

ABSTRACT

Enactivism, the Regression of Medicalized Rhetoric and Transdiagnostic Treatment Approaches in Psychological Care

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Unfortunately, our contemporary understanding of science has condemned psychology for being a ‘soft’ discipline. This perception, in part, is rooted in the historical challenges experienced by psychology as a field of study, where explanations for human behavior were frequently attributed to experiences of divine intervention and demonic possession. Consequently, to build a respectable reputation, psychology has had to overcompensate through developments of flawed transdiagnostic and biomedical treatment approaches that rely on medicalized rhetoric, limiting a client’s agency in treatment decisions, and baseline frameworks that operate under the inaccurate assumption of there being a normal and abnormal functioning human brain. However, through a unique integration of the physiological, experiential, sociocultural, and existential dimension, the methodology of enactivism serves as a representation for how future adaptations in psychological treatment can successfully possess the intricacies required to navigate the depth of complexity behind the human brain. Nevertheless, modern psychology along with its ‘mental’ health practices stands at a crucial junction today, begging the question: will psychology reset its narrative or continue optimizing the industry it has created?

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ENACTIVISM, THE REGRESSION OF MEDICALIZED RHETORIC AND
TRANSDIAGNOSTIC TREATMENT APPROACHES IN PSYCHOLOGICAL CARE

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INTRODUCTION

The human brain stands as perhaps the most complex phenomenon in the world. Its responsibilities are convoluted, its purpose is intricate, and its total functions are essentially unfathomable. While the heart is established for pumping blood to all organs of the body, the lungs are acknowledged for transferring oxygen from the atmosphere to the body, and the kidneys are recognized for regulating fluid within the body, the complexities of the brain defy such definitional certainty. Instead, the operations of the lumpy three-pound mass of fat that we call the human brain extends beyond a singular responsibility. Considering the number of uncertainties surrounding this organ, neuroscientists and psychologists have had to develop a vast number of perspectives and methodologies in an attempt to delineate the role of the mind. Importantly, one of the many breakthroughs we have made is that the more knowledge we obtain about the mind, the more we become aware of the vast amount of information that remains unknown. Nevertheless, as time has progressed, our success can undeniably be attributed to the inquisitive minds that have engaged in this never-ending quest, and this thesis is the start of my contributions to this conversation.

Why Psychology?

My personal fascination with the human mind began when I was challenged by my own at a very young age. Like an alarm clock hardwired in my mind, when the hour struck three in the morning I would promptly rise from my bed. From the age of four, when this hour came, I would routinely walk over to my mom's room, wallow up tears in

my eyes, and beg her to let me stay with her for the night. When faced with her unavoidable query of why I was awake, I rarely had an answer. Be it the anxiety about experiencing a nightmare, the fear of someone coming into my room, or the mere panic of being alone, my body and my brain consistently awoke at this inexplicable hour. Eventually this habit I had created made the simple act of brushing my teeth before bed a stress-inducing experience. I hated the process of getting ready to sleep, as it was the time my mind would be inundated with the uncontrollable “what if” questions. What if I can’t find my mom in the middle of the night? What if I’m forced to sleep by myself? What if I’m alone with my thoughts?

To be clear, this wasn’t the typical toddler fearing monsters under her bed, rather as my preteen years approached these habits remained persistent. In fact, not only did I continue waking up at the same hour, but as I got older, I adopted additional nighttime rituals. Touching the four corners of the whiteboard in my room and running around the couch in the darkest room of the house three times were both tasks that became integral to my nighttime routine. In my mind, consequences for not completing these tasks were catastrophic, often resulting in death for myself or those around me.

To those unfamiliar with ‘mental’¹ health complications, this delineation of my battles throughout childhood likely seems illogical and bizarre. Why would failing to run around a couch three times result in dying in one’s sleep? What I can recognize now is that these irrational thoughts and fears were my first experiences with anxiety, and, if you’re a ‘mental’ health professional you’re likely also acknowledging the obvious

¹ Words in single quotations indicate theoretical doubt about their application to the human mind.

obsessive compulsive ‘disorder’ tendencies that were apparent in my behavior. While most people experience anxiety at some junction in their lifetime, including feelings of nervousness, restlessness or impending fear of failure, the emergence of these feelings at such a young age along with their disruption to my daily function make it clear my anxiety was well beyond the scope of normalcy.

With age my anxiety continued to manifest in a variety of different forms, from experiencing panic attacks before an exam, to thoughts suggesting that my pain would dissipate if I was no longer here. Even as I write this thesis today my racing thoughts continue to question my abilities - what if I’m not smart enough to finish this project? What if people laugh at the work that I’m proud of? What if people are just telling me what I want to hear regarding this project? Alongside this close relationship with my anxiety is my exploration of numerous psychological treatment methods: stress management programs, antidepressants, mindfulness, and cognitive behavioral therapy. I provide this information to my reader because I feel my credibility in discussing psychology as both a study and a treatment option for ‘mental’ distress is enriched by my experiences as a client.

Like most obstacles in life, there is a beneficial component to experiencing challenges. All of my experiences with ‘mental’ distress have built the foundation for my career aspirations today. I am one of the few lucky students that didn’t wrestle with those dreadful self-identifying questions throughout adulthood, at least in regard to my career. Rather, I always knew that I had a passion for the sciences and an immense desire to work in the ‘mental’ health field. I have always wanted my future job to consist of helping people feel understood and valued. As someone working towards a STEM

degree, I have been persistently told that I should attend medical school. Unwarranted and external opinions that I am putting in too much work for the mere goal of becoming a clinical psychologist and not a medical doctor have been an unceasing narrative in my undergraduate career. To such perspectives my response remains the same. Despite my anxiety making simple daily decisions feel like climbing up a wall, I have never been more certain of anything than my career choice.

CHAPTER ONE

Disclaimer

Before I begin, to avoid any misconstructions, I believe it is crucial for me to articulate my fundamental intentions with this thesis. As I discuss the need for qualitative growth in psychological interventions, my point is not to discredit our current scientific advancements nor is it to discourage future technologically based innovations. In other words, my discussion about the problems associated with mechanistic treatment designs should not be misunderstood as suggesting their abandonment. In fact, such a dogmatic claim would be contrary to this thesis' intention. Rather, I have written these chapters to remind people that the fields of neuroscience and psychology are relatively novel, emphasizing that for this scientific discipline to continue advancing, evolution and adaptation are central to its prolonged success. Succinctly put, my thesis is designed to articulate why our current psychological treatment approaches are in need of a transformation. Contrary to historical perspectives, the content of this work offers an explanation for why psychology's ambiguity stands as one of its most significant, positive characteristics.

Some Might Ask: Don't We Have It Figured Out?

According to an article written by Radoslaw Stupak (2021), there has been a “65% increase in antidepressant usage between 1999 and 2014 [and] a suicide rate increase of 33.3%” (p. 3). While the respect behind studying the brain as a discipline has advanced immensely since the 18th century, many of the intricacies in our present-day

society have both amplified and diversified the distress of individual's experiences. One of the most obvious explanations for an increase in these statistical values comes from the ideologies manifested through social media. In a study conducted by Lin et al. (2016), they illustrated the specific link between social media and depressive symptoms. Among their sample of 1,787 participants, 3.2% indicated no social media usage, while 29.2% of those who did use social media showed moderate levels of depression and 26.3% indicated experiences of severe depression. This strong correlation led the researchers to conclude that it is "valuable for clinicians to assess social media use among depressed individuals to probe for maladaptive patterns...[that] may be contributing to mood dysregulation" (Lin et al., 2016, p. 238). Additional contributions include hustle culture idealization, exacerbating feelings of anxiety, and the collectively traumatic 2020 COVID-19 global pandemic. Considering these modern complications, I am intrigued by the choice to persist in current treatment approaches. If the prevalence of psychological 'disorders' is rising, shouldn't that serve as a sign that change is needed? To dramatize my point, the definition of insanity is doing the same thing over and over again and expecting a different result – a concept that appears to be unfolding in some capacity within the world of psychological treatment.

Underlying Challenges

The present emphasis on mechanistic treatment within psychology is a product of its historically challenged reputation. Often criticized for its perceived lack of a scientific paradigm, psychology has had to fight in order to gain credibility in the world of science. To illustrate this point, select which of the following terms is different from the rest.

A) Chemistry B) Biology C) Psychology D) Physics

Chances are slim that you chose any answers besides C, but why is that? When presented with this question it is almost instinctual for individuals to assert that psychology is not a *real* science, or at best psychology is not a *hard* science compared to the other possible answers. To further solidify the perceived differences between psychology and other fields of science, let's investigate a viewpoint from college institutions. For collegiate level students, a Bachelor of Science degree is provided by the institution when they have completed an undergraduate program, ranging from three to five years, in a science or technology related field. Notably, at a plethora of universities and colleges students pursuing a bachelor's degree specifically in psychology have the option between choosing a curriculum in which they receive a Bachelor of Arts degree or a Bachelor of Science degree. Typically, such a distinction is based on courses in chemistry, biology and mathematics required to obtain a Bachelor of Science degree. Clearly there is no Bachelor of Arts degree offered to biology or physics students. Thus, answering C is not surprising when our current system of academia spends considerable effort isolating the scientific practice of psychology.

One of the primary hinderances that has caused academia to question whether psychology should be recognized as a legitimate science is the field's inability to identify a concrete set of beliefs throughout its development. If you have knowledge of psychology's beginnings or have been introduced to its works within an educational setting, it's fair to assume that you are aware of these historical challenges. Importantly, this foundational understanding carries substantial weight in the perception of psychology today.

As will be discussed in greater detail throughout this chapter, psychology's developmental origin was found within supernatural forces and otherworldly interventions, ultimately setting up numerous obstacles for its reputation in the years to follow. Despite its own inaccuracies, it wasn't until the introduction of the humoral theory during the Renaissance that individuals began to suspect that 'mental' complications incorporated imbalances within the human body. Moreover, it wasn't until the late 19th century and early 20th century that medical science was believed to contribute to the development of 'mental' distress, indicating that scientific approaches to psychological complications have only been relevant for roughly the past 150 years. In other words, it was a tedious journey for processes like emotional regulation, social interactions, and behavioral changes to be perceived as contributors to psychological distress.

In the late 1800s, ideas of psychoanalysis were introduced through Sigmund Freud's publication of *The Interpretation of Dreams*. Although Freud's practices are not applicable in modern day, this publication was one of the first to elaborate on the theory of unconsciousness. Freud's work proposed that our human behavior could be influenced by our perceptions, desires, and thoughts even without our awareness. Regardless of the content flaws, his understanding of repressed thoughts and dream analysis remains a creditable work for shaping our present understanding of the mind. Similarly, in 1942 American psychologist Carl Rogers published his monumental ideas regarding the importance of personal connectedness and genuineness within psychotherapy. Rogers transformed the approach to counseling by recognizing the significance of fostering a nonjudgmental and accepting relationship between the client and 'mental' health

professional. Furthermore, cognitive behavioral therapy, one of the most successful modern branches of psychotherapy, wasn't introduced until the 1960s. Commonly known as CBT, this therapeutic method focuses on adjusting disrupted 'mental' processes through guided changes in behavior patterns and emotional regulation. All of this suggests that recency prominently characterizes psychology's timeline and indicates that change in the future is inevitable.

Physics Envy

To return to the proposed question at the start of this chapter, contrary to the other fields of study in our multiple-choice options, answers in psychology are less concrete. While the practice of chemistry is complex, its principles are grounded in physical properties. There is no variability in determining the quantitative relationships in stoichiometry or in navigating the reactants and products within chemical reactions. This unwavering tangibility, however, is not offered in the practice of understanding the mind. For instance, let's look at the psychological concept known as extinction. Extinction is a term often comprehended in a conditioning method first discovered by Ivan Pavlov in 1897. Known as classical conditioning, this method pairs an originally neutral stimulus with an unconditioned stimulus. The unconditioned stimulus automatically results in a response without the requirement of prior learning. As you read the words on this page you have adapted to the sensation of the lights around, but if someone knocked on your door it would intrinsically result in you turning your head towards the sound coming from the other side of your door. In this brief example the lights serve as the neutral stimulus and the knock functions as the unconditioned stimulus.

In Pavlov's experiment, using different types of stimuli he successfully conditioned dogs to salivate for food with the mere sound of a bell. To achieve these results, Pavlov's conditioning trials included a simultaneous presentation of both a bell, the unconditioned stimulus, and food, the conditioned stimulus that naturally elicited an unconditioned response of salivation, to the group of dogs. After a plethora of training in which both of these stimuli were presented together, Pavlov had conditioned the dogs to salivate at the sound of the bell. In classical conditioning, once the neutral stimulus has become completely paired with an unconditioned stimulus it can then be referred to as a conditioned stimulus producing a conditioned response. However, if trials in which the newly conditioned stimulus is presented without the unconditioned stimulus are repeated for an extended period of time it can induce an extinction phase. In other words, in this stage the animal or subject begins to learn a new association between the presentation of the conditioned stimuli and the absence of the unconditioned stimuli, and as a result the condition response begins to decrease. Importantly, this phenomenon can be accompanied by various experimental side effects such as increased aggression, frustration, resurgence, or the presence of spontaneous recovery. Spontaneous recovery is another important yet complicated term to understand in the application of classical conditioning. By definition spontaneous recovery indicates an unexpected reappearance of a previously extinguished conditioned response. If the experimental dogs had heard the conditioned stimulus of the bell but no longer produced the condition response of salivation, that is an example of extinction. However, if then the bell continued to be presented to the dogs and they suddenly began to produce the conditioned response of salvation, after numerous sessions of not doing so, that would be an example of the phenomena spontaneous recovery. To

clarify, these concepts are not only difficult to explain, but their variation across experiments helps emphasize the conceptual component of many psychological ideas.

Interestingly, the practice of classical conditioning, and specifically the concept of extinction and spontaneous recovery, can be applied to the clinical side of psychology when understanding anxiety. As one of the top four most common ‘mental’ health ‘disorders’, anxiety has prompted numerous studies and approaches aimed at helping researchers gain a better understanding. Individuals with anxiety typically experience varying levels of apprehension to certain stimuli. Thus, classical conditioning can assist in explaining how a previously unconditioned or neutral stimulus can unexpectedly become a conditioned stimuli producing a conditioned response of anxiety. Additionally, when considering the range of physiological reactions and associations possible with anxiety, understanding the application of spontaneous recovery and extinction becomes more straightforward. With environmental changes, therapeutic techniques, and general maturity, extinguishing an unhealthy association between an established conditioned stimuli and an unconditioned stimulus is possible. Similarly, the unpredictable nature of anxiety coupled with individualized response make spontaneous recovery, in which these extinguished responses suddenly reappear, an equally common result. All this to say, attempting to understand constructs foundational to the work of psychology necessitates explanations from multiple perspectives, and requires intentional applications, to be adequately comprehended.

According to Mental Health America, 1 out of 5 Americans experience anxiety. While experiencing anxiety is an adaptive response to stress, when such symptoms are persistent and begin to hinder someone’s ability to function in their normal life, it

indicates the presence of one of the four understood anxiety ‘disorders’. The most common of these is generalized anxiety ‘disorder’, recognized by symptoms of persistent stress and worry. It is more specifically characterized by uncontrollable worries that frequently result in physiological reactions such as headaches, restlessness, trouble sleeping, and muscle tension. Panic ‘disorder’ is an anxiety ‘disorder’ characterized by frequent and unexpected panic attacks that include symptoms such as racing heart, shortness of breath, sweating and impending fear. When these symptoms constitute a ‘disorder’, individuals will attempt to avoid specific situations and experiences associated with previous panic attacks, ultimately disrupting their ability to live comfortably. The third type of anxiety ‘disorder’ is referred to as social anxiety ‘disorder’ which includes intensive fear of being judged or perceived negatively by others. The last of the four anxiety ‘disorders’ is known as phobia ‘disorder’. Commonly displayed in the entertainment industry as an aspect of characterization, a phobia includes intense aversion and panic targeted towards a specific object or situation. There are multiple different types of phobias that vary depending on the individual, each resulting in the experience of excessive worry about encountering this object or situation. Nonetheless, throughout each of these ‘disorders’ the most prominent symptoms of anxiety include future-oriented stress about an unpredictable and uncertain negative event. Nevertheless, as we know from the concept of conditioning, these ‘disorders’ originate in individuals differently, present distinctively, and impact unpredictably.

Referring back to our initial multiple-choice question, it is now clearer just how vastly different the study of psychology is compared to the other sciences. Rather than working through problems and identifying solidified answers, psychology is

multidimensional. There is no equation to determine the moment of association between a neutral stimulus and an unconditioned stimulus. Rather, to efficiently approach these complex ideas, the field of psychology combines concepts from chemistry and biology along with social sciences such as sociology and philosophy to understand its object of inquiry. Consequently, the field of psychology suffers immensely from a concept known as physics envy. This is a term that censures fields of study such as liberal arts, humanities, and social sciences that fail to effectively deduce a numerical answer from predetermined formulas. It argues that such studies intentionally incorporate complex language and use meticulous procedural approaches to their work with the hope that they will appear parallel to fields such as physics, chemistry and biology. According to researcher Richard Nelson (2015), while psychologists might be envious of the efficiency associated with mathematical quantifications, “diversity or variability is the essence of what [psychologists] study” (p. 76). Nevertheless, without the ability to calculate a specific answer, the information regarding the study of psychology is not only more convoluted but it also allows for a greater amount of unsolicited criticism. To clarify, psychology lacks an element of predictability necessary for the outside world to believe it equivalent to other sciences, and physics envy is a term that successfully encapsulates this believed inferior nature of psychology. However, the field’s dynamic essence does not make its components less ‘real’, but rather solidifies its position as a study of importance.

