Science, Psychiatry and Psychotherapy

Philosophical and Ethical Issues of the Medical Model

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Abstract

The paper is a critical deconstruction of the medical model. I examine the medical model in medicine, and how it drives psychiatry and psychotherapy. Using the notion of 'structure determinism' as outlined by Humberto Maturana (Chilean neurobiologist and leading constructivist thinker) I demonstrate the confusion that inevitably arises in daily life when theories about, explanations of, and metaphors for, human behaviour and conduct are confused with physiological processes.

I suggest that such theories are about human conduct and therefore are a part of ethics and religion and do not belong to medicine proper. Considering such explanations, theories, and metaphors to belong to medicine, maintains a power of medical expertise to predict and control human conduct. To this extent the medical model in psychiatry and psychotherapy is an issue of power and control and hence belongs to ethics and morality; and not to medicine.

I also suggest that human freedom, responsibility, dignity, and integrity may lie in reclaiming such expertise for oneself.

Introduction

The purpose in presenting this paper is to restore the notion of human freedom, whereby we are free to choose to decide about issues of everyday life.

Much of modern language is peppered with medical explanations for everyday conduct. Depression, we are cautioned, is on the rise. 25% of people we are told

may suffer from it. As mental health professionals we are exhorted to be vigilant and hone our diagnostic skills with the implication that we might be missing a diagnosis that is all around us. We might ask ourselves: If I am getting mood swings maybe I should seek treatment before it gets any worse. How are my chemicals? Maybe I need prophylactic prozac or lithium maintenance for my depression just in case. Should I go for a jog to boost my endorphin levels? Am I exercising my right brain sufficiently? Maybe my cognition needs correcting. My great grandfather ended up in Carrington, my aunt in Porirua, and my uncle in Sunnyside[1]. I've obviously got mental illness in my genes and I need expert advice. Tell me what to do?

So go the pleas for expert 'medical' advice. We are becoming a people preoccupied; selves with an endless medical preoccupation with our own conduct, feelings and neuro-chemistry. We become unwilling victims of the new technology that subjects our everyday lives, our relationships, our gender, our intentions, our moods and concerns to medical diagnostic scrutiny. Our daily living becomes endless fodder for the mindless machinery of medical diagnosis.[2]

Everyday conduct, including our politics is seen in diagnostic terms. It is turned into a syndrome. Our anti-nuclear stance was described recently in an American newspaper as the "New Zealand Disease", to be pitied, the sufferers treated. We have these antinuclear beliefs through no fault of our own, and we need treatment. Successful treatment here, just as in psychiatry, means to abandon such beliefs, and 'insight' means 'realising' one is ill to have them. Of course any treatment can be justified because we are treating an illness, and ill people have a right to such treatment even though they might resist it. In this paradigm any means of eliminating resistance or opposition can be justified. People have a right to have their illnesses treated, and be given drugs against their will if a medical authority deems it necessary. They should not be denied their rights. So goes the psychiatric rhetoric.

Everyday we hear how our undesirable or problematic conduct is a function of abnormal physiology, or abnormal genetic structure. Our beliefs, our thinking, our emotions, our everyday conduct is teased out under the microscope by a medical gaze, searching for pathology. The self that is revealed by such a gaze

1 Mental Hospitals in New Zealand.

2 See for example a proposal to classify happiness as a psychiatric disorder. Major Affective Disorder, Pleasant Type Bentall, R.P (1992) A proposal to classify happiness as a psychiatric disorder. Journal of Medical Ethics, 18,44-98 in British Journal of Psychiatry (1993), 162, 539-542

is a self, we are told, conflicted, divided by genetic instinctual drives, primitive pathological defence mechanisms. It is a self, torn by conflicting personality types, a self at the behest of chemical imbalances, a self torn by hormonal dysphoric syndromes, in dire need of balance and correction. It is a self that construes everything chaotic or problematic about our behaviour to be the result of mental disorder and/or abnormal chemistry, and everything downright unpleasant or unwanted as an illness or disease. A self tossed about on a sea of biological instinctual unconscious drives, victim of its own genetic and cerebral chemistry. A self that requires the constant help and advice of those experts in psychiatry, physiology, behaviour, or psychology, who teach us what we suffer from, what illnesses we have, and what treatment we need, in the same breath.

I recall a colour therapist who did exactly this. He walked amid his houseful of seated patients waving a dowsing rod topped with coloured wool while he diagnosed their various ailments. His patients looked stunned as he reeled off diagnosis after diagnosis. They would exclaim "How did he know that? That's why I feel so bad! Now at last I know I'm not imagining it". They would sit there for the day, with wires trailing from expanding wire cuffs attached to their wrists. The wires from his seated 'patients' snaked in large cables to a central room and were attached to a large polished copper plate in which there were egg sized indentations filled with various bits of coloured wool. Attached to this large plate were four spark coils of the sort used in the model T Ford car. Under the table were three large car batteries. A series of four electric arcs from these coils formed the backdrop, an electric reredos, to this persuasive altar, the buzzing and crackling of which could be heard throughout the house. After one or two diagnostic passes of his rod he would attach a newcomer by a wire leaving him or her to sit among the enthralled, sometimes sceptical but always wondering conversations that were taking place. He would return after 30 minutes or so making more diagnostic passes, remarking, "Well I think we've got it this time" or "I think about another 15 minutes should see you straight" Many would stay the day, at $60 a time. Cheaper than their GP. They got a whole day treatment instead of 10 minutes from their GP who wasn't able to even diagnose their complaints let alone treat them.

The intention of this paper is to show that experts in the field of mental health are doing a similar thing to the colour therapist. The technology and expertise is a lot more sophisticated and the paraphernalia many times more expensive and elaborate, concealed in mountains of journal articles, but the techniques of persuasion and power remain unaltered. In psychiatry the EEG, MRI and

PET scan equipment has replaced the T-Ford coils, the DSM has replaced the coloured wool and dowsing rod, but the structure and techniques of persuasion are clearly recognisable once the aura of power is removed.

It is an enormous reverse placebo. Just as administering an inactive substance or prescription (placebo) is held to be curative and relieve symptoms, so can the administration of a physiologically inactive substance or prescription cause illness and generate symptoms, (a 'reverse' placebo). It is persuading someone else without a shred of physical evidence, firstly, that they do have an "illness" or "disorder" that causes suffering, and secondly that some expert has the answer; persuading people that you know what they need better than they do and therefore they should pay you to take away their unhappiness.

Medical pamphlets exhort us to seek medical advice before stopping medication. Before attempting exercise please see your doctor. If pain persists please see your doctor. For heavens sake don't do anything without consulting your doctor. Without denigrating the practice of medicine itself, I wish to examine this presupposition that in order to live our lives we should depend on so-called scientific medical expertise.

I wish to demonstrate that much of this persuasion is propaganda, a self-serving tautological rhetoric, and that the outcome of such rhetoric is the preservation of the medical viewpoint. I intend to show that this view in psychiatry and in psychology is neither scientific nor logical; that it is incompatible with the notion of human freedom and hence human dignity, integrity and responsibility.

