

Seminar “Reading Levy’s *Neuroethics*”  
Session 11 (13:30-15:30, January 25, 2008)  
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In this session, we read the chapter 8 “Self-deception: The normal and the pathological” (pp. 258-80). The aim of this chapter is to investigate one of the problems in moral psychology: self-deception. We often deceive ourselves or observe that others deceive themselves. Why and how is such a thing possible? What is the nature of self-deception? These are the questions that Levy examines in this chapter.

Levy first examines the traditional view of self-deception. According to it, there are two requirements for self-deception: the contradictory belief and the intentionality requirements. The first requirement is that self-deceived agents believe two contradictory propositions at the same time. For instance, my wife is faithful, and my wife has an affair with someone. They are contradictory. If they believe these propositions at the same time, agents can be regarded as self-deceiving. The second requirement is that self-deceived agents intentionally or deliberately believe two contradictory beliefs. In the traditional view, contradictory beliefs are isolated from each other, and one of them is held unconsciously. This is the traditional explanation of self-deception.

According to Levy, some philosophers criticize the traditional view for being too demanding, and propose deflationary accounts of self-deception. According to deflationists, their accounts can provide a better explanation of self-deception without the contradictory belief and the intentionality requirements. In their view, self-deception can be explained by motivationally biased belief acquisition mechanisms. Psychologists in the tradition of heuristics and biases investigate these mechanisms (e.g. Daniel Kahneman). According to them, when testing a hypothesis, we tend to look for confirming evidence of the hypothesis. If we find negative evidence, we often ignore it to save our favorite hypothesis. This reminds me of what Karl Popper once said: confirmation is cheap. Anyhow, if we accept the deflationary view of self-deception, self-deception is not intentional, as the traditional view assumes. Levy explains it as follows:

[I]t is the product of biased reasoning, but there is no reason to think the agent is always aware of their bias (neither in general, nor of the way it works in particular cases). Nor is there any reason to think that the agent must have contradictory beliefs. Because the agent is motivationally biased, they acquire a belief despite the fact that the evidence available to them supports the contrary belief: they cannot see how the evidence tends precisely *because of their bias* (p. 262; Italics in the original).

Relying on such a view, deflationists argue that their accounts explain self-deception better than the traditional view. Levy tries to meet their challenge by showing that “there are cases of self-deception in which the self-deceived person has contradictory beliefs” (p. 262).

To make his case, Levy examines the case of anosognosia for hemiplegia. Anosognosia for hemiplegia is “denial of partial paralysis.” “As a result of a stroke or brain injury, sufferers experience great or lesser paralysis of one side of their body (*usually the left side*), especially the hand and arm. However, they continue to insist that their arm is fine” (p. 263; Italics added). Some might think that anosognosia is a case of self-deception. But according to Levy, most neurologists contend that anosognosia should be seen as a neurological phenomenon, not as a psychological one. The reason for this is that “a motivational explanation of anosognosia fails to explain its asymmetry: it is rare that a patient denies paralysis on the right side of the body” (p. 264). As to the asymmetry of anosognosia, V. S. Ramachandran’s hemispherical specialization hypothesis and Michael Gazzaniga’s studies of the split brain are helpful. According to Ramachandran and Gazzaniga, the left hemisphere works as an “interpreter” who creates a coherent narrative framework using available information. Following them, Levy explains the asymmetry as follows:

When the right hemisphere is damaged, the left hemisphere is free to confabulate unchecked. It defends the agent against unpleasant information by the simple expedient of ignoring it; it is able to pursue this strategy with much more dramatic effect than is normal because the anomaly detector in the right hemisphere is damaged. But when the right hemisphere is intact, denial of illness is much more difficult. On the other hand, when damage is to the *left* hemisphere, patients tend to be more pessimistic than when damage is to the right (p. 265; Italics in the original).

While accepting Ramachandran's and Gazzaniga's points, Levy tries to argue that anosognosia is a neurological and a psychological phenomenon. To do so, Levy proposes three conditions under which anosognosia can be regarded as self-deception—although they are not necessary conditions, but sufficient ones.

- (1) Subjects believe that their limb is healthy.
- (2) Nevertheless they also have the simultaneous belief (or strong suspicion) that their limb is significantly impaired and they are profoundly disturbed by this belief (suspicion).
- (3) Condition (1) is satisfied *because* condition (2) is satisfied; that is, subjects are motivated to form or retain the belief that their limb is healthy because they have the concurrent belief (suspicion) that it is significantly impaired and they are disturbed by this belief (suspicion) (p. 269; Italics in the original).

Referring to Ramachandran and others' studies, Levy goes on to provide cases for the above conditions—although I cannot recount Levy's arguments here. But here is a question. Even if Levy can make his case for the above conditions, what does this mean? Even if anosognosia is a self-deception, it might be a special case of self-deception. How about self-deception in general? As to this point, Levy argues that “given what we know, and what we can plausibly speculate, about anosognosia, it is reasonable to suspect that the processes at work in anosognosia are also at work in less pathological cases” (p. 277). But it seems to me that Levy's argument here is scarce, and thus it is not so strong. The reason for this would be that he spends much of his discussion in this chapter to examine whether anosognosia is a case of self-deception. Yet in my view, without considering a more general case, one cannot provide a better explanation of self-deception in our daily lives.