What is Normal?

When the behavior of a ‘mentally’ distressed person was first observed in civilizations of antiquity, corruption of reason was believed to be the distinguishing factor

between normal and abnormal behavior. This abnormality was suspected to be manifested in intense emotions and violent actions, and once societal isolation was placed on individuals who were different than the majority there was an additional experience of condemnation among them. For instance, those perceived as lacking this reason were commonly referred to as ‘mad’. Historically, due to the incomprehensible behavior of those ‘mentally’ ill, people believed their physiological complications of ‘madness’ stemmed from demonic possession or varying types of supernatural causes. According to American sociologist Andrew Scull (2015), representations of such ‘madness’ assigned to those experiencing ‘mental’ distress is depicted in Homer’s *The Odyssey*, and many, many other classical sources.

As the story goes, while waiting for her husband, Odysseus the King of Ithaca, to return from the Trojan War, a plethora of suitors began presenting themselves for Penelope’s hand in marriage. In an attempt to stall for the arrival of her husband, Penelope deceptively told the suitors that she would decide who among them to marry after she completed her weaving project. However, each night Penelope unraveled layers of her work to ensure no one other than Odysseus would be her husband. As time progressed and the suitors’ pursuit of Penelope continued to fail, their behavior took a turn. They began exhibiting manic actions including violence against each other and the destruction of Odysseus’s home. In Scull’s description of the suitors’ behavior, he notes “they laughed with jaws not their own, and ate meat dripping with blood, and their eyes filled with tears and their minds were impelled to lamentations” (p. 21). Deconstructing this quote provides ample information for how varied experiences of distress were historically perceived. Succinctly put, ‘jaws not their own’ refers to the perspective of

demonic possession, 'meat dripping with blood' parallels the behavior of an unhinged animal, and minds 'impelled to lamentation' denotes the alienation placed on these individuals. Defined within the context of 'mental' 'illness', the term 'madness' not only labeled individuals as sick but also a danger to society. The tale of Penelope and the suitors exemplifies such societal perspectives. Upon his long-awaited return home, Odysseus and his companions were outraged and frightened by the damage that had been a result of the suitor's behavior. With encouragement and divine protection from Athena, Odysseus and his son, Telemachus, went about slaughtering all the 'mad' suitors in defense of Penelope and for the safety of his people.

In Scull's research, he claims that obtaining a labeled of 'mad' is "the most profound form of human suffering –[including] isolation, alienation and the death...of consciousness" (p. 11). Specifically, it is a diagnosis characterized by an inability to control one's thoughts and a loss of relations with reality. Scull's description allows individuals to understand the severity of alienation resulting from the societal perspective that 'mad' individuals were abnormal. Moreover, the employment of labels with such degrading connotation unsurprisingly resulted in greater divide between normal and abnormal or similarly sane and insane individuals. Thus, it can be reasoned that the copious amount of 'mental' health stigma prominent today is rooted in the historical marginalization of 'madness'.

Generally speaking, the desire to separate between normal and abnormal 'mental' health exemplifies our human instinct to alienate those in the minority. This fabricated ideology of what it means to be normal remains an ambiguous concept in the 'mental' health world today. In her 1970 article titled "Mental Illness and Understandable

Excuses”, sociologist Arlene Daniels mentions how psychologists and other ‘mental’ health professionals develop a personal conception of normalcy throughout their work in the field. Importantly, these definitions depend on the opinions of each ‘mental’ health professional. Daniels states that professionals are “given the authority to make decisions based on [their] conceptions...enforcing a definition of reality...to those who encounter it” (p. 169). Daniel’s words are insinuating that the definition of normalcy is not immutable and instead is something that experts have to determine in their psychological assessments. Importantly, crafting individualized versions of reality is not unique to the role of ‘mental’ health professionals, instead it is a practice involuntarily occurring in the minds of all individuals. Hence, an all-encompassing definition of normal behavior wrongfully exists in historical settings and should be recognized as a flawed concept within our modern understanding of ‘mental’ health.

The limitations associated with universal normalcy in ‘mental’ health are further exemplified in the various perceptions of emotional expression across cultures. Considering cultures vary in language, dress, gender roles, and life scripts, it’s reasonable to assume that there are also differences in the amount of acceptance surrounding the conversation of ‘mental’ health. Interestingly, researchers Batja Mesquita, Jozefien De Leersynder and Dustin Albert (2007), explored this topic in greater detail investigating how appropriate patterns of emotional expression depend inherently on the cultural backgrounds of individuals. They specifically discovered that European Americans display more “socially disengaging” behaviors whereas individuals of Japanese and Asian descent report more “socially engaging” behaviors. They state that the emotions of socially disengaging behaviors seen in European Americans “underline an individual

independence, and emotions on the engaging end foreground the connectedness between people” (Mesquita et al., 2007, p. 286). Learning how emotional regulation is dependent on the individual, environment, and culture works to support the claim that normative ‘mental’ experiences is fallible, thus the historical foundation of ‘madness’ is not only arbitrary, but inaccurate.

Psychology in Philosophy

The complex nature of psychology can further be exemplified in the contradicting views of Greek philosophers Plato and Aristotle. While it is important to understand that psychologists today likely don’t agree with these historical perspectives, it is nevertheless vital to include when discussing how psychology’s beginnings contribute to its present day understanding. For instance, Plato believed in an encephalocentric viewpoint, indicating that our emotions and feelings originated from the head of the body, whereas Aristotle believed in a cardiocentric viewpoint stating that emotions originated from the heart. These opposing ideas resonate with contemporary understandings of philosophy given Plato’s emphasis on the power of reason. In fact, much of Plato’s contribution to philosophy centers around his belief that reason, unique to humans, leads to genuine knowledge and genuine knowledge leads to a good life.

In his work titled *Phaedrus*, Plato’s belief in the power of reason is exemplified. The story details a dialogue between the renowned philosopher, Socrates, and a young student named Phaedrus set outside the city of Athens. At the beginning, the young student repeats a speech he once heard from the writer Lysias indicating that people who are in love are blind to reality and become so infatuated they can only operate acting under the compulsion of love. The young student described love as a type of

overpowering passion that has the influence to wrongfully dictate an individual's thoughts, decisions, and feelings. The young student states that Lysias has advised him to seek relationships with the absence of love in an attempt to avoid this all-consuming mindset. However, with the help of Eros, the god of love, Socrates responds to this troubling monologue with his own opposing speech about love. He articulates that the mindset Lysias is describing is actually a form of divine 'madness' gifted to a true lover, and that when in the right combination with reason and trust, this type of endearment can increase the success of a relationship. Socrates supports his ideas with a metaphorical representation of the human soul as a winged chariot guided by two horses. The left horse is referred to as sporadic, prideful, and disobedient, ultimately representing the souls' attraction to desires and impulses. In contrast, the right horse is rational and symbolizing *ethos*. He is resistant to temptations and composed throughout all environments and interactions. Socrates goes on to describe the charioteer navigating the pull and direction behind both horses. Representing reason, the charioteer guides both the passionate horse who provides energy and the rational horse who provides stability to independent truths. To the young student, Socrates exclaims that a healthy mind in a relationship can experience the divine 'madness' of love while still being grounded in their connection to reason.

Despite the limitation of these historical examples, epics such as Plato's *Phaedrus* and Homer's *Odyssey* are crucial in understanding psychology's evolving significance throughout history. Additionally, Plato's fixation on the power of reason, seen in the role of the charioteer and in his encephalocentric belief of the mind, not only endures the test

of time but also holds particular importance to the Greeks' physiological contribution to the story of psychology.

The Brain and the Body

As we progressed throughout history, while our explanations for the mind became less extravagant, our developments remained defective. Around 300 BCE, Plato's emphasis on reason and balance were first explored by the Greek physician named Hippocrates. Fascinated by the relationship between the mind and body Hippocrates claimed "that bodily fluids [were] not merely the building blocks of physical constitution, but also affect[ed] mental dispositions" (Bos, 2009, p. 30). Hippocrates suspected that the body was comprised of various bodily fluids that he called humors, and that it was a lack of balance amongst these fluids that resulted in great psychological distress. Through a practice he discovered called humoral theory, Hippocrates believed the human body specifically contained four different types of humors: black bile, yellow bile, blood, and phlegm and that a deficiency, imbalance, or predominance present in any these fluids would result in one of the following psychological phenomena: melancholia, sanguine, choleric, and phlegmatic. When an excess or limited amount of a specific personality trait was expressed, the exact humor that was unbalanced could be detected. Despite this typology being immensely outdated today, humoral theory was one of the first methodologies claiming that 'mental' distress resulted from health concerns rather than the consequence of an otherworldly power.

In addition to 'madness', Andrew Scull's research also focused on the melancholia temperament of the humoral theory. His research states that melancholia was uniquely defined by loss of mood stability along with hallucinations and delusions, and

that potential symptoms for melancholia included medical complications amongst the liver and bowels, troubled imagination, and even distracted attention. According to the humoral theory, melancholia was a product of an excess amount of black bile present within the human body. As one of the first conditions marked by both physical causes for ‘mental’ symptoms within the 18th and 19th centuries, melancholia became a widely recognized medical diagnosis. Until the 1850s the humoral theory remained a creditable explanation for the development of melancholia. Its imbalance of humors was said to be a direct cause of hyperbolic emotions and hallucinations. Remedies including a dietary focus on naturally based foods, prolonged exposure to fresh air, and meditation practices thought to holistically heal individuals with melancholia. Other temperaments of the humoral theory, such as sanguine, consisted of individuals who appeared to have too much enthusiasm or excitement in their personality due to excessive amounts of blood, choleric came from excessive amounts of yellow bile resulting in great anger, and phlegmatic came from excessive amounts of phlegm that resulted in a reserved and relaxed personality. As a result of the fluidity imbalance preset within all conditions of the humor theory, bloodletting became an infamous treatment for those suffering from humor complications.

With its own rich history spanning 3000 years, bloodletting as a treatment method carries great significance in the development of psychological care. According to expert Liakat Ali Parapia (2008), bloodletting was originally part of Arab medication, with many of the approaches carried over from Arab physicians to Europe during the Renaissance era. In Europe, the practice of bloodletting began to flourish when Galen of Pergamum, a Greek physician, approved the procedure as a valid medical treatment. Referred to as the

“father of experimental physiology”, Galen of Pergamum not only prescribed bloodletting for humor imbalances but also fever, head pain and other medical complications. To actually perform bloodletting, the most common procedure was known as venesection; typically involving penetrating the median cubital vein located in the elbow. All bloodletting methods believed that the more severe the disease or condition the greater amount of blood needed to be removed from the body. Bloodletting continued to be the chosen treatment for different types of ailments throughout the beginning of the 19th century. Prior to his death in 1799, George Washington was also a patient of this infamous technique. In an attempt to heal his throat infection over 3.5 liters of his blood was withdrawn across a ten-hour time period (Weinberg, 1994, p. 134). The dangers of this practice gradually gained recognition during the late 19th century. Nonetheless, its focus on physiological influence marks the beginning of the biophysical approaches used to address psychological distress.

Psychology As an Early Study

Developing our present, scientific understanding of the mind took immense time, and the 1800s marked a transitional period for such conversations. It was a period in which old viewpoints persisted and new theories flourished. At the time it was difficult for people to discern which of these two perspectives held more validity, but nevertheless each were vital in building the reputation that psychology holds today. By declaring bloodletting as a pseudoscience in the late 1800s, a space was fostered for ‘mental’ health treatment to explore alternative behavioral techniques. The work of Austrian physician, Franz Anton Mesmer was one of the first to ignite this shift through his therapeutic practice known as mesmerism. With a strong passion for natural energy, Mesmer

discovered a magnetic internal fluid within the body akin to electricity, which he believed he could control to heal body and brain ailments. The procedure typically included him making physical passes through the client's body, in which pressing his finger was believed to bring about sensations and ultimately to cure psychological complications. Mesmer used hypnotic techniques to perform these passes and ensure the magnetic fluid flowed seamlessly throughout the body (Elkins, 2022). The works of both Hippocrates as well as Mesmer can be remembered as the beginning stages of a biomedical approach to psychological treatment.

Rather than focusing the influence of humors, Freud believed that the solution to 'mental' distress originated within one's unconscious. Also in the late 1800s, his theories practiced in psychoanalysis stated that attending to one's unconscious, and releasing repressed emotions from the past, would cure an individual's 'mental' disturbances. Freud used a concept known as free association in which a client would relax and articulate all thoughts on their mind in an attempt to ultimately discover their unconscious thought processes. He believed that this uncensored information would uncover a client's childhood experience, allowing him to gain greater insights into the operations of their mind. As mentioned earlier in the chapter, Freud was fascinated by the role of dreams. Inspired by Greek mythology, Freud derived insights from Hypnos, the God of Sleep, and Morpheus, the God of Dreams, to regard dreams as one of the primary methods to reaching the unconscious. He believed that deeply repressed memories couldn't be accessed unless in an unconscious state which ignited his work on dream interpretation. Importantly, Freud's focus on having the client articulate their experiences opened the door for a practice known as introspection.

Discovered by psychologist Wilhelm Wundt at the end of the 19th century, introspection was a psychological process that asked individuals to figuratively look inside themselves and examine their inner thoughts. It was an attempt to identify one's emotions, thoughts, perceptions, and feelings from their own perspective. With no method for discerning what was true and what was a false reality made up by the client, introspection was faced with immense backlash for its limited reliability. As the use of introspection began to fade out, the field of psychology began to focus on applying the scientific method to the study of the human mind.

An early example of experimental approaches comes from physiologists Ernst Weber and Gustav Fechner. In the 1830s their study discovered the central ideas of sensation and perception taught today. In their experiment the 'psychophysicists' had two cans with slightly different weights. By merely holding the cans, without sight of the amount of liquid inside, they determined that despite the different physical sensations, people's perceptions remained the same between the two. They continued adding more liquid into the cans until participants were able to perceive a difference simply by holding the two cans in each hand. Weber and Fechner found that this detectable difference was proportional to the object's original size, a formula they called the *just noticeable difference* equation. Additionally, in 1868 Francisco Donders conducted a study investigating the difference in simple reaction time and choice reaction time. Interested in determining how long it takes a person to make a decision, Donders designed an experiment measuring the reaction time to a stimulus between two different groups of participants. In the simple reaction time experiment, one group of participants were asked to press a button as soon as they perceived a light in front of them, and in the second

group, with the choice reaction time task, participants were required to push different buttons corresponding to if the stimulus appeared on the left side or the right side of their face. By examining the difference between these two groups Donder discovered that humans take a greater amount of time when a decision was tasked. While these findings might seem simple to us today, they were revolutionary in understanding the functions behind the skull.

Introducing the scientific method into psychological research was the first time in which psychology was seen through an experimental lens. Processes such as formulating hypotheses, articulating research questions, developing treatment conditions, and performing data analysis required experimenters to focus on a specific aspect of the mind, forcing researchers to narrow down the human consciousness into ideas of memory, knowledge, perception, and other distinctions. By studying the specific variables within the realm of psychology these studies provided tangible evidence demonstrating not only how we can study psychology, but also the importance in doing so. Towards the end of the 19th century researchers began publishing their results in scientific journals allowing for the development of the field's reputation and advancing its credibility. In 1887, American psychologist G. Stanley Hall founded the *American Journal of Psychology* and today it remains one of most well-known journals focused on experimental psychology,

Before we discuss the 20th century, let's reflect on the significance of learning about psychology's timeline. There are three main reasons why I have chosen to emphasize our previous techniques and approaches. The first has already been mentioned: they're remarkably recent. Information about why psychological distress exists, how it should be managed, as well as its role in our society is not significantly

dated. The field is complex and the information that we have gathered throughout the 18th and 19th centuries is just the beginning. Second, while it might be clear to the contemporary reader that these previous approaches hold many flaws, there are some cases in which they are the foundation for our modern-day practices. While removing blood as a psychological treatment tactic would be considered unethical and dangerous today, melancholia discovered in humoral theory is the foundation of depression diagnoses today. Similarly, navigating the flow of a magnetic fluid through the human body is immensely flawed; however, its principles served as the beginning of clinical hypnosis practiced today. Furthermore, it is also crucial to recognize that many of the questions asked in these past approaches still remain unanswered entering into the 20th century. What's the best way to approach psychological treatment? Can a single model of treatment be effective for all individuals? Answers for these questions were not provided in the conversations between Socrates and Phaedrus, or in the practice of introspection.

Psychology in the 20th Century

Next, we introduce a theory of learning called behaviorism. Discovered by psychologist John B Watson, behaviorism focused on the importance of empirical evidence and practical applications. Due to its subjective nature and the lack of reliability, behaviorists strictly rejected both the practice of introspection as well as the study of the mind's multidimensional components in any capacity. Instead, they believed in an intense application of operational definitions. For context, these operational definitions are applied theoretical constructs allowing for specific measurable testing to be assessed to theoretical concepts. The number of breaths an individual takes in three minutes being used to measure their level of anxiety and the number of names one individual calls

another being used to measure their level of aggression are both examples of operational definitions.