In construing problematic or unwanted human conduct, contentious beliefs and utterances as symptoms of medical or physiological abnormality, biopsychiatry conceals its beliefs, actions, motives and concerns behind a cloak of spurious medical and scientific legitimacy. These beliefs are concealed from the scrutiny of others by the claim that a human self is divided, and is perpetually at the behest of strange, pseudo-scientific, out-of-control urges that compel and therefore can be seen to excuse one from the consequences of one's actions.

Structure Determinism

Chilean neurobiologist and leading constructivist thinker, Humberto Maturana, says that science can be studied by observing what scientists *do* when they say they are doing science.[1] He claims that science can only operate with structure-

determined systems.[2]

If we are to examine the implications of the medical model in psychiatry we need to consider what scientists do when they say they are doing science and the implications such actions have for psychiatry and psychotherapy.

Structure determinism is a notion he and his colleague Francisco Varela define in a book entitled *Autopoiesis and Cognition*[3]. Structure determinism is the idea that the behaviour of any entity we distinguish is determined by its structure, and not by the interaction with the medium in which it exists. Further, such an entity can only undergo those changes its structure permits. Like water to the fish or air to the bird we tend not to notice we operate in this way.

Suppose I hold out in my right hand an egg and in my left a tennis ball. I drop them both on to a concrete path. The egg will smash, the ball will bounce. While the interaction with the concrete is the same in each case, the outcome is completely different for each entity. The impact of the egg and the ball with the concrete *triggers*, but does not determine the outcome. The outcome is determined by the object's structure, not by the interaction with the environment. The interaction *triggers* but does not determine the changes the entity undergoes. That is structure determinism. It is a simple notion, but profound in its implications.

If I have a tape recorder and I push the play button but it does not play, I assume there is something wrong with the tape recorder, not with my pressing finger. Similarly, if my car does not stop when I put my foot on the brakes, I think there is something the matter with the car's braking system, not my foot. Thus I get my car fixed, not my foot. The same applies to living systems. A living cell or a human being can undergo only those changes that its structure permits.

Science deals only with structure determined systems. Science looks at the structure of entities and their behaviour in terms of this structure. Science says *nothing* about non structure determined systems. If the tape recorder fails to work when I put my finger on the play button and there in nothing the matter with the recorder, I can say that it fails to play because I put a spell on it. This is the domain of magic, miracles, the *super*-natural. Science does not say this cannot occur. Science remains mute on this point. There is nothing to be said, and no scientific explanation possible. In this sense the world of science is the world of everyday experience. Chemistry is an extension of cooking, physics of house repair. To explain a miracle in scientific terms which is concerned with the everyday world is to place it in the natural world. Miracles by definition are

of the *supernatural*. If it can be explained in terms of structure determinism it is not a miracle, and may have a scientific explanation.

Incommensurable Domains

If we then distinguish something from the medium in which it exists, we can observe that there are two distinct domains, areas, fields or realms. Such realms are generated by the very act of making the distinction we perform.

- The realm of the structure of the entity.
- The realm of the medium in which it exists.

Maturana sees these two domains as incommensurable. They do not intersect, and are operationally distinct.[4] They have become so in the act of distinguishing them. They have a generative relation between them through mutual triggering one of the other. For an entity such as a tape recorder the two domains are:

- The domain of the internal structure of the tape recorder i.e. the motor, printed circuit, silicon chips, plastic support, loudspeaker etc. This is coherent in that the pulleys, tape speed and electronic componentry can be explained in terms of their interactions.
- The domain of the medium from which the tape recorder is distinguished, the background in which it exists, the air and surrounding environment.

Each domain is coherent within its own structure but is operationally distinct from the other. No examination, however detailed, of the electronic and mechanical components of the recorder will inform you about the music it is playing. Similarly listening to the music will shed no light on the internal structure of the tape recorder. In the course of everyday living we do not confuse these two domains. We go about our lives knowing that this is the case. It happens to us without our thinking about it. At the same time we do not consider the implications of it. Humberto Maturana says; "We have the double look, but we do not always have the double think."[5] We have the double look, we make this distinction, but we do not necessarily reflect on its implications.

Our everyday actions demonstrate that we never confuse the structure of a violin with the music that it plays. We don't even have to think about it. Yet the wider implication of this is crucial in our lives, in the domain of mental health, and in particular in the domain of psychiatry and mental health.

Science and Scientific Medicine

Scientific medicine treats the human body as a structure-determined system. Textbooks in medicine all refer to the structure of the body to explain its physiology. The disciplines of anatomy, physiology, histology, morbid anatomy, haematology, biochemistry, cellular biology, endocrinology hang together as a coherent whole and can be explained in terms of how the body works the way it does. With respect to physiology none of these domains are incommensurable. Cells are common to the nervous system as they are to the haematopoietic system and to the endocrine systems. They are all part of the structure of the human body as a distinguished domain of coherences. They all interact together in specified ways that are coherent. The organisation of the human body does not change from continent to continent, with social class or race. Textbooks of anatomy are pretty much the same for the bushmen of the Kalahari as they are for the Inuit of Greenland. The medical practitioner is trained to look for abnormalities in this structure. Such structural abnormalities are construed as the bases for illnesses, and scientific medicine is the study of their investigation and treatment. The protocols of history taking, examination (inspection, auscultation, palpation, percussion) and investigation are repeated endlessly, until they become second nature to the practising doctor. The lay public relies on this specific training, that they do not have, to diagnose illness.

What the patient says and does are symptoms, guides only to the underlying physiological dysfunction. For example complaints of weight loss, passing excess urine, and intense thirst, may not mean diabetes. As patients we have no direct access to our own blood sugar, the state of our neurochemistry, our serum cholesterol or our blood pressure. Scientific medicine undertakes to find out what that state is and to correct it. Performing a glucose tolerance test may confirm or exclude diabetes. Medical treatment is aimed at correcting the physiological abnormality, based on the pharmacology and the biochemistry of insulin or other drug. All this is scientific medicine and lies in the coherent domain of anatomy and physiology.

What a person says and does, however, belongs to the domain of interactions between the person and the context in which they find themselves. This domain has no common measure with the domain of physiology. If it did have a common measure it would be possible to know the state of our chemistry at any time just by sensing or looking. Physiology and biochemistry as a separate study would be superfluous and blood tests unnecessary. We would automatically know that we had cancer or hypertension or leukaemia.

In the same way the domain of physiology has no common measure with the domain of interactions. How someone voted in the election will not be found by examining their brain. All that will be found in the brain will be neurones, neuroglia, connective tissue, neurotransmitters being released and absorbed, nerve impulses, oxygen being metabolised, ATP being converted to ADP and back, blood and so on. You will not find thoughts, ideas, beliefs, delusions or hallucinations there. You won't even find any information there. Information is not transmitted by nerve fibres. Nerve impulses are transmitted by nerve fibres. Nerve impulses are constitutively *not* information nor are they data. They are nerve impulses. Information, data, thoughts, ideas, beliefs, delusions or hallucinations belong to the domain of language which is the domain of our interactions in the context of our lives with other people.

