

Science and Structure Determinism: The Ethics of the Medical Model in Psychiatry, Psychology, and Psychotherapy

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Abstract

In this paper I examine explanations offered by scientific medicine. I wish to show that such explanations are based on structure determinism in all branches of medicine except psychiatry and the psychological medicine. I hope to show that the distinctions of illness/disorder made in these disciplines are violations of structure determinism, and, while being legitimate as explanations, the distinctions do not belong to science but to ethics and morality. I do not intend to present a “balanced view”, but to deconstruct psychiatry and, through this, present an alternative viewpoint from the Biology of Cognition.

Waitara

I tēnei tuhinga ka whakamātauhia ngā whakamāramatanga tuku mai a te rongoa pūtaiao. E hiahia ana au ki te whakaata, ko aua whakamāramatanga e whai ana i te tū whakatau a ngā peka katoa o te mātauranga rongoa hāunga ia te mātauranga mate hinengaro me te rongoa hinengaro. Ko taku wawata ka taea te whakaatu ko te whakarerekētanga o ngā mate/pōkiki whakaritea i ēnei pekanga mātauranga he mahi takahi i te anga whakatau, ā, ahakoa e tika ana hei whakamāramatanga, ehara nō te taiao ēnei whakarerekētanga engari nō te matatika kē. Kāre au i te mea ki te tuhi i tētahi ‘tirohanga rite’, engari ki te wāwāhi mātauranga mate hinengaro, ā, mā tēnei, ka tuku tirohanga kē atu.

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Scientific medicine treats the human body as a structure-determined system: assuming that the behaviour of the body (a living system) is determined by its structure and not by

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a perturbing agent (Maturana, 2005). To clarify with an analogy, if nothing happens when I press the Play button on my old tape recorder, I automatically assume there is something wrong with the tape recorder and not my pressing finger. It is the structure of the system at any moment that determines what happens, not, in this example, my pressing finger. We ourselves as living systems are no exception. Any instant our behaviour is determined by our structure at that moment and not by any outside agent. Science only deals with structure-determined systems. Maturana (1978) claims that science can be studied by observing what scientists do when they say they are doing science. In other words, science can only handle structure-determined systems. Structure determinism is simple in explanation but has profound implications.

The specifications of illness and disease in a standard textbook of medicine (Longo et al., 2011) include explanations referring to abnormalities of the structure of the human body and descriptions of generative mechanisms that, if allowed to operate, generate the symptoms complained of. For example, the enlargement of a space-occupying lesion pressing on a nerve gives rise to pain while the action of an osmotic diuretic medication produces the symptoms of urinary frequency. This is structure determinism.

Explanations as Generative Mechanisms

The disciplines taught by medical schools throughout the world are based on the demonstration of generative mechanisms; a series of physiological processes that produce the symptom. Anatomy, physiology, biochemistry, pathology, and cellular biology are part of the curriculum of medicine. How coherent morbid physiological processes give rise to symptoms and how symptoms are produced by disordered physiology is at the core of medical training. Techniques from physical examination to sophisticated radioimmunoassay are devoted to demonstrating generative mechanisms that link physiology to behaviour and thus the problematic symptoms.

Scientific medicine, practised in this way, has been extremely successful in demonstrating these mechanisms and correcting the structures that cause the symptoms. But, strictly speaking, scientific medicine cannot be said to use a “medical model” because scientific medicine is not a “model” of anything. This is relevant to the readers of *Ata* because scientific medicine is the original on which psychiatry models itself.

Psychiatry and the Medical Model

While psychiatric medicine also attempts to ameliorate human suffering, it is the one branch of medicine where no diagnostic structural evidence of disordered physiological malfunction of structure is found. Curiously, many of the diagnoses in psychiatry are made whether a generative mechanism can be generated or not. Here diagnosis is confined to a meticulous list of descriptions of categories of suffering behaviour. No physical disordered diagnostic structural changes have been shown to exist in mental disorders. In fact, no diagnostic physiological evidence is necessary to make a diagnosis of any mental disorder, although some diagnoses have required demonstrating the absence of a physiological generative mechanism.

