

## REVEALING THE SECRET OF ENIGMAS: NON-PATHOLOGICAL CLINICAL PSYCHOLOGY

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*Psychological problems have been and continue to be pathologized, converted to psychopathology. This article gives a brief historical outline of this process and a critical analysis of its logical and epistemological inadequacies as well as an analysis of the problems posed for their understanding and solution. From the paradigms of psychology, it is possible to make a paradigm shift and offer a non-psychopathological alternative that enables us to understand the significance of the problems.*  
**Key words:** Psychopathology, Mental disorders, Neuromythology, Psychological problems, Biographical model.

*Los problemas psicológicos han sido y siguen siendo patologizados, convertidos en psicopatología. El artículo hace una breve referencia histórica a este proceso y un análisis crítico de sus insuficiencias lógicas y epistemológicas y un análisis de los inconvenientes que plantea para su comprensión y solución. Desde los paradigmas de la psicología cabe hacer un cambio de paradigma y ofrecer una alternativa no psicopatológica que permita comprender el significado de los problemas.*

**Palabras clave:** Psicopatología, Trastornos mentales, Neuromitología, Problemas psicológicos, Modelo biográfico.

### **A** N EPISTEMOLOGICAL AND ETHICAL REBELLION, AND A RADICAL PARADIGM SHIFT

It is well known that throughout the course of history many psychological problems and problems in living have been pathologized and psychopathologized, being considered as illnesses, particularly "mental illnesses". And this pathological perspective is pervasive in professional practice, both in the area of "mental health", as it is called, and even in the broad sectors of clinical psychology. This is even more surprising given that the study of the causes of these problems has, from a psychological perspective, such a large amount of empirical support that it becomes indefensible to explain them on the basis of single causes, as for example, a morbid process, an uncontrolled emotion or a deranged thought.

#### **Psychopathology turns psychological problems into enigmas**

Experiences such as hearing voices, washing one's hands so many times that lesions appear, losing control in normal and non-threatening social situations, not leaving the house for years, getting depressed when things seem to be going well, and being sexually aroused by

inappropriate objects or by animals, among other things, turn into enigmas when they are called an illness and, above all, when the supposed illness does not exist because there is no detection of it in the many biological tests and analyses that are carried out. It is not surprising then, that, pathologized in this way, these problems have come to be considered a "psychological enigma, without any appropriate cause" (Kraepelin, 1988:38), that delusions are "psychologically incomprehensible and do not derive from other symptoms or events in the patient's life" (Vallejo-Nágera, 1971:44), and that cyclothymia and schizophrenia are, for Kurt Schneider, an "anthropological mystery (...) the scandal of human psychiatry" (1997:35). We agree with Thomas Szasz in that "the labeling of individuals incapacitated by problems in living as having mental illnesses delayed the recognition of the true nature of these phenomena" (Szasz, 1968:39).

#### **A critical analysis of psychopathological orthodoxy**

In our recent book (López & Costa, 2012), *Manual de Consejo Psicológico. Una visión despatologizada de la Psicología Clínica* [Psychological Counselling Handbook. A depathologized view of Clinical Psychology], we denounce this psychopathological perversion. In the book, we propose the need for a radical paradigm shift, which involves carrying out a critical analysis of the orthodoxy of the psychopathological model, rescuing psychological problems from the world of pathology, depathologizing them, emancipating them from the old

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doctrine which states that “this is an illness,” and which dictates that some people who experience a problem in living have an illness that needs to be cured, and that their life experiences are a pathological phenomenon, or indications, signs or symptoms of an illness. For many years, we (Costa & López, 1986, 2003, 2006, 2012) have been strongly committed to this epistemological and ethical depathologizing rebellion, trying to reach the deepest roots of psychological problems, to find answers to the copious inheritance of the paradigms of psychology, and to establish synergies with many others who are carrying out the same search, both in Spain (Bayés, 1977, 1980; Pérez-Álvarez, 1996, 2011; Vila & Fernández-Santaella, 2009) and in the rest of the world.

### ***We try to resolve a problem, not treat a psychopathology***

We genuinely believe that it is necessary and possible to restore the true nature and meaning of psychological problems, and reveal their enigmas, if we examine and recognize them under the light of basic psychology paradigms, if we analyze them through the hermeneutic filter of Functional Behavioral Analysis, and if we approach them with psychological techniques and procedures aimed at change. Furthermore, we believe that this examination of psychological problems also requires a regeneration of clinical psychology, emancipating it from psychopathological orthodoxy, depathologizing it. For this reason, in the Psychological Counselling Handbook (López & Costa, 2012), we try to resolve a problem, not treat a psychopathology, a mental illness or the symptoms of an illness.

In this article, we will focus particularly on the denaturalization that is required to consider psychological problems from a psychopathological perspective, and on the critical analysis of the psychopathological model.

