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Shrug Ambivalence and Disagreement; Search Commonalities in Psychiatric Phenomena**

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ABSTRACT

Holistic understanding is necessary to study intimate nuances of psychological/psychopathological processes; also, individual manifestations and individual approach are laudable goals in treatment and approach. But we cannot forget that major therapeutic advances result when we are able to delineate commonalities and stable symptom clusters that cut across geo-cultural boundaries and are amenable to study and intervention. Even though the purpose and approach of psychiatry, as of all medicine, has to be humane and caring, major therapeutic advancements and aetiologic understandings result only from a scientific methodology that stresses and figures out the commonalities of psychopathological phenomena.

It is a mistake to stress individuality so much that commonalities are obliterated. Although stress on the individual's needs has helped psychiatry at times become more humane, it has hurt the task enormously by making some very bright minds question the very scientific basis of psychiatry and its status as a medical discipline.

Hence, even as it is necessary to promote holistic and individualistic caring, it is equally necessary to shrug ambivalence and crippling disagreements that can result if individualism in therapy is carried beyond limits.

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Psychiatry's tradition, and field, will always allow for diversity in its practice, even in its theorising. For, psychopathology has both a personal, deep inner dimension — due to biogenetic and personality factors - and social, manifest/unmanifest, outer dimension — due to the environment. And the practice, and theory, of both are likely to be different, although we do try to amalgamate them in our 'bio-psycho-social' model. Such differences are only manifestations of an intricate network of influences that make for the human condition in health and disease.

Psychiatry is the one branch which realises this diversity the most, but equally important for it is to stress its unity:

1. *Of purpose – that of reducing individual and social psychopathology;*
2. *Of goals – that of unravelling the aetiopathology of psychiatric disorders; finding precision in diagnostics and investigative tests; finding biomarkers; and finding precise therapies for precise disorders that control such disorders; and not just control, but finally cure them; finding methods of primary prevention; of moving from mental disorder to mental health; and, further, of progress to individual actualisation and personal and collective well-being with longevity;*
3. *Of practice – a) in therapy: By synergising psychopharmacology/somatic therapies with psychotherapy/therapies, social therapies and pharmacogenetics; b) in diagnostics: By identifying the phenotype-genotype-endophenotype axis; and (c) by promoting such therapy and diagnostics as brings about control, and finally, cure/primary prevention of psychiatric disorders.*

The future course for psychiatry involves a goal oriented forward movement - while allowing for diversity in practice and theory, stressing on unity of purpose, goals, and practice.

Key Words: *Caring approach; Commonalities and stable symptom clusters; Holistic understanding; Idiographic-nomothetic orientation; Scientific methodology; Therapeutic advances*

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Introduction

Every branch has its fair share of critics and detractors, of course, but none of these branches faces the type of decimating opposition that psychiatry does (Singh, 2007[16]). There are various reasons for this. Firstly, those who are benefited from psychiatry prefer to remain anonymous due to the attached stigma; and, secondly, psychiatrists themselves are often reticent to speak about their positive contributions, probably under an assumption that their work speaks for them anyway. Both of these attitudes are much in need of repair from our side.

Other reasons for such criticism can be: 1) the 'psychologising' or pop-psychology over social phenomena that some of us are prone to do over events

about which we have no special expertise; and 2) allowing psychiatry to be used to stifle political dissent, as has been done in some countries. Prudent psychiatrists have realised the perils of indulging in either.

One another reason the unjustified critics of psychiatry have had a field's day is probably because there is a lot of ambivalence about the contributions of psychiatry in the thinking of psychiatrists themselves (Singh, 2007[16]; Singh 2014[19]). There are reasons for this ambivalence too, remedying which is part of the task for the branch ahead: Amongst them, the lack of biological markers for psychiatric disorders (Turck, 2009[23]), our lack of precision with our investigative tools, our diagnostics and our therapeutics (Singh, 2013[18]), and our load of chronicity in many mental disorders.

Along with such ambivalence, goes its inevitable twin: Disagreement. Psychiatrists seem to thrive on disagreement amongst themselves. There is disagreement over the aetiopathology, the diagnostics and the therapeutics of almost every psychiatric disorder.

