Chapter 5
Psychiatric Nosology, Its Philosophy and Science

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1 Introduction

Psychiatric nosology is currently under intense international scrutiny, both by the public and the professionals. Everybody is a stakeholder and everyone is speaking out, because it is a matter of their personal lives, more particularly of their private mental life. Everybody is also a stakeholder, because everybody has a mind and potentially everyone is a psychiatric patient. The right to liberty, right to expression and right to life empower them to assert their views. It is being questioned as to whether the recently published DSM-5 is a nosology of disorders, or just a list of labels of doubtful validity. Against this backdrop, the status of the psychiatric nosology needs to be examined dispassionately and objectively. Its limits, its strengths and weaknesses should be acknowledged explicitly to obviate undue criticism. A more fundamental analysis of the possible sources of this perpetual ambiguity in terms of the validity and applicability of the principles employed in formation of such nosologies is a matter of urgent concern.

Nosology has been defined as a branch of medicine that deals with classification of diseases.[1] Disease again is a medical concept, which signifies departure from health or the converse of health (Pearce 2011). As the concept of a particular disease evolves to 'mature' form, its symptoms get reliably defined and described.

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[1] Nosology—Wikipedia, the free encyclopaedia

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This is followed by delineation of its pathogenesis in terms of disruption of structure and function and, still later, its aetiology is determined. One of the first indicators of departure from health, at least to the primitive man, must have been the pain and suffering associated with the activities of daily life.

Sufferings of purely mental nature must also be equally old, because it is the mental dimension that truly defines the essence and uniqueness of man. Recorded medical history does bear testimony to this. Man is primarily and pre-eminently a mental organism. Evolution has allowed a massive quantum jump in his mental faculties. It is a paradox though that despite this massive enhancement of his cognitive abilities, he still appears condemned to remain a mystery unto himself. Actually, he is existentially structured to be so. This is so because mental dimension of man is not accessible to objective observation and analysis in the same way as his physical dimension is. It is not surprising, therefore, that the human race had to wait for several millennia, till the arrival of the 'information age', for such massive attention to get focused on the sufferings involving his mental dimension. Yet it appears to be just a prelude to the beginning. This is testified by the sudden emergence of many fierce and some pessimistic reactions to the just published DSM-5, with some calling it 'a snap-shot of a field in flux,' (Jabr 2012) while the National Institute of Mental Health (NIMH), USA, calling it at best a dictionary.[2]

2 The Dilemmas

Psychiatric nosology is to psychiatry what the soul is to individual human beings. Like the soul, nosology also continues to remain at the existential centre of psychiatry, but all the same continue to remain elusive and indefinable. The most fundamental issue surrounding psychiatric nosology is the issue of validity of its diagnostic categories.

Even though reliability has certainly improved tremendously through intensive international efforts, no progress has been made in the area of establishing validity. The search for validity is important, because that alone will separate real entities from pseudo-entities. Only real entities will be definite, definable and stable. Only real entities will permit predictability and be amenable to control. In fact, the validity issue has become further murky in modern times, because of the accumulation of an enormous amount of data from population and general hospital-based observations and studies. There is near universal applicability of 'spectrum phenomena' to almost all categories, a very high occurrence of co-existing or co-morbid diagnoses, and increasing necessity for use of not otherwise specified or not elsewhere classified categories (NOS/NEC) (Goldgerg 2010). Uncertainty about validity gets further highlighted by the frequent observation of diagnostic instability over time at the individual level, as well as by substantial changes made in the nature of categories and criteria, even by the international bodies in the subsequent editions of their classificatory systems. 'Zone of rarity' as a paradigm of separating different entities and defining their boundaries has not been supported by the observational data. The above mentioned observations are possibly because of

[2] NIMH Blog, http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml

extremely large number of factors operating simultaneously leading to enormous variability at the level of mental or behavioural phenomena. Very large number of factors lead to generation of innumerable, mostly unique 'disposition-profiles' of both normal and abnormal states, which defy classification as categories. Since it is not repetitive, it will not form a class and thereby would not permit classification. This raises a more fundamental question.