### **THE ANATOMOCLINICAL AND PHYSIOPATHOLOGICAL MODEL: THE SEAT AND CAUSE OF THE ILLNESS**

It was towards the end of the 18th century when society formally delegated to the medical profession the job of explaining why “insane people” behaved in a strange way (i.e. being aggressive, nervous, melancholy, mute, catatonic, delirious or self-harming), and of finding ways to control these behaviors. In response to this assignment, and in order to find a way to deal with these behaviors, the medical community used, as a frame of reference for analysis and intervention, the human pathology models with which they were already familiar in their usual

praxis. In fact, at that time, the anatomo-clinical, physiopathological and etiopathological models were being established, which would eventually lead to the biochemical and molecular models of the 20th century, and which set the scientific foundations for human pathology, in contrast to the demonological and hippocratic-galenic models of the time. In accordance with these models, the seat and cause of the illness and signs of pain had to be looked for within the body, and would be visible in an autopsy, by using a microscope, or in a laboratory using the appropriate technology.

### ***“This is an illness”: a declaratory metamorphosis***

When these models are applied, such behaviors experience a radical change in their social and conceptual categorization. They end up being recategorized, via declaratory metamorphosis, as an illness or as the symptomatic manifestation of an illness. A behavior considered to be abnormal, belonging to the category of psychosocial incidents and processes, ends up being renamed as a pathological behavior, belonging to the category of anatomo-pathological and physiopathological incidents and processes, as if it were cirrhosis of the liver or a tumor. The person who was previously considered to be “mad” or “insane” is now considered to be “ill”, and whilst they were previously thought to be “possessed by the devil”, they are now considered to be possessed by “morbid entities”. For Kraepelin, insanity is simply “the expression of pathological brain operations” (1988:134) and “the main thing to determine the morphology of mental disorders is the extension in the brain of the process that causes them” (1988: 147). Furthermore, the application of this anatomo-clinical model to behavior would soon become contaminated by body-mind dualism, and the pathological entity would become a “pathology of the mind” or a “mental illness”.

### **A SERIOUS LOGICAL AND EPISTEMOLOGICAL ERROR**

But, as Szasz also said, the labelling of certain problems in living as “illnesses” is “the most serious logical error in modern psychiatry” (Szasz, 1968:39).

### ***A discouraging lack of evidence***

Indeed, a review of the writings of key figures in the field of psychiatry in the 18th, 19th and 20th centuries reveals that there is absolutely no evidence that the observed behaviors are, in accordance with the anatomo-clinical model, an illness, a biological dysfunction, or a sign or



symptom of an illness, or that the corresponding lesional pathological anatomy (a cause-effect relationship between a hypothetical lesion, dysfunction or imbalance and the behavior), and the corresponding physiopathology and pathogeny exist, in the same way as they do, for example, with hepatitis and jaundice, or pulmonary emphysema and dyspnea.

Lasègue's accounts of delusions of persecution and auditory hallucinations are no more than descriptions of life experiences based on the stories of the people who experienced them. And, despite affirming that "There is something more to this than the exaggeration of a natural tendency (...), it is a new pathological element introduced in the moral organism" (Lasègue, 1994:55), he does not offer any evidence to prove the existence of this "pathological element". Kahlbaum expressed his surprise at the lack of "explanations" offered by the pathological anatomy of the brain, perhaps due, he supposed, to not having "dissected and examined enough corpses of mad people" (1995:98).

Therefore, regardless of the name used, psychopathology does not exist; it is not sitting there in the brain waiting to be "discovered". Regardless of the name used, the only consistent finding is that of the behaviors upon which the declaratory metamorphosis occurs. And the only evidence that these behaviors constitute an illness is the fact that some people declare that they do.

### ***A logomachy, a fictitious disease***

So, without any empirical foundation, the metamorphosis that declares "this is an illness", "this person is ill", "they have a mental illness", is reduced to a social-verbal construction, empty of meaningful content, a verbal illusion, pure logomachy. At the same time, the supposed illness is, in itself, a fictitious disease, created by the pathological statement and existing only in this statement. "I'll call this 'schizophrenia,'" says Kurt Schneider. Laín Entralgo calls experimental neuroses a "pathological behavior disorder," and believes that "the process of becoming ill due to human neuroses—and, mutatis mutandis, due to psychoses—is the same as any other illness that humans suffer from" (1987:16). This is in spite of the fact that, in the whole process in which an experimental neurosis becomes established, there is nothing to demonstrate any kind of physiological or morphological injury in the organism; on the contrary, the physiology is in perfect working order. Even Leon Eisenberg, who was one of the main people responsible for inventing ADHD (Attention Deficit Hyperactivity

Disorder), which continues to generate large profits for companies who manufacture and sell methylphenidate, declared, in a belated confession that some may consider cynical, that "this disorder is a prime example of a fictitious disease" (quoted in Blech, 2012:100).

