Towards an Ideal Paradigm

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A great deal has changed in the 200 years since Reil coined the term 'Psychiatry' into medicine. The concept of custodial asylum prevailed in the initial period of Psychiatric history during which biological concepts held sway. Then the doctrine of Psychoanalysis came increasingly to the fore. The period between 1970 and the present time is witnessing the emergence of Biological psychiatry again with a vengeance and psychodynamic explanations have largely been unhorsed.

The history of Psychiatry reveals jolting changes and discontinuities that are less common in other specialities. This is because, certain details with reference to underlying causes were unidentifiable and un-understandable. With the lack of solid pathophysiology or understanding of the mechanisms of disease, it cannot delineate disease entities on the basis of anatomical pathology. Thus the discipline is subject to faddism—anything could be true and nothing can be disproven.

Thomas Kuhn coined the term 'Paradigm' to denote conceptual structure within which scientific work occurs. It is the sum of underlying assumptions. Theories and models which are specific become hypotheses and function within a paradigm. In Psychiatry, no single paradigm is able to explain fully the nature of mental illness, relation of mind to brain, definitions of cause, course and treatment of specific pathologies, guidance on how to cope with mental illness.

The medical Philosopher Lawrie Reznek (1987) said, “Concepts carry consequences-classifying things one way rather than another has important implications for the way we share towards such things”

Kraepelin was committed to a biological ontology. Neo Kraepelinians gave up this biological ontology; at least overtly but extended Kraepelin’s nosology beyond the major psychoses. In the Victorian period there was a challenge to construct knowledge base to underpin a form of medical authority over lunacy. There was an editorial in the Journal of Mental Disease (the former title of British Journal of Psychiatry) in 1858 which in two sentences captures the essence

“Insanity is purely a disease of Brain; The Physician is now the responsible guardian of the lunatic and must ever remain so”

For over fifty years, this concept remained in the ascendency about lunacy.

The asylum system was taken over by Biodeterminism and contributed to the Zetgeist of eugenic thought of western intellectual culture. There was a fundamental incompatibility between the eugenic view harboured by the Victorian asylum doctors and the grim reality of the fine officers and Gentlmen breaking down with predictable regularity in the trenches of great war. To offer an eugenic view for the neurotic reactions among the traumatised soldiers was tantamount to reason. At this point the monopoly of biodeterminism was broken and neurosis and psychosis came within the ambit of Psychiatry and psychoanalysis. Between world wars a compromise was worked out with medical Psychotherapy and Biological Psychiatry and Eclecticism provided a middle position.

Eclectic Psychiatrist is one who practises a moderate type of Psychiatry; using whatever seems likely to work, while deliberately avoiding the more extreme schools. In an Eclectic department of Psychiatry, it is possible to hear the staff talking about one patient in behaviourist terms, about the next from a strictly biological point of view and the third wholly in psychodynamic terms. Practitioners try to fit the theory to the patient,
rather than vice versa. Eclecticism became a mark of moderation in an intellectually unstable world. It leads the Clinical Psychiatrist into a good deal of tightrope walking. An eclectic Psychiatry mirrors the diverse world wracked with uncertainty and overloaded with information. Eclecticism means borrowing freely from styles which suffer only in aesthetic grounds.

Adolf Meyer’s views were stemmed out of British Clinical Psychiatry as a form of psychiatric orthodoxy. Meyer argued that the elucidation of a patient’s problems must be in relation to their personal history, not merely their current mental state. According to him, mental illnesses represented accumulation of patient’s unhealthy reactions to their environment. Meyer’s model was known as ‘Psychobiology’.