The idiographic-nomothetic integration

While healthy difference of opinion is a sign of vitality and dynamism, there has to be a fundamental unity over the essentials of a branch. Some in the field stress individuality almost to the point of denying any commonality and scientific categorisation. While it is true that each patient is unique and requires individual handling, he is also part of the human race, which has many things in common, including the way psychopathology manifests across cultures and geographical boundaries. An idiographic orientation which stresses individuality cannot, and should not, preclude the nomothetic or norm laying thrust that is the crux of scientific progress (for idiographic-nomothetic orientation, see IGDA, 2003a[7], 2003b[8]). The major contribution of science has been to recognise such commonalities so they can be researched, categorised, and used for human welfare. For, 'An *excessive preoccupation with individuals* is heuristically sterile. Physics would not have advanced very far if every natural phenomena had been regarded as unique rather than as a member of a class of similar phenomena. Progress depends on recognizing similarities in phenomena which may, superficially, differ very greatly, for from these similarities we may deduce general causes' (Slater and Roth, 1984[22]; p4)

The difference between a lay intelligent observer and a scientist is that a lay intelligent observer would try to find out the individual variations and peculiarities of abnormal behaviour as it manifests in different individuals and different cultures. A scientist will try to decipher the commonalities in the abnormal behaviour across cultures and peoples so he can find stable symptom clusters that can be labelled as diseases/syndromes etc. (Singh, 2007[16]; Singh 2014[19]).

It is a mistake to stress individuality so much that commonalities are obliterated. While holistic understanding is necessary to study intimate nuances of psychological/psychopathological processes, and while individual manifestations and individual approach are laudable goals in treatment and approach, we cannot forget that major therapeutic advances result when we are able to delineate commonalities and stable symptom clusters that are amenable to study and intervention. Which then form the basis of our diagnostic formulations and our therapeutics. If we reject the need to find such commonalities in the name of individuality, and uniqueness of the person, we are likely to start questioning the very need for psychiatry to remain a science, or continue as a medical discipline. Although stress on the individual's needs has helped psychiatry at times become more humane, it has hurt the task enormously by making some very bright minds question the very scientific basis of psychiatry.

Commonalities of psychopathological phenomena

While the purpose and approach of psychiatry, as of all medicine, has to be humane and caring, major therapeutic advancements and aetiologic understandings are going to result only from a scientific methodology that stresses and figures out the commonalities of psychopathological phenomena. In other words, the science in psychiatry.

Hence while it is necessary to promote holistic and individualistic caring, it is necessary to shrug ambivalence and crippling disagreements that can result if individualism in therapy is carried beyond limits. And it is necessary to vigorously pursue the search for commonalities in psychiatric phenomena and their scientific study without of course neglecting that each patient is unique and will need the universal approach to diagnosis and therapy to be tailor made to suit his individual needs.

Difference in approach at collective and individual level

Let there be no ambivalence here. There must be a difference in approach at the collective and the individual level.

Our approach at the collective level of research into diagnostics and therapeutics of psychopathological disorders has to be to primarily find commonalities, and secondarily, also its individual variations across cultures and geographies. For example, what makes for schizophrenia, whether in India, the US or UK? What is common to this diagnosis, irrespective of where the patient resides? And then, secondarily, also study how this schizophrenia manifests differently in these regions, and is yet schizophrenia.

Our approach at the individual level of the patient has to be to primarily apply such universal findings for the welfare of the individual patient, even while

secondarily noting that he is part of a human collective that has many factors in common, including psychopathology, from the study of which common factors significant leads in individual diagnosis and therapy will result. In other words, to take the same example, the diagnosis of schizophrenia having being made, what is the peculiar human condition of *this* patient, the stage of *his* sickness, the nature of *his* caregivers, *his* amenability to different treatment modalities, the amount of insight *this* patient has, and the amount of psychological exploration/ assistance *he* needs and can accept. And even while tailoring all this for the individual patient, not forgetting that he is one amongst the common pool of schizophrenia patients from all over the globe who benefit from the current common pool of therapies and will benefit from new advancements in this common pool of therapeutics that results from any corner of the globe.