### ***Psychopathology, a profession of faith***

Therefore, the declaratory metamorphosis is not evidence; it is a belief, a "revealed truth" that we have to believe, based on the authority of the person who issued it. In fact, Kurt Schneider recognized that his hypothesis on cyclothymia and schizophrenia has to be "a profession of faith" (1997:35), given that "we do not know the underlying morbid processes for cyclothymia and schizophrenia". The only supporting evidence that Schneider can provide is the behaviors that define cyclothymia and schizophrenia, onto which he arbitrarily imposes the pathological declaration, thereby reinventing them as "psychopathological facts", as psychopathological symptoms. This radically modifies the nature of somatic pathology defined by the anatomo-clinical model, which, on the other hand, Schneider claims to support. But Schneider was to take an even more decisive step toward the pathologization of human behavior. Even whilst not considering "abnormal personalities" and "abnormal experiential reactions" to be illnesses, but, rather, abnormal variations of the psyche, he does, however, use the term "psycho(patho)logy" for a group of abnormal personalities: "psychopathic personalities". The invention of something being psychopathological thereby became official with Kurt Schneider, as something different to the somatic-pathological.

### ***Like a demon in the body: the logical fallacy of reification***

Even though "mental pathology" or "psychopathology" is a statement empty of meaningful content, the social and institutional support that the psychopathological "profession of faith" (and the professionals that declare it) receives gives the statement social relevance and puts it on the same level as real illnesses. This allows it to be used in a literal way in practice, as if the declared illness genuinely existed. The psychopathological becomes functionally equivalent to something which is anatomo-pathological and physiopathological, the same way that the declaration "he has a demon in his body" can be interpreted literally as someone truly being possessed by the devil, so literally, in fact, that exorcisms may be carried out to try to eliminate it.



This functional equivalence was the basis for the logical and epistemological leap that meant that the psychopathological category ("this is an illness", "this person has an illness"), which began only as a name to identify the observed behaviors, became objectified and manifested itself as a real entity ("mental illness", "borderline personality disorder", "obsessive-compulsive disorder", "social anxiety disorder"), and which constitutes the logical fallacy of reification that William James had already denounced. People believe that, as if by magic, the words "it is an illness" means that it is a genuine illness, as if giving something a name magically makes this "thing" real, as if the words were "evidence" for the existence of the thing being named.

### ***A disease of the brain***

According to the "seat and cause" model, the alleged pathological entity would have its roots inside the mind ("he has a personality disorder", "he has a mental disorder", "he has a post-traumatic stress disorder", "he has a social phobia", "he has an attention deficit hyperactivity disorder"), also reified as something that genuinely exists, as a "place" (Frith, 2008) in which it would be hidden, waiting to be "discovered" using the appropriate diagnostic technique ("in the examinations carried out, a disorder was found..."). If the mind is inside the brain, and even is the brain itself, or a creation of it, as Frith ("it is the brain that creates the mental world" 2008:201) and Damasio ("the brain creates a mind" 2010:23) propose, the problems would furthermore be "problems of the brain", or, to be more precise, biochemical imbalances or due to the genetic molecular physiopathology of the neurons (Insel, 2010).

### ***Delusions as a form of secretion***

At the peak of its metamorphosis, the alleged pathological category becomes "prior" to the behavior that it names and is the causal agent "pathogen" ("his behavior is caused by the personality disorder which he suffers from", "he washes his hands compulsively because he has an obsessive-compulsive disorder", "his delusions are due to the fact that he is schizophrenic"). In the same way that bronchitis causes a cough or phlegm, or urine comes from glomerular filtration, so the mental-brain illness would cause the delusions and other manifestations, like a secretion. For Vallejo-Nágera, the delusional idea "arises directly from the illness (...) it does not come from other symptoms or events in the life of the patient" (Vallejo-Nágera, 1971:44-45).

### ***The rhetoric of the symptom, and challenge as a symptom of a defiant disorder***

The psychopathological model establishes, furthermore, that, once diagnosed as "ill", anything that that person says or does may be an indicator of the fact that they do, in fact, have the diagnosed illness. Their behaviors lose their autonomous nature and their biographical relevance, and are recategorized as signs or symptoms of the illness that they are suffering from, like a cough and phlegm can be symptoms of bronchitis. However, if the supposed illness is a logomachy, the symptom, which is supposed to be an indication of it, is also a statement empty of relevant meaning, a verbal illusion that is, nonetheless, given the same functional relevance as the symptoms of an illness. In this sense, confusing human behavior and behavioral problems with the "signs" or "symptoms" of an illness constitutes both a logical and epistemological fraud, as well as a tautology.

Maudsley was aware of this tautology: "(...) this leads to a vicious circle of arguments (...), we infer the lack of health in the mind from the person's actions; and, on the other hand, it is because we think there is a disorder of the mind that we declare these actions to be deranged" (1991:194). Kraepelin, however, didn't seem to be so aware of it, attributing the apathy of depression to a supposed "impediment of volition" (Kraepelin, 1988: 31-32). If shyness and its different defining behaviors are recategorized as a "social anxiety disorder" or "social phobia", as in the case of the DSM-IV, from there it can be described as being "caused" by the supposed disorder ("he avoids social contact because he has social anxiety disorder"). The same applies when we say "we know that he doesn't pay attention in class because he has attention deficit hyperactivity disorder", or when we say "he challenges adults or refuses to do as he is told because he has oppositional defiant disorder".