As a physiologist I observe my quadriceps muscle in my right leg contract. I could formulate a coherent scientific explanation that describes contraction of actin and myosin fibrils, the oxygen uptake, the mechanics of the articulation of the femur with the tibia, the blood supply, the rate of carbon dioxide production. However this will not tell whether I am kicking for touch, kicking the cat or kicking the next door neighbour. Conversely if I kicked the winning goal at Carisbrook, no study of the game will inform me of the metabolism of my quadriceps.

Accordingly, structure determinism means that political beliefs, and theories, will not be found in the brain any more than the meaning of the Mona Lisa will be found in the paint, or found by subjecting the painting to a CAT or MRI scan. Political beliefs, theories and meanings are to be found and understood in the context or medium in which they are uttered.

Structure determinism means that genius will not be understood by examining one's genes. All one will find will be sequences of DNA. Operationally, a genius is an attribution conferred by a society on a person for what they do. Lenin was once a bright young man, then he became the genius who helped to found a great nation, and had a city named after him. Since his death he has been judged a misguided nonentity and the city that bore his name has been renamed. Biologically, we would accept that his genes remained the same. This is not to say that genetic structure has no impact on the ability a person has to succeed in our society. The word genius, in the course of everyday life, is distinguished in the context of its everyday usage, not by the genetic or biological structures through which it is realised.

Scientific medicine has been successful in almost all fields of medicine. Science not only gives reasoned coherent physiological explanations for illness and diseases, but also demonstrates day to day its physiological claims and assertions in the course of diagnosis and treatment of every patient seen.

Scientific Rigour and Biopsychiatry

This scientific rigour applies in all field of medicine except Psychiatry. As far as I know Psychiatry is the only field of medicine where a positive diagnosis of "illness" is made when all physiological investigations have been found to be negative. In most other fields of medicine negative physiological findings exclude diagnosis of illness. There is no other branch of scientific medicine that claims the ability to diagnose "illness" in the *absence* of demonstrable physiological evidence.

I came to psychiatry in the mid 1970s and at that time I was intrigued to read a book by Thomas Szasz called the *Myth of Mental Illness.* At first, I thought he was just an outspoken radical of the anti-psychiatry movement. I was astounded to find he was not only a Professor of Psychiatry at the State University of New York but a trained psychoanalyst who was also President of the American Psychoanalytic Association, and was still practising. I thought, would it be possible for a professor of orthopaedics to write a serious paper entitled "The Myth of Fractures" and still have any patients left, let alone hold the position.

I found another professor of psychiatry debunking diagnosis in psychiatry, Karl Tomm[6], and another eminent psychiatrist with doubt about diagnosis, the former President and Examiner for the Australasian College of Psychiatrists no less. In his 1992 paper entitled *New White Elephants for Old Sacred Cows: Some Notes on Diagnosis*, John Ellard says; "I feel strongly that the relentless pursuit of an authorised diagnosis for each patient is in many cases an exercise in pseudo precision and that the more axes there are the greater the error."[7]

Yet in psychiatry, we still continue to hear about the importance of an accurate diagnosis. We are told for example that there is a tide of undiagnosed "depressive disorders" present in society because they are not being "diagnosed". In the referrals to our Community Mental Health Centres we are asked to distinguish between depression and an entity called 'clinical depression' which is entirely the product of speculative thinking. This entity called *clinical depression* manifests itself only before the gaze of a trained specialist psychiatrist or mental health professional. The laity, comprising those who are supposed

to suffer from it, are unable to distinguish it for themselves. Since there is no physiological evidence that can be tested for in order to justify the diagnosis, patients have to be convinced of their illness, persuaded that they are "ill" by medical rhetoric alone. This applies to most mental illnesses.

Biopsychiatry claims to be scientific. My claim is that it is not. I claim that most psychiatry is a body of rhetoric that throws science itself into disrepute by making speculative claims that are unable to be substantiated, about origin and causes of human conduct. In my view biopsychiatry is a body of pseudo-knowledge that is an enormous tautology. This tautology not only throws doubt on the practice of orthodox scientific medicine but creates and dis-enfranchises the lay public by its confusing and unsubstantiated claims of expertise about what it is to be human. Such claims of expertise imply that the origins of human conduct lie in genetic structures, instinctual drives, and personality structures. I claim this constitutes a total disregard for the notion that *any* person could, and might be able to, have any say over their own conduct.

Our society, by being convinced that "mental" illnesses really exist, grants biopsychiatry permission to present its beliefs as fact, without scientific evidence, much as the society of the 15th and 16th centuries granted the Catholic Church the ability to present witchcraft as fact. This was an act of conserving power, not finding the truth.

I assert that the preservation of the medical view of human behaviour has nothing to do with the relief of suffering, or the care for human beings in need of relief, nor has it to do with the furtherance of scientific knowledge. Rather it has to do with the conservation of its own ideology and dogma. Such beliefs and dogma are maintained by misrepresenting them as fact, under the cloak of expert scientific knowledge or as caring for the "mentally" ill, and this to the very public who pay them to continue such rhetoric. The lay public who accept such expertise relinquish control over their own lives to the extent they accept the authority of such dogma. In this way an ignorant public is created whose lives depend more and more on the proclamations uttered by such experts. The extent to which this authority is not questioned or scrutinised, is the extent to which the power of such authorities is maintained. Such authorities can maintain their power with assertions that human conduct is at the behest of genes, biochemistry, heredity or whatever such authorities say it is. An ignorant laity accepting such authority as scientific, in the absence of verifiable

evidence, have little option but to live their lives according to the latest religion such "experts" put their faith in.

Diagnoses and the DSM

This is not a popular view. The popular view is that we can turn to those experts to tell us what to do and how to behave for the best. In biopsychiatry, the DSM IV justifies diagnosis based on the conduct and utterances of the patient. Most of these diagnoses can be made only in the absence of organic abnormality, when all physiological abnormalities have been excluded. In other words when one's physiology is normal. Biopsychiatry then deftly turns around and implies that such conducts *are* the result of abnormal physiology, when it has just defined normal physiology as a requirement of the diagnosis that it makes in the first place! This is a very crude attempt to cover all bases. Such thinking is not only oxy-moronic, but downright duplicitous when it makes claims to scientific veracity. Remember Mark Twain's observation of Christian Science, that it has: a perfectly astonishing talent for putting words together in such a way as to make inquiry into its intention impossible.