How valid and applicable is the notion that validity of psychiatric conditions can be established on the same parameters as that for other medical conditions? This notion is intrinsically flawed.

The intrinsic flaw is that we overlook the boundary between the physical and the mental when it comes to the issue of examining the validity of disorders in these two domains. We treat them both with the same yardstick. It would be a matter of common sense to presume that medical disorders would have features of physical domain, whereas psychiatric disorders would have features of mental domain. Physical and mental domains are qualitatively different. The physical domain is constituted of matter, whereas the constituents of mental domain are unknown. Properties of matter would apply to physical domain, but would not apply to mental domain. Therefore, the concept of validity as applicable to material domain would not be the same as that applicable to mental domain.

Inherent in the search for validity is the premise that the real has to be separated from the artefacts. The real is the one that exists 'on its own' in nature, whereas artefacts would be the subjective creations of human mind. It is something like the relationship between the waking experience and the dream experience. The physical or the material domain exists purely in the objective realm, whereas the mental domain exists exclusively in the subjective realm. It is not accessible to 'objective' observation. We cannot observe somebody else's mind in the same way as we can observe his body and its different parts. As regards the mind, only subjective individual introspection is possible. Its existence beyond the immediate conscious experience remains unknown.

But, introspection is not considered a valid scientific method of observation, because it cannot be consensually validated through its agencies of observation. All the same, the validity of introspective truths cannot be denied; we have to focus our creative energies to devise paradigms for convergence of introspective and observational truths. Till the time we are able to do that, we have to make do with limited 'validity' for the psychiatric entities, commensurate with the primary dimension to which it refers to, that is the mind. In fact, international efforts should focus more on unravelling and establishing the nature of mind rather than its neurophysiologic correlates.

Modern age is dominated by doctrines of science. Science is dominating, because it has empowered people in their struggle against nature and has also transformed their lives. Science is a product of the human mind, but, unfortunately scientific methods are not applicable to the study of mental phenomena. Even most advanced neurophysiologic studies should not be equated with the study of mental phenomenon per se. At best, it can be a specific or a non-specific substrate for the other. The two cannot be considered interchangeably. Forcing a universal 'brain' explanation for all mental phenomena is like forcing a square into a circle. This is one of the reasons why such limited progress has been made in this area of brain–behaviour relationships, despite so much investment of resources of time, talent and treasure. Since psychiatry is a relatively

recent offshoot of modern scientific medicine, it is still nurturing fond and nascent hopes, and aspirations of being similar to its brethren from the world of physical medicine. This natural-looking, seemingly acceptable goal appears completely oblivious of the fact that the physical and mental dimensions of man are completely and qualitatively different from each other. Even though they are seamlessly one and mutually interdependent, they are not on the same plane. They complement and supplement each other into emergence of a 'supra-ordinary' being, with some limited autonomy to impose certain rules of its own on itself and the milieu.

3 The Differences

Some of the qualitative differences between the physical and mental domain has already been mentioned above. Further, it appears that even the concept of aetiology may not be uniformly applicable to both the mental and physical dimensions. Mental events and its manifestations are quite often dictated and guided by the goals or the end points to be achieved, which becomes obvious when we analyse our speech and behaviour. All our speech and behaviour is always guided by a goal. On the other hand, physical events are guided and dictated by the antecedent or the initiating influence. One is guided by the past, whereas the other seemingly is guided by the future as set from beforehand. This is a mystery as well as a paradox that both kinds of operating paradigms should not only co-exist within the same organism, but also should work seamlessly in consonance with each other. In fact, this should be considered as one of the most important attainments of the evolutionary process. Evolution is not simply about movement from amoeba to homo sapiens; it is as well a movement from antecedent driven causality to consequence driven causality, from 'command' driven causality to 'demand' or 'goal' driven causality. It is a very fundamental difference; therefore, different yardsticks become obligatory to be used for these two domains. In fact, it may be conceptualised that emergence of consciousness was necessitated to provide a transcendent plane where goals and directions could be preset for emergent behaviours to be expressed by organism. This would also make the behaviour of the organism predictable, and thus, setting the stage for collective living to form societies, civilizations and cultures.