### **THE IMPACT OF THE PSYCHOPATHOLOGICAL ORTHODOXY**

As we assert in the previously mentioned book (López & Costa, 2012), once social legitimacy and power has been awarded to psychopathological invention and its functional equivalences, the psychopathological diagnosis becomes a thesis which leaves no room for doubts or discrepancies, and which becomes immune to any kind of refutation, as the only evidence for the nosological declaration is the declaration itself.



***A diagnosis that creates defenselessness***

The power of this diagnosis puts the person who has been diagnosed in a situation of defenselessness, losing power and control over their own life, turning them into "victims" of the supposed illness. This can have negative effects on change processes ("this is happening due to something out of my control; it's because of the illness which they say I have", "what can I do if I'm schizophrenic or bipolar?") The diagnosis of "illness" is so irrefutable that one of the "symptoms" is the lack of acceptance of it: the inability to recognize and accept oneself as a sick person: "you are too sick to realize that you are sick". If the person is unable to accept that they are sick, this "proves" that they are still sick, which invalidates their disagreement, reaffirms the diagnosis, and may result in an increase of any "treatment" that may have been chosen to be applied.

***It's not me; it's an imbalance of my neurotransmitters***

If a person's actions are "induced" by the illness that the person "has", then responsibility for these actions becomes reduced, annulled or absolved. "It's not me, it's the illness controlling me; it's my dopaminergic imbalance," the person who has been diagnosed could say. The absolution of responsibility may even include criminal responsibility, as demonstrated historically by the "prison or asylum" polemic. Szasz (2007a) refers to the sexual abuse committed by a Boston cleric on more than 100 children over three decades. In his defense, the "pathology of the illness of pedophilia" and "sick acts" were alleged. If his actions and impulses are "uncontrollable", they are diagnosed as symptoms caused by the "illness of pedophilia" which supposedly compelled him to abuse the children, and they absolve him of responsibility. "How can he be responsible and be blamed for them? His illness needs to be treated", claimed the experts. Once more, we come up against the same tautology: the actions are "uncontrollable" because they are "pathological" and they are "pathological" because they are "uncontrollable". If these impulses were "normal", they would be controllable, but as they are "abnormal" and "pathological", because the diagnosis deems them to be so, then they are "uncontrollable" and therefore absolve responsibility.

***A pathological colonization of life***

Giving diagnostic names to certain behaviors and life experiences, and making it look as though new pathological entities are being "discovered", is easy to

do, providing it is not necessary to demonstrate their correspondence with the facts. From the second half of the 18th century, and throughout the 19th and 20th centuries, the process of pathologization, which so many have denounced (Moynihan, Heath & Henry 2002; Follette & Houts, 1996; Szasz, 2007a; Blech, 2005; González & Pérez, 2007), has been uncontrollably colonizing almost all areas of life, to the extent that even in Kraepelin's time, it was recognized that "there is no psychiatrist who hasn't been accused, either in seriousness or in jest, of seeing mad people everywhere" (Kraepelin, 1988:303).

This, furthermore, has caused chaos in psychiatric nosology (Szasz, 1968) and a proliferation of taxonomic categories, "an enigmatic arbitrariness, and an eagerness for innovation which reminds us of the fruitless work of Sisyphus" (Kahlbaum, 1995:38).

It is possible that the upcoming publication of the 5th edition of the DSM nosological classification may extend this easy pathologization of life and problems in living even further. If, during this process, promoted by professional circles with the support and collusion of pharmaceutical companies, people accept the psychopathological discourse and allow themselves to be persuaded that the problems affecting them are an illness, they are more likely to disregard the life events and experiences that have led to the problem and that give it meaning, and accept, or even defend, their condition as a "sick person", and accept, or even demand, the medication given as a supposed "treatment". In fact, the number of prescribed psychoactive drugs has increased exponentially (Szasz, 2007a; González & Pérez, 2007; Bentall, 2009).

***Cast out demons, cure diseases***

If psychological problems are labeled as diseases, in order to resolve them, a therapy capable of "curing" and expelling the underlying disease must be used, like an exorcism expelling a demon from a body. If the person is ill, if they have a psychopathology, this needs to be treated and cured for their own good, by force if necessary (Szasz, 2007b, Bentall, 2009), even when the patient him- or herself doesn't believe they need the treatment, doesn't want to be treated or rejects the treatment, frequently coming up against a crusade in favor of "treatment compliance". When coercive intervention ends up being seemingly legitimized as a "therapeutic act", one can say, "What's so bad about what they're doing? They're curing him". And if the treatment has clearly harmful or disabling side effects,



what can you do—people may say—it's all part of the "treatment".

From bloodletting via leeches on the jugular to cure insanity to the latest psychotropic drugs, passing through insulin coma therapy, surgery to cut away nerve fibers (lobotomy), and electric shocks to the brain (these days euphemistically called electroconvulsive therapy), with the consequent convulsions and frequently irreversible brain damage that this can cause, there have been many different types of intervention considered to be "therapies" or "cures" for the problems that affect people. However, if the psychopathological model is a chimera, and the diagnosis is a logomachy, the supposed "cure" must also be a chimera as well: a pretend cure.

