# Chapter 14
# The Discontents of Psychiatry: What Can the History of Psychiatry and Values-Based Medicine Contribute to Resolving Them?


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## Contents



This chapter examines how a better understanding of how our current scientific views regarding psychiatric diagnosis and treatment have evolved may help us understand why many of the criticisms levelled against psychiatry make little sense or apply only in a qualified way. It was written from the point of view of a practising clinician. I will not present new findings from the history of psychiatry here; instead, I will endeavour to argue the potential usefulness of those for the clinician. I will also look at how approaching the history of psychiatry from the perspective of values-based medicine (VBM) could enhance our historical analysis, especially for the purposes of developing a theoretical approach and clinical practice of psychiatry that is more suited to our needs and preferences.

Psychiatry is one of the most often criticised medical specialties, perhaps because it deals with conditions that can be more visible to others through their effect on behaviour and impact on a wide range of things in one's life beyond what is typically affected by nonpsychiatric conditions. Also, psychiatry is concerned with areas of human experience and behaviour in which human values are particularly diverse. Many of the modern criticisms levelled against psychiatry are old problems appearing in new disguises. The division between mental and physical health, the

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idea that psychiatry is unscientific, the arbitrariness of where one draws the line between mental disorder and normality or the necessary criteria for diagnoses, the lack of identified biological causes for most disorders or biological tests to aid diagnosis or that psychiatrists focus too much on the brain and the biological and ignore the psychological and social aspects of mental disorder are hardly new contentions.

We can argue about the level of success with which they operate, but the primary interest of psychiatrists, like in other medical specialties, is to help the patient. As German Berrios puts it at the beginning of his monumental volume on *The History of Mental Symptoms* (Berrios 1996, p. 10), 'clinicians are primarily interested in the capacity of psychopathological descriptions to diagnose disease and predict clinical outcome'.

## How can the History of Psychiatry Help us Better Understand Our Current Theory and Practice?

It is important to note that psychiatry, lying at the intersections of neuroscience, psychology, sociology and social care, philosophy and law, occupies a unique position in that it behaves in some respect as a natural science but in other respects as a so-called inexact science. If one regards the history of an exact or empirical science as a history of ideas or practices that have been proven incorrect or wrong and the history of an inexact science as the science itself, psychiatry will share features of both.

As German Berrios (1996) points out, nineteenth-century alienists understood that 'knowledge of history', by which he means how our conceptual understanding developed, enhances our understanding of psychopathology. This was evidenced by them writing entire books or at least including a chapter in their textbooks on the history of psychiatry.

The history of descriptive psychopathology can help us identify symptoms that have been described consistently in not just one episteme but show consistency over several ones. The distinction between 'form' (the impersonal element with stability) and 'content' was one of the most important contributions of nineteenth-century psychopathology in this regard (Berrios 1996). In order to explain mental symptoms, the clinician will seek a correlation between these and certain entities (e.g. a neurobiological variable) or concepts (e.g. a psychological variable). An important question is to what extent a particular entity or concept is invariant (i.e. has transepistemic continuity) and to what extent this is due to ontological invariance versus social construction. Depending on this, as Berrios explains, one could think of the clinician's job as cataloguing plants in a garden (the traditional medical history approach) or carving out shapes from formless matter like a sculptor (the constructionist approach, exerting more influence in current studies).

I concur with Howells that 'By knowing the past, we are better oriented to judge the present' (Howells 1975, p xviii). Reviewing the neurobiological story of psychiatry offers an opportunity for reflection. Certain themes have been in the focus of

attention throughout, such as the issue of how many different diagnostic categories exist (fluctuating between very few and very many), to what extent mental disorders have an organic (i.e. the brain) origin, whether mental illness should be viewed as a moral problem (e.g. whether patients bring it onto themselves) or even the question of whether mental illness represents degeneracy or progression. As Braslow (1997, p. 274) points out, 'For Berrios, who is a psychiatrist as well as a historian, psychiatric disease is real in the sense that it has a neurobiological substrate. However, its apprehension as a disease is always mediated by the physician's theoretical framework and his or her social and cultural milieu'. This theoretical approach is also reflected by including a clinical and a social section within each chapter in his earlier book coedited with Roy Porter, *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (Berrios and Porter 1995).