Focused on aligning their studies with those of the credible hard sciences, behaviorists ensured that all variables involved in their psychological experiments were not only operationally defined, but also directly observable. If they couldn't see or receive any quantitative data from their findings, then it wasn't valid for their study. As mentioned early in this chapter, one of the most well-known behaviorists remembered today is Ivan Pavlov. In his classical conditioning experiments with dogs his procedure included attaching a test tube to each dog's mouth in order to directly measure the accumulated saliva produced from the presentation of the bell during conditioning trials. By placing heavy emphasis on measuring observable actions and behaviors, behaviorists were not only discrediting unquantifiable concepts, but more importantly disregarding the emotionally rooted internal processes of their clients. In other words, many people viewed behaviorism as a mechanistic approach to psychology in which there was a right and a wrong way of treating and analyzing the human brain. While an advantage of behaviorism was removing unreliable and unnecessary methods utilized in introspection along with igniting conversation about translational psychology, its automated overcompensation is credited with dismissing the ecological aspects to studying psychology.

In the 1950s, we entered a time known as the cognitive revolution. This period in psychological history introduced many advancements in neuropharmacology as well as clinical applications of neuroscience seen in both our research and diagnostic practices. Although the modernness of this era allowed for integrative conversations, its innovations

ultimately perpetuated the systematic nature of behaviorism. The cognitive revolution's foundational ideas such as thinking, knowledge, problem solving and metacognition, coupled with simultaneous advancements in the world of technology, marked a transformative time prioritizing the science behind the brain rather than the concepts behind the mind. Logically speaking, the brain is a physical object made up of blood vessels, neurons, and glial cells – all things you could see. It is a bodily component housing numerous structures and functions that can be located and identified. In contrast, the mind is an abstract concept consisting of an individual's conscience, thoughts, and perceptions. Considering the drive to prolong the requirement of observable variables, hierarchy was given to the brain over the mind during this time period.

The underlying purpose of the cognitive revolution was to develop the most succinct and effective methods for psychological treatment. For example, instead of conversing with a client about their experiences of anxiety, the influence of the cognitive revolution allowed psychologists to examine a functional magnetic resonance image (fMRI) of a client's brain. In this case, they could claim the anxiety to be an outcome of an overactivation in the extended amygdala rather than contextual factors present within the client's life. Technology such as fMRI machines represent key technological advancement that stemmed from the cognitive revolution.

The primary function of fMRI machines is referred to as Blood Oxygen Level Dependent imaging (BOLD). Blood supplies oxygen to brain cells and neural activity is associated with changes in blood oxygenation levels. Therefore, active cells increase blood flow to brain regions which then allows the magnetic properties of this oxygenated or deoxygenated blood to be detected by the fMRI machine. However, the temporal

resolution for fMRIs, defined as the machine's ability to detect changes rapidly, is poor. In other words, the results of these scans take time to develop. However, one of its most revolutionary successes is its ability to detect minute changes in the brain with great precision – a concept known as spatial resolution.

The cognitive revolution also introduced the neuroimaging technique known as positron emission tomography (PET). In PET scans, professionals insert a ligand, a radioactive molecule, into the client's body before the scan begins. The distribution of this molecule indicates the level of activity present within targeted tissues. The mechanics of the PET scan are beyond the scope of this thesis, but as the radioactive molecule undergoes radioactive decay it emits positrons which have the ability to work with the body and emit gamma rays detectable to the PET scan. Thus, PET scans are instructive resources for distinguishing which regions of the brain use the most energy. Both PET and fMRI scans have the ability to detect psychological challenges such as obsessive-compulsive 'disorder', dementia, Alzheimer's, strokes, schizophrenia, and other 'mental' diseases. Even though these models deliver extraordinary information in the field of neuroscience, they must be integrated into applied treatment cautiously.

So, What's the Problem?

Throughout psychology's evolution, all of these approaches have sought to conceptualize the complex interplay between the human mind and our behavior and have assisted in establishing the field's credibility. However, whether through a hyperfocus on one approach or through failed attempts to rectify prior flaws, each have uniquely contributed to the imperfections of psychological treatments today. The requirement of observable variables in behaviorism removed the interpersonal factors of treating

psychological distress and the technological advancements in the cognitive revolution superimposed a predetermined biomedical treatment outline to studying the brain.

Attempting to adopt these mechanistic treatment methods highlights the field's flawed desire to suppress the ecological and multidimensional features central to the brain. It is simply impossible for our definition of reality, and guidelines for the disruption of that reality, to be unanimous without ignoring the cultural, social, genetic, and environmental differences amongst people. Therefore, not only is it problematic for our method of diagnosis to be based on predetermined experiences, but it is also an issue for psychological treatment methods to be viewed as universally successful. Adhering to the pressures of the scientific world has resulted in limiting our opportunities to grow as a field and instead made psychology an instrument of power.

Attempting to synthesize the natural complexity of the human brain into transferable biomedical methods aligns with the objective of our society. What drives our current culture, you might ask? The answer is simple: mastering crafts. As a society we have cultivated an environment that is focused on outwitting and outlasting our competitors by ensuring optimal efficiency in every task. Such aspirations are what has ignited our desire to find out what's 'wrong' with our brains throughout the history of psychology. It was the motivation behind developing mechanistic and biomedical approaches to psychology seen in behaviorism and cognitive revolution. A psychological concept known as expected utility theory is a great representation of this phenomena. This theory states that all individuals in our society make decisions that will maximize their ability to reach a specific goal, as it is human nature to rationalize decisions that will provide the greatest opportunities for success. The integration of psychology into the

medical world has done just that. Decisions have been made to establish the most efficient treatment mechanisms in exchange for being perceived as a credible study. Importantly, professionals within the field are also obliged to adhere to this system. In order to advance their careers and make an income, they must partake in the mechanistic decisions that will result in this success. These decisions might include involuntarily quantifying information in research not suitable to a numerical value or even applying universal treatment models to individuals to increase the number of clients a clinician can be seeing.

As we discuss how society has impeded these ambitions onto the role of psychology, recall the multidimensional intricacies present in the human mind we have learned throughout this chapter. Recall the changes psychology has made throughout its history because of its intrinsic inability to stay confined to one approach. Neglecting these definitional elements to ensure a profitable reward has made psychology a subordinate tool in a larger operation of power and success. True success will come for psychology when we let go of our desire for scientific dominance.

The Next Step

In the early 2000s, psychiatrist and professor at Universität Heidelberg, Thomas Fuchs, offered a revitalized and dynamic approach to psychology known as enactivism. Enactivism is a philosophically based approach to cognition centered around the mind's relationship with the brain, environment, and, most importantly, itself. Fuchs' belief, emphasized in his 2017 book publication, *Ecology of the Brain: The Phenomenology and Biology of the Embodied*, is that the mind cannot be studied efficiently in isolation, and that "reality is not something predetermined and external, but continuously brought forth

by living beings' sensorimotor interaction." (p. 7). Meaning, the way a person individually makes sense of the world cultivates a representation of their specific reality that can develop or not develop into experiences of psychological distress. Therefore, assuming that the reality one individual experiences is indistinguishable from others is an oversimplification of our abilities as humans. While establishing baseline frameworks is an effective approach to disseminating information in psychology, implementing universal ideologies overlooks the variables that make each individual unique. As will be discussed later, there is an important element to enactivism called sense-making. Simply put, it utilizes this moldable definition of reality to understand that psychological distress is a result of one's damaged relationship with their distinctive surroundings. Enactivism claims that disordered patterns of sense-making, or 'mental' 'disorders' can arise from impaired interactions between oneself, social functioning, or surrounding environmental factors. Thus, instead of our previous deterministic ways of thinking about psychological processing and care, enactivism recognizes the power of individualism.

Moreover, Fuchs articulates how and why to study these differing interactions on various levels of detail. First, micro level analysis incorporates our molecular and neurochemical bases of the brain along with our understanding of its physical structure. Secondly, enactivism works with meso levels of analysis for the brain which offer a wider perspective of our relations between the brain and its environment. This might include interactions with other individuals, communities, or physical spaces. Lastly, focused on the broadest concepts, the macro level of analysis within enactivism navigates cultures as a whole as well as the impact of an individual's ecological surroundings. In this approach to psychological treatment, none of these levels are submissive to the other, but rather the

relationships between them allow for operation in a circular process. For instance, when a client's symptoms concern their relationship with themselves, their 'mental' distress is "marked...by the disruption of vertical circular causalities...of the interplay of lower-level processes and higher capacities of the organism" (Fuchs, 2017, p. 256). This means when disruption between one's neurochemical baseline is accompanied by disruptions in one's interaction with their encompassing environment a client will frequently possess a flawed sense of self requiring all levels of analysis. Conversely, 'disorders' concerned with flawed social interaction focused on meso analysis "lead to negative feedback loops in socio-functional cycles, which are crucial on the course of one's illness" (Fuchs, 2017, p. 256). These layered distinctions offer a great testament to how enactivism has broken away from the oversimplified methods of psychology seen throughout history. There is no objective solution to the psychological distress, but rather it is entirely dependent on the factors of the client.

In 2020, Sanneke de Haan, a mentee of Fuchs, published a research article discerning what contemporary models of enactivism should encompass. Her work is centered around not only the benefits that come from studying the mind with enactivism, but also on describing why our current approaches to psychological care are not achieving what they should be. de Haan operationalizes enactivism as a successful approach to psychological practice because it incorporates the four necessary dimensions to effectively evaluate a person and their mind – physiology, experiential, existential, and sociocultural. You will gain a greater understanding of these dimensions as you continue in this thesis, but the primary purpose of de Haan's work is to show how and why our current systems of psychological care fail without the proper integration of these

dimensions. She states that current assessments “fall short by referencing fewer than the four dimensions and/or by insufficiently integrating them” (de Haan, 2020, p. 4). One sided treatments, dualistic perspectives and even modern holistic models are all unsuccessful in the proper integration needed for psychological care. Take for example, approaches in the cognitive revolution regarding the use of neuroimaging techniques to treat psychological distress. Looking at the biology and function of a brain image covers the physiology dimension, and investigating what is contributing to that brain damage resulting in behavioral distress covers the experimental dimensions, but assessment of how that client perceived their anxiety or how having to take a brain scan made them feel fails to be considered.

While de Haan acknowledges that one-sided approaches have the capacity to relay valuable insights, she notes that their inherent disregard for other perspectives makes them ineffective. An example of this kind of model is neuro-reductionism. This method takes on the approach that all psychological ‘disorders’ are solely because of damaged neurological functioning and that all higher cognitive processes are a mere result of active neural circuits. The infamous experiment on Little Albert can effectively illustrate this point. At a mere age of nine months, psychologist John B. Watson conditioned Little Albert to fear all white fluffy objects. As seen with Pavlov’s original classical conditioning experiment, this procedure paired white fluffy objects, the neutral stimulus, with the unconditioned stimulus of a loud bang. While the experiment was successful in that Little Albert eventually began to produce the conditioning response of crying after seeing any white objects in the absence of surrounding sounds, the results were presumed solely to be a result of the pairing between these two stimuli. Rather,

elements such as little Albert's exhaustion throughout the experiment, how much food he had eaten that day, or if he was surrounded by any white furry objects at home were not considered. I'm not arguing that the association between stimuli did not occur, but including these possible correlations within their findings would have added more validity to their results. In other words, in one-sided models behavioral, social, or cultural symptoms are only analyzed to the extent that they support their predetermined theory.

Despite efforts to counterbalance one sided approaches, dualist models, which intentionally integrate two psychological dimensions, still leaves information uncovered. According to de Haan, these models propose the separation between fact and value. They fallibly make the distinction that psychiatric research should deal only with facts whereas scientific discoveries, in which their findings are applied to treatment, should focus only on value. The main disadvantage of these models is the missing information regarding how these two realms interact with one another. In the words of de Haan, "this mere juxtaposition, however, does not provide insight into how physiological facts and existential values come together in one person" (p. 5).

The last of the models addressed in de Haan's article are integrative approaches. By a mere glance at the name, it is reasonable to assume that these methods are designed to be more encompassing, to include both facts, values, and how they relate to each other. De Haan notes that the goal of this model is to remember that "psychiatry should not try to squeeze itself into a limited medical model but should rather serve as an example to other medical specialties that would also benefit a more encompassing approach" (p. 5). The most notable example of this model is called the biopsychosocial model. It was

designed to assess biology, psychology, socio-environmental factors, and most importantly the interaction between these disciplines. According to de Haan however, this approach is missing, along with all other modern integrative approaches, the existential dimension. There is no aspect of this model that analyzes how clients associate themselves with their 'disorder'. For instance, if a client is failing to accept the 'disorder' they have been given, or ultimately lacking belief that help will assist them, then the applied treatment from the biopsychosocial model is guaranteed to fail. Further, while the biopsychosocial approach claims that there is an interaction between a multitude of factors, it does not mention why their interconnectedness is so vital to understanding the human psyche. Surrounding any diagnosis of 'mental' distress comes the shame of feeling incapable and broken, and such a feeling, found in the existential dimension, can inadvertently discourage individuals from believing themselves worthy of receiving treatment. While these integrative models successfully show that a linear process of treatment is powerless in psychological care, continuing to lack and integrate all four dimensions indicates that the world of psychological treatment remains in need of an alternative system.

Conclusion

In this chapter, we have extensively delved into the historical upbringing and implications of psychology as a field of study. From uncovering the concept of physics envy, to discussing the continuum of normalcy, and engaging in the perspectives of notable figures such as Homer, Plato, Hippocrates, Rogers, and Freud, this chapter has provided valuable insight into how the contemporary world of psychology has developed over time. In the following chapters, we will not only transition to investigating modern

day perspectives, but we will also begin conversations centered specifically around psychological interventions. Towards the conclusion of this thesis, I will return to this enactivism approach, digging deeper into its purpose as an integrative approach to psychology, but to truly appreciate such conversations, let's first look at one of the hinderances present in our current psychological modalities – medicalized rhetoric.

CHAPTER TWO

So far in this thesis I have been putting the terms ‘mental’, ‘disorder’, and ‘illness’ in scare quotes for a reason this chapter will explain. To start, we will identify the complexity of rhetoric and then discuss how the presence of medicalized rhetoric in the field of psychology is not only inaccurate, but more importantly, inappropriate when assessing health complications related to an individual’s identity. This chapter will also illustrate how rhetorical choices and their associations with power have worked together to shape our modern understanding of ‘mental’ health. Specifically, this chapter will provide a rhetorical analysis of the psychological term’s ‘mental’ ‘disorder’, ‘mental’ ‘illness’, and lastly ‘mental’ wellness and conclude with a delineation for why medicalized rhetoric is not transferable from the work of medicine to the work of psychology. However, before proceeding further, it is imperative that my reader understands the definition of medicalized rhetoric as it is vital to comprehending the foundations of this chapter. In essence, medicalized rhetoric is a method of interaction between doctors and patients that allows medical professionals to inform individuals of medical diagnoses, findings, and results. Moreover, what’s important to understand about medicalized rhetoric, is that given the exactitude that medicine is rooted in, it is a form of discourse that intentionally uses simplistic language to ensure a patient’s comprehension of medically based information.

Knowledge Discrepancy

As humans, when we encounter questions we cannot answer or lack information for a particular topic, we turn to others. We hope that they might possess the very knowledge that we do not. Interestingly, we embark on this theoretical quest for external information from the moment of birth. Apart from evolutionary adaptations such as reflexes, sensations, involuntary movements, and other biological functions innate to human abilities, the development of infants is inherently reliant on the knowledge of those around them. In other words, to ensure both safety and the proper methods of learning, a baby is instantaneously dependent on medical staff, nurses, their mother, and their father. To illustrate this concept more, the design of our educational system provides further support for this ingrained tendency to learn from others. Advancing through elementary, middle, high school, and even undergraduate and graduate careers, our educational structure is deliberately crafted for unknowing individuals to acquire knowledge from accredited teachers and professors who possess the expertise that they lack. My purpose in mentioning this is not to claim flaws in the education system, but rather to exemplify our prolonged reliance on others. If we suddenly experience a tooth ache we book a dentist appointment, if we are looking for a specific section in the grocery store, we ask a team member for directions, or even if we are in a situation where we need to change a tire, we can look up a video to learn from someone explaining the steps online. Although it is experienced in a less systematic manner, adulthood remains rich in diverse manifestations of this dependency, suggesting that obtaining knowledge from people encapsulates a large component of our everyday lives.

Importantly, what comes along with a reliance on others is an acknowledgement of partial relationships between an information provider and an information seeker. In these connections there is an obvious discrepancy in knowledge, which considering its frequent association with power, necessitates a delicate balance between helping and controlling the information seeker. In other words, while this discrepancy is needed for learning to occur for the information seeker, the intricacy behind this dynamic requires communication to be handled with care. Let's return to our current educational system for a clarifying example. If a student is coming to a professor for assistance on a paper, the professor can provide their knowledge through suggestions of good sources, reviewing the guidelines and rubric with the student, or simply sharing some helpful writing tips with the student. However, it is crucial that the professor refrains from telling the student the precise content or answers to use when completing their essay. If this were to occur, the word of the powerful, the professor, could not only stunt the student's ability to propose their independent thoughts, but it also risks instilling the notion that there is a correct version of the paper. Unintentionally, such assistance would not only limit the growth of a student's original ideas but might also diminish the effectiveness of their writing, heighten their stress levels, or even reduce their overall self-confidence outside of the assignment. All this to say, dynamic relationships in which there is an imbalance of knowledge provide the potential for the misuse of power that can be particularly damaging to the individual on the receiving end.