If biopsychiatry says that its theories suggest that you are depressed, psychotic, obsessional, anorexic, because your inter-synaptic serotonin levels, dopamine neurotransmitter levels, winter sunshine levels, hormonal levels, serum lithium levels, or genetic predisposition, cause you to be so, we need to understand that such claims are speculative, not scientific. They remain speculation until they can be demonstrated in the course of routine clinical practice, in the same way that science is practiced in all other branches of medicine. The reliance on such arbitrary "expert" authority enables such statements to be accepted by a laity as scientific when they are not. The patient in the psychiatric consulting room has no inkling that such statements are not backed up with scientific evidence. The lay public are then expected to believe fiction as fact simply because of the authority of those that proclaim it. No physiological proof or evidence is necessary or required, on which to base its claims, as it is in every other branch of scientific medicine.

Currently, biopsychiatry is involved both in a frantic attempt to turn the discomforts of everyday life into illnesses, and in a mad scramble of technological drug and brain research to justify these claims under the guise of scientific verisimilitude. This is all a bit futile when, by its own definition, no evidence other than the behaviour and utterances of their patients is required for the diagnosis of mental illness. This is none other than what seems so far, to be a

pretty successful attempt by biopsychiatry to save itself lest it be swallowed up by neurology on the one hand and social anthropology on the other, and would therefore cease to exist as a separate discipline.

Biopsychiatry suggests that research with PET scans and brain imaging will eventually provide biological evidence for its claims. Again this is speculation: speculation that mental disorders are expressions of physiological disease in the first place. Claims based on the supposed positive outcomes of experiments that have not been performed cannot be used as evidence to back diagnosis or treatment let alone be used to back speculative theory. This is neither biology nor is it science. Such thinking in biopsychiatry is used not only to make diagnoses but also to justify treatment. If speculation is accepted for long enough it tends to be seen as fact rather than fiction and any treatment to control behaviour can be justified.

I propose that the terms "mental illness" and "mental disorder" are metaphors for conduct and utterances we do not like or understand, conduct that is currently chaotic, inexplicable, or causes suffering to others. In my view biopsychiatry not only fails to distinguish between metaphor and the actualities of everyday living, but also fails to realise that behaviour occurs in the domain of human relations, *not* physiology.

The focus then becomes physiological and medical in the face of no demonstrable abnormality. The domain of one's humanity in living one's life is ignored. Psychiatric referrals for assessment to local Community Mental Health Centres commonly contain the query: Psychiatric assessment please. "Major depression? Suitable for fluoxetine?" in patients who have extreme emotional disturbances. The fact that they have for instance had a marital separation, following the suicide of an adolescent child, is often seen as a side issue.

No competent physician would diagnose pneumonia relying just on what the patient said without listening to the chest, let alone taking a chest x-ray. No competent haematologist would diagnose leukaemia based on the patients statements and behaviour alone without examining that patient and taking a blood test and bone marrow biopsy. No competent doctor would do this let alone begin specific treatment. Yet biopsychiatry routinely treats patients on the unsubstantiated speculation of abnormal dopamine or serotonin neurochemistry without any check on serotonin levels let alone doing a PET scan of the limbic or pyramidal or frontal lobe systems. When all investigations are normal, explanations of chemical imbalances are trotted out. Such

explanations appear on brochures distributed by drug companies to the public[8]. When patients apparently recover, this explanation is taken as proved, if not by the clinician, then by the patients and their families who accept their changed conduct as a legitimate illness that has been properly treated.

In America 'psychiatric patients' are distinguished as patients (for the most part) on the basis that their conduct and utterances constitutes a "mental disorder" according to the DSM. The DSM is able to maintain a view that certain sorts of human conduct are 'disorders' by deleting, omitting or glossing over other contexts by which such conduct and utterances might be given some other meaning than that of 'disorder'. Firstly, the *context* in which patients' conduct and utterances occurs is deleted. The DSM makes no mentions of their lives, their culture, their day to day existence, their view of the world, or the issues they face in dealing with others. Secondly, criteria of what constitutes order from those of disorder are covertly implied or glossed over as automatic presuppositions. Thirdly, the declaration that disorders can occur in the absence of physiological abnormality, means that what is ordered, disordered or ill about human conduct lies solely in what 1000 or so psychiatrists agree to, simply because they grant themselves the authority to say so with each edition.

Biopsychiatric Diagnoses as Descriptive Tautologies

Treating human language and behaviour as if it reflects abnormal chemistry is to collapse the domain of conduct into that of physiology, as if these two domains were commensurable. This assumption that the two domains have a common measure and are therefore operationally indistinguishable means that:

- Structural determinism does not apply.
- Scientific explanations do not apply. Explanations will be tautologies (saying the same thing in different words).
- We are in the same domain as magic, or myth.

It means that biopsychiatric explanations that are made about human conduct are not scientific explanations, but descriptive tautologies. As a consequence in psychiatry it means that a committee of psychiatrists can declare certain human utterances and conduct to be symptoms of physiological disease simply because they choose to do so. No evidence is required.

The DSM IV evades the notion of an actual illness by specifying unwanted

conducts as 'disorders' rather than illnesses, yet the whole of psychiatric literature speaks about symptoms, and about psychiatric patients being 'ill'. The use of the term 'disorder' is a euphemism for illness without actually saying that. The word 'order' has an ecclesiastical origin referring to the various orders of angels and the religious orders that comprised the hierarchy of God's Church. To be out of order or disordered implied being out of the Church's order. Now, as then, this was to be an alien. That is why psychiatrists were and still are called 'alienists' in many dictionaries.

As human beings we sometimes act in strange and problematic ways. We have strange beliefs, act irrationally, and cause suffering, heartache, unhappiness to ourselves and others. Such suffering and distress may be alleviated with medication or even by involuntary restraint. Claiming that such conducts are an illnesses doesn't turn them into medical illnesses.

Categorising human conduct into what is ordered and what is disordered does not mean we have a whole new range of illnesses just because psychiatry categorised them. Such categorisation of behaviour reflects a view of psychiatry and does not necessarily reflect how human beings are. In our culture only the medical profession can make arbitrary claims about who does or who does not have a disorder. If a lay person insisted they were still ill after their GP pronounced all investigations normal we might say they were mistaken, misunderstood, or that their doctors were incompetent.

Not according to psychiatry. The patient may receive a diagnosis because they don't accept the word of the doctor that they are well. What do they suffer from? They have a disease whose specifications lie in disagreeing with medical authority. What disease do they suffer from? They suffer from 'hypochondriacal delusions', a mental disorder that can only exist in the complete absence of any physiological abnormality. Such is the appalling nonsense of biopsychiatry.

Why are such beliefs maintained and preserved in the face of the complete failure of psychiatry to provide any scientific medical evidence to back its claims and theories in clinical practice? Providing such scientific investigative evidence is not only everyday routine but mandatory in all other branches of diagnostic medicine. They are preserved because psychiatry construes the psyche not as a domain of how a human being behaves in the world but construes the psyche as biological part of the human body.

