Trading the Soul of Psychology for Medical Science

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The Trade

In this paper I argue against the medicalization and "scientification" of psychology in its attempt to distinguish between defective and intact mental functioning, that is, mental illness[1] vs. mental health. My thesis is that psychology's reliance on medical and scientific frameworks has taken it to the point of completely missing the point. As a profession, we have literally traded soul, our *raison d'être*, for the benefits of a medical science façade.

Psychology's prime target of interest is the immaterial soul. I am being deliberate in using this term, but not in the religious sense. Other terms such as psyche, mind, experience, and consciousness would be synonymous in describing this basic and subjective sense of human awareness. However, I think soul best captures its elusive and personal nature.

Other than soul, there is nothing else for psychology to study that isn't already studied by another discipline. Behavior might come to mind; however, the importance of behavior rests only on how it reflects the soul, despite radical behaviorists' claim that the soul is irrelevant. This focus of psychology is consistent with the etymological origins of the terms psychology and psychiatry: from the Greek *psykhē* and *logia* – soul study, and

[1] I'll use the conventional term "mental illness" throughout this paper just for convenience in communicating, but I don't think anything mental can literally be an illness.

psykhē and *iatreia* – soul healing, respectively. It could be argued that soul is the most important feature of humankind's evolution.

However, psychology has lost its way by attempting to use a medical defect-correction ideology and nomothetic science to examine this unlocatable, intangible, private, always-in-process, and immensely meaningful essence of soul. It has come to treat the soul as if it were a material object on nature's public stage that is composed of distinct parts with cause-effect relationships among those parts, as well as between the parts and the overall soul. Furthermore, psychology asserts that defects of these parts cause the problem we now know as mental illness (soul illness).

Psychology assumes that the soul can be accessed and understood from an objective third-person perspective, even though the only way to attempt this is from a first-person perspective. Any examination of the soul must use itself to examine itself. This is like trying to touch the tip of your finger with the same finger,[2] and it suggests that we cannot rely on traditional scientific methods to fully or directly know the soul in the same way we can with objects in nature, such as brains, rocks, and stars. Furthermore, each of us, psychologist or not, is only capable of knowing one soul, our own, and that is through direct subjectivity. We cannot access other people's souls, and we are only speculating when we construct an abstract model of the soul to place on the public stage for examination. This fact must be remembered when psychologists work with people who struggle with emotional distress and troublesome behaviors, as it necessarily privileges their understandings and choices over the psychologist's.

[2] An analogy used by the late Alan Watts, a 20th century popularizer of Eastern religious and spiritual views.

Medical Science and the Soul

Before the scientific revolution of the 16th and 17th centuries, problems that now get diagnosed as mental illness were commonly seen through supernatural lenses and thought to arise from religious or moral defects that allowed evil to triumph over good. The proposed solution was to correct those defects through religious restoration or punishment that would cast out the evil presence. But with the advent of science, as a project distinct from religion and philosophy, a different framework became available in the attempt to understand and intervene with these claimed defects of the soul. It was ostensibly a radical shift away from faith in dogma and morality, and toward empirical investigation and critical thinking as the best path to knowledge. The burgeoning field of 18th century medicine was the first science to take up the task of trying to better understand mental illness by searching for natural defects of the soul, not supernatural ones.

In addition to rejecting religious methods, medical science also tried to improve upon secular methods. The notorious insane asylums had the de facto purpose of subduing and controlling people with disturbed souls, mostly for the benefit of others. Medical science envisioned a transformation of these institutions into hospitals, the inmates into patients, their experiences into symptoms, and their control into treatment. However, the abysmal institutional conditions continued primarily because medical science failed to discover the causal defects that could be corrected. Many theories were proposed, but none were substantiated.

A key figure in this early attempt at medicalizing the soul was Benjamin Rush, who is considered the father of American psychiatry. He proposed that "…the cause of madness

is seated primarily in the blood-vessels of the brain, and that it depends upon the same kind of morbid and irregular actions that constitutes other arterial diseases."[3] His treatment methods were thusly focused on controlling cerebral blood flow. Rush did address the concept of soul (he used the term "mind"), but only as a conduit to the brain. In addressing the causes of "mind diseases," he said, "They have been divided, 1, into such as act, *directly* upon the body; and, 2, such as act *indirectly* upon the body, through the medium of the mind" [italics in the original].[4] Yet, despite his claimed anecdotal successes, his theories didn't pan out. Other medical scientists attempted in Rush's footsteps, but similarly failed in finding bodily defects that caused illnesses of the soul. Still today, there are no discoveries or robust theories that withstand critical thinking and empirical scrutiny, and the medical treatment of mental illness continues to have only control or palliative benefits.