Medicalized Rhetoric

This power contrast is especially apparent in a variety of different healthcare settings. In these environments, medical doctors spend a plethora of years undergoing a

rigorous education with the intention to provide others with information they would otherwise lack. Importantly, the delivery of knowledge in these fields holds much greater significance than where you can find the milk in the grocery store, often including the delineation of prolonged health concerns to a patient or their loved ones. Therefore, in the healthcare profession it is even more vital for doctors and health professionals to intentionally transform their identified expertise into communication that is comprehensible and supporting of the information seeker. Without this purposefulness, the knowledge shared from the information provider has the possibility to not only be misunderstood, but more impactfully misapplied by the information seeker.

The educational rigor and professional demands of ‘mental’ health professionals make them equally important to this conversation. In fact, when considering the complexity of the human mind, it’s reasonable to discern that individuals in the ‘mental’ health field have to carry an additional rhetorical weight in delivering their expertise. Clinical psychology, for example, requires four years of undergraduate schooling to earn a bachelor’s degree, possibly two or more years earning a master’s degree in some psychological discipline, five to seven years working towards a doctoral degree and postdoctoral years focused on training, internships, and licensure completion. The extensive training undergone by psychologists imposes an additional rhetorical challenge in therapeutic settings. Amidst the sensitivities of discussing the client’s distress, there exists a wealth of specialized knowledge accumulated through the clinician’s education that is inaccessible to the client. For people familiar with the process of seeking information from a psychologist, it’s the vigorous typing on their keyboard or the endless scribbles of their pen that reminds us of this educational divide between the client and the

clinician. This operation makes sense, given that ‘mental’ health professionals are compensated for their understanding of human behavior and ability to analyze potential explanations for an individual’s experience of distress. Though, with emotions frequently running high in a psychologist’s office and the natural discomfort of telling your struggles to a relative stranger, it is particularly crucial for a clinician to acknowledge the need for delicate communication between the information provider and the information seeker. In ‘mental’ health, one of the primary ways to cultivate this type of environment is for clinicians to implement foundational empathy into their practice, to ultimately foster a strong bond between themselves and the client.

Empathy As a Tool

The significance behind establishing a strong relationship between the client and clinician was first documented by American psychologist Carl Rogers (1975) in his development of unconditional positive regard, a type of unqualified acceptance that is given by one person and received by another. Generally speaking, his approach recognizes that people come from a unique background, and that success in relationships will come when support and respect for one another is authentically displayed. Put differently, Rogers’ ideas, first evident during the 1940s, ignited our modern day understanding of empathy. He viewed empathy as a word that encapsulates the action of setting aside your own views to step inside the reality of another, or in Rogers words to “enter the private perceptual world of another and becoming thoroughly at home in it” (p. 3). In a clinical setting, this ability to immerse oneself into the reality of another is the responsibility of the clinician. With an unconditional acceptance of the client, clinicians practice empathy and can effectively use their knowledge to adopt their client’s

perception of their emotions. The intention behind Rogers' work was not only to limit the isolation experienced by an individual in distress, but also to improve a person's understanding of their own experiences. For instance, in a clinical environment, this could be seen as a client recognizing the care and compassion displayed by the clinician and then feeling empowered to implement that same perspective towards themselves, ultimately "unblock[ing] a flow of experiences and permit[ing] it to run its uninhibited course" (Rogers, 1975, p. 11). Nevertheless, given the ongoing importance of empathy in our modern context, implementing the work of Rogers allows for growth in the information provider and the information seeker both inside and outside the realm of psychology,

Expanding on these ideas, contemporary writer, and research professor at the University of Houston Graduate College of Social Work, Brené Brown has become notable for her own elucidation of empathy. She claims empathy as a space in which you choose to feel *with* people verses sympathy as an obligation to feel *for* others. To dramatize this contrast, she figuratively compares empathy to sitting with someone in a dark hole, and sympathy as screaming from the top of that hole that things will get better (RSA, 2013). While Rogers was one of the first to highlight how significant external factors, such as the client and clinician relationship, can influence the effectiveness of psychological care, continued research from people like Brené Brown have helped sustain the conversation. With the tool of empathy, both Rogers' and Brown's goal was to reduce the clients' feeling of alienation through an establishment of trust, emotional support, and validation. However, in light of the drastic knowledge difference within these relationships, it is important for clinicians to understand the appropriate balance of

applied empathy. Entering too far into the reality of the client puts them at risk of losing sight of their training and professional role. Regardless, if not handled with care and empathy, expertise has the ability to be expressed as a wall, functioning as the primary separation between the information provider, the clinician, and the information seeker, the client. Given the complexity of their subject, the challenges posed medicalized rhetoric, and the need for emotional intelligence and empathy when communicating with clients, it is clear that professionals in the ‘mental’ health field face even greater complexities than their colleagues in more purely biological fields.

The Power of Rhetoric

Throughout the remainder of this chapter, we will view psychological rhetoric as a tool to break down the wall between the clinician and the client. Importantly, the concept of rhetoric holds two pivotal qualities: the ability to identify and the capacity to establish connections with others. For instance, in a realm like psychology, terminologies of the brain have been imperative to developing the fields transferability amongst professionals and to construct shared meanings for various concepts. However, as those different concepts evolve throughout time, it necessitates the corresponding evolution of psychological rhetoric. Broadly speaking, looking at psychological treatment with such an understanding of rhetorical responsibilities allows us to analyze how the language used by a clinician can involuntarily influence the perspective of the client.

As it was noted throughout chapter one, words such as ‘disorder’, ‘illness’, and disease express the flawed assumption that a client’s current ‘mental’ status contradicts the believed to be normal human brain. Moreover, the persistent usage of such limiting rhetoric is the primary contributor to the stigma surrounding ‘mental’ health today and

ultimately expands the figurative distance between the information provider, the clinician, and the information seeker, the client. The underlying notion of inadequacy evident in these words has resulted in both society's disapproval of 'mental' health conversations along with the shame placed on those seeking care. For years we have attempted to surpass this stigma that surrounds 'mental' health, allowing for psychological clinics in institutions, openly campaigning for 'mental' health awareness, and even having various public figures become transparent about their struggles with 'mental' health experiences, yet by continuing to use this dichotomous language we limit the overall effect any one of these advocacy attempts could ever have.

When discussing terminology in psychological care, my feelings of trepidation are once again founded in our flawed belief of a universally normal brain. As we have been considering, we all have different ways of processing, expressing, and feeling our emotions, thus, to use rhetoric as a channel to claim that there is a correct method of function is not only damaging to the client, but also to the development of psychological treatment. When clinicians and professionals classify individuals into pre-established patterns of 'disorder' we are removing the crucial empathetic component of psychological treatment, and more importantly the control from the client. For instance, rather than recognizing a client's feelings as being a product of interlacing factors of their environment, self-perception, and socialization, the agency is appropriated from the individual in distress as we assert something is objectively abnormal with their brain. While I have learned to transform my anxiety to become an asset in my life, I would be dishonest in saying the diagnosis wasn't initially challenging. Being told you have a poorly functioning mind at any age is difficult, especially when it concerns the innocence

of a child. At this young age, I lacked an interpersonal skillset, that when coupled with a diagnosis of the mind, resulted in life functioning as “Hi, I’m Madison and I have anxiety.” Broadly speaking, we are a society that idealizes the classification component of labels, but when in context of the human mind, it must be understood that labels hold a greater significance.

Medicalized Terms in Psychology

Diagnosis

According to the etymology online dictionary, the word diagnosis comes from the Greek *dia-* meaning to go through or between something, and *-gnosis* meaning knowledge. Succinctly put, these root definitions can be translated as knowledge going from the information provider to the information seeker. Considering healthcare hinges on a professional’s ability to dissipate a client or patient’s experience of physical or ‘mental’ distress, this meaning has persisted despite the passage of time. With the goal of identifying the reason for distress in an individual, merely using the term diagnosis oversimplifies an individual’s condition, neglecting possible environmental, social, and cultural contributing factors. Despite its foundation within the medical field, the term diagnosis ‘is particularly prevalent within treatment and assessment environments of psychological care. As a simplistic example, clinicians will say “my diagnosis is…” to the client or will transfer information across providers centered around a client’s diagnosis. Importantly, diagnostic details of a client are not provided until after the clinician has gathered all necessary background information, conducted a clinical assessment, and standardized their findings with the comprehensive review of ‘mental’ ‘disorders’ with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Here

we can note that one of the primary complications with diagnoses is how their conversational elements inadvertently maintain an inappropriate hierarchy of power. In other words, if the clinician is dependent on the descriptive experience of the client, then a diagnosis is as much a product of the client's knowledge of themselves as it is of the clinician's knowledge from training. Nevertheless, accredited by the American Psychological Association, the DSM is a preestablished framework that enables 'mental' health professionals to effectively classify a combination of symptoms into specific 'disorders'. However, regardless of the diagnosis, any display of universal classification will inevitably fail to capture the range of facets contributing to an individual's unique psychological experience. Rather, the information gathered by the clinician might be more effective if used to establish an individualized treatment plan for a client. Having a framework for psychological assessments is not inherently wrong; however, when thinking about the influence of metacognition it is imperative to not deliver this information with comparable directness. To be clear, my proposed solution is not to keep the client entirely uninformed, but rather to be intentional in both the quality and quantity in which professionals communicate their assessments. This means considering not only the content or amount of information shared, but also presenting such knowledge in a format conducive to the needs of a particular client. A proposed format should be empathetic in tone, and the clinician should aim to achieve an appropriate amount of complexity that is both relevant to the client, clear and as non-stigmatizing as possible while remaining clinically accurate. More of this will be addressed as we delve deeper into our conversation on enactivism in the following chapter.

'Mental' 'Disorder'

Also indicated in the etymology online dictionary, the word 'disorder' can be broken into components of *dis-* and *-order*, *dis-* comes from the Latin meaning apart and *-order* meaning to arrange in an organized row or column. Thus, when something is 'ordered' it requires both precision to be established and control to be maintained. Conversely, the word 'disorder' is an expression of the disarray and irregularity in which a particular situation or environment fails to match such intentional arrangement. In other words, the psychological use of the word indicates again that there is something wrong with a person's health relative to a universally accepted standard of operation. Nevertheless, the term 'mental' 'disorder' is probably the most commonly used when referring to troubled 'mental' health experiences. Not only is it included in the title of the *Diagnostic Statistical Manual of Mental Disorders*, but it also places itself at the end of almost every acknowledged psychological condition today - bipolar 'disorder', borderline personality 'disorder', major depressive 'disorder', generalized anxiety 'disorder' to name a few. To help emphasize the influence of this terminology, let's assess obsessive compulsive 'disorder'. While there are many characterizations of this 'disorder', I have found Purves' et al., editors of the sixth edition *Neuroscience* textbook, to exemplify the restrictive yet vague language associated with this condition. They claim that people with obsessive compulsive 'disorder' can be identified with atypical levels of activity in the anterior cingulate cortex along with a sensitivity to stimuli that most individuals have the capacity to ignore. Here, continuing to use words that hold restrictive meanings perpetuates the arbitrary narrative that there is a typical function of the brain that can act as a control model for all people. Simply put, from everyone's perspective besides the

professional, the use of these words begs a lot more than they answer. Without a true representation of this perfectly normal mind, the use of the word is not only inaccurate but also dismissive of a client's experience. Growing up with a diagnosis of severe generalized anxiety 'disorder', I recognize first hand the challenges that are associated with feeling like your brain is flawed. For me, grappling with the identities associated with the term 'disorder' made me want to keep my thoughts and feelings to myself, I didn't want others to know the experiences that made me clinically different from them. Consequently, this additional layer of complexity exacerbated my experience of anxiety before any improvement could be made.

In other words, the precision and order seen within the medicalized rhetoric cannot be effectively transferred over to the brain. Take for example a broken radial bone in an individual's forearm. Under the direction of a location of pain from the patient, a doctor has the ability to see the external complications, visualize the break from an x-ray, and provide a cast to ensure healing. While this isn't referred to as a bone disorder, the example provides the insight that the medical world has concrete representations of a typically functioning individual, in this case, there is an ordered structure to how the bone should look and there is a correct way of functioning. However, as we have gathered throughout the reading of this thesis, the brain is not as tangible as a broken radial bone. With 90 billion neuron cells, trillions of synaptic connections, countless different structures, and many components that remain unknown, an individual's psychological distress cannot simplistically correlate to a dichotomous decision of broke or unbroke. The complexities of the brain do not allow for a cause-and-effect methodology.

To further illustrate the inaccuracy in the term ‘mental’ ‘disorder’, let’s review postpartum depression ‘disorder’. According to researcher Micheal O’Hara (2009), postpartum depression can be seen in new mothers up to a year after they have given birth. Symptoms are often parallel to major depressive ‘disorder’ including sleep deprivation, decreased emotional regulation, increased anxiety, unexplainable concentration difficulties, divided attention and many other distressing experiences. Despite its irrefutable associations with complications encapsulated in the mind, a woman would not be experiencing these challenges without the necessary and obvious component of actively having the child. For instance, the possible sleep deprivation component of this ‘disorder’ is likely a product of her inability to sleep continuously throughout the night with the demanding needs of a newborn baby. Without the cultural role of a mother catering to her child, or the environmental factors of her baby crying in the middle of the night, sleep deprivation would not have temporarily resulted in an imbalance between the sleep promoting brain region, the ventrolateral preoptic nucleus, and awakening regions, the ascending reticular activating systems. It is also interesting to note that research has shown an individual’s experience of postpartum depression is dependent on their countries’ level of development. In a study assessing postpartum depression across 80 different countries researchers Wang et al (2021), found that both developed countries as well as those classified as high-income countries showed a relative reduced prevalence of postpartum depression in women. Their research went further concluding that cultural norms for things such as marital status, education levels, and living can also contribute to the experience, or lack thereof, of postpartum depression in women. For instance, prevalence rates in Southern Asia were significantly higher than

other geographical regions, which Wang et al. note is likely, in part, an outcome of marriage traditionally occurring at a younger age in that area. Thus, with the biological component of physically giving birth, the social component of relationship dynamics likely changing with your spouse, and the various cultural differences in traditions and perspectives for women after bearing their child, the situation is too complex to claim that all roads exclusively lead back to disordered ‘mental’ patterns.

‘Mental’ ‘illness’

The etymology online dictionary further states that the word ‘illness’ is derived from *ill-* in the mid-14th century meaning morally evil or difficult and *-ness* indicating the action or quality of something. While ‘illness’ can manifest in a variety of ways, it is universally understood as your body actively fighting a condition of poor health. Growing up, the concept of ‘illness’, often conveyed by our parents, resulted in the process of staying home from school or afternoon activities to avoid the spread of our sickness. The general goal was to stay away from others in an attempt to limit the spread of harmful ailments. Thus, medical ‘illnesses’ can be contagious, through either indirect or direct contact, allowing infections to be transferred from one person to another. However, in the world of psychology the majority of ‘disorders’ are not communicable. These biological implications surrounding the word ‘illness’ are further emphasized by looking up its synonyms: sickness, disease, ailment, complaint, malady, affliction, and attack. Each of these words carry an infectious undercurrent perpetuating the stigma we see surrounding ‘mental’ health today, and prolonging applied medicalized perspectives in psychological care. Furthermore, in medicine, diagnosing someone with an ‘illness’ typically indicates their poor health is fighting some type of condition, illness, or viral

complication, and that the present abnormalities are likely a result of microorganisms entering the body. Again, while both ‘mental’ ‘illnesses’ and biological illnesses indicate that the patient or client is not living to their greatest potential, the lack of identification of a living organism entering the brain distinguishes psychological distress from purely biological explanations.

Another reason for why these experiences require rhetorical distinction lies in the expression of symptoms. In order for a biological illness to be identified, the expression of symptoms is required for a patient to even know that something is wrong. Moreover, something as simple as a runny nose, or a noticeable increase in internal temperature could also signal to a doctor what a patient is experiencing without hearing from them. On the other hand, in the majority of ‘mental’ ‘illnesses’, clinicians don’t always see objective and external indications for a client’s distress. Furthermore, biological illnesses possess a multitude of assessments that allow doctors to search for symptoms when the patient has ambiguity on what they are experiencing. Take for instance a patient who has a sore throat, with this information a doctor can decide to perform a physical examination looking for signs of irritation, redness, and possibly swelling. If they then decide the examination indicated some discomfort, they can perform a rapid strep test in which a cotton swab collects a sample from the patient’s throat and tests for the presence of streptococcal bacteria. Within a matter of minutes, they can identify the presence of the illness. Considering none of these steps have the ability to be replicated when examining one’s ‘mental’ health, we can deduce that illnesses in biological illnesses are different than ‘illnesses’ in ‘mental’ ‘illnesses’ and should be rhetorically respected in such a way.

