he or she was doing? Was the person aware it was wrong? Did the person have the capacity to resist doing it? If all three questions can be answered in the affirmative, the person is responsible for that act. We can now ask what happens if the same three questions are applied to people with mental disorders outside the forensic context. Here it helps to introduce what O'Shaughnessy has expressed simply as 'the concept of *doing something by choice*' (his italics) (O'Shaughnessy, 1980: p. 302). People with mental disorders may be fully aware of their behaviour but will nevertheless do something that is harmful to self or others. This leaves the third question about the capacity to resist. In the context of a consulting room or ward, the psychiatrist or nurse may consider whether the person has chosen to do something and is therefore responsible for their behaviour.

In cases of severe psychosis, many people would fail on all three of Mackay's questions. Kraepelin referred to impairments of self-awareness and self-regulation in schizophrenia as being part of the deficit in executive control. A defect in volition was central to his notion of dementia praecox, which he saw as being ultimately linked to a loss of will. It is now known that executive function is subserved at least in part by the prefrontal cortex and that there is prefrontal cortical dysfunction in schizophrenia. Most clinicians would accept that a person with schizophrenia or affective psychosis, who carries out an act that is harmful to self or to others, may not be responsible. Having a psychosis will often be a sufficient excuse. But what of conditions such as the following: antisocial or borderline personality disorders; some acts of violence or abuse of others in psychosis; alcohol dependence; gambling; sexual offences; parasuicidal acts; shoplifting; the eating disorders; and the continued use of cannabis after recovery from a psychotic episode?

In each of these, the person usually knows what he or she is doing, and is aware that the behaviour is undesirable, unhelpful or harmful to self or others. In his commendable book on the legal response to actions by persons with mental disorders, Alec Buchanan writes, 'If psychiatric conditions are to be grounds for exculpation, they must impair the sufferer's ability to choose' (Buchanan, 2000: p. 80). He is referring to forensic context, but the same could be said in ordinary clinical practice. Buchanan describes how mental disorders may impair the ability to choose by several means: through a defect in consciousness, a change in mood, in perception, in the ability to think or the content of thought. Buchanan rightly acknowledges that it can be difficult for clinicians to estimate how much the person has an impaired capacity to choose and therefore to be responsible. Indeed, quantification of capacity to resist carrying out an act is not at present possible by any psychometrically established method. No instrument exists and constructing one may not be feasible. In day-to-day psychiatry, that capacity is assessed by the subjective judgement of the clinician. As an example, in an acute psychiatry unit, nursing staff will say of someone with a psychosis whose actions are causing a problem, 'But some of that is behavioural'. This expression means that the presence of a severe mental disorder is accepted, but in the nurse's opinion there is a component that is volitional, that is not a product of the disorder itself, and that the person could stop if they chose. It is this aspect of volition that deserves more formal consideration in clinical practice.

RECENT PROGRESS IN UNDERSTANDING VOLITION

Impairment of volitional control is now known to be associated with specific neuropathology (Libet *et al*, 1999). For instance, Raine *et al* (2001) reported an 11% reduction in the volume of prefrontal cortical grey matter and reduced autonomic activity

https://doi.org/10.1192/bjp.186.4.273 Published online by Cambridge University Press

in 21 people with antisocial personality disorder, compared with controls. This means that such people may differ from others in the part of the brain dealing with executive functions including volition and will, although psychiatrists are unlikely to agree whether this removes personal responsibility.

Molecular genetics is producing evidence about heritable vulnerability to some personality traits and psychiatric syndromes (Holden, 2003). There are now a number of studies, all unconfirmed, reporting associations between neurotransmitter polymorphisms and personality traits such as novelty seeking, violence, gambling and alcohol dependency. Alper (1998), however, argues that 'even if human beings are genetically deterministic systems, their behavior may still be unpredictable and they may still possess free will'. He adds, 'behavior influenced by genes is no more deterministic than is behavior influenced by the environment'. These scientific advances are prompting the wider community to be concerned about the extent to which free will really exists, in contrast to behaviour that is biologically determined.