Modern claims of the biological defects causing mental illness have failed as well because they don't address defect. Instead, they merely point to biological functioning associated with mental problems. The chemical imbalance notion is one example that has been long debunked, even by leading mental health authorities (still it remains prescribers' "go to" explanation). The idea that brain chemicals change along with a person's experiences and actions does not make that change an imbalance or defect. That's just how the brain works.

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[3] Rush, B. (1830). *Medical inquiries and observations upon the diseases of the mind* (*4th Edition*). Philadelphia: John Grigg. p. 15.
[4] Ibid, p. 28.

The related idea of faulty brain circuitry causing mental illness is merely a "version 2" of the chemical imbalance notion, as it asserts that brain activity, which is driven by the same neurochemicals, is the defect underlying mental illness. Abnormalized terms like "overactive," "dysregulated," and "inhibited" are commonly used to imply such a defect, when in fact, the brain activity referred to this way is merely what the brain does when people experience those problems.

Genetic mutations are also claimed as the biological defects causing mental illness. These assertions come from twin studies and genome-wide association studies. However, just as with the chemical imbalance and faulty brain circuit notions, this idea fails and for the same reasons. Twin studies, that show a greater chance for identical vs. fraternal twins to share the same mental illness diagnosis, thus suggesting genetic causation, fail to account for the fact that identical twins are treated more similarly than are fraternal twins, the flawed equal environment assumption. Also, the field of epigenetics tells us that environmental influences change gene expression, and those expressions can be seen as signatures of the environmental context.[5] Finally, if human behavioral and experiential features are in fact caused by genetic differences among people (there isn't replicated research showing this), it doesn't necessarily warrant a conclusion that those differences are defects, or the results are illnesses. At best, they would merely be the genetic causal roots of those things.

[5] For example, genes are expressed during physical exercise. See Barrès, R.; Yan, J.; Egan, B.; Treebak, J.; Rasmussen, M.; Fritz, T.;…& Zierath, J. (2012). Acute exercise remodels promoter methylation in human skeletal muscle. *Cell Metabolism, 15(3)*, 405-411.

Presenting the preceding three ideas (chemical imbalances, faulty brain circuitry, and genetic mutations) as evidence of the causal defects for mental illness is tantamount to claiming the preposterous idea that physical exercise is an illness and then pointing to elevated neurochemicals, a "dysregulated" motor cortex, and unique genetic signatures as the defects that prove it is an illness. Nearly every human behavior and experience is associated with these three processes of biology. That association is not evidence of defect or illness.

Despite the preceding failures, medical science presses on. However, its attempts to search for defects seems to inescapably end in an oxymoronic dilemma. If defects are discovered, the problems necessarily leave the domain of psychiatry and the rubric of mental illness and enter the domain of other existing medical specialties that assess and treat bodily disease. Therefore, success in identifying the biological defects responsible for mental illness leaves psychiatry with fewer and fewer targets of its discipline. The alarming conclusion from this must be that to remain a matter for psychiatry per se, no biological defect can cause the illness.

Physical illnesses, that produce mental and behavioral symptoms, are not psychiatric matters. A few examples are brain tumors, head trauma, hormone deficiencies, and infections.[6] These are the targets of other medical specialties like oncology, neurology, endocrinology, and internal medicine, not psychiatry. Their symptoms might have been initially seen as mental illness and assessed by psychiatry; however, once the

[6] Many categories in the *DSM* are illnesses that are caused by bodily defects. Examples are neurocognitive disorder due to Parkinson's disease, Alzheimer's disease, and HIV infection; substance withdrawal, breathing-related sleep disorders; substance-induced disorder; and disorder due to another medical condition. It is a stretch to make these the targets of psychiatry by including them in the *DSM*.

biological defect is discovered, it would be misguided for psychiatry to continue working on the problem, at least for the purpose of trying to correct the defects responsible for the symptoms. This is why it is important to undergo a good medical examination of one's physical health prior to engaging in any psychiatric or psychotherapeutic work. Doing otherwise could lead to a substantial waste of time and money, as well as serious harm that could result from overlooking a life-threatening biological defect.