The art should not override the science in psychiatry

Psychiatry is unique in handling the intimate affective and cognitive aspects of an individual patient's subjectivities, as also the way his sensory and motor activities are regulated by such affect and cognitions, both of which have an inner personal and an outer social dimension. An intricate and delicate matrix of thoughts and feelings woven into perceptions, volitions, and behaviour. And so it is an art. It is an art in the manner in which the principles of objective science are tailor made to suit the subjectivities of the individual patient. It is also an art in the manner in which each therapist applies his unique understanding and methods, his own special 'touch', to relieve psychopathology. But it does so on the basis of certain objectively verifiable scientific principles based on commonalities that cut across individuals, even cultures, countries and races. And so it is very much also an [objective] science. In fact, it should deal with patient subjectivity in an objective manner, and even use therapist subjectivity under the over-arch of objectively verified, and verifiable, evidence; not allowing anything more than such subjectivity to influence his therapy and his theory.

A delicate balance indeed.

While it is true that for the rest of medicine, the science of objectivity should not paper over the art of subjectivity – in other words, human beings should not become mere diagnostic slots – in the case of psychiatry, the greater danger is that the art of subjectivity does not override the science of objectivity — diagnostic slots themselves become redundant, whereby we overstress our humanistic orientation — the problem is not with stressing, the problem is with *over*stressing.

It amounts to overstressing mainly when we consider the medical model in psychiatry and the need for diagnosis itself to be *incompetent* to handle psychopathology (see a recent attempt by Johnstone, 2013[10]). It is insufficient, and unable, at times to capture the nuances of psychopathology, and so needs to be made more sensitive to such issues; but it is not *basically*, or *fundamentally*,

incompetent to handle such issues. For diagnosis is not a matter of merely naming and labelling. Ideally it implies judgment of causation and a plan of treatment (Slater and Roth, 1984[22]; p5). If psychiatry has to remain a part of medicine, it cannot reject the diagnostic model, in whatever renewed incarnation it may take, including the present DSM-5 emphasis over entities like 'psychopathology domains crossing diagnostic boundaries' (Carpenter, 2012[2]), in other words, Research Domain Criteria Project (RDoC) (NIMH Research Domain Criteria (RDoC), 2011[12]; See also National Institute of Mental Health Strategic Plan, 2008[11]. Also see its critique by Sisti, Young, and Caplan, 2013[15]).

It can expand/alter the medical model, but cannot reject it wholesale. That would amount to throwing the baby out with the bathwater.

Rejecting diagnosis altogether is specially a danger in psychiatrists who continue to do psychotherapy, mainly in the psychoanalytic/humanistic psychology tradition, as also those who analyse its conceptual foundations (Pilgrim, 2013[13]). While the special insights and deeper understandings of the human condition that these approaches foster have to be appreciated, and indeed furthered, they must be based on a solid foundation of replicability and refutability, and an objective verification that cuts across individual idiosyncrasies and anthropomorphism.

Insights and idiosyncrasies

After all what is the difference between *insights*, which we need to welcome, and *idiosyncrasies*, which we need to shun? The difference is not of views and prejudices. The difference is purely of objective verification. All 'insights' that do not stand the ultimate test of verifiability must become idiosyncrasies. The example of Freud's emphasis on libido comes to mind here. A brilliant insight, but in danger of becoming an idiosyncrasy because no one wants to provide objective proof for its verifiability.

In other words, while we appreciate that many approaches to the psychopathology of the human condition have their own unique take and 'flavour', they must equally subject themselves to objective verification, mainly through the experimental approach, of course with special tools to assess them and their unique methods and modes of therapy.

When we talk in terms of replicability, objective verification, experimental method etc., we are essentially searching for the commonalities of phenomena. When we talk of refutability, we are similarly searching for evidence that exists to refute the basis of such commonality.

After all what do we do when we make a diagnosis according to certain

criteria, clinical or research? We find signs and symptoms that are common to patients across geo-cultural boundaries. When we replicate a study by our objective verification using the experimental method, we similarly look for such common features across geo-cultural boundaries, and find evidence-based diagnostic categories and therapies. To the extent and till such time that such commonalities stand the test of replicability, we continue to accept them as scientifically valid. When we find any evidence that refutes such a finding, or corrects it, and provided it is similarly backed by replication, again stressing on commonality, we reject/modify a certain diagnosis/therapy. And thus results scientific progress. This is how the whole of medicine has progressed, and psychiatry is no exception. Any serious student of psychiatric history will vouch for this.