The 'Psyche' as part of the Body

The 'psyche' in everyday terms according to Dorlands Medical 'Dictionary is the 'human capacity to think, to make judgements, to feel emotions'. It is a process, something *we do*, but it is treated in psychiatry as if it were an organ of the body, as if it were a physiological entity, like our liver or heart. Psychology is the study of the psyche just as Neur-ology is the study of the nervous system and Endocrine-ology is the study of the endocrine system. Psychiatry, Psychological Medicine, and some aspects of Psychology convey the idea that the study of the behaviour of a human being as a whole is a part of medicine. We treat our conduct as if our conduct itself could become 'ill' and demonstrate 'psycho'-pathology, just as the functioning of an organ can show pathology.

Conduct we do not like, we diagnose and treat as if such conduct were *part* of the body rather than an expression of its totality. Biopsychiatry examines a person's 'mental state' as if their mental state could be compared to their stomach or spleen. Discovering that a patient has 'suicidal ideation' or a 'thought disorder' is treated by psychiatry as if it had the same implications for health as discovering that the patient has, say, a peptic ulcer or a pulmonary embolism. Statements such as: This person has poverty of thoughts; this person has grandiose delusions, this person has obsessive traits, are made in psychiatric case presentations as if they were statements describing physiological properties of the patient, rather than medically jargonised restatements of what the patient said and did. The ordinary English language of description that we all understand is turned into medical jargon that has the appearance of carrying some expert scientific meaning when it does not. For example, not being interested in sex becomes having a low libido, having difficulty sleeping becomes having insomnia, feeling good at certain times of the day and not so good at others means having diurnal mood variation, checking once or twice to make sure the lights are off means having obsessional traits, believing God has singled you out for special favour is having grandiose delusions, not wanting to do what your boss wants you to means you have issues with authority figures.

The list could fill a book. Such jargon is misleading and obfuscating because it has the appearance of saying something scientific and meaningful when it does neither. It is misleading because it is just a restatement of the original conduct that adds nothing. It is obfuscating because it misrepresents human conduct by depriving such conduct of the context which originally gave it

meaning. The medical model distinguishes conduct as an expression of disorder rather than an expression of who someone is in the circumstances in which they find themselves. The meaning of a person's being disappears in a welter of descriptive medical, psychiatric, and obfuscating psychological jargon.

This distinction is crucial. It is crucial because while it is makes sense to ask someone to stop what they are doing or alter their behaviour, it makes no sense to ask a person to lower their blood glucose to stop producing cancer cells. The medical model, in construing our conduct and behaviour in this way, creates an impression that we have as little say over our conduct as we do over our physiology. This is mistaking mental illness for medical illness. We are applying something that is metaphorically the case but not literally true. As Humberto Maturana says, we have the double look, but we do not have the double think. 'Mental illness' might be similar to a medical illness in that there is human suffering, problematic conduct that we do not understand in ourselves or in others, but this does not mean there is any physiological abnormality. By deleting context, the medical model is able to distinguish behaviour and utterances as individual disorders, characteristics of the individuals, rather than legitimate expressions of who persons are in the circumstances in which they find themselves.

In medicine, standards of laboratory accuracy are rigorously checked. Standards do not rely on opinion. An error in a result might mean either missing the diagnosis or giving a false diagnosis. Biopsychiatry however has blind faith in the patient's opinion of their own depression. If a patient says they have a belief that their TV set is sending out thoughts into their brains how can biopsychiatry tell if this is actually the case or whether the patient is mistaken, lying, or simply pretending? Conversely, if the patient claims they do not think the TV is sending thoughts into their brains how can biopsychiatry tell if the patient is just trying to mislead him, genuinely believes this, or is covering up. How can biopsychiatry tell whether the patient who claims to have no energy is telling the truth, is mistaken or just pretending? Do a PET scan? Take a lie detector test? It should be obvious that any answer to such questions will not be found in any physiological examination of the body, or the brain, but can be found in precisely that context of the patients life that biopsychiatry ignores, the domain of what the patient says and how they conduct themselves in the business of their everyday living in society.

Misrepresentation

Biopsychiatric beliefs and theories about the origin of problematic human conduct continue to be maintained because there is no way in the course of clinical practice to prove or disprove such ideas. Yet day to day psychiatric practice has the appearance of validating its claims. For example, a patient goes along to their doctor complaining about lack of energy. The GP, knowing that depression is a diagnosis frequently missed, asks a series of questions aimed at eliciting a diagnosis. How long have they had this lack of energy? Do they think life is not worth living? Are they sleeping well? Have they ever thought they might end their lives? Are they still interested in sex? Do they have a low mood? Have they lost weight? If the patient answers these questions affirmatively the GP proclaims "I think you are suffering from a Major Clinical Depression." Then the GP, not wanting to burden the patient with guilt might then say that according to modern theory, depression has to do with an imbalance of chemicals in the brain. They may explain that medication to correct this imbalance will help. The patient is very often reassured and accepts this speculation. The doctor then thoroughly examines the patient and gets a full blood picture. If all these investigations are *negative* the GP then reassures the patient that they indeed have an "endogenous" clinical depression and need treatment. However patients usually think the blood test results must have *confirmed* they have this imbalance; why else would the would the doctor test their blood and give medication. Few patients realise that it is a*normal* test that enables the doctor to diagnose psychiatric disorder not an abnormal test. This is the duplicity of Biopsychiatry because the facts the patients are invited to believe are quite the reverse. The blood test and investigations confirm not that there *is* an abnormality but confirms that there is *no demonstrable physiological* abnormality. In psychiatry the evidence itself demonstrates that it is not the creation of a chemical *balance* by the medication that has the patient recover but the artificial creation of a chemical *imbalance* by the medication. Pharmacological treatment does not correct an existing chemical imbalance but *creates* one. No person normally has fluoxetine, antidepressants, and their metabolites circulating everywhere in the brain. Any so-called *imbalance* that was supposed to be corrected is the product of research speculation. In my experience many patients on lithium think they have a deficiency of the substance, and that the frequent tests are to check if they are having adequate replacement to correct this imbalance. Again the *reverse* is actually the case. Lithium is a trace element in the body. Its natural level has nothing to do with

bipolar disorder or manic conduct. The onset of mania has nothing to do with low lithium levels. How many patients actually think this? The tests are required to make sure the patient's kidneys and nervous system are not damaged because the margin between the level at which it controls manic behaviour and the level at which it is toxic to the human body is so narrow.

I am not saying medication does not alleviate human suffering, nor am I saying that medication does not relieve the anguish of those who find themselves proposing attitudes and beliefs at odds with the society in which they find themselves; nor am I saying medication should not be used in circumstances where, in all humanity, the suffering calls for relief. But let us at least get the facts straight and not bamboozle the patient with pseudo scientific speculations about spurious chemical imbalances that lie in the minds of research scientists. In my view they should remain there and stay out of routine psychiatric practice until it can be demonstrated otherwise, as speculation is in all other branches of scientific medicine.

Currently, a patient officially has a psychiatric "disorder" when their conduct or utterances attract the attention of a psychiatrist. In other words, a psychiatric disorder is that conduct or utterance that a psychiatrist takes exception to. Currently, a patient does not have a psychiatric "disorder" when their chemicals get unbalanced, or their genes become expressed. That a group of around 1000 psychiatrists arbitrate what is and is not a disorder makes no difference to our neurochemistry.