Psychological Science and the Soul

Several decades after medical science, psychology joined the scientific revolution bandwagon. It emerged from philosophy to become a science in its own right, with the likes of Gustav Fechner and Wilhelm Wundt in Europe, and G. Stanley Hall and William James in the United States. What obviously differentiated psychology's rise to scientific status from that of medicine's was its primary interest in the psychological, not biological, aspects of soul. Behaviors would later enter the picture as an additional interest but, as pointed out earlier, only because they reflect what's going on with the soul.

After its rise as a science, psychology would soon focus on mental illness. Neurologist Jean Martin Charcot was a pivotal figure in this change of interest from the biological to psychological. Even though he claimed it to be an organic illness, he asserted that hysteria was a psychologically driven malady brought on by emotional distress. One of his students, Sigmund Freud, extended his work by theorizing mental illness as the result of defects in the resolution of developmental and emotional conflicts, triggering the psychodynamic approach. Many others would follow, branching out into different directions in the search for the claimed psychological defects underlying mental illness.

Behavioral, cognitive, humanistic, and existential perspectives would later emerge in the 20th century with differing claims of soul defects related to thoughts, behaviors, relationships, the sense of self, and meaning. It is important to note that even though 20th century perspectives shifted focus away from the biological and toward the psychological, they still retained a medical mindset by viewing the causes as psychological defects, and the effects as mental illnesses.[7]

In this manner, psychology adopted the extant medical model of mental illness. This model was further hardened in the 1930s with the introduction of electroshock and lobotomies, in the 1950s with the rise of psychiatric chemical approaches, and in the 1980 publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*).[8] *DSM-III* was advertised as abandoning previous editions' theoretical foundations of categorizing mental illness. But despite this advertisement, it effectively strengthening the medical theoretical foundation that continues to the present.

Psychology's new focus in the 19th century offered a solution to the previously mentioned oxymoronic dilemma plaguing psychiatry. It gave psychiatry rationale for reinforcing itself as a medical specialty, standing alongside the others, but one that searches for and treats purported psychopathological defects responsible for mental illness. This merging of the medical and psychological was reflected in the 1892 name change of psychiatry's professional member organization to the American Medico-

[7] Manifestations can have many causes, both biological and psychological, but only a subset can be considered defects. The important determinant as to whether the cause is a defect is if there is pathology – an injury, malformation, lesion, or contaminant that jeopardizes viability or functioning.
[8] American Psychiatric Association. (2013). *The diagnostic and statistical manual of mental disorders* (*5th Edition*). Washington, DC: American Psychiatric Association.

Psychological Association, the same year that the American Psychological Association was created.[9,10,11]

Defining Illness

The preceding historical perspective shows us how the scientific revolution offered a new method of understanding the problematic experiences and behaviors associated with the soul. It established and elevated the reputations of psychiatry and psychology as they joined the ranks of the other emerging 19th century natural sciences such as biology, chemistry, and physics. It also led to a merging of medicine and psychology in the search for the causes of mental illness. However, despite this scientific progress and boost to reputation, psychiatry and psychology left a major question unanswered. That is: What makes a problematic soul state qualify as an illness and what makes the causes of that state qualify as psychological defects?

One longstanding definition[12] asserts that any feeling of unease or unwell noted by the individual constitutes an illness. This contrasts with the definition of disease, which is the defect that might be causing the ill feeling. With this definition, it is proposed that both illness and disease can exist without the other. While it is true that disease can exist without the person experiencing symptoms, it is incredulous to suggest that illness can

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[9] National Institute of Health. (2015). Diseases of the Mind: Highlights of American Psychiatry Through 1900: The 1840s: Early Professional Institutions and Lay Activism. Retrieved from: https://www.nlm.nih.gov/hmd/diseases/professional.html. It wouldn't be until 1921 that the organization took on its current name of the American Psychiatric Association

[10] American Psychological Association. (2024). APA History. Retrieved from: https://www.apa.org/about/apa/archives/apa-history.

[11] I sometimes wonder when the American Psychological Association will change its name to the American Psycho-Medical Association.

[12] Eisenberg L. (1977). Disease and illness: Distinctions between professional and popular ideas of sickness. *Culture, Medicine and Psychiatry*, 1, 9–23.

exist without some causal defect, not just a cause, but a pathological cause. If we apply this illness-without-defect idea, the gates are left wide open for medicalizing very common and personal predicaments that have no associated defect but that are still considered illnesses merely because the person experiences emotional pain or displays unwanted behaviors, or both.