### ***The therapeutic chimera of psychotropic drugs***

The pretense these days is particularly focused on psychotropic drugs, declared to be the "recommended treatment" for supposed neurochemical imbalances (dopaminergic for psychosis, serotonergic for depression, GABAergic for anxiety), the supposed "seat and cause" of the psychopathology to be cured. There is no doubt that psychotropic drugs—just like alcohol, nicotine and cocaine—alter the biochemical processes that affect behavior and psychological problems, albeit with undeniable secondary effects, which are often severe and irreversible (González & Pérez, 2007; Bentall, 2009). But psychotropics, the bloodletting of yesteryear or lobotomies are not therapies; they cannot cure anything in the place where they have their effect because there is no "mental illness" there, no molecular disturbance, no neurochemical imbalance that could be considered to be the seat and cause of the psychological problem they are trying to "cure", as opposed to, for example, the way antibiotics cure meningitis or encephalitis, which originate in the brain.

To say, therefore, that a psychotropic drug is a "treatment" for an illness is a false therapy, a therapeutic chimera. And to say that the physiological alterations that are produced are "proof" of the existence of this illness is a logical fallacy of the "post hoc, ergo propter hoc" variety, and a tautology, in the same way, for example, as when the effects of a drug on dopamine levels are considered to be "proof" that the problem is due to a dopamine deficit (Rose, 2008). The supposed "therapeutic efficacy" of psychotropics on the theoretical seat and cause of the problem have no more epistemological value than the alleged therapeutic efficacy of bloodletting to relieve the so-called "brain

congestion" that Esquirol claimed to be the seat and cause of insanity. The physiological alterations of the hypovolemia and the severe anemia produced by bloodletting on the whole of the organism and on behavior were considered to be the "cure" for insanity and "proved" the existence of brain congestion as its cause.

However, in the same way that the chimera of the psychopathological model hasn't prevented the declaratory metamorphosis of diagnoses from being taken literally, neither has it stopped the pretence of a "cure" and the literal interpretation of the words "treatment", "cure" or "therapy" as being functionally equivalent. In fact, the supposed "therapeutic efficacy" of psychotropics plays an important role in the pathologization of psychological problems, giving "pharmacological support" to the psychopathological logomachy. As Szasz (2007a) claims, if a drug is approved as "treatment" for a problem—diagnosed, for example, as "attention deficit hyperactivity"—this means that the problem starts to be treated as an illness. In this way, treating certain problems with drugs is an effective strategy to "pathologize" them, and, at the same time, for the pharmaceutical industry to promote the drug (González & Pérez, 2007; Moynihan, Heath & Henry, 2002).

### ***Take a pill and case closed***

The supposed therapeutic efficacy of psychotropics also plays a role in the simplification of the biographical complexity of psychological problems, in their caricaturization as a matter of molecules that do not function well in the brain and professional intervention being limited to "just give them a pill". If this is an illness and this (a bloodletting, a psychotropic) is a "treatment" that "cures" it, then case closed. In this sense, the therapeutic chimera of psychotropics is reinforced because it is useful and convenient, both for professionals as well as for the people being treated pharmacologically, to simplify the explanation, confrontation and solution of problems in living ("it's as easy as taking a pill"). On the other hand, the disabling and tranquilizing effects (sedation, somnolence, psychomotor retardation, anhedonia, reduction of attention reaction, behavioral avoidance inhibition) of drugs that block dopaminergic action could become, at least for professionals, a powerful reinforcer that increases the probability and frequency of prescription, the reaffirmation of the dopaminergic hypothesis and



the masking of the serious and irreversible side effects of neurochemical blockage.

### *I don't understand you*

The psychopathological model also complicates our understanding of what happens during meetings between professionals and psychopathologized people, to which psychiatry and psychology have, throughout history, made uncountable valuable contributions. But this communication is affected when what happens during it is reinterpreted in psychopathological terms, when the dynamic meaning of the life experiences told autobiographically is frozen and trapped by the rhetoric of the symptom: "My way of understanding you is to tell you that you have an illness, a disorder, something wrong inside, an imbalance of your neurotransmitters. Although maybe this is also me refusing to understand you."

Kraepelin's lessons on clinical psychology (1988) demonstrate how the psychopathological model also impedes recognition of the impact of the interpersonal relationship and the behavior of professionals on the behaviors that are exhibited in the classroom of the clinical lesson, treating them as if they were a skin discoloration, jaundice or ascites. From the model's perspective, these behaviors (protests, attempts to escape, refusal to cooperate or refusal to speak) bore no relation to the conditions under which people were forced into the classroom, or the coercion and humiliating procedures carried out by Kraepelin (prodding them with needles, throwing cold water over them or forcibly restraining them to prevent them being able to move), without their protests and cries being taken into consideration. The profession of psychopathological faith allows the exemption of responsibility: "I'm not responsible for these behaviors", Kraepelin could say, they are the responsibility of the "morbid state", symptoms of the disorder that this person is suffering from, as if, for example, it were jaundice caused by a cirrhotic liver, or phlegm caused by bronchitis.