There are a few other ways in which aetiology for psychiatric disorders would be different from aetiology for physical disorders. Because of a higher order multi-factoriality of psychiatric disorders, the possibility that several factors may be equally contributing to the causation of disordered states is very high as against solitary factors, which are often sufficient to cause specific disorders on the physical plane. In this context, it will be more prudent to talk of 'aetiology-spectrum' for psychiatric disorders as against mostly single aetiological factor for physical disorders. This appears to be an interesting combination of 'spectrum clinical phenomena' linked to 'aetiology-spectrum' of causes. Another very important difference is that mental plane is in dynamic equilibrium with not only itself, but also with social, spiritual as well as physical planes. Therefore, a causal influence may be located in any of these planes. Accordingly, causation of mental phenomena would be 'trans-dimensional,'

as against predominantly 'iso-dimensional' causation for physical phenomena, where cause and effect take place on the same plane, that is the material plane.

Another unique feature about mental phenomena is that they operate at different levels of consciousness, which is the primary quality of this domain. Events and influences get stratified into conscious, subconscious and unconscious compartments, which keep interacting. There is no such arrangement in the physical dimension. There is nothing like the sub-material plane. On the top of all these differences, there is the confounding variable of 'autonomy' available on the mental plane. Autonomy implies personal control over self, of whatever limited magnitude it may be. In instances of disorder, the surface manifestation of the disorder at the mental plane may get modified by the exercise of this faculty of autonomy, which may be used either to react or adapt or compensate. So the final picture of psychopathology that emerges in any particular instance would be the net result of the sum total of all the commands and demands of all the dimensions as modified by the autonomy-based responses of the individual. This would be very different from the generally linear iso-dimensional cause and effect relationship seen on the dimension of physical plane. The identity of a disorder on the physical plane is at the aetiology level, whereas the identity of a disorder at the mental plane should ideally and desirably be at the manifest level, that is the consequence or the product level. The aetiology in such situations are generally multiple, diverse and scattered along different co-variate dimensions.

4 The Difficulties

There is absolute lack of clarity about the nature of the mind. There is further lack of clarity about the nature of relationship between the mind and the body. In the absence of any reasonable answer or even hypothesis about these two questions, we, the mental health professionals, are in complete darkness. However, most of us seem blissfully unaware of it. We keep exploring and experimenting about mental disorders as if we are under full noon sun. The often discussed neural-circuitry or a chemical imbalance can be a substrate for a particular emotion or an idea, but it cannot be a substitute for them. A neural-circuitry or a neurotransmitter is not the same as any emotional or cognitive experience. Any mental phenomenon can best be described only in terms of mental attributes and not in terms of neurophysiology or neurochemistry. It is absolutely improbable that there ever shall be a neurophysiologic dictionary of different mental states. While it is commendable that we should direct research efforts to discover the physiological substrates for different mental states in health and disease, we should also keep ourselves cognisant of its severe limitations. We have several examples today wherein the same drug molecule is equally effective against widely diverse type of symptomatology. The classic drug haloperidol is effective not only against thought disorders, but also against motor and mood symptoms of great diversity.

Another difficulty relates to the cut-off line that requires to be drawn between normal and abnormal, between order and disorder. For physical, bio-medical sciences it is much simpler. A cut-off value, inclusive of a range, is determined on the basis of population-based sample studies. But the value remains stable and

static. The same does not hold true for mental dimension. Here, the cut-off line has to be dynamic and different not only for different individuals, but also sometimes within the same individual. The cut-off line, most often, cannot be defined in absolute terms. It can be meaningfully defined only in terms that are relative to the concerned individual. Every individual provides his own measure of comparison in terms of the baseline of his functional state. Now, this baseline is not a static entity. It is a dynamic entity and changes with the changing socio-economic and cultural context of the individual (Rosenberg 2006). Human capacity to adapt and change is tremendous and this would lead to changing parameters of judgment for states of disorder, because with every adaptation the baseline changes. A simple example from the physical world will make the statement more explicit. Human capacity to see visually ranges from pitch darkness to extremely bright sunlight, which would represent a difference of several thousand times in terms of brightness, requiring very specialised modes of adaptation for the visual apparatus. Similar adaptation, multiplied manifold, is also seen at the level of mental plane.