It is also important to address the former component of the phrase ‘mental’ ‘illness’. First, the usage of the word ‘mental’ might not strike someone as problematic in psychological care, as our entire historical record of psychology originates in the brain. However, claiming behavioral challenges as being entirely ‘mental’ is another example of using simplistic rhetoric to reduce psychology’s level of complexity. As we have mentioned, there are a number of different dimensions that work together to develop an individual’s psychological experience, thus overlooking their contributions claims that all the psychologically based symptoms and pain experienced by the client is solely due to brain malfunctions. Addressing this area of health care as ‘mental’ care, our understanding of the client’s condition is again limited, and development of true comprehensive interventions is hindered.

‘Mental’ Wellness

An important divergence from ‘mental’ ‘illness’ is the concept of ‘mental’ wellness. As anticipated, Etymology Online states that the word wellness is derived from *well-*, an adjective meaning “in a satisfactory manner” and *-ness* indicating the quality of something. Since the 20th century, the concept of modern wellness has become a massive movement within society, ultimately fostering the potential for consumerism to add an additional challenge to healthcare. Focused not just on being free from ‘illness’ but rather on optimizing your health, the wellness industry has attracted consumers who prioritize maximizing the strength of their body both internally and externally. For the purposes of this chapter, the wellness movement is particularly important because it removes the clinical element from psychological care. Instead of prioritizing a conversation with a clinician, the wellness movement tends to place health control into the hands of the

individual themselves; in fact, it is designed with the hopes of preventing the need for assistance from any medical professionals in the future. In ‘mental’ wellness, our health concerns often shift towards everyday occurrences rather than the severe and prolonged effects that accompany established ‘mental’ ‘disorders’. Therefore, daily stress, work life balance, cleanliness in your living environment, emotional stability, and nutritious dietary consumptions are example components of ‘mental’ wellness. All this to say, when someone is told that their ‘mental’ wellness is disrupted it is inadvertently stating that they have independently failed at taking care of themselves. However, unlike ‘mental’ ‘illness’ and ‘mental’ ‘disorder’ we don’t often go around telling someone that they have poor ‘mental’ wellness, rather its insinuations of damaged self-care where these connotations of ‘mental’ wellness are impactful. It is important to remember in discussions of ‘mental’ wellness that solutions are rarely as simplistic as taking a multi vitamin, getting more sleep, or merely prioritizing yourself. Focusing on these constructs can’t hurt, but there are more expressions of distress that lay beyond daily decisions.

Rhetorical terms such as ‘mental’ ‘illness’ and ‘mental’ ‘disorder’ don’t carry particularly positive connotations, thus a unique problem associated with wellness rhetoric is how it attempts to present as supposedly helpful discourse yet inadvertently continues to dismiss individuals’ agency. For instance, the phrase self-care encompasses the pursuit of numerous materials, products, and opinions aimed at enhancing a person’s health and ultimately seeks to mitigate the need for psychological assistance and the position of the information seeker. However, as the concept of ‘mental’ wellness becomes commodified with consumer markets, the wellness focused individual

unknowingly takes the position of the less powerful as they succumb to the hierarchical structures of companies selling healthcare.

Additionally, the rhetoric seen specifically in health wellness has been a key component to its success in the modern world. According to professor of rhetoric at Toronto Metropolitan University Colleen Derkatch (2016), the proliferation of wellness comes from the strategically unattainable language used within its marketing, and thus wellness is an ideology always out of reach. Derkatch's fascinating argument stems from the belief that there are two primary motivating factors for why people invest both their money and time into the wellness market: either they are attempting to restore their body to a previous desired level of health, or they are aspiring for a level of appearance and health greater than their current. Derkatch claims that these two factors work in tandem to cultivate a positive feedback loop through unattainable rhetoric in which nothing can be achieved. Furthermore, she notes that there is a risk factor embedded in the restoration concept of wellness in which satisfaction does not come from present health, but rather from incorporating preventative habits that reduce the possibility of 'illness' in the future. Therefore, in the world of 'mental' wellness, those who are not 'mentally' well are then understood to have not done enough preventative work to optimize their 'mental' health, once again possessing an underlying notion that the experiences of a client are a result of their failed obligations. In a broader context, I include Colleen Derkatch's work on wellness to serve as a testament to the influential role of controlling rhetoric within healthcare.

Conclusion

In the start of this chapter, we discussed how humans possess an innate tendency, throughout all stages of life, to seek information unbeknownst to them from others. We discussed how these relationships between an information provider and information seeker need to be handled with great care as power accompanies knowledge. Particularly in healthcare settings, the rhetoric within these connections is often the bridge that allows for the sharing of knowledge. Furthermore, we noted that when considering the intricacies of psychological treatment, avoiding terms such as diagnosis, ‘disorder’, and ‘illness’ to fill this gap of knowledge is crucial to the success of the intervention.

Succinctly put, all of the terms we have identified are an oversimplification of the capabilities of the human mind. To begin to shift our understanding of proper communication in these therapeutic settings we might start by addressing how we as a society view the role of a psychologist. Presently, as has been explained in this chapter, we think of psychologists as professionals who get paid to provide credible psychological knowledge to the client, and that such knowledge is best presented in the form of a diagnostic claim towards a client. One suggestion here is to alter our general societal perspective to be that psychologists get compensated to both possess this knowledge and communicate it in a truthful, empathic, individualized, and comprehensible manner. In other words, to place as much significance on the delivery of our professional information as we do on its content. This transition could allow strategic communication to be understood as a primary role for ‘mental’ health professions. Again, Rogers was one of the first psychologists who initiated conversations around the importance of communication delivery in psychological care. With his use of unconditional approval,

Rogers advocated for a communication style that recognized the unique perspectives of each of his clients and successfully suggested psychological interventions best suited for their experiences. Expanding upon these ideas, transparency is another key characteristic vital to this shift in communication. Without rendering them entirely ineffective, I suggest a dynamic in which clinicians can authentically state that some interventions are founded on baselines not effective for their specific experiences. These suggestions cultivate a space in which the client can successfully focus on themselves rather than being an exchangeable unit of mechanistic psychological care.

As with every good argument, it's important to mention the anticipated countermeasure. There are many people who struggle with their 'mental' health, that might claim they find peace in receiving a diagnostic label. In some sense, it is as if the label validates that they aren't alone in their feelings, or that they have found relief in finding the supposed answers to their problems. For some people, it's a quick and simplistic process to accept a diagnosis, and it's these clients who might be reluctant to subscribe to a treatment system in which communication is less objective. This same mindset is also frequently seen when individuals are presented with psychiatric medication as a treatment method. For some people, it is believed that the relief experienced from taking Advil for a headache is likened to the experience that will happen when taking Fluoxetine for anxiety. Importantly, a partial reasoning for this peace experienced by some stems from our innate desire for efficiency, having fast answers along with concrete evidence is both convenient and satisfactory. Put differently, having the ability to possess rational thought results in us being uncomfortable when lacking control of a situation, so not knowing the reasons for experiencing various levels of

psychological discomfort can be temporarily healed with a label – and that’s desirable. I add here that our future improvements in both rhetoric and agency-based conversations in psychological interventions can easily accommodate for such situations. Preserving the agency can be exemplified in a mere pre-assessment conversation between a clinician and a client. In this circumstance the act of a client contacting a clinician indicates the request for psychological assistance, but it fails to address the manner in which that assistance is desired. Thus, in these cases the clinician can ask whether the client prefers a more objective assessment or a more empathetic discussion about the intricacies of the client’s discomfort. This allows the placement of agency to be addressed first, rather than dealing with the complications of disregarding this conversation later in the treatment process.

We have all, at some point or another, experienced the power of language. Whether it was something said in an argument with a family member, joyously listening to our favorite song, or getting advice from a close friend, life quickly teaches us that words are immensely impactful. While the unique complexity of language is what separates us from most other species, in the world of psychology, navigating the use of words can be one of our most formidable challenges. We learn language and then we use language to learn everything else. Language is a construct that shapes our world along with our individual place within it, so naturally it’s important to think critically about how we use language as a form of representation for our emotions and experiences. Contemplating this foundation of language, I note again that it’s the improper use of words between the clinician and the client, that I believe to be one of the primary downfalls of psychological care. By no means am I saying that a client seeking psychological assistance should remain unaware of their health deficits, rather I’m saying

that informing clients with stigmatizing labels may in some cases perpetuate their existing sense of culpability for their distress as well as validate their societal experiences of alienation. There are ways to provide a client with serenity throughout their treatment process without providing a potentially damaging label. So, while I acknowledge the presence of opposing viewpoints upon unique cases, I believe the potential for mere word choices within the *Diagnostic Statistic Manual of Mental Disorders* to inadvertently have harmful effects on clients is enough of a risk to require a reform.

Nevertheless, for me to write a concrete suggestion on the correct word choices for the entire psychological conversation would be naive. However, while a solution might take time to propose, the problem takes no time to call out. Right now, what I can do is suggest the continued need for improvement in the training of ‘mental’ health professionals in proper communication, as well as advocate for more empathetic deliveries and transparent conversations within psychological treatment. Put differently, our expectations and qualifications in this profession should extend beyond knowledge, also encompassing the importance of intentional rhetoric and communication abilities.

Importantly, the central issue with each of these specific terms lies in their ability to effectively diminish a client’s level of self-efficacy. First described by Canadian psychologist Albert Bandura, self-efficacy refers to an individual’s belief in their ability to complete and successfully accomplish tasks. Such a characteristic is vital in having confidence in yourself to confront challenges and to assert control over one’s life direction. Individuals with poor self-efficacy, when encountered with a challenge, will prioritize their feelings of inadequacy and fear of encountering obstacles. These individuals are motivated to avoid all tasks that could possibly display their deficiencies.

Conversely, those with high self-efficacy often possess fast recovery after setbacks and an ability to view life difficulties as novel experiences or obtainable challenges. Thus, in the ‘mental’ health context, employing rhetoric that claims someone is abnormal from the rest of society diminishes their sense of agency over their experiences, and level of self-efficacy. Therefore, placing clients into fixed categories in the form of diagnostic labels is only for the benefit of psychology as a tool of power, ultimately coming at the cost of the client.

As mentioned at the end of chapter one, enactivism is an approach to psychology that has begun to recognize the need for transformations in our current modalities of care. What really separates enactivism is its inclusion on the existential dimension, an optimal realm in which self-efficacy focused terminology can be integrated into treatment approaches. This existential dimension fosters a place for metacognition, having the awareness of your own thoughts, thus encouraging the prioritization of client agency in the treatment process. This dimension, and numerous other components of enactivism we will discuss later, serve as a representation for the all-encompassing practices and perspectives that psychology could hold in the future.

CHAPTER THREE

Regardless of your education in psychology or expertise in writing, attempting to delineate the intricacies of the human mind is a challenging endeavor. There is no scientific article or research study that can accurately articulate and properly disseminate all information regarding the brain. Nevertheless, to assist in the clarity of this thesis's specific questions, let's take a moment to reflect on how the previous chapters have allowed us to reach this point.

In chapter one, I discussed psychology's development throughout time and how its borrowed conceptual apparatus from the biomedical field has impacted its current role in society. After adequately assessing psychology's development throughout history, this chapter then emphasized how reducing the multidimensional nature of the brain to optimize treatment efficiency sacrifices our true understanding of the mind's ability. In chapter two I discussed how reductionist approaches to the brain have become systematically normalized in modern diagnostic models of psychological care. Specifically, I discussed how our inability to provide a universal representation of a normal functioning brain necessitates the use of rhetoric that isn't based on the sick/healthy dichotomy seen in the medical field. Embarking on this third chapter, I will show that while psychology as a field of study has solidified its scientific standing, the concept of 'mental' health is now at a crucial junction for what its future holds. To acknowledge this, I will discuss the limitations inherent to current mechanistic models of care while also recognizing the practical benefits that have emerged from their development. In an attempt to represent the possible future for the field of psychology,

this chapter will articulate how enactivism, a holistic approach of psychology, utilizes a treatment framework for ‘mental’ health that effectively encompasses the complexities of the human brain.

When critiquing psychological treatment, it is important to acknowledge that many ‘mental’ health professionals, as well as present treatment models, do currently work from a holistic perspective. By employing integrative treatment approaches, these modern clinicians and models of care provide their client with a sense of validation, utilize multidisciplinary approaches to ‘mental’ care, and ultimately cultivate more sustainable health outcomes for clients. Such approaches prioritize understanding how the development of the client’s ‘disorder’ evolves from the interconnectedness of different factors in their life. Rather than oversimplifying complex psychological phenomena via medicalizing rhetoric, these integrative approaches embrace the ambiguity of psychology by emphasizing the interconnectedness of the underlying science. Unfortunately, despite some practices already utilizing holistic models, what psychology fails to do is systematically put forward an integrative methodology that is flexible enough to reflect the complexity of psychological care in individual cases, but concrete enough to be replicated by clinicians across the field. To be more specific, what psychological treatment lacks is a foundational framework that explains the rationale behind integrative approaches in psychological care, articulates a clear description for how treatment can be consistently modeled from a comprehensive lens, and incorporates detailed procedures for how clinicians can craft individualized benchmarks for clients within this approach. Successfully developing this framework is crucial to express the intention of psychology as a field of study and to assist in training future ‘mental’ health

professionals with the most accurate and diverse curriculums that ultimately ensure the progress of psychological treatment.

Enactivism Introduction

Towards the end of chapter one was when I first introduced the therapeutic approach to psychology known as enactivism. Sanneke de Haan, researcher of enactivism and Professor of Psychiatry and Philosophy at Erasmus University Rotterdam, claims that the success of enactivism in psychology comes not only from its inclusion of all contributing dimensions, but also from its intentional articulation for how the collaboration of each involved dimension is necessary to ‘mental’ health treatment. To promote a better understanding of the intricacies of the human brain, enactivism “supports holistic psychiatric practice by offering an integrative account of how the diverse aspects of psychiatric disorder relate” (de Haan, 2020, p. 4). Importantly, comprehending all that the enactive approach encompasses can assist in highlighting the flaws evident in current methods. de Haan reasoned that modern systems of psychological care are lacking either the proper integration of all dimensions or, in some cases, an adequate understanding for why such assimilation is needed in psychology. Nevertheless, enactivism is an approach that views perception as an integral component of treatment and believes that the interactions of an organism with its surroundings are the primary influence in developing cognitive processes. Enactivism breaks human experience into the physiological dimension, the experiential dimension, the sociocultural dimension, the existential dimension, and the unique concept known as sense-making.

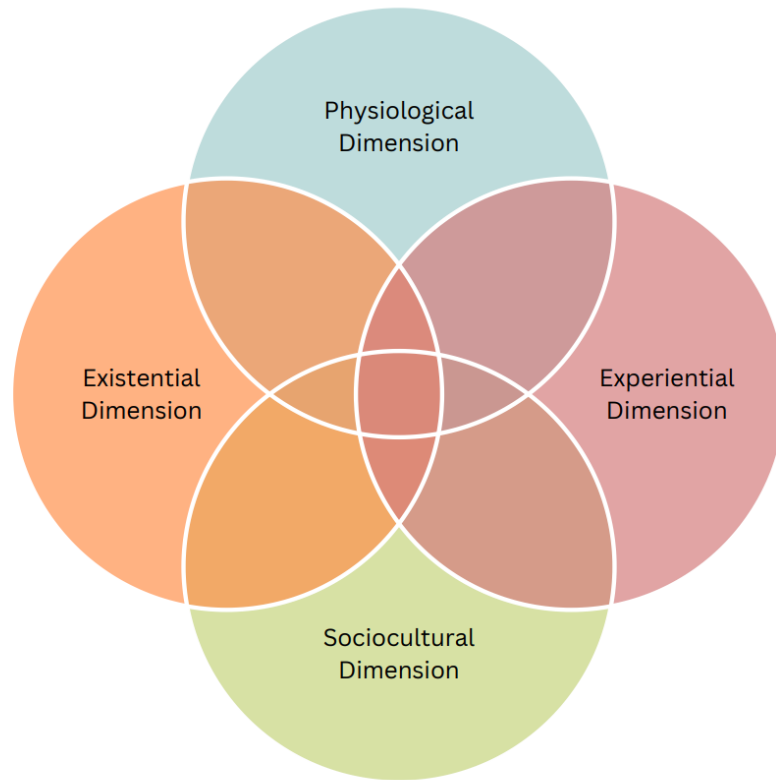


Figure 1: Dimensions of Enactivism

Physiological Dimension

To begin, let's discuss the purpose of the physiological dimension. This dimension is focused on the biologically based operations that occur in individuals experiencing 'mental' distress. In other words, the physiological dimension addresses psychology's scientific underpinnings by prioritizing the role and function of the human body, and believes that alterations in normal functioning are the results of 'mental' distress. Thus, this dimension focuses on how chemical, biological, and neurological imbalances are the symptoms that a professional would utilize when determining the type of distress the individual is experiencing. Examples of distress in the physiological dimension range from increased heart rate, and unregulated patterns of breathing, to imbalances of

neurotransmitters in the biogenic amine group. Therefore, the physiological dimension only encapsulates the symptoms that we have historically categorized as observable, dismissing all subjective constructs such as emotions and feelings as they cannot be visualized by the information provider or the information seeker.