For example, an unhappy man goes to see his doctor who finds her patient has been feeling guilty, not sleeping, has feelings of hopelessness, and has had thoughts that he might as well not be here. The doctor says he might be suffering from a Major Clinical Depressive Disorder. She then performs a physical examination and orders blood tests that show no physical ailments therefore confirming the Major Clinical Depressive Disorder diagnosis.

The foundation of psychiatric diagnosis rests on the very absence or scarcity of physiological evidence. That is why it is called psychological medicine and not neurology: the amelioration of the suffering of the “soul” or mind because that is what the word psyche means. For ease of understanding I have used the words “mind”, “psyche”, and “soul” interchangeably hoping the reader will get the intent without getting involved in spiritual or philosophical definitions. The soul is not in the brain. Attempts to find biological causes of distress distract psychiatry from its special position of medicine, which is ameliorating the suffering of the soul. Finding ways to enable and empower patients to deal with their suffering as part of a community in relationship with others and themselves is at the core of psychiatry.

Locating Suffering in the Person

The *DSM-5* (American Psychiatric Association, 2013), which in its current and previous versions is a basis for diagnosis in psychiatry throughout the world, does not base its nosology on specific coherences between the physiological and behavioural domains, but simply on agreed-upon features of certain aspects of human suffering, conduct, and utterances. The authors claim that the *DSM-5* is descriptive only and make no etiological claims, yet it consistently refers to diagnoses rather than syndromes, as if what were being distinguished were not simply descriptions of behaviour but diagnoses in the scientific medical sense. Diagnoses in scientific medicine rest on a generative process or mechanism that links physical and anatomical findings, pathology, pathogenesis, etiology, and laboratory and imaging findings; scientific medicine is not just lists of symptoms. In a sleight-of-hand manoeuvre the *DSM* diagnostic system generates a separate diagnosis if the syndrome is associated with an organic medical illness. (The utility of the *DSM* is not in question here; it is the fundamental premises on which it is based that are in question.)

Psychiatric syndromes categorise suffering conduct as if behaviour can be distinguished in the absence of context. They do not expand the diagnoses specified as disorders through any scientific methodology. In the *DSM-5* (American Psychological Association, 2013), suffering behaviours are distinguished in a context of scientific medicine and not in the context of descriptive cultural anthropology. They, therefore, carry an implicit assumption that the exhibitors of such conduct are “ill” or diseased, either physiologically or metaphorically, and are therefore “ill” or “disordered” in the same way as a person who has diabetes or cancer is ill. And because they are deemed ill their conduct requires treatment.

Categorising problematic human behaviours isolates and locates the cause within the individual without recourse to domestic, social, family, or cultural concerns. For example, the diagnosis of depression can be made without mentioning family conflict,

job loss, drug taking, divorce, death of a spouse or loved one, earthquake, etc. This is a bit like giving antidepressants to the inmates of a concentration camp to cure their Major Clinical Depressive Disorder.

For more than 75 years psychiatric medicine has attempted to locate the origin of suffering within the disordered physiology of the patient, vaguely citing possible chemical imbalances, disorders of neurotransmitter function, genetic loading, and many more. With the development of the fMRI and imaging, neurophysiological diagnostic evidence is being looked for in the brain (Tallis, 2011). We are repeatedly assured of cutting edge breakthroughs in mental health. There is even a European Brain Council, which appears to have a budget of 798 billion euros (see www.europeanbraincouncil.org). Yet these promised breakthroughs keep receding over the horizon and there is still no diagnostic evidence to substantiate diagnostic claims relating to any psychiatric disorder.