For instance, the fear preceding an important job interview would qualify, as would the despair when failing at a relationship, the shame when publicly committing a serious blunder, the confusion when questioning reality or one's purpose, and all the choices made in response to these ill feelings. This is especially true if those feelings of distress persist over time. If the critical element in designating something as an illness is the intensity, duration, and impact on daily living, then the question becomes how intense, persistent, and impactful must it be to qualify as an illness, and, most importantly, who decides this?

With biological illness, none of these considerations is present because the illness is based on verified or theorized bodily defects and at some point, those defects naturally jeopardize life or physical functioning. Moreover, the patient is the one who decides if the symptoms are serious enough and whether to accept treatment. Knowing the biological defect responsible for illness enables the potential correction of the cause. Yet sometimes we aren't sure of the specific defects and can only theorize about them, or the known causal defect can't be successfully corrected. In these instances, palliative treatment may be the only option.

On the other hand, no defect has ever been found for psychological illnesses. There are only so-called symptoms. Mental illness diagnoses are based only on the effects of an assumed defect that the *DSM* claims is "a dysfunction in the psychological, biological, or developmental processes underlying mental functioning."[13] This exclusive use of symptoms for mental illness diagnostic purposes is not surprising, given that those claimed dysfunctions (defects) have yet to be identified with any reasonable level of scientific agreement.

Also, these mysterious defects are said to impair mental functioning, including decision-making capacity. Thus, the individual[14] so affected is not always the one who decides whether the symptoms are serious enough to pursue treatment. Instead, the clinician (or spouse, employer, judge, probation officer) takes on a paternalistic role in making that decision. This violates the principle of respecting the dignity, worth, and self-determination of people, which is stated in all clinical professions' ethical codes.

Honoring Individual Realities

I would have no problem if psychology respected the individual's experiences and decisions, allowing them to choose whether to accept offers of assistance in dealing with distress of the soul. It is one thing to seek out help on one's own terms when dealing with problem issues, whether from psychiatry, psychology, a trusted friend, a clergy member, or even an AI avatar. Help of this nature can be quite beneficial, as we are all in the

[13] American Psychiatric Association. (2013). *The diagnostic and statistical manual of mental disorders* (*5th Edition*). Washington, DC: American Psychiatric Association, p. 20.
[14] I am referring only to adults. The situation with children and those deemed incompetent due to biological compromise is a different matter altogether.

position of potentially suffering greatly throughout life. But it is quite another thing to be cajoled, blackmailed, or physically forced to get help "for your own good."

Honoring individual realities means allowing people to experience the world as they do and to make decisions as they might, even if most people disagree with them. Those experiences and decisions could very well result in self-injury, law enforcement response, and social disapproval, but on what expert basis are we as psychologists and psychiatrists supposed to predict their future consequences? If that has become our role – preventing poor outcomes by intervening in individuals' experiential/decision-making process – then psychology has indeed strayed very far from its original purpose of knowing the soul and instead has become a self-righteous arbiter of human living.

The "parts" of soul (emotions, beliefs, experiences, thoughts, judgment, values, choices) cannot literally be defective, even if they cause significant problems as above. Instead, what has happened is that the resulting problems have been declared illnesses and then, as the reasoning goes, the causes must be defects. The tail is wagging the dog. Further, the illness, symptoms, and defects are all one and the same. For example, if we are asked as clinical psychologists to point out a person's major depressive disorder, its symptoms, and its causal defects, for each of those we could only point to things like the person's loss of interest, psychomotor retardation, intense sadness, thoughts of suicide, and global passivity. All these things simultaneously qualify as the illness, the symptoms, and the defects.

I am not proposing that feelings of unease or unwell are without cause. The point I am making is that their causes, whether biological or psychological, are not necessarily

defects to be medicalized and corrected. Remember what I said earlier about how changes in neurochemicals, brain circuits, and genes are not necessarily biological defect causes. The same is true for psychological causes. We all respond to current experiences based on our unique and meaningful histories of past experiences. These are the causes; the basis or rationale for responding the way we do, whether they are in or out of our awareness, and regardless of how powerful they are.

Experiences affect our responses, which would include our thoughts about those experiences, and our responses affect subsequent experiences. Therefore, it stands to reason that we will each develop different, complex, and nuanced experience-response trajectories throughout life. None of them is more legitimate or valid than the others, and the only difference is to what extent they are useful, and as the individual determines that usefulness. This difference among us reflects our uniqueness as meaning-makers. It is not a reflection of defects. It is also why soul is not a universal construct functioning and experienced the same by all people.