Unsurprisingly, this dimension is the home of neuroreductionist frameworks that predominately believe disruptions of the nervous system are the foundation for ‘mental’ health complications and treatments respectively. Let’s look at major depression ‘disorder’ as an example. In prioritizing the physiological dimension, this ‘disorder’ would be classified by its malfunctions in the HPA Axis along with neuronal atrophy and decreased neurogenesis in the prefrontal cortex and the hippocampus brain regions. To emphasize the biological underpinnings of this dimension, let’s also take a moment to explain this neuroscience. The HPA axis represents the hormonal communication from the hypothalamus to the anterior pituitary gland to the adrenal cortex, it’s the primary mechanism for releasing cortisol in the body. Additionally, the primary function of the hypothalamus is to keep the human body at homeostasis, as it regulates body temperature, blood pressure, hunger, sex drive and more. As part of the endocrine system, the pituitary gland is specifically responsible for producing and releasing hormones throughout the body, and lastly, the adrenal cortex is the outer layer of the adrenal gland, and considering its stimulation from the pituitary gland, it also functions as a place for hormone production and most importantly cortisol. Vital to the function of the HPA axis, the corticotropin releasing hormone (CRH) is released between the hypothalamus and the anterior pituitary, and the adrenocorticotrophic hormone (ACTH) is released between the

anterior pituitary and the adrenal cortex. Importantly, HPA Axis uses these hormones to regulate the body's reaction after a stress response has been induced.

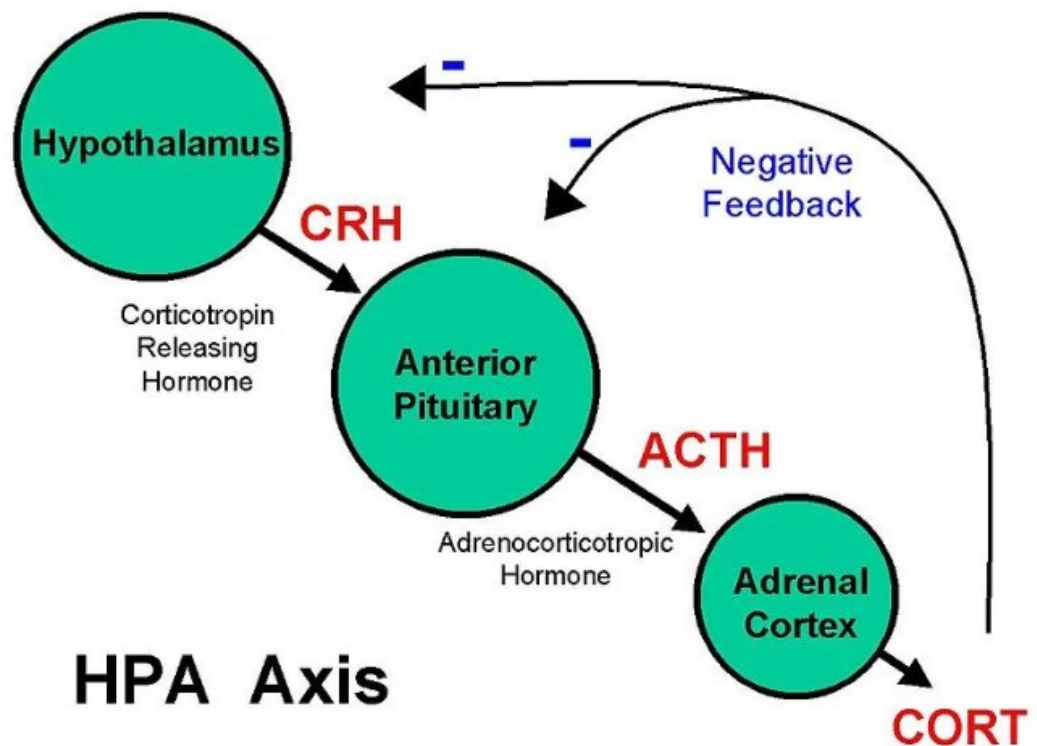


Figure 2: Communication Flow in the HPA axis (taken from Neuroscience News)

Interestingly, the HPA Axis has a negative feedback system that activates when the increased amounts of cortisol released from the adrenal cortex eventually attach back to the hypothalamus through a ligand receptor complex, signaling maximum levels of cortisol and the need to reduce communication between the hypothalamus, anterior pituitary, and adrenal cortex. In the context of neuropsychopharmacology, a ligand receptor complex refers to the interaction between the signal molecule, the ligand, and a protein structure known as a receptor. On each receptor there is a binding site in which

the ligand molecule, typically represented as either a neurotransmitter, hormone, or drug, can attach in a lock and key like fashion. Thus, the overall purpose of the HPA axis is to release cortisol when appropriate and self-regulate its levels when needed. In people with major depression ‘disorder’, research has shown drastically elevated levels of cortisol due to insufficient regulation by the negative feedback system within the HPA axis. Within this ‘disorder’, these increased levels of cortisol can not only lead to feelings of depression and anxiety, but are often also accompanied by muscle weakness, weight gain, blood pressure changes and suppression of digestion function.

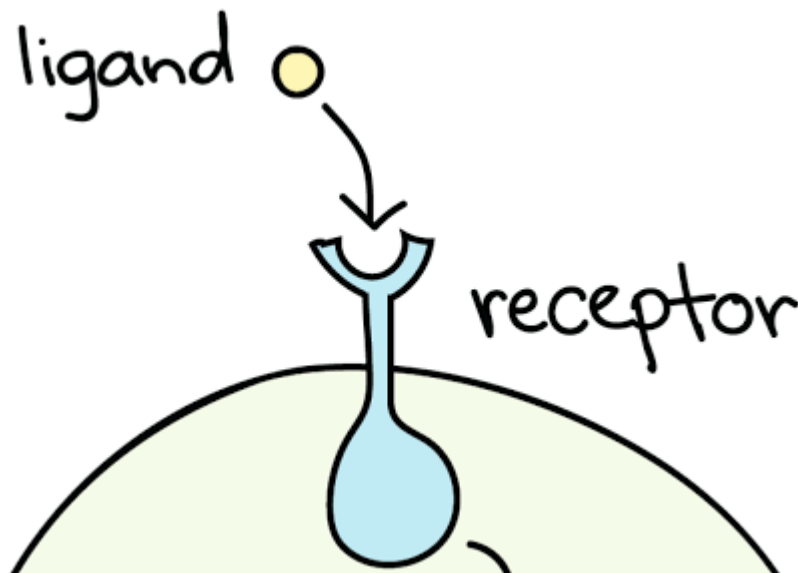


Figure 3: Ligand Receptor Complex (taken from Khan Academy)

The entire neuronal atrophy component of major depression ‘disorder’ is rooted in a more complex understanding of neuroscience that goes beyond the intention of this thesis. Succinctly put, recent studies have found that a protein known as brain-derived neurotrophic factor (BDNF), which is responsible for promoting the survival of nerve

cells, is heavily incorporated into the neurology of people with depression. Known as the neurotrophic hypothesis of depression, this approach claims after the onset of depression from increased cortisol levels, levels of BDNF begin to reduce. Limited access to this protein then causes atrophy in the hippocampus, the brain region predominantly responsible for memory formation, and the prefrontal cortex, the brain region that regulates the majority of our executive functions and decision-making abilities, ultimately damaging the cell functioning and overall structure of these regions. In the physiological dimension, these are the reasons depression occurs.

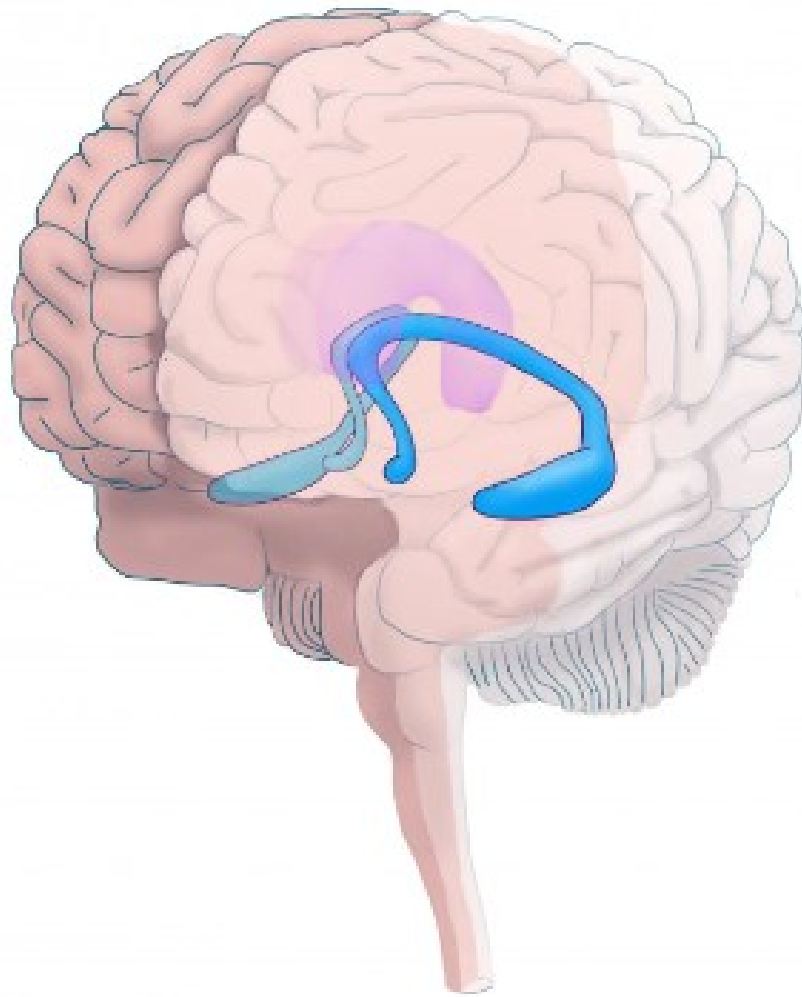


Figure 4: General Location of Hippocampus (taken from the University of California Davis)

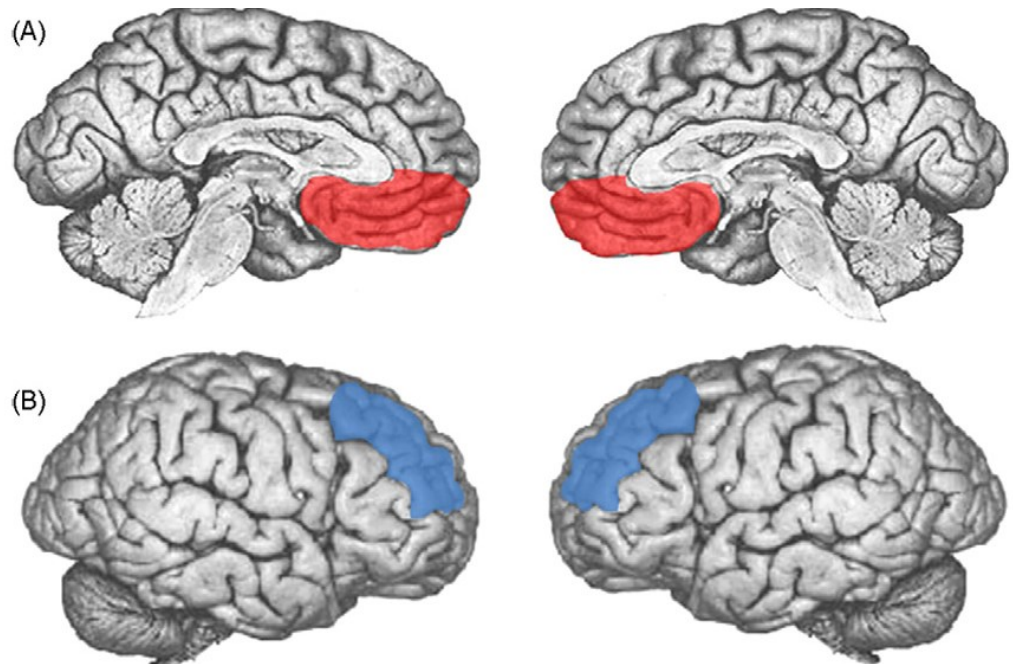


Figure 5: General Locations of Dorsal (Top) and Ventral (Bottom) Prefrontal Cortex
(Koenings & Grafman, 2009, p. 240)

Reflecting on chapter two, recall the fundamental problems with a significant amount of the rhetoric used in present day psychological care. As a reminder many of our most common terms used in ‘mental’ health today such as, ‘mental’ ‘disorder’ and ‘mental’ ‘illnesses’ are rooted in a medical framework that is not transferable to the complexities of the brain. Originating in the physiological dimension, these words operate under an assumption that biological symptoms are the most important symptoms for ‘mental’ distress. Just as I discussed in the context of this medicalized rhetoric, the physiological dimension operates with an understanding between normal and abnormal functioning, as there is a standard representation for a correctly functioning human body. Again, in the case of an individual’s radial bone, we know it is broken for a multitude of different reasons. First, the patient can identify where the pain is located and can likely articulate when and why this pain started. Second, it’s also likely that the medical doctors

can objectively see the pain experienced by the patient through irritated skin, bruising, or possibly swelling of the arm. Third, and most important, the doctors can perform an x-ray on the arm to see the break in the bone underneath the skin and compare that x-ray to those of correctly functioning arms. All this to say reducing ‘mental’ distress to ligands and receptors misses the experience of depression in all its complexity. While the neurological knowledge we have gained by leaning into the psychological dimension is useful, an overemphasis on this dimension is commonplace, creating intense psychological treatment complications.

Experiential Dimension

The experiential dimension assesses the role of an individual’s interaction with the environment. The primary purpose of including this dimension in enactivism is to consider how one’s active engagement with the external factors around them directly influences their ‘mental’ experiences. Elements such as an individual’s relationship status with their parents, their involvement in extracurricular activities, or even their enjoyment of their occupation are all potential contributors in the experiential dimension that could shape someone’s ‘mental’ experiences. It is also important to note that as the first theory to incorporate the significance of an individual’s subjective experiences, the experiential dimension played a crucial role in the development of psychotherapy. As it is abundantly clear, relative to the physiological dimension, the experiential dimension incorporates a much wider range of contributing factors. Thus, with a desire to assess all lived experiences of an individual, the experiential dimension can be recognized as a steppingstone that allowed for the expression of emotions, feelings, and past experiences which are central to the practice of psychotherapy today.

To further clarify the role of the experiential dimension, let's return to the example of major depression 'disorder'. In the physiological dimension I noted that recent studies have claimed that depression comes from an increase in cortisol which leads to a decreased expression of BDNF in the body, and ultimately to neuronal atrophy and decreased neurogenesis in vital brain regions. But why did an individual with major depression 'disorder' experience increased levels of cortisol in the first place? The answer is rather simple and falls within the operations of the experiential dimension –stress. Therefore, the entire reason for the activation of the HPA axis that I discussed comes from the various environmental stressors experienced by an individual. The types of environmental stressors can vary depending on the surroundings of the individual, but could include factors such as family complication, work or school related pressure or financial concerns. Importantly it is when these environmental stressors reach their maximum that cortisol increases and reduction in the expression of BDNF follows. What is to be understood here is that without the initial experience of environmental stressors, the physiological components of depression would be nonexistent.

Furthermore, the differentiation between the psychological and experiential dimension, as exemplified in the case of depression, is also represented in the distinct methodologies that each dimension uses to depict its functions. Considering its focus on individual experiences and subjective accounts, the experiential dimension often involves qualitative measurements. Case studies, which are strategic and detailed investigations into specific individual experiences, self-reported surveys and behavioral observations are each experiential methodologies used in the interpretation of non-numerical data to identify patterns and themes in research. Conversely, the physiological dimension works

with quantitative methodologies by obtaining numerical and objectively based data. In the fields of psychology and neuroscience, the physiological dimension often obtains this data with neuroimaging that can represent the brain in pixels and statistical values. Nevertheless, as de Haan notes, the majority of current psychological care models neglect the distinctions between these two dimensions., by incorrectly placing the experiential as a part of the physiological dimension, or vice versa. Where overreliance on the biological dimension has given us tools like MRI and CAT scans, overreliance on the experiential dimension has given us talk therapy. While MRI, CAT scans and talk therapy are all useful tools and widely recognized for their combined effect to treat mental distress, enactivism pushes us to include yet more dimensions of human experience.

Sociocultural Dimension

The third dimension in enactivism is known as the sociocultural dimension. Given the name, one primary responsibility of this dimension is to recognize how an individual's social relationships are heavily intertwined with the success of their cognitive functioning. Having relationships in one's life that are strong enough to foster a reliable support system can provide an individual with numerous involuntary and voluntary benefits. For example, strong relationships can be a source of advice, a place for motivation in times of struggle, and when cultivated effectively, an environment that can cultivate a dynamic of emotional safety. Thus, when an individual's sociocultural dimension is a source of negative or unhealthy inputs, it results in increased feelings of loneliness, an amplification of previous insecurities, and an overall decreased satisfaction in one's life.

Importantly, there are numerous individualistic components to the sociocultural dimensions beyond the quantity and quality of one's social relationships. In this dimension the plurality of one's social identities also holds great significance, meaning factors such as race, gender, sex, religion, and sexual orientation are all central to the status of an individual's cognitive functioning. Each of these identities contribute to an individual's sense of belonging both within themselves and within their respective communities. Considering the history behind many of these identity categories, we know that people of particular races, sexes, religions and sexual orientations will find themselves more or less welcomed in their societies, communities and families, potentially negatively impacting their overall 'mental' health. On the other hand, if an individual holds great confidence in their social identities and seldom experiences social alienation, these factors might enhance one's 'mental' experience. Confidence in one's social identities allows individuals to authentically present themselves, promoting positive social relationships and establishing a sense of worth that limits the negative self-perception often associated with experiences of 'mental' distress. In the context of identities in 'mental' health, it is also important to add that sociocultural assumptions around masculinity frequently make men less likely to seek health care in general but especially psychological assistance.