The psychiatric research endeavor falls into what Imre Lakatos (1978), a philosopher of science, described as a degenerate research program. This refers to a scientific programme that keeps failing to produce new evidence in spite of ongoing research. Here, I am arguing that psychiatry is not just a degenerate research programme but a degenerate research paradigm. In my view, the process of psychiatry is based on a paradigm that is flawed. It began when Emil Kraepelin (1856-1926) first described patients' problematic behaviour as symptomatic and assigned it to medicine.

The Biology of Cognition

The "Biology of Cognition" is also known as "Autopoiesis Theory" and "The Observer Cosmology". It refers to a substantial corpus of scientific knowledge about the biology of living systems by neurobiologists Humberto Maturana and Francisco Varela (1980, 1992).

This understanding demonstrates that living systems can be said to exist in two different and separate phenomenal domains. Firstly, the domain of components comprises our internal anatomy, physiology, cellular biology, neurobiology, and metabolism i.e., everything inside the boundary and including the surface of our skin. Secondly, the domain of being and action in which we act as whole complete living systems, as totalities. We live as whole human beings in our relationships with others and the environment. This second domain includes our languaging, the social domain of relationships, and our culture. It is in this second domain that language and therefore meaning, art, culture, religion, and literature arises. It is also the only domain where psychiatric diagnoses are made.

It can be seen that these two domains are incommensurable; they do not intersect, they have no common measure and cannot be reduced to each other. Because we act in the domain of being and action as totalities our actions cannot be reduced to that of individual components. Conversely, the activity and metabolism of our individual components cannot be accounted for in our behaviour as complete autonomous unities.

In our social lives we do not encounter ourselves or know ourselves as assemblages of structural components i.e., organs, stomachs, or brains. Our physiology is opaque or

invisible to us. We make decisions as whole intact human beings in language, and we encounter each other as whole complete entities, whole autonomous persons. It is in this domain that meaning arises: as an angry person, a weeping person, not as a weeping brain.

This is why the psychiatric medical paradigm is flawed. It is attempting to join or link behaviour to the organic function of our components without understanding that the two domains do not meet, that they are incommensurable. Of course they affect each other but cannot be reduced to each other. To quote Maturana: “We have the double look but we don’t have the double think” (H. Maturana, personal communication, 1991).

For example when you hear Arnold Schwarzenegger say “I’ll be Back!” in the movie *The Terminator* you understand his meaning. The neurophysiology of both brains *allows* the relational meaning to arise between audience and actor. At the same time the meaning arises in the relationship not in the brain (Maturana, Mpodozis, & Letelier, 1995). In this way the neurophysiology of the brain *allows* the relational meaning to become present in that moment within the social environment of viewing the film. Examining the electronics of the motherboard of the video player or the brain will not reveal the meaning that the actor and the audience mutually generated and understood.

The relationship between language, meaning, and the central nervous system could be likened to the relationship between orchestral instruments and the music produced; in examining the instruments playing Beethoven’s Fifth Symphony you will not hear the music. In this respect, psychiatric research is endeavouring to mimic the scientific methodology used by other medical research but has lost sight of the fact that it is a science of the soul dealing with distressing and problematic thoughts and feelings. It is not directly concerned with the nervous system. That is the province of neurology.

The current edition of the *DSM-5* (American Psychiatric Association, 2013) still mentions that with more evidence and research from cognitive neuroscience organic explanations for psychiatric distress may be found. While I do not claim that this is not possible I do claim that such an explanation will have to also explain the moral absurdities and incomprehensibilities of responsibility that such explanations would inevitably entail. For example, it would have to explain whether I as a whole human being am responsible for pulling the trigger or I whether I am suffering from some psychiatric/biological disorder or dysfunction of my neo-cortex that made me pull the trigger. Commencing with our parents and caregivers the “self” arises in language from our history of relationships from the moment we are born. It does not arise in the brain although we have evolved a special sort of brain that allows this to occur.