The importance of individualized experience-response trajectories (individualized souls) weakens clinical psychology's longstanding search for evidence-based practice standards. This is because the essential tool in the search is the randomized controlled trial (RCT) method, which is the same tool used in medical science. The RCT is a nomothetic research tool that is intended to derive general laws that apply to "people," not necessarily to an individual. It does this by basing its results on the differences between the averages of experimental and control groups. But averages ignore individuality. Rarely is anyone represented well by the average and, instead, there is much

variation in people's experience-response trajectories that can't be accounted for in the RCT.

Alarmingly, even in RCTs with strong p-values and good effect sizes, the psychotherapy can be ineffective or even harmful to some. But if most people being treated in the study benefit, the average would still indicate overall efficacy and safety, and used to declare evidence-based status and manualized treatment protocols, even though it can be ineffective or harmful to a sizable portion of the very people participating in the study. I demonstrated how this can happen in a hypothetical RCT[15] in which the results showed the psychotherapy to be efficacious with a medium effect size. Still, 27% of the people being treated in the study with the "efficacious" form of psychotherapy were worse off at the end of the study. Also, in this hypothetical study, only 7% of the variance of the outcome was explained by the form of psychotherapy being studied. That leaves 93% of the variance being attributable to other things not accounted for in the study. Could this be evidence of the individualize experience-response trajectories?

At the least, these issues place into question our ability to scientifically determine legitimate forms of psychotherapies to use with all people who come to us for help with problems. If the answer is to modify the certified psychotherapy formula for one out of four people (if based on my hypothetical example) being treated, then what is the point of having these guild-anointed, standardized, and manualized protocols in the first place?

[15] Ruby, C. (2020). *Smoke and mirrors: How you are being fooled about mental illness – An insider's warning to consumers*. Welcome, MD: Clear Publishing, pp. 192-197, and Appendix D, pp. 299-301.

Morality Enters the Picture

So how does the orthodox mental health industry identify illness of the soul, as distinct from a healthy soul, when no defects have been found, or even possibly can be found? When we look closely at the so-called symptoms of mental illnesses, we find they are exclusively based on subjective judgments about the appropriateness of experiences and responses, meaning the appropriateness of a person's soul. This includes judging what problems are severe enough, how many must be present, and how long they persist. These judgments were derived through several iterations of committee negotiation and voting about the types and specifics of problems to be deemed an illness. They were not developed through a discovery process of defects in soul functioning that cause the symptoms. Therefore, these can be nothing more than moral standards being passed off as symptoms of illnesses.

Whereas biological components have natural ways of functioning to sustain life, psychological components do not. There is no natural way that psychological components of soul operate, given that they are purely about individualized and meaningful experiences, and our responses to those experiences. How sad is the proper amount of sadness? How frightening is the correct amount of fear? What is a good choice? What is real? These questions have no authoritative scientific or medical answers as we have with biological defects and illnesses. They are strictly moral judgments about whether you experience the world in the right or wrong way and whether you make good or bad choices in response. This is certainly an important consideration in our interpersonally connected world, but is it really a task we want to assign to psychology?

This makes it clear that the "scientification" and medicalization of psychology in the 19th century retained the antecedent religious concerns of authoritative morality but cloaked it in science and medicine. The only difference is it isn't based on a formal religion. Instead, it is based on a moral ideology of medicine. Decades of medical science language and research have obscured this moral core. The result is a kind of medico-psycho-morality where medical and psychological authorities have established the parameters of the appropriate ways that soul should function and this has changed over the years as societal views of morality have changed (e.g., slave behavior, homosexuality, masochism, gender dysphoria). The morally appropriate has been declared healthy, while the inappropriate is relegated to illness. And just like the pre-scientific religious authorities using restoration and punishment to cast out evil, present day mental health authorities all too often use similar methods to cast out illness.

So, just as medical science encountered the ironic dilemma in its search for bodily defects as the causes of mental illness, psychological science set the stage for its own, yet different, dilemma in seeking out psychological defects of soul as the causes of mental illness. This was the Faustian bargain – selling soul at the crossroads of philosophy, science, and medicine. To claim scientific and medical status, psychology had to objectify the unobjectifiable subjectivity of soul and instead of studying it, they have only been able to study a medico-moralized caricature of it. This is not just the indirect study of a phenomenon as might be thought. It is the direct study of a substitute for the phenomenon of interest – a grand bait and switch. In the process, the knowledge gained only applies to the substitute while the mysterious but essential nature of soul is ignored because it

doesn't lend itself well to traditional notions of empirical observation and scientific medicine.

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