The objective of neurobiological research in psychiatry is to identify the biological causes of mental disorder and to develop treatments for it. Although scientific theories linking disordered functioning of the mind to lesions of the brain can be traced back to antiquity, a major strand of criticism of psychiatry has been that research has failed to produce evidence for any biological causes for most mental disorders. The fact that our understanding of the causes of mental disorders has been, for the most part, partial explains why discoveries of neurobiological treatments have often, though not always, happened to a large extent through chance.[1] Because of the level of their complexity, the comprehensive explanation of most mental disorders is likely to include, in addition to neurobiological causes, social, cultural or even economic contributory factors. Most of these tend to change at a timescale only historical research can grasp; therefore, history of psychiatry will be instrumental in understanding them.

As regards the lack of biomarkers, the biological tests relevant to psychiatry are more likely to be found at behavioural rather than molecular or tissue level. There is a relatively long tradition of measurement of mental phenomena at the behavioural level. The idea that psychological experience was measurable can be traced back to Christian Wolff (1679–1754), the German philosopher Johann Friedrich Herbart (1776–1841) who envisaged the 'statistics' of the soul and Wilhelm Wundt (1832–1920) and Emil Kraepelin (1856–1926) who developed techniques to measure psychiatric symptoms, including fatigue and memory impairment (Berrios 1996). In some conditions psychometric measurement can reach sensitivity and specificity on par with biochemical laboratory tests for physical health conditions (e.g. the Addenbrooke's Cognitive Examination in the diagnosis of progressive degenerative dementia (Mioshi et al. 2006; Dudas et al. 2005)). The incorporation of subjective experience into descriptive psychopathology was a major achievement of nineteenth-century psychiatry. This process was helped by changes in psychological theory that made the study of inner experience and the content of consciousness on the basis of introspection possible (Berrios 1996).

[1] Only future scholarship in history of psychiatry can describe the exact impact on this of the current academic and funding structure and the way research ethics works.

Clinicians operate in the given economic, social and cultural context of their era. They are guided by what is considered state of the art at the time and, to the extent they are aware of it, the knowledge and skills that the profession has accrued over its history. These contextual elements influence their pre-existing knowledge, attitudes, interests, needs and preferences and have an impact on what they think constitutes a symptom or appropriate treatment for it. The thought that throughout the ages thinking about insanity reflected social and political values was present in historical thinking as early as the nineteenth century (Gine y Partagas 1876). Tracing the influences of great thinkers in different disciplines on each other is common practice, but research comparing the psychiatric curriculum during a particular time period in undergraduate and specialty training and contemporaneous curricula in the natural sciences and the arts and humanities can also provide valuable insight.

Various strands of psychiatry have held more sway at various points in the history of psychiatry. For example, after the burst of neurobiological research towards the second half of the nineteenth century, the first half of the twentieth century saw the rise of the behaviourist approach which viewed pathology as socially maladaptive or deficient behaviour. Psychoanalysis also exerted a very powerful influence around the same time. In recent decades, cognitive science and medical neuroscience have become more dominant. The risk is, of course, that in a specialty where multiple viewpoints are not just legitimately present but necessary to develop a full understanding, one persuasion holding all the dominant positions of academic and clinical power, filling all textbooks, receiving all the honours and distinctions and last but not least controlling all the funding can be a serious obstacle to progress. Historical research can contribute in (at least) two important ways here. First, it can provide vital insight into how psychiatric conditions arose in certain epistemological orientations. Second, it can show how dominant schools of thought and their infrastructure developed and influenced the way society looked after the mentally ill.

Working with historians of cognate fields can enhance our chances of success here. There have been some examples of genuine multidisciplinary working, although not with a focus on historical studies. Yale University's Institute of Human Relations was started up around 1930 and operated until the early 1960s. Its objective was to encourage collaboration between psychologists, psychiatrists, sociologists and anthropologists. A similarly multidisciplinary institution in the United Kingdom, the Tavistock Clinic, was set up during the same era.