This dimension also denotes how one's communal experience can also shape the development of their cognition. Conversations around the perception of 'mental' health, and the practices of healing treatments are both key contributors to understanding the relationship between 'mental' health and culture. Additionally, access to resources is another important point in this topic. Addressing the reasoning behind disparities in

access is beyond the scope of this thesis, but the structural inequalities and historical injustices experienced by members of marginalized communities results in many minority groups facing systemic barriers that drastically limit their access to certain forms of self-care. Of additional significance is the differing stigma of ‘mental’ health across cultures. For example, Scandinavian countries display a vastly different understanding of ‘mental’ health than the United States; Denmark, Sweden and Norway offer a universal health care system consisting of robust ‘mental’ services and government policies ensuring accessibility for all people. Additionally, by successfully normalizing the conversation around ‘mental’ health, all approaches in ‘mental’ health in Scandinavian countries are holistic, allowing individuals to feel validated in their experiences of distress. While the United States has made attempts to replicate such reduced stigma around ‘mental’ health, people suffering from distress in the United States continue to be given labels such as “unstable” and “lazy” and are often viewed as responsible for their distress.

Further evidence of sociocultural differences is seen in the prevalence of specific ‘mental’ ‘disorders’. In a research investigation conducted by Bashiri and Spielvogel (1999), investigated the prevalence of postpartum depression (PPD) across numerous different cultures. Their results found that in a sample of 193 women in North America 11.9% experienced PPD, in a sample of 352 women in Europe 13.1% experienced PPD, in a sample of 66 Hispanic identifying women 53% experience PPD, and in a sample of 183 African women 10% experienced PPD. With these numerical disparities it is evident not only that cultural practices and traditions can impact a women’s experience of postpartum depression, but it also sparks conversations for how various cultural attitudes towards sociocultural concepts such as motherhood might be impactful to a community’s

perception of 'mental' health. For example, Bashiri and Spielvogel noted that significant differences can be identified in the recovery practices of new mothers across cultures. In North America, they note that the most vulnerable time for a new mom occurs after returning home from the hospital. Previously she attended ritualistic medical appointments with access to help and continual reassurance for the health of her baby, but upon her return home she undergoes the emotional experience of being truly alone for the first time in months. Conversely, in Punjab, a province of India, it is traditional for women to experience a purification ceremony nine days after giving birth. Additionally, it is part of their culture for women to take three months away from her husband and family to focus on herself along with the emotional and physical demands of having a child. Although statistics from Punjab were not included in the above findings, these logistical differences in the practices of healing show variations in cultural traditions that have the potential to impact the 'mental' health of the mother. Considering PPD is just one example for how cultural determinants can influence psychological distress, inclusion of the sociocultural dimension is crucial as it explores the interplay between social dynamics, identity influences, and cultural contexts in the development of one's 'mental' experiences. Lastly, by recognizing the significance of both individualistic and communal contributions, this dimension also underscores the importance of personal experiences and societal expectations in determining one's 'mental' health.

In the context of our depression example, the sociocultural dimension is introduced after we have experienced the environmental stressors, in the experiential dimension, and prior to the onset of neurological changes in the physiological dimension. Simply put, the sociocultural dimension assists in how we manage environmental

stressors, along with how the possession of these environmental stressors is perceived by the communities around us. For instance, if an individual with depression has environmental stressors caused by their family beliefs in ‘mental’ health, does their culture require them to suppress those conflicts, or is the expression of their emotions opposing their family an acceptable practice? The answer to this type of question is not only found in the sociocultural dimension, but will also help determine if decreased neurogenesis or hippocampal atrophy will be an outcome of their experience with these environmental stressors.

Existential Dimension

The last, and often most forgotten, dimension is called the existential dimension. Focused on an individual’s metacognition and process of meaning making, this dimension goes beyond what a clinician, or even a client, can measure in any capacity. Nevertheless, the existential dimension addresses how the client specifically relates to their recognizable distress or provided ‘disorder’. Do they feel like they will never get better? Do they feel like their ‘disorder’ has control over them? Do they believe that the action of seeking help will be successful? Considering that all answers to these questions necessitate a reflection of one’s own cognition, they are pertinent to the existential dimension. In other words, a common thread throughout these questions, and the existential dimension as a whole, explores how an individual experiences their ‘mental’ health in relation to the multiple variables that have crafted their present environment (e.g., biological health, social relationships, cultural traditions) and, most importantly, in relation to their self-perception. Utilizing this dimension in psychological treatment models not only helps ‘mental’ health professionals understand the client’s perspective on

their experience, but also helps professionals accommodate treatment methods to the individual needs of their client.

Importantly, in the context of our depression example, the primary purpose of the existential dimension comes after an individual has undergone the biological changes that accompany depression, and in the context of modern-day psychological care, after they have been diagnosed with major depression ‘disorder’. How an individual perceives themselves with this label and how much an individual believes in the existence of life after this label are again the important ideas housed in the existential dimension. If someone diagnosed with major depression ‘disorder’ feels incapable of being treated by ‘mental’ health professionals or carries an immense amount of shame for the way their mind works, their environmental stressors will continue, their cortisol levels will increase, their BDNF levels will reduce, and ultimately their experience of neuronal atrophy and decreased neurogenesis will worsen. The perceptual components of the existential dimension are influential throughout the development of depression, but the power of the existential dimension will become most evident when an individual is faced with the journey of treatment.

Referencing back to American psychologist Carl Rogers, the existential dimension is where much of his work makes significant contributions. To promote a client’s belief in themselves, Rogers used his admired developments of client-centered therapy as well as unconditional positive regard. In the practice of client-centered therapy, Rogers emphasized the importance of therapeutic relationships, describing the establishment of empathy between client and clinician as the most vital part of talk therapy. Similarly, as noted earlier, unconditional positive regard is a construct

promoting an authentic, accepting, and nonjudgmental perspective from all clinicians and therapists to foster an environment in which clients feel safe and encouraged in their treatment journey. In the context of the existential dimension, Rogers' work shows how empathy promotes self-directed growth in clients and an even deeper self-understanding for their experiences.

Importantly, this dimension is also where our previous discussions on self-efficacy can be understood. As a reminder, self-efficacy is a concept coined by psychologist Albert Bandura that can be understood as an individual's belief in their ability to perform a task successfully. From a 'mental' health framework, self-efficacy reflects an individual's belief in their competence to improve from the treatment they are receiving. With little self-efficacy, clients hold immensely low levels of motivation, essentially guaranteeing a treatment to be ineffective. Reduced levels of self-efficacy are similar to the consequences of low self confidence in an individual, because, as with low confidence levels, little belief in one's ability to succeed at a challenge is experienced by people with low self-efficacy, resulting in weak displays of persistence and an overall negative self-perception. For de Haan, one primary component of the existential dimension is its dependence on the practice she calls "sense-making".

Sense-making

When learning about the concept of sense-making it is helpful to recognize that as humans, we have the unique ability to self-organize both the information innate to us and the information we choose to engage with in the external world. The process of sense-making extends beyond an individual's mere interaction with their surroundings, encompassing also how and why those interactions are chosen and how they are

interpreted. Nevertheless, while the capacities for complex interpretation and self-organization are specific to humans, that capacity also allows for distinctive mistakes in which our species can engage in unhelpful sense-making patterns. To help illustrate the purpose of sense-making, let's discuss its importance in each of the dimensions I have discussed so far.

Despite the objective foundation of the physiological dimension, de Haan notes “the matter of living things is already different from the matter of objects” (p. 12). In this statement she suggests that there is an intrinsic interconnected component necessary to the biological functioning of living things. Although not tangible to the beholder, sense-making in the physiological dimension works with the relationship between the human body and the human self. Considering the physiological dimensions deep interwovenness with the bodies processes, sense-making here is often expressed in practical circumstances. To live, a body requires the baseline operations of receiving nutrients and water, removing wastes, maintaining homeostasis, and ensuring adequate time for restoration, thus, when the physiological dimension signals the need for a specific function, we make sense of this information and perform the necessary actions that will ensure survival. For example, one signal that represents the need for sleep occurs when the ventrolateral preoptic nucleus releases the brains primary inhibitory neurotransmitter known as GABA, effectively turning off all brain regions responsible for promoting wakefulness. Through the physiological sensation of sleepiness, these actions are then made sense of by an individual, which is followed by the decision to go to sleep. Importantly, the complementary actions that occur in response to the body's physiological demands are often performed unknowingly, which emphasizes de Haan's note about how

the human self has an automatic understanding of its requirements. In essence, “living is never a given”; thus, the ongoing processes of sense making in the psychological dimension allows for the necessary navigation of the body’s needs (de Haan, 2020, p.7).

Within the experiential dimension, sense-making is used to determine how an individual’s mind relates to the world around them. Going beyond one’s experience with their environment, sense-making in the experiential dimension assesses how an individual consciously perceives themselves as a contributor to the context surrounding them. Importantly, to actively construct meaning from the environment around an individual, sense-making requires a narrative between an individual’s embodied experiences and cognitive processes. Considering how our cognitive status is a result of this narrative, healthier sense-making in the experiential dimension provides us the tools to use our environment to ensure a strong ‘mental’ status, or in cases of distress, the tools to adequately understand the ramifications of our external stimuli. Conversely, unhealthy patterns of sense-making with our surroundings will result in a flawed theoretical understanding for the reasoning behind distress, and therefore a flawed practical understanding for how the environment could be used to improve our ‘mental’ status. To deepen our understanding of the role of sense-making in the experiential dimension, let’s revisit the example of an individual with major depression ‘disorder’. In healthy experiential sense making, an individual with depressed feelings has the ability to conceptualize how their external surroundings could shape their internal feelings. Therefore, ordered experiential sense-making for an individual with depression could potentially look like them understanding how their dad’s history with depression, their lack of a strong friend group at school, their inability to understand their classes, and their

negative self-talk are all factors that have the capability to result in their experiences of emotions akin to sadness and loneliness. Conversely, unhealthy patterns of sense making in an individual with depression, characterized by an inability to reflect on the impact of their surroundings, would manifest in an internalization that their experiences are a personal failing in which blame is placed on the self. As a result, an individual with depression coupled with disordered sense-making in the experiential dimension is likely to possess little belief in their response to treatment, ultimately intensifying their feelings of isolation and perpetuating their distress.

Rather than sense-making correlating with an individual's place in their immediate surroundings, the sociocultural dimension utilizes sense-making to understand an individual's place within their surrounding interactive relationships. An important component to sense-making in the sociocultural dimension is that it's continually evolving just as an individual's social environments and cultural context evolve over time. For instance, the way an infant views their relationship with their mother is vastly different than how an adult views their relationship with their mother. Nevertheless, considering the communality of group dynamics in the sociocultural dimension, it would be dishonest not to admit that problems of sense-making within the sociocultural dimension are common. Conversations from how one makes sense of their ethnicity within group dynamics in which they are a minority, to how a little girl forces herself to obtain the societal beauty features seen in her social interactions, are examples for the heavy and often problematic topics of sense-making seen in this dimension. Thus, sense-making is particularly significant in the sociocultural dimension as it shows how our cognitive status can rely on our relationships with others.

Finally, the concept of sense-making in the existential dimension can also be split into two distinctions – basic and existential. In basic sense-making the environment functions superficially, in which “meaningfulness is a reflection of its relevance for survival” (de Haan, 2020, p. 9). Often completed at an unconscious level, basic sense-making happens a plethora of times throughout the day. Something as simple as feeling cold and then taking the action to find an extra layer of clothing is an example of basic level sense-making. At this level, there is a further distinction of sense-making known as evaluative basic sense-making. Here the intention for the interaction with one’s environment increases from the mere goal of survival to surviving with an intentional purpose. In the clothing example, evaluative basic sense-making can be seen if your choice of extra clothing will assist in keeping you warm but was also selected to match your outfit. This additional reasoning could make you feel happier with your appearance, allowing you to have a more satisfactory day.

Moreover, the concept of existential sense-making delves further into the human psyche, investigating what de Haan refers to as “instances of deliberate reflection” (p. 9). This entails a philosophical level of insight that is represented in our patterns of thinking. In de Haan’s explanation of existential sense-making, she provides an example of a client being provided medication as a treatment method for ‘mental’ distress, and in this case existential sense-making is exemplified in asking, “what does it mean to [me] to be taking this psychiatric medication?” (p. 9). Therefore, in ‘mental’ health, existential sense-making also encapsulates the topics related to how the client feels about their ‘disorder’, their beliefs in the effectiveness of treatment, or their belief in ‘mental’ distress being a product of their inadequacies as a person. Similar to the existential

dimension as a whole, existential as a type of sense-making works to increase the connectedness between external knowledge and the abstract nature of the human soul.

Interestingly, basic and existential patterns of sense-making are not mutually exclusive to one another. According to de Haan, when one engages in an existential pattern of sense-making once, they are likely to not always understand how “meaning...surpasses function” (p. 9). Referring back to the clothing example, basic sense-making is seen in the selection of an extra layer of clothing due to the cold weather, evaluative basic sense-making is seen when we think about which jacket will keep you warm while also sustaining the style of our outfit to feel good about yourself. In this context, it is also important to note that this good feeling is linked more to meeting the sociocultural expectations for what your role as a civic person should wear when cold and is based less on personal desire. Thus, existential sense-making is illustrated in selecting a jacket that not only will match for a good appeal but will also make you feel the most personally confident throughout the day. To be clear, evaluative basic sense-making results in the feelings of happiness because the matching jacket achieved extrinsic rewards from society, yet in existential sense-making the jacket results in embodied feelings of confidence motivated by intrinsic rewards.

The relationship between basic sense-making and existential sense-making is very complex. For example, in some contexts, individuals can successfully abstain from the use of basic sense-making with the intention of satisfying other values in the existential dimension. As de Haan notes, many instances of these situations are seen in religious and social environments, for instance fasting as a religious practice is a prime illustration. For Muslims fasting is a practice that occurs in the month of Ramadan from dawn to sunset,

in which individuals show self-discipline to gain a deepened connection to their spiritual journey. However, the effect of not eating or drinking for extended periods of time can be very challenging to the basic functions of the human body. Thus, the intentional decision to alter eating patterns to grow in one's faith shows the prioritization of existential values over the instant gratification of consuming food. An additional example is seen in the American tradition of waiting for the birthday person to have the first bite of cake. Despite the intrinsic tendency to consume the sweet treat when it is placed in front of you, to subscribe to social standards, you must wait until all are served and the birthday person takes their first bite, once again neglecting your basic sense-making to satisfy existential values. The reason we have the ability to forgo our basic sense-making is because existential value often holds greater significance or serves as an essential element to the achievement of something in the future.

Interestingly, when an individual is sense-making in the existential dimension, they are often motivated by either positive or negative reinforcement. In the world of psychology, reinforcement is the term used to refer to anything that increases the likelihood of repeating a behavior. Broken down further, in positive reinforcement, something is added to one's environment with the intention of increasing the behavior. A mom providing her child with extra screen time for cleaning their room, or a boss providing words of affirmation to their employees who have performed well are both examples of positive reinforcement. Conversely, negative reinforcement consists of situations in which something is removed from one's environment to encourage the increase of a behavior. Taking out the trash to avoid your roommates getting mad at you

or pressing the snooze on an alarm to increase your amount of time in bed are both representations of negative reinforcement.

In the context of sense-making, de Haan discusses how the standards of social communities are often the foundation for reinforcing the placement of existential sense-making over basic sense-making. For example, as a consequence of historical beauty standards, many women have a desire to obtain a smaller frame to appear societally beautiful. In these cases, it's not uncommon for women to reduce the amount of food they consume to increase the amount of weight they are losing, negative reinforcement. Similarly, historically based aesthetics for men are to be taller and larger than their counterparts. In these cases, reinforcement is often exemplified in adding weights to their workout routine or adding pre-workout substances to their body to increase the behavior of obtaining a larger figure. Intriguingly, from a big picture perspective, understanding the complex impact of beauty standards along with their prolonged consequences can aid in understanding the phenomena behind psychology and thus the overall purpose of this thesis. Both beauty and psychology's reputations were founded on flawed historical ideals, in which seeking to uphold these images in the modern era has damaged the wellbeing of individuals in some capacity. In other words, attempting to sustain a pre-established concept, has effectively reduced the meaning in life of both psychology and beauty in society respectfully. All this to say, sense-making is a crucial component to how individuals find meaning and function in the world around them.