Shepherd, because of his hostility towards Psychoanalysis, used the term ‘Biosocial Model’. Meyer’s ideas had little impact because of displacement of Psychoanalysis which enjoyed alternating hegemony with biodeterminism in North American Psychiatry. Its emphasis on lack of sufficiency of bioreductionism and upon biographical and social context of a person’s functioning prefigured in systemic position taken by Engel. He propogated the North American version of Biopsychosocial (BPS) model, Anthony Clare in his “Psychiatry in Dissent” created turbulence and it was known as “AntiPsychiatry”. It subsumes intellectual challenge to a Biomedical model and posed many questions with reference to logical status of mental illness, the intelligibility of madness, dehumanisation of institutional care and reframing of mental illness as deviance. Anthony Clare dwelt upon inclusive compromise and presented a Portmanteau model lying between the biomedical model and radical social critiques of Psychiatry.

The mainstream ideology of contemporary psychiatry is the biopsychosocial model. Many, who see psychiatry as too biological, advocate greater loyalty to this model. Compared with the medical model, some perceive the biopsychosocial model as more scientific and others see it as more pragmatic or humanistic. RoyGrinker actually coined the term ‘biopsychosocial’ long before Engel.

Grinker applied it to psychiatry to emphasise the ‘bio’ against psychoanalytic orthodoxy; Engel claimed that the biopsychosocial model was a ‘blueprint for research, a framework for teaching, and a design for action in the real world of health care. It encompasses the following assumptions: 1) Mental disorder emerges within individuals who are part of a whole system. 2) The whole system has physical elements namely a) sub personal (nervous system, networks, organs, molecules and atom. b) suprapersonal (individuals existing in psychosocial contexts). 3) The elements are conceptualised ‘in hierarchy’and General systems theory is axiomatic. Lower levels of organisations are necessary for higher ones to exist but they are not sufficient to describe or explain their nature. With each level of organisation, emergent characteristics appear which are not present at lower levels. This may create tension between holistic and reductionistic knowledge claims both in natural and human science.

The biological component of the biopsychosocial model seeks to understand how the cause of illness stems from the functioning of the individual’s body. The Psychological component looks for potential psychological causes for a health problem such as lack of self control, emotional turmoil and negative thinking. The Social part of its economic status, culture, poverty, technology and religion can influence health. The Biopsychosocial model is based in part on Social cognitive theory. In a philosophical sense, the biopsychosocial model states that the mind can affect the body directly and through intermediate factors.

The Biopsychosocial model does not provide a straightforward, testable model to explain the interactions or causal influences by each components. The model has been a general framework to guide theoretical and empirical explorations. Some critics point out that the distinction and determination of the roles of illness and disease runs against the growing concept of the patient-doctor partnership or patient empowerment as ‘biopsychosocial’ becomes one more disingenuous euphemism for psychosomatic illness. Some believe BPS model as flawed, in either formulation or application. According to Epstein et al.,’ habits of mind may be the missing link between a psychosocial intent and clinical reality. David Pilgrim suggests that necessary pragmatism and a form of ‘mutual tolerance’ has forced a coexistence and not genuine evidence of theoretical integration. It seems to have been pushed into shadows by a return to medicine and the re-ascendency of a biochemical model.

With the basic idea of ‘more is better’, the attempt to add more perspectives to go near highly complex reality may be considered as common sense but not scientific one. Reductionism is not always wrong; peptic ulcer disease, long considered a classic psychosomatic illness, proves to be caused by Helicobacter pylori. In a hallmark of science, the apparently complex proved to be simple. Another conceptual defence sees the biopsychosocial model heuristically, reminding us to pay attention to three aspects of illness. Then the question becomes: How do we choose? How do we prioritise one aspect versus another? Some might propose that evidence-based medicine provides the mechanism of choice, but...
often evidence is limited or absent. The biopsychosocial model, as classically advanced, does not guide us on how to prioritise. Consequently, prioritisation happens on the run, with each person’s own preferences, and the model devolves into mere eclecticism, passing for sophistication.

An empirical defence of ‘the more is better’ philosophy sometimes is made based on the eclectic biopsychosocial intuition that medications and psychotherapy are always, and inherently, more effective than either alone. Empirically, sometimes this is so, sometimes not. Using one method or treatment purely often produces better results or is more valid than using multiple approaches together.