Some patterns seem to repeat themselves throughout history, for example, fluctuating between holistic and dualistic approaches as regards the relationship between body and mind (i.e. somatic and psychic illness and medicine). For the most part, we do not have enough detailed records to do an analysis on how each of these approaches worked for various forms of psychiatric illness in various circumstances (e.g. data on the prevailing cultural, economic, geographical, political and ecological factors). Methodological insight from history of psychiatry could be instrumental in designing and documenting current-day treatment trials and other research (e.g. epidemiological or phenomenological studies) in order to make the data more usable for future historical studies. A relevant area to benefit from the usefulness of

such an approach could be the appearance of anorexia nervosa in Hong Kong and other societies going through Westernisation.

In conclusion, having an understanding of how psychiatric concepts and treatments were developed in their historical context will help us to recognise their value in different circumstances. In other words, it will help us to understand why certain treatments were effective and what factors contributed to this at different times and in different situations. In turn, this should give us some tools to enable us to design better or more useful treatments and services in the future.

## Towards a Model of Values-Based Psychiatry

As noted earlier, psychiatry is concerned with areas of human experience and behaviour in which values are particularly diverse. If values are so different, is there any framework that could help us handle this value diversity? Values-based medicine is a parallel approach to evidence-based medicine, whereas in the latter the emphasis is on producing objective evidence about the efficacy and safety of diagnostic and treatment interventions by removing subjectivity, values-based medicine focuses specifically on the subjective value of these for the patient.[2] One would be right to observe that there is nothing fundamentally new in doing so, as medicine has always aimed to combine the technological aspects of medical science with the art of tending to the ailing person with his or her preferences. What makes VBM original, and a powerful tool, is combining the abstract logical orientation of analytic ethics (i.e. the meaning and implications of value terms) with the empirical aspects of psychiatry (Fulford 2011).

Whilst both the history of descriptive psychopathology and VBM pay careful attention to the language of description of psychiatric symptoms, the former is primarily interested in the trans-epistemic continuity of symptoms, and the latter is concerned principally with the value of terms inherent in symptom descriptions and diagnostic criteria. Values-based medicine posits that although certain aspects of being ill may not have changed for millennia, the rapid growth of scientific knowledge and the changing way we live often create new challenges in everyday clinical decision-making. The focus is not on necessarily finding the one 'right' solution, but instead, it suggests 10 principles (Table 14.1, adapted from Fulford 2007) that can guide us as to how to have a good 'process' (Fulford 2007). Values-based medicine entertains, where necessary, dissensus as an outcome. This is where it can go further than conventional bioethics. In dissensual decision-making, different values remain in play. They are balanced sometimes one way and sometimes in others,

[2] A lesson from history epitomising the inappropriateness of excluding the subjective or introspective in order to be 'scientific' in psychiatry is behaviourism which, although reaching a high degree of sophistication at its peak, failed to provide a plausible explanation of mental illness or to produce treatments for more than a few forms of it (e.g. systematic desensitisation for some phobias).

**Table 14.1** The ten principles of VBM

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| **Theory principles** | | |
| 1 | The 'two-feet' principle | Clinical decisions stand on two feet: values and facts |
| 2 | The 'squeaky wheel' principle' | We tend to notice values when they are diverse or conflicting and likely to be problematic |
| 3 | The 'science-driven' principle | Scientific progress opens up more choices and increasingly brings the full diversity of human values into play in healthcare |
| 4 | The 'patient-perspective' principle | The first call for information is the perspective of the patient or patient group |
| 5 | The 'multi-perspective' principle | Conflicts of values are resolved primarily, not by reference to rule prescribing a 'right' outcome, but by processes designed to support balancing legitimately different perspectives |
| **Practice principles** | | |
| 6 | The 'values blindness' principle | Raising awareness of values through careful attention to language |
| 7 | The 'values myopia' principle | There is a variety of empirical and philosophical methods to improve our knowledge of other people's values |
| 8 | The 'space of values' principle | Ethical reasoning is used to explore differences of values rather than to determine what is 'right' |
| 9 | The 'how it's done' principle | Communication skills have a substantive as opposed to merely executive role in clinical decision-making |
| 10 | The 'who decides?' principle | VBM, although involving a partnership with ethicists and lawyers, puts the decision-making back where it belongs, i.e. with users and providers at the clinical coalface |