At this point you might be wondering; how does sense-making actually relate to someone's level of 'mental' distress? According to the enactivist approach to psychology, 'mental' 'illnesses' actually result from disordered forms of an individual's sense-making

across dimensions. This means that the distress experienced by an individual arises from difficulties in their relationships with their body, their surroundings, their interactions, and/or themselves. However, de Haan notes that disordered sense-making can result in a ‘mental’ ‘disorder’ only when it functions in a reoccurring pattern. Single instances of disordered sense-making, like the experience of a panic attack in an individual when trapped in an elevator, represents a moment of disorder but without repetition it cannot qualify as a true ‘mental’ ‘disorder’. Additionally, enactivism claims that ‘mental’ ‘disorders’ must also result from rigid experiences of dysfunctional sense-making. This means that the disordered sense-making must not only repeat, but also be distressful to the client throughout the formation of its pattern, ultimately disturbing the daily functioning of the client. The specific reasoning behind one’s inability to adjust their functioning to interrupt this pattern can provide insight into which type of ‘mental’ distress an individual is experiencing. For example, failure to adjust overly structured patterns of sense-making, such as an inability to stray away from routine, might represent symptoms of obsessive-compulsive ‘disorder’. Conversely, examples of lethargic sense-making, such as staying in bed for long periods of time or reduced appetite, are likely to relate to a depression ‘disorder’.

There are, however, important cases in which the experience of disordered sense-making comes as a secondary symptom. For instance, while Parkinson’s disease and Huntington’s disease both effect the brain, they are more accurately categorized as neurodegenerative disorders. Importantly, this classification is because the main symptom of these disorders revolves around motor impairments, thus placing a patient’s disrupted patterns of sense-making as an underlying indication for their distress. All

neurodegenerative diseases are chronic conditions, characterized by the death or loss of neurons within the central nervous system; consequently, it can be inferred that neurodegenerative diseases are founded within the biological complications of the physiological dimension. In the context of enactivism, it is important to understand that in healthcare situations in which one dimension overwhelmingly dominates the other, the application of an enactivism framework for treatment is ineffective. In fact, such an approach would undermine enactivism's purpose of establishing a psychological treatment that addresses an individual as a whole entity, rather than its constituent parts. Nevertheless, de Haan's work validates the distinction between these complications of the brain by explaining precisely how sense-making is different in neurodegenerative diseases versus 'mental' distress. She states that "sense-making problems [in neurodegenerative diseases] have a *cause* whereas in psychiatric disorders ['mental' health distress] have a *reason*", thus, in Parkinson's disease, sense-making disruptions are caused by the experience of motor impairments, rather than reasoned through the individual's flawed interconnectedness of the dimensions contributing to human experience (de Haan, 2020, p. 11). I mention this caveat to illustrate that despite enactivism's aim to establish an improved approach to treating the brain, the range of psychological complications will always reject a one size fits all model.

In summary, the primary intention of enactivism is to develop an overarching framework to psychology where individuals are assessed through a person-world complex in which fixed and repetitive sense-making patterns evident in any combination of the four dimensions indicate the experience of psychological distress. For my reader, if there is one thing that should be understood as the mission statement of an enactivism

approach to psychology it's that 'mental' 'disorders' are "not of the brain, not even of the body, but of the persons" (de Haan, 2020, p. 11); thus, understanding how an individual interacts externally as well as how they relate those connections to themselves is crucial to developing optimal approaches that treat 'mental' health. By providing a holistic understanding of how cognition incorporates the body, the brain, and the environment, enactivism shows how 'mental' 'disorders' are unique to an individual by nature and thus require intentionally distinctive treatment plans.

It is important to remember that not all practices of enactivism are missing in contemporary treatments of psychology. As I have previously mentioned, both de Haan and myself recognize active attempts to create integrative holistic frameworks, the most commonly known being cognitive behavioral therapy. Combining the roots of both cognitive therapy and behavioral therapy, cognitive behavioral therapy gained much of its popularity in the 1980s. Throughout various clinical trials cognitive behavioral therapy has shown its effectiveness as a unique form of psychotherapy focused on the interactions between feelings, behaviors, and cognitive functioning. The primary purpose of cognitive behavioral therapy is to identify and alter patterns of negative thoughts expressed from dysfunctional emotional processing and behavioral dysregulation seen in clients. Admirably, cognitive behavioral therapy was among the first therapeutic modalities to recognize that how we feel along with how we think mutually impact one another. How clinicians treat individuals with cognitive behavioral therapy includes a wide range of techniques such as skill building, goal setting, relaxation, and desensitization.

Numerous meta-analyses have shown that cognitive behavioral therapy can effectively treat 'mental' 'disorders' including but not limited to schizophrenia, anxiety

‘disorders’, substance abuse ‘disorders’, depression ‘disorders’, bipolar ‘disorders’, eating ‘disorders’, personality ‘disorders’ and psychotic ‘disorders’. Despite the clinical effectiveness found in assisting these ‘disorders’, as one of the first integrative treatment designs, the scientific community has undoubtedly found the need for improvement in both the practices and scientific foundation of cognitive behavioral therapy. Just as I mentioned in the start of this thesis, my intention is not to claim cognitive behavioral therapy as ineffective, but rather to show how enactivism can carry on its legacy while simultaneously making improvements necessitated by our modern understanding of the brain.

In an article assessing the efficacy of cognitive behavioral therapy, Hofmann et al. (2016), found that while most studies have emphasized the effectiveness of cognitive behavioral therapy across many ‘disorders’ they also found “the efficacy [to be] questionable for some problems, suggesting that further improvements in CBT strategies are still needed” (p. 436). In particular, their research noted strong reliability in cognitive behavioral therapy in different anxiety and personality ‘disorders’, but less concrete evidence in mood complications with pregnancy, bipolar experiences, and dysthymia. However, of even greater significance, Stefan Hofmann et al. noted limited research published on cognitive behavioral therapy with diverse populations. They explicitly state that “except for children and elderly populations no metanalytic studies have been reported on particular subgroups” (Hofmann et al., 2016, p. 436). Importantly, this finding also addresses how cognitive behavioral therapy’s foundation in the experimental dimension results in a flawed analysis of diverse social identities and thus how its avoidance of the sociocultural dimension further weakens its overall effectiveness.

Furthermore, cognitive behavioral therapy, like most modern psychology treatment approaches, also neglects the presence of the experiential dimension. Considering that the introduction of an integrative treatment approach to psychology was already risky given the field's fixation with holding a scientific reputation and desire to optimize its profit, failure to acknowledge the existential dimension is not surprising. The ability to provide measurable phenomena in psychological research established the field's credibility, thus adding a dimension prioritizing constructs not visible to the human eye would undoubtedly invite even more scrutiny. Put in de Haan's words, "perhaps more than in any other specialty, psychiatrists are confronted with the struggle between adopting the naturalistic perspective characteristic of medicine and the wish to account for the role of values and meaning" (p. 18). Thus, despite the importance of the existential dimension, it has remained a highly controversial conversation in psychology. Not only does attention to the existential dimension of human experience perpetuate the scientific instability feared by many objective psychologists today, but a standard inclusion of the existential dimension would also require more training for 'mental' health professions. However, neglecting the profound impact of the existential dimension, we not only risk overlooking crucial components of an individual that benefit our treatment, but we also jeopardize the possibility for further development in psychology. In other words, our resistance to change now predicts our resistance to change in the future.

Conclusion

The best way to articulate the significance of the existential dimension is through my own experiences. My early symptoms of anxiety and obsessive compulsive like traits placed me in therapy at a very young age. In my youthful years, my thoughts felt uncontrollable, and I distinctly recall believing, with the utmost sincerity, that there was no one in the world who could possibly understand the operations of my mind. With the belief that my anxiety was incurable, my refusal of any treatment was strong. When forced to go to therapy, I would walk into the room with that brown leather couch, believing that the following hour would consist of me being provided various meditation options or relaxation techniques that would ultimately be ineffective. And that's exactly what happened. Despite the legitimacy of my psychologist and the multitude of treatments she provided, my mind was made up.

However, when the incessant thoughts, shaking of the leg, and constant worrying not only sustained but persevered, it became evident to me that seeking assistance was literally my only choice. I had to make an intentional effort to train my mind into realizing that the word anxiety exists only because others have experienced symptoms adjacent to my own. I had to recognize that those who were helping me went to school to work with clients just like myself. I had to believe in the design of the treatment not for others, but for me. I had to switch thoughts from "nothing will help me" to "I have to trust what I don't know". It wasn't until this existentially rooted shift in my sense-meaning that I began to notice a change in both how I viewed my anxiety and my response to treatment. Although it was far from easy, investing in treatment allowed me to recognize that my anxiety was not a fixed disease in my brain, it was a manageable

challenge of my personality, and ultimately I became enthralled with recognizing my control in determining the success of the treatment. Utilizing this fascination, I not only sought relief from my anxiety, but also grew a passion to pursue a career in psychology. Without the shift in how I perceived my anxiety I would not be where I am today.

What comes with a complicated object of inquiry is complicated interventions such as enactivism. While enactivism can be used to show the gaps in many of our current psychological models of care, its primary purpose is to provide a “theoretical grounding for a holistic practice of psychiatry” (de Haan, 2020, p. 18). Notwithstanding the significance of the existential dimension, the framework of enactivism ensures that no one dimension is more important than the other. Such prioritization would be hypocritical given enactivism’s intention as a treatment model. Rather, each of these dimensions are interconnected and proportionally influential in the person-world complex of enactivism treatment. My goal for enactivism is for it to operate as an integrative baseline model for both clinical and research settings. Nonetheless, as I recognized the effectiveness of cognitive behavioral therapy in relation to its time of development, it is vital that I subject my suggestions to the same claim. Thus, enactivism too must acknowledge its willingness to evolve and adapt as the field of psychology continues to advance. While researchers such as myself might view the dynamics of enactivism to be the most effective for the resources available today, I hope for further changes as our understanding continues to grow. Importantly I also recognize that enactivism is not a perfect solution. Rather I provide these insights to my colleagues to continue our prioritization of holistic care in a more systemic yet clinically individualistic treatment design. And I provide these insights to my reader to depict the beneficial traits, that with

the help of other professionals and clinicians holding a mutual respect for psychology, can allow psychology to transform what was once perceived as its biggest weakness into an unparalleled strength of the field.

CONCLUSION

If you have reached this point in the thesis and believe you have comprehended every component of each chapter, I fear you may have overlooked the complexities of these topics, because just as psychology lacks answers, so too does this thesis. Rather, my intent behind crafting these chapters was to transform your perception of the study of psychology, allowing you, as my reader, to recognize it as both a philosophical discipline as well as a scientific practice.

In pursuit of this objective, I hope that from chapter one you gained a greater understanding into how the historical consequences of psychology have instilled a persistent sense of physics envy that has continued to influence our modern approach to psychological care today. I hope you have recognized how the works of many monumental figures throughout history, such as Homer's depiction of Penelope's suitors in the *Odyssey*, have widened the arbitrary gap between normally and abnormally functioning individuals. Moreover, I hope from chapter one you were able to deepen your knowledge for psychology's 20th century timeline, and comprehend how its attempts to compensate for past inaccuracies led to the birth of flawed mechanistic approaches to psychological care that ultimately shifted the field's focus from assisting the client to optimizing the industry.

From the contents of chapter two, I hope you not only recognized how rhetorical choices in psychology can serve as a representation for the overcompensation mentioned in chapter one, but also how such mechanistic underpinnings within care can directly affect the client. Additionally, I hope you obtained an understanding of how rhetorical

techniques are particularly influential in relationships between an information seeker and an information provider and thus how empathy functions as a vital communication tool within healthcare professions. Through the analysis of medicalized terms such as diagnosis, 'mental' 'disorder', 'mental' 'illness' and 'mental' wellness, my aim was that this chapter enabled you to learn how psychology's inability to establish a representation for a normal functioning brain has resulted in these terminologies possessing controlling connotations which inadvertently blame the client for their experiences of distress. Taking this all into consideration, my ultimate desire for this chapter was for you to grasp why future approaches to psychological care need to not only focus on what they are saying but also how they are objectively communicating it.

Lastly, my goal in chapter three was to provide you with a representation of what the future of psychology could be. By articulating the integration of the physiological, experiential, sociocultural and existential dimensions while also acknowledging the differences between these divisions, this chapter demonstrated how enactivism is a treatment approach that successfully implements a majority of the brain's needs that were articulated throughout this thesis. Furthermore, I hope this chapter facilitated your understanding for the concept of sense-making and specifically how complications with an individual's pattern and order of sense-making are the qualifications that constitute experiences of 'mental' distress in enactivism. All this to say, I hope you understood that my intention behind this final chapter was to illustrate how the complexities of the human brain can be met with equally intricate psychological approaches of care, ultimately highlighting the inherent ambiguity within psychology and 'mental' health as a strength.

Before I bring my contributions to this psychological conversation to a close, I find it imperative to remind my reader that I by no means have the expertise to claim enactivism as the most effective and optimal baseline framework for psychological care. As an undergraduate neuroscience student who has only scratched the surface of this field, I recognize that my delineation of enactivism, along with my general notes for how ‘mental’ health care models should improve, is not comparable to the knowledge of those who have been deeply immersed in this area for years. However, this is why I plan to pursue graduate school. In the next stage of my life, I will be attending Palo Alto University to obtain my PhD in clinical psychology with a hopeful emphasis in neuropsychology. Here I will have the opportunity to grow in my knowledge, expand my clinical experiences, and deepen my research on psychological assessments to ultimately become a representation for how, as this thesis has described, the complexities of the human brain and the intricacies of human behavior should be treated. Moreover, as a testament to my belief in the sociocultural dimension coupled with the underlying theme of individualism in psychological care seen throughout this thesis, I find it important to note that I chose to embark on my journey to becoming a clinical psychologist at Palo Alto University because of their emphasis on diversity and inclusion in ‘mental’ health. In addition to offering opportunities to specialize in areas of diversity and community ‘mental’ health or LGBTQ psychology, Palo Alto University is transparent about how they intentionally select their cohorts to have students both with diverse backgrounds and diverse minds. Therefore, I selected Palo Alto University to advance in my expertise because I can not only learn from faculty and professionals who understand the

interconnectedness of ‘mental’ health, but I can also engage with fellow students who share a mutual understanding for the importance of diversity within psychological care.

After completing this program, my ultimate career goal is to open a private practice that offers clinical neuropsychological and psychological assessments for adolescent clients. Furthermore, I aspire to open this practice to the employment of other ‘mental’ health professionals and train them on how to provide the comprehensive, individualistic, and replicable treatment approach to psychological distress that I hope to craft throughout graduate school. Upon expanding my knowledge at Palo Alto University, my hope is that this approach will not only set the stage for how future treatment approaches can truly navigate the brain, but that it will also provide objective evidence to those who remain resistant to including the physiological, experiential, sociocultural, and existential dimension in psychological care. However, I want to remind my reader that my future practices in the field of psychological treatment will not abandon the use of psychiatric medications or medicalized equipment such as neuroimaging techniques. Rather it will recognize these tools as resources for a clinician to offer only when the distress of an individual goes beyond something that is responsive to a dimensional approach.

From a client’s perspective, I understand how reading about the need to implement an enactivist approach does not provide a guaranteed method for how it will work to dismantle your individual distress— however it’s not meant to. Rather, as noted at the start of this thesis, the intention behind these chapters is merely to call out the quiet side of psychology. To bring to the surface the questions, conversations, and ideologies that we have feared to discuss as a field of scientific study prioritizing our reputation. To

be specific, the intention of these chapters is to note that by understanding the intricacies of the brain, appreciating the unknowns of psychology, and acknowledging the innovative worldview of society today, we can recognize that a hard science reputation is not required for success in a field of study. In fact, if we gradually make this change in our perception of science, I believe there will not only be a more authentic prioritization placed on the field of ‘mental’ health, but more importantly a reduction in the stigmatization that surrounds these conversations. Nevertheless, I again acknowledge that for current clients, clarity regarding this prolonged vision for enactivism is likely compromised by their distressful experiences. To them, I extend a disclosure of what I have learned, as a fellow client, throughout this writing process.

As I disclosed at the beginning of this thesis, my history with anxiety starts off at an impressively young age. Before I could even conceptualize the label of anxiety, my disordered sense-making was apparent to those close to me, and I am here to say, that at the age of 22, I am still grappling with my anxiety. Despite my successful existential shift in sense-making, I still seek assistance from a psychologist, despite my direct education in neuroscience, I am still part of the Office of Access and Learning Accommodations at my university, and despite my 100-page undergraduate senior thesis delineating how to treat distress, I still have anxiety. I mention this because one of the primary things I have taken away from this process is that, much like the multidimensional nature of psychological treatment approaches, life with ‘mental’ distress is far from a linear process. For me, there are times in which my perspective on my ‘mental’ health has taken a negative or positive turn, times in which I have spent months trying different psychologists, and even times in which I found no type of treatment to be successful. My

explanation of this foundational characteristic within ‘mental’ distress is not to daunt you with the potential for its persistent presence, but rather I aim to show that while the journey of ‘mental’ health is unpredictable, the ultimate control lies within you. Thus, to those who presently lack the ability to believe in the success of any future adaptations to psychological care, I invite you to 1) recognize that this is a transient viewpoint on your evolving journey with ‘mental’ health and 2) that you too have the power to shift your placement in the existential dimension.

Lastly, as I mentioned at the start of this conclusion, the deliberate absence of definite answers within these pages is intentional. In fact, my aim is that you’ve reached this point in my work with more questions than answers. Succinctly put, my sole goal for my reader, is for the points presented in this thesis to have inspired you to examine your preconceived notions of psychology along with its application to the world of ‘mental’ health. If you’ve begun to ask more questions about these topics, pondered future suggestions for treatment, or even challenged my presented viewpoints, then I have successfully sparked modern conversation around the evolution of psychology, and thus achieved the objective I set out to accomplish with this project.

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