5 The Realities

The reality is that we have a huge burden of mental sufferings and dysfunctions at the population level. The pattern of suffering also exhibits bewilderingly diverse variety of presentations. Mental 'pain' quite often is more excruciating than any kind of physical pain. One mentally sick person in the family has a distressing and disruptive impact on the whole family. Therefore, there is an urgent and immediate need for reducing the nosologic complexity to make it comprehensible and manageable by average human cognitive abilities. We need to simplify our system of classification to be able to deliver the services to alleviate sufferings of people. Individual life and its sufferings cannot wait till the issue of validity is resolved. What we need to pragmatically do is to modify our expectations from the massive international efforts being put in preparation of psychiatric nosologies. There appears to be some merit in the comment that it is just a dictionary, but the reality is that compilation of a dictionary of this nature and magnitude is definitely a step forward, and therefore an achievement. All the same, there is general international consensus that our categories do not have established validity. It is also true that we have not been able to comprehensively and effectively define psychiatric disorders and also that our disorders do not meet the set medical criteria of disease.

Till the time we are able to address the above mentioned issues adequately, we should stop calling our compendium of sufferings as a nosology, but continue at the same time to evolve strategies to remedy the mental maladies. We should try not to match our discipline with the profile of physical sciences. Many distortions which creep into psychiatric nosology are because of our anxiety and compulsion to match with the 'hard sciences'. Methods of science are aptly applicable only for the material sciences. As mental health professionals, we should accept this difference and evolve a different set of concepts and principles to

deal with the immaterial phenomenon of inaccessible mind and its expressions through body which are amenable to observation. In that sense, it is half science and half beyond-science. We should acknowledge our ignorance about this 'beyond-science' component, and let it be reflected in our system of classifications internationally. All knowledge does not and need not fall within the jurisdiction of science alone. We should not feel compelled to be called a science to acquire validity. Validity will originate from valid and stable human experiences of qualitatively different nature. Knowledge of those dimensions which are beyond the realm of sensory observation can only be gained through internal revelations, which were the method and practice of our ancient sages.

Even in the field of material sciences, there has been a trend to move towards paraphysics, (Shamasundar 2008) to explain some of the unpredictable behaviours of subatomic particles by invoking an element of consciousness. On the other hand, we, the trustees of consciousness, tend to look backwards and try to wear the mask of definitive material sciences to assume validity and acquire respectability. This is an unrealistic aspiration and endeavour and, therefore, is likely to fail. In the final analysis, even the most valid truth shall remain a relative truth, relative to the existential human predicament. None of our truths can be truer than the truth quotient that can be assigned to our existence in this cosmos. Therefore, we should accept the 'surface' manifestations of disordered psychiatric states as valid and true. Nothing that may be discovered in the name of putative aetiology of the disorder can be truer than the surface psychopathology. At best, it can be equally true. If someone were to ask for the validity of my perception of an object and its colour, it cannot come from any source other than me. No one else can validate my perception. The only ways available at present for such validation is the demonstration of stability over time and collective concordance of experience.

6 Indian Contributions

India has generally been at the forefront of discourses relating to mind, intellect and soul. It may be considered one of the world leaders. However, its contribution to the field of psychiatric nosology in the recent past has been very limited. This may be a reflection of very small size of psychiatric professionals in our country. Apart from some bold proposals and suggestions from Wig (1967), Varma (1971), Teja (1971), Singh (1980) and Rao (1971) in the initial part of last half-century, no significant effort to comprehensively address this fundamental issue has been made. One notable contribution has been the description of a culture-specific syndrome, the 'Dhat Syndrome' by Dr. N.N. Wig and its subsequent international acceptance (WHO 1992). These attempts have been beautifully reviewed by Khandelwal (2000) and Jacob (2010).