### *The ideological alibi of the psychopathological model*

The orthodoxies of the psychopathological model, by situating the supposed entity that the "pathological" behavior is directly caused by in the mind or the brain, allows the life circumstances that affect the appearance of psychological problems to be ignored, and avoids the critical analysis of the processes of social control and judgments by which some behaviors are defined as "abnormal", "deviant" or "pathological". However, for the

theory of social control (Scheff, 1999), a behavior is not "problematic", "deviant", "abnormal" or "pathological" per se, regardless of the label it is given. This means that, when deviant behavior is defined as something that has its seat and cause inside the individual, critical analysis of the social control system related to what has been defined as deviant is avoided. By masking, in this way, the practice of control and social labeling, it can happen in a more subtle and effective way.

Thus, the psychopathological model and the psychopathological diagnosis become social ideology (Ribes, 1990), ideological support for the covering up of these life circumstances, which makes them the preferred option of conservative political thinking and the authorities (Albee, 1996). If psychological problems exist, if something is not working well, it is due to morbid processes in the mind, biochemical errors in the brain, a "sick mind" or psychopathology. The solution for these problems, then, involves "curing" this mental pathology, repairing the alleged biochemical imbalance: "cure the illness he is suffering from to restore his mental health". By awarding the act of diagnosis this authority and status, social institutions are also deciding that this person is "suffering from an illness" that must be cured.

The chimera of the pathological model and the act of diagnosis, and the illusion of "curing illnesses", also appear then as avoidance behaviors that are reinforced because they allow the arduous task of understanding and confronting the complexity of life experiences and problems in living to be simplified, and they reduce the anxiety produced by uncertainty as well as offering a "simple" solution via pharmaceutical intervention. There are many other reasons why this logomachy enjoys such widespread ideological, social, institutional and professional power and support, and why a paradigm shift and an epistemological, logical and ethical rebellion need to be encouraged sometimes by a heroic spirit.

### REVEALING THE SECRET OF ENIGMAS

For psychology, behaviors and psychological problems are not an enigma. They are its object of study, upon which is based all the strong heuristic and hermeneutical potential of the conceptual, methodological and technical heritage of its paradigms, with which its nature, origin and meaning are analyzed and understood.

### *A radical, biographical and transactional model*

On other occasions (Costa & López, 2003, 2006, López & Costa, 2012), we have proposed and developed the



ABC Model, which includes and organizes all the heritage of psychology in its architecture, and which we are not going to discuss in this article. Here, it is sufficient to say that ABC is a radical model because it goes to the root of behavior and behavioral problems, and because, in our opinion, it could lead to the radical paradigm shift of the psychopathological model that we mentioned at the beginning of the article. Furthermore, it is a biographical model because each behavior and behavioral problem is treated as a complete biographical event, as the work of the whole person who, likewise, has his or her own unique and unrepeatable biographical history.

For the ABC model, and for the paradigms of psychology, behaviors and behavioral problems are not brain emissions, but appear as such in the transactional processes of reciprocal influence between biography and context in which they carry out a function and have meaning. In this transactional process, one's personal biography becomes permeated by the activating power of the context, and the context becomes permeated by the operational power of the actions in one's personal biography.

### ***Delusions do not come from the brain or from an illness***

In light of this transactional perspective, the place where phobias, delusions, hallucinations, depression, feelings of anxiety, and their meanings, are produced and originate is not, therefore, in the person's biography. They are not events inherent in the biography or intrinsic in the brain's synaptic circuits, they are not the effect of bile on the brain, as Huarte de San Juan claimed, or the alleged brain congestion of Equirol and Maudsley, nor are they an imbalance of neurotransmitters as new psychopathological orthodoxy claims. They do not arise from a particular place, like blood from a wound, nor are they a brain "secretion", in the same way that language isn't either. The way they are produced is not the same as the way cortisol is produced in the hypothalamic-pituitary-adrenal axis or urine is produced in the renal glomerulus. Delusions are not "produced" by an illness, as Vallejo-Nágera asserted. They are not psychopathologies; they do not belong to the category of pathological facts or symptoms.

### ***Psychological problems arise from transactional experiences***

Psychological problems are life experiences that are inherent and intrinsic to the transactions between

biography and context; they arise from this, with the complexity of biographical and contextual factors and of the biographical history that defines them, the nature of which is analyzed and explained by the paradigms of psychology. Describing them as pathologies and supposed biochemical imbalances imposes a nosological category on them that is just a tautological logomachy: hijacking the life transactions and experiences that are their seat and cause and replacing contextual and transactional circuits with pathological circuits, is to deny their true essence and denaturalize them. Stripped of the transactional significance that enables them to be understood, it is no surprise that, as we said previously, in the eyes of the psychopathological model, psychological problems lack meaning and are an enigma.

This transactional, and particularly interpersonal, nature of psychological problems did not go unnoticed by many representatives of the pathological model, including Harry Snack Sullivan and Carlos Castilla del Pino, when trying to understand the existential meaning of life experiences.