REINSTATING VOLITION IN TREATMENT

It is timely for psychiatry to consider the merits or inadvisability of reinstating some degree of personal accountability among its patients. Some behaviours need not invariably be attributed to the disorder, but to the individual's choice. Such a proposal is not intended to be harsh or reactionary. Patients can be seen as responsible in whole or part for what they have done. To remove all responsibility for the behaviour may often be unhelpful; it can also be demeaning, because it implies that the person is in some way incomplete, being deficient in self-control, as in the *minderwertigkeiten*, a sinister term used in the era of Nazi psychiatry. In a recent exchange in *The Lancet*, Tan (2003) raised the question of whether people with anorexia nervosa are competent to make valid treatment decisions. In response, Sato (2003) argued against the autonomy axiom as the guiding tenet of Western bioethics, a tenet founded on the belief that doctors can help patients only insofar as they help themselves or as they allow others to help. Sato argues that, 'psychiatrists should help the patient so that he will eventually be able to help himself' (Sato, 2003). What is explicit in this recent exchange of views is that anorexia nervosa is one disorder in which volition – the capacity for choice and self-regulation of behaviour – becomes a central issue in treatment. In a similar way, the psychological treatments of alcohol misuse, gambling or borderline personality disorder all include an attempt to augment self-regulation. Through this, individuals are helped to regain their own volitional control.

CONCLUSIONS

Reinstating the place of volition in clinical practice would do much to temper the assumption that behaviour harmful to self or others is usually excusable if a mental disorder is present. It would also point the way to cognitive psychotherapy focused on augmenting the person's power of choice in action. With the advances now being made in the neurosciences and behavioural genetics, it is all the more important that clinical psychiatry be well informed about biological determinants of volitional control. For free will to be eclipsed by biological determinism would impoverish an essential aspect of human existence. Psychiatry has a contribution to make here: in both assessment and treatment, it could place more appropriate weight on volition and personal responsibility.

SCOTT HENDERSON, MD, Hon MD, DSc, FRCP, FRCPsych, FRACP, FRANZCP, Visiting Fellow, John Curtin School of Medical Research, Australian National University, Canberra, Australia

Correspondence: Emeritus Professor A. S. Henderson, 9 Timbarra Crescent, O'Malley, ACT 2606, Australia. E-mail: ashenderson@netspace.net.au

(First received 25 March 2004, final revision 19 October 2004, accepted 12 November 2004)

DECLARATION OF INTEREST

None.

REFERENCES

Alper, J. S. (1998) Genes, free will, and criminal responsibility. *Social Science and Medicine*, **46**, 1599–1661.

Buchanan, A. (2000) *Psychiatric Aspects of Justification, Excuse and Mitigation*. London: Jessica Kingsley.

Dennett, D. (2003) *Freedom Evolves*. Harmondsworth: Penguin.

Holden, C. (2003) Getting the short end of the allele. *Science*, **301**, 291–293.

Hume, D. (1777) *An Enquiry Concerning Human Understanding*. Reprinted (1993) (ed. E. Steinberg). Indianapolis, IA: Hackett.

Libet, B., Freeman, A. & Sutherland, K. (1999) *The Volitional Brain*. Oxford: Blackwell.

Mackay, J. (1998) Mental responsibility. *Medicine, Science and the Law*, **38**, 281–282.

O'Shaughnessy, B. (1980) *The Will: A Dual Aspect Theory*. Cambridge: Cambridge University Press.

Raine, A., Lencz, T., Bihrle, S., *et al* (2001) Reduced prefrontal gray matter volume and reduced autonomic activity in antisocial personality disorder. *Archives of General Psychiatry*, **57**, 119–127.

Sato, Y. (2003) Autonomy and anorexia nervosa. *Lancet*, **362**, 1937.

Tan, J. (2003) The anorexia talking? *Lancet*, **362**, 1246.

Watson, G. (1982) *Free Will*. New York: Oxford University Press.

https://doi.org/10.1192/bjp.186.4.273 Published online by Cambridge University Press