Feeling "Normal"

At a seminar run by a drug company last year, a professor of psycho-pharmacology from California presented a case history of a woman who was depressed about her life and the state of the planet. She fulfilled the criteria for a major depression, and was given fluoxetine. In the course of the next few weeks she gave up her concerns and said that she felt normal for the first time in her life. According to the presenter, normal people don't respond to fluoxetine. He suggested that if she said she felt normal when taking fluoxetine then she must have had depression all along. He did not appreciate the bizarre presuppositions of his argument. Feeling well or normal has nothing necessarily to do with the balance of one's chemicals. Whilst taking cocaine Freud said "You perceive the exhilaration and euphoria of the healthy person. In other words you feel *normal*."[9] He said this over 100 years ago and recommended the use of the drug to his colleagues for neurasthenia. Freud seems to be equating

exhilaration and euphoria with feeling normal. The eminent professor from California was implying that if one did not feel normal one was ill. No one in their right mind would suggest that Freud had a cocaine deficiency or that taking sufficient cocaine in order to feel a normal euphoria was correcting a chemical imbalance. There was an elixir peddled in the middle of the nineteenth century that contained a mixture of arsenic and opium. It was good for everything, from cancer to arthritis, TB to syphilis. It was found that many of those who took it regularly and proclaimed its beneficial effects eventually died of arsenical poisoning. They died feeling great, feeling normal in all probability, but make no mistake, they died of arsenical poisoning. That someone in pain or distress feels better when they take morphine doesn't mean they are ill because they have a distress disorder caused by a morphine deficiency. Because someone cannot get to sleep doesn't mean they are an insomniac and that insomnia is a sedative deficiency disorder.

The domain of human conduct is a domain of language and relationship, ethics and morals—not medicine. Of course medication affects behaviour, and of course we as human beings behave in ways that cause suffering to other and to ourselves. This has been the case throughout history. But let us behave ethically and give medication advice and counsel to ease suffering, alleviate confusion and morbidity when we find this occurring, and not obscure our concerns about each other with vague, spurious and unproved speculative notions that some neuro-physiological imbalance that cannot be demonstrated must be the cause of human suffering. This is the same as locating the source of music we do not like in the piano, the upsetting and violent TV program in the TV set, and leads to the mutilations of leucotomy for depression or castration for sexual offenders. If we truly believe otherwise we must then equally explore the genetic behaviour of those psychiatrists who feel so compelled to write diagnostic and statistical manuals to which we are so wedded. We then end up as seeing through God's Eye [10], expert onlookers in some sort of genetic and chemical evolution that manipulates humanity to do what it does and in which we have no part. However we cannot escape the reality that it is human beings, not genes that are saying this. Everything said, is said by *someone*.[11]

One must draw a distinction between treating illness and controlling unwanted behaviour. Failure to make this distinction is the confusion the medical model engenders. This is not a trivial matter.

Psychology, Psychotherapy and the Medical Model

Just as biopsychiatry with its untested claims of abnormal physiology confuses mental illnesses with medical illnesses, so psychotherapy stops short of entering the strictly medical arena by using the *metaphor* of mental illness. The medical model in psychology and psychotherapy applies the medical lens to our conduct. Here groups of symptoms become not just syndromes, but illnesses in their own right without needing to be justified by demonstrable physiological abnormalities.

How does this happen? It happens through a process called *reification*.[12] Reification is converting an abstract concept into a material thing. Reification turns abstract ideas, products of human thought, into things that seem to exist independently of the thinking that invented them in the first place. In Humberto Maturana's view, we do this every time we distinguish an object or thing. Further, when we distinguish a chair we are also distinguishing our human capacity for sitting. We do not imply however, that the chair causes us to sit.

Reification in psychology and psychotherapy creates just this confusion. The "psyche" and the "mind" are examples of reification. Generally speaking, the psyche/mind is that human capacity for thought, judgement, imagination and feeling.[13] Thinking, judging, imagining, and emoting are all processes. When we treat this capacity as if it were an object in its own right, treating it as if it existed independently from us, we reify it. We speak of our mind as if it were an entity we possessed independently of our thinking. In psychotherapy we say "there is me, and there is my mind." We consider the interaction between the brain and the mind as if they were objects and therefore had some common measure and were operationally the same. We try to compare being aware, reasoning, feeling, and deciding, with neuro-physiological processes as if behaviour and physiology had some measure whereby we might determine some final sense and basic cause. This is like asking: What is the actual interaction between the run I went for down the street in the early morning light, and the actions of my legs running? As if such understanding were crucial to the understanding of what such a run actually "was" and what legs "really were."

The Id, the Ego and the Superego are all examples of reifications, conceptual structures that Freud originally invented to explain the behaviour and utterances of the patients he saw. Yet, once accepted, such reifications are seen as real. That is, they are seen as if they were fundamental aspects of all human

behaviour, rather than rich explanatory concepts. It is difficult to use Freudian theory and not believe that an entity called an ego really exists, and that there really is an entity called a superego that all human beings possess, that there really is something called "transference" that is a fundamental part of all human relationships. These are conceptual tools that Freud made up, to assist him in generating meaning in his observations. In this way such conceptualisations are a part of a culture of psychodynamic and psychoanalytic psychotherapy, that construes human conduct in this way. They are not necessarily an intrinsic and universal part of all human functioning.

Metaphor

"Psychopathology" is the medical metaphor of pathology carried over into behaviour. Just as pathological (morbid) processes are distinguished physiologically, so it is *as if* there are 'psycho'-pathological processes going on in our thinking and conduct. A metaphor is the application of a name or descriptive term or phrase to an object or action to which it is *imaginatively,* but not *literally* applicable. In psychology and psychotherapy it means that difficult and chaotic conduct in the human experiential domain is not the same as, say, a cancerous change in the physiological domain. Metaphors can be richly explanatory but are not literally the case. Once again we see the confusion between the physiology and conduct. Over the former we have little say but over the latter we hopefully do.

Thinking, speaking, feeling, and deciding are processes I perform as a whole human being. In the experience of deciding, I do not experience my cerebral cortex as making the decision for me any more than I experience my limbic or hippocampal systems as controlling my anger or my memory, in spite of metaphorical declarations by experts that such entities are controlling these functions. The actions of deciding, feeling, thinking, are all actions we perform as totalities, not actions that part of our anatomy performs independently of any other. Metaphorically it might be construed *as if* the parts of our anatomy did control such functions. Physiologically, however, as all physiologists know, they do not. What the cerebral cortex, the limbic and hippocampal systems actually do, is to perform certain operations in the physiological domain. Namely, they receive and send nerve impulses that project to certain cortical areas, metabolise glucose at certain rates, consume oxygen at so many cubic centimetres per minute and so on. Constitutively, these centres do not and cannot make decisions, determine whether we should fight or flee, or tell us to

kill ourselves or others, whether we construe such centres metaphorically as doing so or not. Such decisions belong to the life we live in the circumstances in which we find ourselves, not in the activation of synapses that might allow for such conduct.