depending on the circumstances of the case (Fulford 2014). A somewhat related idea in Berrios (1996) is the need for periodic 'recalibration' of the language of psychiatry due to changes in biology (e.g. caused by genetic mutation), psychology (e.g. new models of behaviour) or sociology (e.g. redefinition of abnormal behaviour). A behaviour that was a symptom in a certain society at a certain time point, for example, may not remain a symptom in a different social context. This recalibration is based on conceptual-historical analyses and data from clinical observation (Berrios and Porter 1995).

It is reasonable to assume that many of the criticisms of psychiatry have been the result of the perception that certain values of people were not acknowledged or taken into consideration. Studying the extent to which the application of the principles explicated in VBM can be traced back into past eras in psychiatry may help us understand the origin of some current discontents. Values-based medicine describes four core skills: *raised awareness of the diversity of values* involved in psychiatric diagnosis and treatment decisions, *ethical reasoning* with an emphasis on opening up different perspectives rather than closing down on prescribed 'solutions', knowing how to find and use *knowledge of values* and *communication skills* for eliciting values and conflict resolution. The contribution of history of psychiatry to resolving psychiatry's current discontents could be through further elucidating

how psychiatric practice developed and was accepted by society in earlier eras. What were its underlying explicit and implied values at the time? A considerable amount of historical research has been done on certain value-laden issues, such as coercion, detention and the setting up and demolishment of the asylum system, perhaps less on the value spaces of various symptoms, diagnoses and treatments – something lying very much at the heart of current discontents with psychiatry. The existing body of scholarship on the moral content of mental illness could be further enhanced by improving our understanding of the ethical reasoning behind earlier practices. History of psychiatry could also provide us with some knowledge about how psychiatric diagnosis or treatment was discussed with patients and relatives and in public discourse in the context of prevailing thinking, practices and values of the time.

On a related note, there seems to be a gap between public understanding and actual current practice of psychiatry. Public understanding seems to reflect earlier practice or, sometimes, simply an inaccurate image. History of psychiatry research could elucidate how this gap changed over time and what the factors involved were. For example, historical research reveals that views as to whether mental illness is permanent once it has developed have changed over time (Berrios 1996), and one can speculate to what extent the deinstitutionalisation of mental patients that has led to the current predominance of community-based treatment has contributed to increased expectations of the public that mental illness would be(come) less severe and that a fatal outcome (e.g. suicide) should always be preventable.

As a fundamental aspect of how psychiatry is practised, VBM actively embraces multidisciplinarity not only for the professional skill sets but also for the multiple value perspectives other professionals can bring. It is important to note that during much of its history, psychiatry was an interdisciplinary enterprise; its practitioners and theoreticians often came from other fields or were practising polymaths themselves. Wilhelm Maximilian Wundt, who is often credited with the establishment of experimental psychology, wrote on medical physics and also, extensively, on philosophy. Sigmund Freud (1856–1939) trained as a medical doctor and specialised in nervous disorders but also was a polyglot, well-versed in literature and mythology. In a similar vein, breakthroughs in psychiatry were often made possible by developments in other fields (e.g. refined histopathology in the second half of the nineteenth century through developments in histological staining and lighting techniques in light microscopy or improved diagnostic differentiation in recent decades owing to the development of brain imaging techniques).

Is there a risk of ‘opinions over facts’ with values-based medicine? There should not be, because it places equal emphasis on the importance of both facts and values. It entertains the idea of legitimately different views and promotes mutual respect. Patient-centred care means focusing primarily on the patient’s values, but other values (including those of the treatment team) are also taken into consideration; it does not put either the patient or the clinician into a god-like position. In a specialty where subjectivity plays such an important role, VBM-informed history of psychiatry research can teach us important lessons on how to avoid some future pitfalls.

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