Mental Illnesses as Opinions

This self is experienced as acting as a totality, a unity. It can be seen to act, respond to requests from others, make decisions, promises, and refuse or grant consent depending on the context in which such a self arises. It is here that human ethics, morality, freedom, and dignity occur, built around this ability to act, to be responsible, and to enter into contractual negotiations. Such autonomous “selves” constitute implicitly the members of the language and society and culture in which we live. Through our actions and language in daily life we, at the same time, generate ourselves in our respective

conversations with each other and our society. Psychiatry is of the opinion that certain distasteful, distressing, chaotic, inexplicable, or unwanted human behaviour or utterances that give rise to suffering are illnesses in their own right. As there is no material scientific evidence to back this up, this amounts to moral judgments of behaviour.

These diagnoses lie in the domain of opinion, ethics, and morality, not science. The creation of the *DSM-III* (American Psychiatric Association, 1980) was based on the collective opinion of some hundreds of psychiatrists who were tasked by the American Psychiatric Association to provide a way of legitimating the domain of psychiatry which had fallen into ridicule in the eyes of scientific medicine in the light of a classical seminal historic paper entitled "On being sane in insane places" (Rosenhan, 1973). Robert Spitzer (2007), who chaired the task force of psychiatrists for the *DSM-III* that formed the basis for later editions, is said to regret some of his work (see http://en.wikipedia.org/wiki/Robert_Spitzer_%28psychiatrist%29). To quote the chairman of the *DSM-IV-R* (American Psychiatric Association, 2000), "The DSMs ... have also had the very harmful unintended consequence of triggering and helping to maintain a runaway diagnostic inflation that threatens normal and results in massive overtreatment with psychiatric medication" (Frances, 2014, p. 74). In these committees, mental illnesses were decided by vote and declared to be illnesses by fiat, and still are. That is to say, by opinion, not by any medical evidence as they would be in every other branch of scientific medicine.

Organic Explanations

Theories, conjectures, hypotheses, and explanations for distressing human conduct can be extraordinarily powerful. The more they endeavour to explain, the more powerful and elegant the theory, the harder they are to resist. In this climate, negative results are taken as evidence to redouble the research efforts rather than to abandon the search for organic causes.

A common view is that science will eventually find out exactly what goes wrong physiologically in clinical depression and bipolar disorder. This is speculation not science. The current biopsychosocial model used by the DSM expands its diagnostic reach with each edition in an attempt to cover every contingency of human suffering. It has generated a meticulous muddle of schemas, lists, axes, and exclusions that appears to be explanatory but actually explains nothing. This biopsychosocial model expands the number of explanations possible and is the reverse of Occam's razor. Occam's principle, the principle of parsimony, is said to underlie all scientific model and theory building. Occam said that one should make no more assumptions than the minimal needed. Yet, as quoted in the *DSM-III* itself, "Ultimately, with time, some of the disorders will be found to have specific biological aetiologies, others to have specific psychological causes, and still others to result mainly from a particular interplay of psychological, social, and biological factors" (American Psychiatric Association, 1980, p. 7). In this way, causes of suffering can be multiplied without number while preserving the flawed medical notion that suffering people are ill or disordered in some way. The diagnostic expansion turns just about everything distressing or problematic in daily life into a disorder. For example difficulties with numbers may mean you have a mathematics disorder and grief over the

death of a loved one a Major Depressive Episode. This expands psychiatry away from its original role of alleviating the suffering of the severely disturbed where a diagnostic behavioral description is extremely useful. It is then left up to human ingenuity to invent explanations and treatments for manufactured illnesses rather than the simple explanation of personal autonomy: “I did what I did because I chose to in the circumstances and context of my life” (suffering notwithstanding).

Mental Illness as a Phenomenon

“Tooth Fairy Science” is an expression coined by Harriet Hall, M.D. (see www.skeptdoc.info) to refer to doing research on a phenomenon before establishing that the phenomenon actually exists. This type of science uses research data to explain things that have not been proven to have actually happened.