It is commonalities that is the bedrock on which a theory, hypothesis or movement ultimately stands or falls. At least in science. Well, for individual flights of fancy, or nuances, there are many other disciplines available.

Medicine, psychiatry, science and art

The rest of medicine needs to become more of an art. True. By listening more, by soothing words, by a comforting touch, by in general being empathetic. Psychiatry, fortunately, is already all this (although losing out on these strengths at times), and needs to become more of a science. That is equally true.

How will psychiatry become more of a science? It will do so only by finding the precise biological correlates of its disorders so that these 'disorders' can legitimately become 'diseases' (Singh and Singh, 2009[21]); by developing precision in its diagnostics, its investigative tools and its therapeutics (Singh, 2013[18]), and thus finally graduating from an interim to a full-fledged medical discipline (Singh and Singh, 2009[21]). All part of the unfinished agenda that beckons the branch.

Unity in diversity

Psychiatry's tradition, and field, will always allow for diversity in its practice, even in its theorising. For, psychopathology has both a personal, deep inner dimension — due to biogenetic and personality factors - and social, manifest/unmanifest, outer dimension — due to the environment. And the practice, and theory, of both are likely to be different, although we do try to amalgamate them in our 'bio-psycho-social' model (Engel, 1977[4]; 1982[5]). Such differences are only manifestations of an intricate network of influences that make for the human condition in health and disease, psychiatric or otherwise.

Psychiatry is the one branch of medicine that realises this diversity the most, and tries to come to grips with it to the best of its ability. This it does by

accepting methodological pluralism, and embracing cultural and intellectual diversity (Fulford *et al*., 2003[6]), in the best traditions of what forms an open society (Birley, 2000[1]). That is what makes it such an exciting branch to be in. But equally important for it is the resolution of the polarisation of its ideologies and approaches (Singh and Singh, 2004[20]). For, in all its diversity, it needs to stress its unity:

1. Of *purpose* — that of reducing individual and social psychopathology;
2. Of *goals* — increasing the validity of psychiatric diagnosis even as we have increased its reliability (Insel, 2013[9]); of unravelling the aetiopathology of psychiatric disorders; finding precision in diagnostics and investigative tests (Singh, 2013[18]); finding biomarkers; and finding precise therapies for precise disorders that control such disorders; and not just control, but can finally cure them; find methods of primary prevention; identify what makes people healthy, happy, and fulfilled in the face of current world challenges (Cloninger 2013[3]); propel movement from mental disorder to mental health; and, further, progress to individual actualisation and personal and collective well-being and longevity (Singh, 2010[17]).
3. Of *practice:*
    a. In *therapy*: By synergising psychopharmacology with psychotherapy/therapies, social therapies and pharmacogenetics;
    b. In *diagnostics*: By identifying the phenotype-genotype-endophenotype axis (Schwartz, 2013[14]); and
    c. By promoting such a *synergy of therapy and diagnostics* as brings about, firstly, efficient control, and, finally, cure/primary prevention of psychiatric disorders.

Concluding Remarks [See also Figure 1: Flowchart of the paper]

Holistic understanding is necessary to study intimate nuances of psychological/psychopathological processes. Also, individual manifestations and individual approach are laudable goals in treatment and approach. But we cannot forget that major therapeutic advances result when we are able to delineate commonalities and stable symptom clusters that cut across geo-cultural boundaries and are amenable to study and intervention.

Psychiatry's tradition, and field, will always allow for diversity in its practice, even in its theorising. For, psychopathology has both a personal, deep inner dimension – due to biogenetic and personality factors – and social, manifest/unmanifest, outer dimension – due to the environment. And the practice, and theory, of both are likely to be different, although we do try to amalgamate them in our 'bio-psycho-social' model. Such differences are only manifestations of an intricate network of influences that make for the human condition in health and disease.