Conversely, through what one says and does one may cause suffering to oneself or someone else. This does not mean however that one's cells are harmful. If one has violent thoughts, this does not mean that such thoughts are the expressions of disordered physiology or chemical imbalances. The way a person acts in society might be similar to how a cell acts in the body, but there the similarity ends. A person is not a cell, neither is a cell a person. A cell does not 'invade', is not 'hostile' in any human sense. Neither is a thought pathological.

As living beings we tend to go about our day to day lives under the compulsion to explain what we do. Yet events just seem to happen to us whether we explain our conduct or not. As therapists we know explanations are not trivial. We also know that the explanations we do make have a marked effect on the lives we live. In explaining actions to ourselves, we as therapists invent theories and explanatory concepts, such as unconscious drives, oedipal issues, acting out in the transference, irruption of narcissistic rage, poor ego boundaries, impulse control, traumatised will, role deficit, a negative introject and so on. Although such explanatory concepts generate rich and powerful theories, they are part of the*therapeutic* lingua franca of psychological and psychotherapeutic practice. They are explanatory metaphors to explain the domain of everyday living; they are constitutively *not* part of everyday experience.

The experience, and the explanation of the experience are in two separate domains that cannot be reduced one to the other.

People simply do not come to therapy complaining about their borderline personalities, their poor ego strength, their maladapted child, their acting out, their narcissistic needs, their grandiose delusions, their thought disorders, their hallucinations, or their co-dependent needs, unless they have accepted the theories of a therapist who construed their behaviour in such terms. Then they do.

Construing certain sorts of human conduct and beliefs on the basis of metaphorical reifications such as mental disorder, mental illness, psychological dysfunction or witchcraft for that matter, not only has the effect of invalidating human conduct, beliefs and expression, but also allows steps to be taken to control those who express such conduct. That follows from such labelling. For

instance, construing a person's indignation with their boss as a symptom of their 'psychological stress' rather than as a legitimate expression of indignation at the treatment they have received, invalidates any indignation, and enables it to be controlled by giving "stress" leave, or medication. Similarly, seeing an expression of what might be seen as deep emotional upset as an expression of mental illness rather than grief is likely to give rise to treatment and medication rather than sympathy and support. Construing a patient's unpunctuality as an expression of deep emotional conflicts, rather than the consequences of say, missing the bus, is likely to produce a whole range of personally probing questions in therapy, rather than simple requests to be on time.

It is my view that the search for a medical and physiological aetiology for understanding human conduct and language, is a degenerate research paradigm,[14] and, like the search for the aether, phlogiston, the edge of the world, witches, ghosts, mental 'health' and a genetic structure that produces genius, is a futile endeavour.

We are observers of our own conduct. As Humberto Maturana says "Everything said is said by an observer and that observer might be oneself."[15] As observers we see ourselves and others behave in various ways, and we reflect on this behaviour, describing it in reifications, explanatory concepts, metaphors, and theories. There are hundreds of such reifications in psychological and psychotherapeutic literature. Some such as "personality" have been around for so long we no longer question the obvious fact that we all seem to have one. Yet if we observe how we generate our personality we can see that a personality is also just another descriptive tautology for our conduct and offers no scientific mechanism for its generation.

Literal vs Metaphorical Meaning

The real trouble begins when these reified descriptions are used as physically causative agents that cause our behaviour in the first place. They become causal attributions.

When we refer to our personality as if it were a part of our body we can say "I didn't finish because I am a procrastinator," as if procrastination was an irrevocable part of our 'self'. Yet what we are actually saying is, I did not finish the job because I am a person who has a history of not finishing jobs. In the same way, "I don't like going out with people because I am an introvert;" means, I don't go out with people because I have a history of not going out with people. "I didn't speak out because I am a shy person", means, I didn't speak out

because I usually don't speak out. "I sit around all day because I have no motivation," means, I sit around all day because I usually sit around all day. Such sentences are uttered as if they mean that there was a "real self" that always behaves that way. Yet such statements mean and explain nothing. They are tautologies. They give the impression that they are saying something relevant about some "real self" that exists apart from the conduct we perform. Yet such statements only restate the obvious. They have the appearance of legitimate, scientific explanations about the way we as human beings behave when they are only restatements of human behaviour put in obfuscating ways.

Since the medicalisation and reification of depression, it is now considered legitimate to say "I couldn't go to work or get out of bed because of my depression". Most people now in our society will accept this as a literal, rather than a metaphorical explanation for why they did not get out of bed. What does this statement mean? It means that I didn't get out of bed because I didn't get out of bed. It is a descriptive tautology that explains nothing, and is not to be construed as being in the same domain as "I couldn't get out of bed because I have multiple sclerosis, because I have a stroke, because my legs were broken, because I am a paraplegic, or because I was strapped to the bed". The former explanation is metaphorical, the latter are literal. The use of the medical model in psychology and psychotherapy is metaphorical not literal. Such domains are conceptual, not biologically physical.

If we as psychotherapists are to help our clients and patients we at least need to operate in the same domain that we as human beings really do operate in, and not treat metaphors, however illuminating, as if they were the scientific verities of everyday life. Yet medical metaphors of 'disorder' are accepted in the course of our everyday living to justify sickness benefits, financial compensation, and time off work.

In the world of everyday physical experiences, we have issues and concerns with other people in the environment in which we live. We have arguments, come to agreements, make decisions and conduct our lives. As a therapist I might explain my behaviour or that of my patients in a way for example that presupposes that a human self consists of separate parts that not only act independently of each other but can actually be in conflict with one another. I can say "part of me wants to get married but there is another part of me that does not," or, "part of me wants to go to the movie but part of me doesn't." Yet, in the biological and physical world, this never happens. In the biological world of our everyday experiences, if I get married all of my biological self gets

married, my brain, my legs and my heart. If I go to a movie all of my biological being goes to the movie, I do not leave my spleen, my lungs or my brain behind.

The metaphor of "mechanisms of defence" and the "psychopathology of everyday life" contains the implicit notion that our day to day conduct with others is an "internal struggle" between various parts of our "selves" in order to avoid overwhelming anxiety. A metaphorical war with attacking and defensive 'mechanisms' is not an actual war where people get killed and blood is shed. The arrogance behind the designation of "psycho-*pathology* of everyday life" hides the notion that some expert has a handle on what behaviour is healthy and non pathological. In my view, determining what is "healthy conduct" is categorically and constitutively not a prerogative that science can distinguish, let alone medicine, however much we hope it might.