As renowned physicist John Wheeler (2004) pointed out, no phenomenon is a phenomenon until it is an observed phenomenon. Before any scientific research can be done on any phenomenon one must first establish that such a phenomenon exists. Psychiatry has failed to do this; no diagnostic organic physiological causal mechanism has been found. If a causal relationship could be shown between neurotransmitters and behaviour the explanation would have to explain whether it was my being depressed that caused the imbalance or the imbalance that caused me to be depressed.

Metaphor and the Reification Fallacy

Many explanations are based on conceptual reifications (Berger & Luckman, 1966); they treat metaphorical abstractions as if they were literal (Lakoff & Johnson, 1980). The word “mind” is an abstract noun describing the collective processes of thinking, believing, deciding, judging, and feeling. Using it as a noun suggests that the mind is an object in its own right. This reification effectively separates the mind from the person who has it with a concurrent loss of personal autonomy.

Mental illnesses are abstract nouns. They have no physiological counterpart other than our behaviour. Yet psychiatry and psychiatric patients often treat them as if they were concrete nouns, compelling us against our will to become anxious or depressed, and in the process personal responsibility, meaning, and autonomy are lost.

For example, it is quite common for patients to say that they could not get out of bed because their depression or anxiety stopped them. A clinician might embark on a wild goose chase to “treat” their “depression”. In literal terms it might very well be the case that someone could not get out of bed because they had broken their legs, had a stroke, or were strapped to the bed. Further psychotherapeutic questioning might reveal that they did not *want* to get out of bed because they did not have anything to *get up for*. This has a totally different meaning that restores autonomy, responsibility, and meaning. Reification is responsible for a great deal of confusion and puzzlement when the ambiguity of abstract nouns is not recognised, and that is a great deal of the time.

Psychological Explanations as Conceptual Abstractions

In both psychiatry and psychology the use of conceptual abstractions to explain behaviour is widespread and underlies much of their theoretical basis. Although such theories may have great explanatory power they have the same circular form. They all originate as abstractions of human behaviour and tend to see human behaviour as occurring in a vacuum, relegating, ignoring, or otherwise dismissing the context of social relationships in which they occur. For example, a client says, "I have explosive outbursts of anger and I feel worthless a lot of the time." If context is included we find a dominating, overbearing boss and an emotionally abusive partner. The patient might be well on the way to being diagnosed as having a "personality disorder" that he thinks "causes" him to react in this way, thus ignoring social context, autonomy, and personal responsibility.

Many such abstract conceptual objects have been created by our current Western psychiatric and psychological culture. Once reified these abstractions can become causal explanations: "It is my depression that makes me so unhappy". Chains of reified conceptual abstractions can be linked together to form a "psychological" generative mechanism to seemingly explain a patient's behaviour. For example, "His angry outburst can be explained by his poor ego strength coupled with his lack of impulse control at a time of hyper-vigilance." Why not invite a person to control their temper rather than treat their "emotional dysregulation"? Such abstractions appear to explain the source of a person's suffering in the person but only by ignoring the social environment in which the behaviour occurred. These abstractions also include the richly explanatory psychoanalytic and psychodynamic neologisms such as the id, ego, and superego, as well the internal object representations of self psychology. There are the mechanistic metaphors of defense, stress, and burnout, and descriptive objects such as instinctual drives, motivation, personality, and a whole cohort of psychological strivings that supposedly "drive" our behaviour. The "unconscious" is in a class of its own as it can be used to account for almost any behaviour known or unknown by its possessor. By definition, a person has no access to it, keeping it free from scrutiny and contradiction and it is therefore a viable resting place for any theory or metaphorical entity an observer might invent to explain another's behaviour. It is not my purpose to discredit these explanations but rather to point out that they are invented, or generated, and exist as abstractions about a person's behavior and are not literal in any material sense in the same way as scientific medical explanations.

Pseudoscientific Medical Explanations.