There are also sectors that investigate and develop their clinical practice from a specifically transactional psychological perspective and which, nonetheless, frequently and partially assume the rhetoric ("symptoms", "syndrome", "mental disorder", etc.) of the psychological model (Vallejo, 1998; Labrador, 2008; Caballo, Salazar & Carrobes, 2011). We wonder if it would not be preferable to avoid this terminology in order to make clearer the specifically psychological and transactional focus of the paradigms of psychology and their own critical approach to the psychopathological model.

### ***The structural bases of behavior and neuro-mythological fantasies***

Also in light of this transactional perspective, particular to Psychology, the important current contributions of the neurosciences should also be filtered. Psychological problems are not brain emissions, but, obviously, without a brain, and without the neurological systems which link it to the rest of the body, there is no behavior or behavioral problems. Without biology there is no biography. Denying that delusions are brain "secretions", as Vallejo-Nágera claimed, is not the same as denying that neurophysiological processes play a role in delusions. These, and many other physiological, biochemical, cellular and genetic processes are the structural basis for one's personal biography, and are always involved, as a necessary condition, as collaborators that enable (Rose, 2008) the transactions.





Life experiences are, therefore, authentic psychophysiological and biobehavioral biographical experiences, as well as also being contextual and transactional. However, the physiological phenomena are not sufficient to produce a behavior. Biology is not biography. In order for the behavior to occur, transactions must take place which penetrate the biology and impregnate its plasticity.

Current research in the field of the neurosciences and molecular biology is making important contributions to our understanding of the neurophysiological, vascular and molecular phenomena that are structural correlates in delusions, hallucinations, feelings of stress, depression, and in all human behavior. But these investigations, in their own right, will not increase our understanding of how language is learned or how feelings of stress, hallucinations or delusions are constructed. Prefabricated behaviors are not going to be found in neuronal circuits, neither will any "homunculus" that produces them, or a "ghost in the machine" (Ryle, 2005) be found, because their seat and cause is not in there: the neurotransmission and the cerebral vascular flow are not the behavior, the "efficient cause" of the behavior, or even the cause of the problematic experience, because "there is no place in the brain where the neurophysiological mysteriously becomes psychological" (Rose, 2008:186).

### GO TO THE ROOT, DRINK FROM THE SOURCE

We believe that psychology and its paradigms can provide a critical view of psychopathological orthodoxy and its insufficiencies, and offer an alternative way of understanding the profound significance of psychological problems, harvesting the rich inheritance accumulated by the disciplines that have been contributing to this understanding for more than two centuries.

However, going to the root of the problems also involves drinking from the source of the copious inheritance of the paradigms of psychology which remain permanently open to the light of basic and applied research, and which require epistemological, ethical and professional loyalty. Perhaps going deep into the roots of psychology paradigms will allow us to find ourselves in a shared place, and recognize ourselves as heirs to a long tradition in which the conceptual, methodological and technological heritage of psychology and its four paradigms has been forged. In this shared place, we can continue to deliberate amongst ourselves and with professionals from other disciplines about the true nature of the life experiences that are considered to be

psychological problems, and about the practical value that classification systems relating to these problems could have, once we have deconstructed the declaratory metamorphosis, the logomachy that has turned them into pathologies, frequently hidden behind the seemingly neutral but reified term "disorder".

We believe that this also requires the depathologization of clinical psychology. We have to say, without any shame, that psychological problems are not psychopathological, renouncing the logomachy and restoring their true nature, origin and significance. We believe that this will allow us to be in a better position to understand these problems and offer strategies to resolve them, in a working alliance based on a relationship of help. Nevertheless, depathologizing human behavior is not an easy task because, as we saw previously, the psychopathological model offers short-term benefits that help it to remain in place. We need to choose, therefore, between these immediate advantageous consequences, which are accompanied by the disadvantages that we have mentioned throughout the article, and the short-, medium-, and long-term advantages that could be produced by the paradigm shift which we are proposing. We, for our part, have chosen to continue with a critical approach to the psychopathological model, defending the correct place of psychological science in the understanding of the problems in living that affect so many people. And we will continue to work on this (López & Costa, in progress). This article is also an invitation to follow this path and continue the debate that is emerging.

### REFERENCES

- Albee, G.W. (1996). Introduction to the special issue on Social Darwinism. *The Journal of Primary Prevention*, 17(1), 3-16.
- Bayés, R (1977). *Introducción a la farmacología del comportamiento [Introduction to behavioral pharmacology]*. Barcelona: Fontanella.
- Bayés, R (1980). *Una introducción al método científico en Psicología [An Introduction to the Scientific Method in Psychology]*. Barcelona: Fontanella.
- Bental, R.P. (2009). *Doctoring the mind. Is our current treatment of mental illness really any good?* New York: University Press.
- Blech, J. (2005). *Los inventores de enfermedades. Cómo nos convierten en pacientes [The inventors of illnesses. How they turn us into patients]*. Barcelona: Destino.
- Caballo, V.E., Salazar, I.C. & Carrobes, J.A. (2011). *Manual de psicopatología y trastornos psicológicos [A*