Another expression of the medical model in psychology and psychotherapy is the way the psyche is seen to be capable of being injured, as if it were an organ composed of organic tissue. We speak of emotional scars, of being emotionally wounded, and as having a "wounded child" within, that requires healing. The metaphor of the "Wounded Healer" is rich in its empathic connotations. In the world of everyday experiences a wound to our biological self is obvious and its healing also obvious. But what constitutes an *injury* to my psyche, i.e. my behaviour and utterances, my feelings and beliefs? How do I *heal* my conduct, my beliefs, my thoughts?. Is a feeling of shame, guilt or embarrassment an "injury"? Does being ridiculed give rise to a "psychological wound?" If so, in what respect? Exactly what does 'psychological healing' entail? If we observe conduct or behaviour in ourselves or others that is offensive or gives rise to suffering, can we legitimately attribute such behaviour to "scars" from past "emotional wounds". Do such labels say something about our reluctance to understand the conduct in the circumstances in which it is expressed? Medically a wound is a wound. Disagreeable, inexplicable conduct that gives rise to suffering is disagreeable, inexplicable conduct that gives rise to suffering. Behaviour is what one does. A wound is a wound, not a behaviour.

Scientific Explanations

A mental health professional, by embracing the medical model, can elicit evidence in support of their medical theory of behaviour by performing a "psychiatric assessment" in which the mental health professional asks pointed questions about past personal development, and childhood experiences. The unquestioned assumption of the medical model is that personal developmental

history explains present conduct. Such an assessment is performed as a knee jerk "psychiatric interview" (see any standard text on psychiatry) of all patients, regardless of the presenting issue, just as a clinical medical interrogation forms part of physiological investigation. Any emotional expression or reflection evinced as a reaction to such questioning in such an interview is taken as evidence of emotional 'scars' already there, rather than as a legitimate reaction to the pointed questions asked. Such emotional expression is then linked to presenting complaints as evidence that is supposed to explain them. Here the medical model deftly turns emotional expressions in the present into evidence of "dysfunction, emotional abuse, oedipal conflict, repressed memories, narcissistic rage, primal pain, faulty cognition", or whatever metaphor is used in the theoretical model that is flavour of the month. The patient who accepts this explanation offered by the mental health professional as a valid explanation for their conduct, is said to have "insight". If they do not accept the explanation offered, they are said to "lack insight" or are "resistant." Since these medical explanations are metaphors only, they cannot be proved or disproved in any scientific sense and therefore they tend to become labels that stick.

Literal scientific explanations can be proved or disproved. That is what distinguishes scientific explanations from metaphorical explanations.

In the same way that the medical model is able to explain mental illness in terms of chemical imbalances, unconscious genetic drives, and other metaphors, so too New Age thinking is able to explain astral travel, out of body experiences, telekinesis and astrology, in terms of atomic, particle and quantum physics. With their vision of a cure for the suffering of humankind and the advancement of knowledge of human behaviour through the study of genes or quantum particle physics, both Biopsychiatry and New Age thinking seduce the public into accepting their explanations as scientific explanations about human behaviour. However, in the course of everyday living, we do not grapple with our genes, or struggle with bad introjected self objects, nor do we order our groceries telepathically, or routinely tele-kinese ourselves to work. And in spite of knowing that matter is mostly empty space, we do not routinely walk through walls; we go out through the door. We perform only those actions in everyday life that our biology allows us to perform and no other.

Conclusion

As therapists we practise talking therapy. Meanings and stories are generated out of the conversations and actions we perform with our patients. The

meanings we generate have as their purpose the well-being of the people we see. Ours is above all an ethical profession in that we embrace human values. The explanations we accept for conduct are not trivial. If I have construed my self as a victim and through therapy now see myself as a hero there will be a difference in the life I will now lead. We talk constantly to each other, to our supervisors, we read journals, go to conferences, generate all sorts of experiences, from dramatising and role playing aspects of our past, our dreams, our future, to talking to whole rooms full of empty chairs, to drawing, painting, and dancing our feelings emotions and thoughts. We explore all the aspects of imagination, generating meaning about meaning, stories inside stories inside stories. I say we do this to enable the patients we see to live more fruitful lives, based on integrity, dignity, respect, well-being and accomplishment.

So we can ask:

- Do explanations of human behaviour, conduct and utterances in pathological and medical terms lead to futures of well-being, growth, dignity, integrity, accomplishment and increased possibilities for living?
- Does telling someone they have a clinical depression on the basis of what they are doing, help them? If the unpleasant nature of their behaviour is ameliorated by medication does such "treatment" lead to integrity, well-being, dignity and respect?
- Does construing a patient's conduct as an expression of their "borderline traits" or their "poor ego strength" or their "unfulfilled narcissistic needs" lead to their increased well being? Does it promote their future self respect, dignity, respect or personal growth? If you as a therapist construe your patients' conduct as borderline, narcissistic, or schizoid are you claiming something concrete about them, or are you claiming to have some special privileged access into how they will behave in the future?
- When you tell patients they are schizophrenic or have for example, schizoid traits, are you again describing something specific about them? Are you declaring your particular theory about their future behaviour; or are you stating your ongoing unwillingness to construe their future conduct in anything other than schizoid terms?

If you think you hold such 'truths' and your patients think as you do, their future is preordained by your own training of them. They will not only conduct themselves accordingly but interpret their ongoing experience as you construe it. They will take medication, and only take those actions in life that are consistent with the theory and explanations they accept from you as gospel. Can we as therapist be responsible for the outcome of the theoretical models we embrace, and what these might mean for the patients/clients we see?

A Possible Alternative

I invite you to consider a person who is already a "healthy" person, a person who is able to determine their own conduct as a domain of free choice. Such a person is free to choose, such a person knows that "instinctual drives" are nothing more than explanations for behaviour he or she already does; that "lack of motivation" is only a restatement of sitting around all day. A person who realises that reified explanations for feelings, thoughts, and actions arise from their own imagination in the here and now. A person who realises that providing explanations for conduct is not necessary for biological survival, but is a part of the social world we belong to. A person who realises that we are free to make up any explanation we choose for our behaviour and that there is not one privileged explanation for human conduct but many, all having different consequences and different outcomes. Such a person restores the possibility of change in the immediacy of the present, by freeing notions of change not only from past explanations, but from any theoretical notions, other than the actual physical capability of the individual themselves in the circumstances in which they find themselves. In this paradigm our utterances and conduct are no longer necessarily at the behest of pseudo-scientific psychological forces, unconscious genetic entities, instinctive drives, or chemical imbalances. Nor is our conduct at the behest of malign forces or evil demons which experts construe as causing our behaviour. As people we are free to use such explanations or not to use them. In this paradigm, to exercise the ability to choose, or to decline such explanatory notions that experts or others have of our behaviour means having the ability to think for ourselves and be responsible for the outcome of our own conduct in the experience of living.

> "If the diagnoses (explanations) we employ are useful then they will allow us to communicate more rapidly, and they may direct our attention towards something that we do not know. If they take on a life of their own, imprisoning us within the opinions of Committees, derived from the

opinions of yet more Committees then (Karl) Popper is still right and we are not moved by the methods of science, but of Aristotle." John Ellard.[17]

"Strictly speaking, the question is not how to get cured, but how to live."
Joseph Conrad

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