Without context, behaviour has no meaning. A person who thinks that the life they are living is hopeless and they want to end it becomes "the patient who has suicidal ideation". The person who is not interested in sex becomes "the patient who has low libido". The person who feels good in the evening and bad in the morning becomes, "the patient who has diurnal mood variation". Without context these statements are engineered to appear as if they are describing aspects of the patient's physiological or psychological structure in the same way as a medical diagnosis would comment on a patient's blood pressure. It is quite common to ask a patient to describe their mood on a scale of one to ten as if

their mood could be measured in the literal way that one might measure blood pressure or blood glucose. Similarly patients may be given questionnaires to complete on a five-point scale. What is often not apparent is that these are *anecdotal self-reports* and are thus heavily influenced by our Western psychological culture. For example, the poor self esteem and guilt which are central to our Western psychological culture are foreign to Tibetan culture; there is no word for guilt in Tibetan (see www.viewonbuddhism.org/guilt.html, also personal communication, Joyce McDougal, 1998).

In keeping with the medical approach these questionnaires are called “psychological” instruments. In the medical model they stand as metaphors for literal instruments in scientific medicine such as a sphygmomanometer or microscope. Psychological instruments are self-reports where the patient is used as their own laboratory. Unlike a human being, a cell cannot lie, become confused, anxious, or mistaken about its morphology, nor does it have an opinion about the microscope or wonder about the motives of the person peering at it. Metaphorical instruments, however valid, measure metaphorical data not literal data, a distinction that is crucial and usually completely lost in translation. In this way, the person and their context seem to disappear in a welter of obfuscating, metaphorical, pseudoscientific medical jargon which, while it has the appearance of explaining, is nothing more than a tautological re-description of what the patient said and did minus the context of their lives in which they said and did it.

The removal of context is essential to the conservation of the medical model in psychiatry. It preserves a view of human conduct as a consequence of hypothetical internal drives, genetic loadings, narcissistic strivings, faulty chemistry, unconscious yearnings, risk factors, and all the other metaphorical paraphernalia that the human ingenuity of experts can invent to explain another person’s behaviour other than that of listening to what the patient actually says about their daily life. Although the use of these terms may be hugely and richly explanatory for those who use them, they do not appear to have much impact on the suffering person who, it seems, has to be persuaded of their veracity. When patients become so persuaded, the power and control of their interlocutors is fortified.

Psychological Persuasion.

Just as the various editions of the *DSM* standardise psychiatric diagnoses, the *Malleus Maleficarum* or *Hammer of Witches* (see <http://www.malleusmaleficarum.org>) published by the Office of the Inquisition in the 15th century standardised the diagnosis of witches and witchcraft. The similarities amongst the confessions of witchcraft in different countries was initially considered to be evidence for the existence of witches and the devil but was later to be found to be a function of the theories, assumptions, and questions contained in the *Malleus Maleficarum* itself (Mackay, 1841). Both psychiatric diagnoses and the Inquisition rely on similar methodologies. Although the methods of persuasion used in the former are more gentle than in the latter the power structure is the same; persuading someone to accept a belief without a shred of scientific evidence simply because someone else has the authority to say what is so. Let us not become so hypnotised and spell-bound by our allegories and metaphors that we mistake them for being the literal or scientific facts about the person in front of us.

Success of Scientific Medicine Versus Psychiatry

Compared to scientific medicine the success of psychiatry is abysmal. More than 20% of Americans are reported to be on psychotropic medication, many for “mental” illnesses that were only invented in the past 30 years. Epidemics of “depressive illness” are supposed to await us in the future, And one out of every 15 Americans enters adulthood with a “serious mental illness” (Whitaker, 2011), antidepressants have been found to be not much better than placebo (Kirsch, 2011), antipsychotic medication has been implicated in loss of brain tissue (Beng-Choon, Andreasen, Ziebell, Pierson, & Magnotta, 2011), and major pharmaceutical industries have been found to be guilty of criminal negligence, and fined billions of dollars for paying academic leaders in psychiatry to put their names to papers ghostwritten by the industry itself, withholding negative outcomes of drug trials and sending psychiatrists on world junkets to conferences lauding their products (Angell, 2005; New York Times, July 2012).