Medical model is the set of procedures in which all doctors are trained. The set includes complaints, history, physical examination, ancillary tests, diagnosis, treatment and prognosis with and without treatment. The medical model is an approach to pathology that aims to find medical treatment for diagnosed symptoms and syndromes and treats the human body as a very complex mechanism. The medical model drives research and theorising about physical or psychological difficulties on a basis of causation and remediation.

DSM designations point towards the equivalents of ‘disease entities’. A disease entity is an abnormality of the brain or body caused by various factors but ultimately involves biological abnormalities. Kraepelin believed his nosology as biologically committed to disease entities and that was restricted to severe psychotic conditions. Neo-Kraepelinian American Psychiatry denies biological commitment in theory but practices as if there were biological commitments to over 300 DSM defined entities, justifying pharmacological treatment.

Pluralism is perhaps Karl Jasper’s most original perspective which has still failed to be adequately accepted and appreciated by Psychiatric profession. It aims at the elucidation of patient’s own inner experiences than at the observation of behaviour. It does not mean definite conclusion and codification but leaves for developments, completing, correcting and changing many aspects of classical and present psychiatric view.

Jaspers sees his task three fold; 1) A purification of science which equates with methodological pluralism. 2) To identify and psychologize worldviews and 3) opening up of prophetic philosophy-a philosophy of transcendence. Jaspers argued that the chaos of phenomena should not be blotted out with some diagnostic label but bring illumination through the way it is systematically ordered and related. According to Jaspers, an ideal schema would have to satisfy the following requirements. It must be such that any given case would have one place within it and every case should have a place.

The whole plan must have a compelling objectivity so that different observers can classify cases in the same way. Jaspers scepticism about nosology, does not end in nihilism. His acceptance of nosology is not merely practical; it is consistent with his entire philosophy that any human activity, including science, is never absolute in its knowledge.

His nosology hinges on the concept of the ideal type which is meant as a standard, or simplified version of reality. Diagnoses cannot be established in Psychiatry completely on the basis of empirical evidence, for the same reason that history cannot be comprehensively understood with facts and figures alone. Interpretations of meanings and motivation are unavoidable. Thus he highlighted the importance of abstraction. Jaspers, who realised that theories rose and fell with their methods, saw two major methods in psychiatry: The objective/ empirical v. the subjective/interpretive. Methodology determined the strengths and weaknesses of theories. Jaspers called for methodological consciousness (one must be aware of the methods and their strengths and limitations). It is not simply that the methodical doing is undertaken deliberately, but that the very doing is a thinking (Jaspers defines surgery as thinking with one’s hands). Dogmatists hold that one method is sufficient, biopsychosocial eclectics that methods should always be combined, Jaspers that (depending on the condition) sometimes one, sometimes another, method is best. Many clinicians conflate the terms pluralistic and eclectic, so perhaps Jaspers’ non-dogmatic, non-eclectic approach should be called method-based psychiatry.

Now we have the following alternative paradigms to Biomedical reductionism and Biopsychosocial model: 1) Method-based psychiatry, as advocated by Karl Jaspers. 2) Medical humanist model, as developed by William Osler.

Osler (modernising Hippocrates) argued that the physician’s role was to treat disease in the body (biomedical reductionism) while attending to the human being, the person, who has the disease. Osler applied the medical model non-reductionistically.

Where disease is present, one treats the body; Where disease is ameliorable but not curable, one still treats with attention to risks; and where no disease exists (some patients have symptoms or signs, but...
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no disease, e.g. cough, rather than pneumonia) one attends to the human being as a person. This approach (which captures the Hippocratic aim: To cure sometimes, to heal often, to console always), has all the strengths and none of the weaknesses of the biopsychosocial model.

Medicine strides the famous dichotomy between science and the humanities: Osler tried to bridge it with medical humanism, Engel through psychologised Scientism. Mental illness is complex; biology is not enough; most of the Paradigms show the direction but not the destination.

An ideal paradigm should focus upon medical humanism and method based. Psychiatry should rise above vague, less generic and less eclectic paradigms.

Though it is madness, There is a method in it.

If there is a method, one should have methodological consciousness.

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