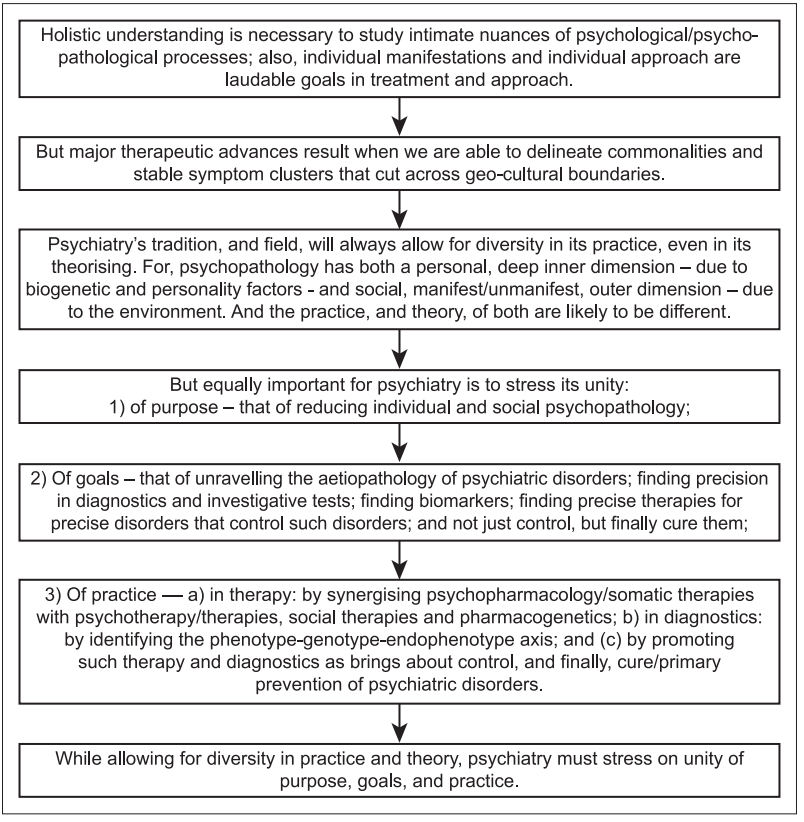

Figure 1: Flowchart of paper

But equally important for it is to stress its unity: 1) of purpose – that of reducing individual and social psychopathology; 2) of goals – that of unravelling the aetiopathology of psychiatric disorders; finding precision in diagnostics and investigative tests; finding biomarkers; and finding precise therapies for precise disorders that control such disorders; and not just control, but finally cure them; of methods of primary prevention; of moving from mental disorder to mental health; and, further, of progress to individual actualisation and personal and collective well-being with longevity; and 3) of practice — a) in therapy: By synergising psychopharmacology/somatic therapies with psychotherapy/therapies, social therapies and pharmacogenetics; b) in diagnostics: by identifying the phenotype-genotype-endophenotype axis; and (c) by promoting such therapy and diagnostics as brings about control, and finally, cure/primary prevention of psychiatric disorders.

Psychiatry has this potential if it realises its true nature and carries forward a more focussed movement. The future course for psychiatry involves such a goal-oriented forward movement — while allowing for diversity in practice and theory, stressing on unity of purpose, goals, and practice.

Take home message

1. Major therapeutic advances result when we are able to delineate commonalities and stable symptom clusters that cut across geo-cultural boundaries.
2. Psychiatry's tradition, and field, will always allow for diversity in its practice, even in its theorising. But equally important for it is to stress its unity of purpose, of goals and of practice.

Conflict of interest

None declared.

Declaration

This is my original unpublished work, not submitted for publication elsewhere.

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Questions that this Paper Raises

1. The science should not overshadow the art, neither should the art try to make the science redundant. How do we best combine the science and art of psychiatric practice?

2. How do we achieve unity of purpose, goals, and practice?

3. Disagreements and ambivalence need to be tackled: how?

4. How near are we to finding precise biological correlates of mental disorders?

5. Do you agree that the only way psychiatric 'disorders' can qualify to become 'diseases' is by finding their precise neurobiological correlates?

About the Author

Ajai R. Singh, MD, is a Psychiatrist and Editor, Mens Sana Monographs (http://www.msmonographs.org). He has written extensively on issues related to psychiatry, philosophy, bioethical issues, medicine and the pharmaceutical industry. ©MSM.