- handbook of psychopathology and psychological disorders]. Madrid: Pirámide.
- Costa, M. & López, E. (1986). *Salud Comunitaria [Community Health]*. Barcelona: Martínez Roca.
- Costa, M. & López, E. (2003). *Consejo psicológico. Una alianza estratégica para el apoyo, la potenciación y el cambio [Psychological counselling. A strategic alliance for support, empowerment and change]*. Madrid: Síntesis.
- Costa, M. & López, E. (2006). *Manual para la ayuda psicológica. Dar poder para vivir. Más allá del counseling [A handbook for psychological help. Giving the power to live. Beyond counselling]*. Madrid: Pirámide.
- Damasio, A. (2010). *Y el cerebro creó al hombre [And the brain created man]*. Barcelona: Destino.
- Follette, W.C. & Houts, A.C. (1996). Models of scientific progress and the role of theory in taxonomy development: a case study of the DSM. *Journal of Consulting and Clinical Psychology*, 64, 1120-1132.
- Frith, Ch. (2008). *Descubriendo el poder de la mente. Cómo el cerebro crea nuestro mundo mental [Discovering the power of the mind. How the brain creates our mental world]*. Barcelona: Ariel.
- González, H. & Pérez, M. (2007). *La invención de trastornos mentales. ¿Escuchando al fármaco o al paciente? [The invention of mental disorders. Are we listening to the drug or the patient?]* Madrid: Alianza.
- Insel, Th. R. (2010). Rethinking schizophrenia. *Nature*, November 11, 468, 187-193.
- Kahlbaum, L. (1995). *Clasificación de las enfermedades psíquicas [The classification of mental illnesses]*. Madrid: DOR, S.L. (Orig., 1863).
- Kraepelin, E. (1988). *Introducción a la clínica psiquiátrica [An introduction to clinical psychiatry]*. Madrid: Nieva.
- Labrador, F.J. (2008). *Técnicas de modificación de conducta [Behavior modification techniques]*. Madrid: Pirámide.
- Laín Entralgo, P. (1987). *La enfermedad humana [The human illness]*. In A. Albarracín (coord.). *Historia de la enfermedad [A history of illness]*. Madrid: Saned.
- Lasègue, Ch. (1994). *Del delirio de persecuciones [On the delirium of persecutions]*. In F. Colina & J.M. Álvarez. *Delirium in the French clinic* (págs 49-77). Madrid: Dorsa.
- López, E. & Costa, M. (2012). *Manual de Consejo Psicológico. Una visión despatologizada de la Psicología Clínica [Psychological Counselling Handbook: A depathologized view of Clinical Psychology]*. Madrid: Síntesis.
- López, E. & Costa, M. (in press). *Los problemas psicológicos no son enfermedades. Un análisis crítico de la retórica psicopatológica [Psychological problems are not diseases. A critical analysis of psychopathological rhetoric]*. Madrid: Pirámide.
- Maudsley, H. (1991). *Las causas de la locura [The Causes of Madness]*. Madrid: Dorsa (Orig., London, 1868).
- Moynihan, R., Heath, I. & Henry, D. (2002). Selling sickness: the pharmaceutical industry and disease mongering. *BMJ*, 321, 886-891.
- Pérez-Álvarez, M. (1996). *La psicoterapia desde el punto de vista conductista [Psychotherapy from the behaviorist point of view]*. Madrid: Biblioteca Nueva.
- Pérez-Álvarez, M. (2011). *El mito del cerebro creador. Cuerpo, conducta y cultura [The myth of the creative brain. Body, behavior and culture]*. Madrid: Alianza Editorial.
- Ribes, E. (1990). *Psicología General [General Psychology]*. México: Trillas.
- Rose, S. (2008). *Tu cerebro mañana. Cómo será la mente del futuro [The 21st Century Brain. Explaining, Mending and Manipulating the Mind]*. Barcelona: Paidós.
- Ryle, G. (2005). *El concepto de lo mental [The concept of mind]*. Barcelona: Paidós.
- Scheff, Th. J. (1999). *Being mentally ill. A sociological theory*. Nueva York: Aldine de Gruyter.
- Schneider, K. (1997). *Psicopatología clínica [Clinical Psychopathology]*. Madrid: Fundación Archivos de Neurobiología. (1st ed., 1946).
- Szasz, Th. (1968). *El mito de la enfermedad mental [The myth of mental illness]*. Buenos Aires: Amorrortu.
- Szasz, Th. (2007a). *The medicalization of everyday life*. New York: Syracuse University Press.
- Szasz, Th. (2007b). *Coercion as cure. A critical history of psychiatry*. London: Transaction Publishers.
- Vallejo, M.A. (1998). *Manual de terapia de conducta [A handbook of behavioral therapy]*. Madrid: Dykinson, Vols I & II.
- Vallejo-Nágera, J.A. (1971). *Introducción a la psiquiatría [An introduction to psychiatry]*. Barcelona: Editorial Científico-Médica.
- Vila, J. & Fernández-Santaella, M.C. (2009). *Tratamientos psicológicos. La perspectiva experimental [Psychological treatments. The experimental perspective]*. Madrid: Pirámide.