In psychiatry what is deemed legitimate has to do with the training and agreement of the community of experts who write the papers. It is their votes that constitute diagnoses rather than scientific evidence. For example, in my experience as a psychotherapist people do not come to therapy in order to come to terms with their “wounded child” or resolve their “narcissistic needs” or correct their “chemical imbalances” or their “dysfunctional metacognitions” unless, of course, they have already been convinced of the literal existence of these entities. They usually come because they are suffering and want to talk, reflect, and give meaning to their lives.

Conclusion

In my view, people who do not fit the constructs of our Western culture are not necessarily disordered, ill, or diseased unless we claim them to be. Rather, their behaviour may be an authentic legitimate expression of the contingencies of human life; an expression of cultural diversity, of new ways of conducting and expressing oneself, which may be problematic and may be associated with suffering and anguish. I follow Maturana’s (1978) approach, considering that our behaviour is the consequence of the autopoietic roots from which we as living systems all spring.

We humans are languaging animals, that is, we live in language as a manner of flowing in coexistence in consensual coordinations of behaviors. At the same time, we are loving animals. Love is a manner of relational behavior through which the other arises as a legitimate other (as an other that does not need to justify his or her existence in relation to us) in a relation of coexistence with oneself. (Maturana & Verden-Zoller, 2008, p. 4)

This manner of thinking has incalculable consequences for psychotherapy. Anything emerging in a patient from the intervention of a psychotherapist is always to be understood as a reorganising of the person’s experience determined by the patient, not by the therapist whose interventions may trigger mental reorganisation but can never specify it (Ruiz, 1996).

My approach has developed from this and results in me viewing people's behaviour from numerous perspectives. Rather than explaining people's behaviour as being the result of their disordered physiology or psychological parts, I take great interest in how people conduct themselves as whole beings in language with others. I might change preferences in order to see what other "verses" there might be from which I might expand my understanding. If I construe someone's behaviour not as an expression of an illness or disorder but rather as a legitimate and unique expression of their suffering I am interested in learning how to ease suffering rather than how to "treat their illness". If I am more interested in the experience of a person who is hearing voices that I cannot hear, I might learn something about what it is to be a human being who cannot tell the difference between perception and illusion (Maturana & Varela, 1992).

From this perspective, a person diagnosed as psychiatrically ill might be seen as behaving legitimately in the context of the meaning of their lives. Rather than "treating" people maybe we can learn what it takes to be an authentic human being in language with others on this planet. Lest I am misunderstood I am not saying that people do not suffer or that their behavior may not be embarrassing, inexplicable, or incomprehensible. There is a section of disordered people for whom a diagnostic descriptive approach and medication can be extremely helpful in alleviating suffering. Nor am I saying that protective care, restraint, or even involuntary restraints should not be used where it relieves suffering. But if we describe an ethic of authenticity, acknowledge why we call such people disordered and then look further, perhaps we would see that such people may be construed as being at the edge of a problematic Western culture, seeing what we do not. This, however, requires the generation of an authentic ethic, a self that is autonomous and legitimate, a self with built-in integrity, a self that can choose and make decisions other than the fragmented disordered, ill self currently given by the medical model of human suffering.

In daily life when we have a spiritual experience with emotions of awe or wonder, we become aware we are part of a wider realm of connectedness than that of our immediate locality. This expansion of consciousness gives character to our daily lives. The wellbeing that arises entails the awareness that we belong to a loving realm of existence that accepts us in the simplicity of our natural being (Maturana, 2005).

Insofar as the biologist or physician chooses to act as a scientist, he has an unqualified obligation to tell the truth: he cannot compromise that obligation without disqualifying himself as a scientist. (Szasz, 1977)

Strictly speaking the question is not how to get cured, but how to live. (Conrad, 1900/2000, pp. 212-213)

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