In the latter part of last half of the century, some robust contributions have been made by Indian psychiatrists to classification of mental disorders, but it has been restricted to acute and transient psychosis, possession states and post-traumatic

stress disorder.[3] Malhotra (2007) has extensively contributed to and reviewed the area of acute and transient psychosis, and Dalal (2009) has examined in depth the challenges facing psychiatric classification. The contributions made by earlier indigenous system of medicine, which is known by the abbreviation AYUSH, have been comprehensively reviewed and documented by Murthy (2001). AYUSH includes all those systems of medicine, which either originated in India or flourished significantly on the Indian soil. It also includes yoga because yogic practices are intimately linked to maintenance and restoration of health. Ayurveda, Unani, Siddha and Homoeopathy systems have their own vocabulary and nomenclature for the mental afflictions, but none of them have gone beyond the surface to make any great revelations. In that sense, psychiatric nosology has not made any progress till date, because the present so-called modern psychiatric nosologies are also stuck at the same level. There has been no further evolution.

Avasthi (2011) has made a strong case for the need for Indianizing psychiatry and not globalising it. This is based on the uniqueness of the Indian psyche, Indian culture and value system, Indian family and social support system, spiritual orientation of Indian masses and to some extent ethno-genetic differences. Despite these differences, he acknowledges that evidence for substantive India-specific syndromes or symptom complexes is yet to come. There was no evidence for this in the International Pilot Study of Schizophrenia (IPSS); however, it may be seen in other categories which have not been studied so far. Part of the reason for this may be the fact that all the tools for study used by us have been validated in the West.

7 Conclusions

Human mind, if at all it exists, is very different from human body. They are qualitatively different even though they function seamlessly as an integrated whole. In case it does not exist, still it is a vital, crucial and practical construct of the indomitable and dominant dimension of man, which does seem to operate independently as well as in conjunction with the body. Deviations and disruptions within this dimension can best be described and understood only in terms of the language of the variables of mind. If we truly want to make progress in the area of psychiatric disorders, we must address some of the most fundamental issues on a priority basis relating to mind. It is most paradoxical as well as surprising that we do not know what mind is, but continue to discuss mental disorders. The simplest corollary of this is that if we don't know what mind is, we cannot know what mental disorders are. Another corollary would be that we can know only as much about mental disorders as much we know about the mind. Under the circumstances, the

[3] Report of the Indian Psychiatric Society's Task Force on the Diagnostic and Statistical Manual-5 (2012).

most scientific and rational approach would be that if we do not understand what mental disorders are, we should acknowledge it and not force them to fit into the scheme of physical disorders. Once we are able to develop a scheme for mental disorders, it should have the provision for accommodating the uniqueness of man as well as uniqueness of his suffering.

A combination of categorical and dimensional approach appears to be the most viable alternative. The categorical approach will take care of the similarities at the more basic level, whereas the dimensional approach will take care of the differences at the higher individual level. This will take care of both the basic and unique aspects of individual's suffering. However, since almost none of our diagnostic categories meet the criteria of a medical disease, it will be a misrepresentation at the moment, if we present them as nosology to the public, because it gives an impression of knowledge, wherein we are actually ignorant. If we agree to replace the word nosology with a word that would mean being a precursor to the nosology, that would take care of the matter, and silence many of the current criticisms. That will also be a bold and de facto statement of the present predicament. Psychiatric nosology of today can at best be an album of the spectrum of psychiatric conditions, which require professional attention and intervention.

Therefore, we should urgently coordinate to focus international attention on unravelling the nature of mind and its relationship with somatic, social and spiritual dimensions of man. Let us first try to understand what the mind is. We will automatically understand better what mental disorders are.

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