Viewpoint

TO PRACTISE PSYCHIATRY, WE BADLY NEED A THEORY

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For us Psychiatrists, Biological vs. Dynamic is not an issue to be settled by debate. It is just one more dichotomy that we face in our day-to-day practice, like many others such as Body vs. Mind, Physical vs. Mental and Neurology vs. Psychiatry. What we are required to do is to bridge each of these dichotomies that fragment our thinking.

Kandel had famously said that "what we conceive as our mind is an expression of the functioning of our brain".[1] But, as Raiser rightly pointed out, "even though the brain is the organ that subserves the functions of the mind, brain and mind are not the same thing. Brain science does not yet, and probably never will, fully explain the mind or make mental functions fully understandable."[2]

While old-timers used to be conscious of this and probably many more deficiencies, the popular view today is that everything is honky-dory in the practice of psychiatry! This attitude has gained momentum from 1990, when the "decade of the brain" commenced. Today, a paradigm shift has really taken place in the attitude of practitioners. For many, the very understanding of a psychiatric illness is based entirely on a medical model. They follow a natural science explanatory model, which is what everyone follows in mainstream medicine!

The main reason for this attitudinal change is the fabulous advances in Biological Psychiatry — Research findings, especially in Molecular Biology, Genetics and Imaging are really spectacular. Currently, we have two ongoing mega-research projects: the "Connectome" project of United States and the "Brain Project", a joint venture by European countries. The fond belief of many is that, once these are completed, a neuroscience-based "scientific theory" will be available for Psychiatry. Every malady that we come across would be explained on the basis of its underlying brain dysfunction!

One reason for this inflated optimism is the success achieved in the "genome project". But, one has to be conscious of the fact that despite insights from that great venture, our understanding of many a clinical conundrum in psychiatry continues to be poor. Our problem is, most people seem to forget the fact that human brain is the most complex mass of matter in the entire universe. With its hundred billion neurons, each with around ten thousand synapses, getting a clear understanding of brain connectivity is bound to be an extremely difficult task.

Also, in the functioning of the human brain, besides neuronal connectivity, many more ways for signal transfer are likely to be there. This means that an understanding of brain function in its totality is likely to be an even more distant dream. So, let us accept in grace that, despite ongoing efforts by many clever investigators, an understanding of brain functioning in its totality is not something in the realm of "possibility" at least in a foreseeable future.

Another factor that has influenced the thinking of psychiatrists in a big way is DSM-III and its successor Manuals.[3,4,5] These Manuals quietly persuade practising psychiatrists to be

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"atheoretical" or "theory neutral".[6] Practitioners are required to make diagnoses based entirely on manifest clinical findings, without bothering to find out the underlying dynamic factors.

So, we have two confounding factors that make contemporary psychiatric practice what it is: an inflated expectation everybody has about neuroscience research findings, and a more than optimal 'faith' in atheoretical classification Manuals. If things are to change for the better, we must be willing to have a more balanced view of our clinical realities.

And for this to happen, we badly need a theory to guide us. After all, the hunger for a theory is a core feature of human nature. Philosophers starting from Marcus Aurelius[7] and Friedrich Nietzsche[8] as well as scientists like William James[9] and Albert Einstein[10] have all emphasized the universal need of all human beings to have a theory.

Even our primitive forefathers used to crave for a theory! When strange phenomena like thunder and lightning mystified and frightened them, they used to instinctively improvise a "theory". For example, their theory would have 'informed' them that nature's fury is because "gods are angry for some reason"! Further, the same theory would offer them a remedy to alleviate their fear and tension: invoke and beg for the mercy of the Almighty!

As professionals who deal with extremely anxiety-evoking human predicaments in their patients, psychiatrists need a theory much more than most other medical practitioners. Actually, a theory would improve a clinician's understanding of a sick person in a true sense. And for this reason, it has been said that "ultimately, the current absence of theory will stultify psychiatry rather than protect it".[11]

It was Kurt Levin, the famous German-American Psychologist, who stated quite elegantly that "nothing is as practical as a good theory".[12] Robert Wallerstein, a former president of International Psychoanalytical Association, had said that "at a very personal level, each one of us needs a theory to be at ease with oneself".[13] Otto Kernberg, a contemporary American psychoanalyst, had stated that "all observations of clinical phenomena depend upon theories. When we think that we are not following a theory, it only means we have a theory of which we are not aware".[14]

Glen Gabbard, that outstanding leader of American Psychiatry of recent past, stated: "To understand the cause and be clear about the meaning of all closely guarded thoughts, feelings, fears, fantasies, dreams, jealousies, ambitions, insults, pains and humiliations of patients, a theory is needed".[15] So, in all humility, let us accept the fact that to navigate with empathy in that turbulent sea of a patient's psyche, each one of us needs a theory. Without a theory, the danger is that the human being in us, quite unknowingly, would force us to take defensive stands and distance ourselves from our patients!

In this background, it is not a good idea for a classification Manual to tell psychiatrists that they must be "atheoretical". Learned authors of such Manuals ought to have been aware that, human nature being what it is, banishment of theory from the thinking of clinicians would be just impossible.

A serious problem for many practitioners is that, even while they agree about its need, their strong belief is that for a theory to be "scientific", it has to be "structural" or based on some "brain functions" as revealed by modern "neuroscience" research! And when such an "all-explaining" theory from neuroscience research is not available, quite unconsciously they fill up the gaps in their understanding by stretching their imagination. They would invent some concepts which may be partially useful in meeting some of their personal needs, but do not have the required qualities of a good theory! This certainly is not an acceptable situation when one considers the huge price patients pay for it by way of poor treatment response.

An all-explaining scientific theory about human existence is unlikely to be available for use in psychiatry at least in the near future. As such, the question we must address is whether we are required to wait for the arrival of such a research-data based

theory? Or, is it not right for us to go for a theory which may not be "scientific" and based on data produced by neuroscience research?

Here, we have to be conscious of the fact that two kinds of theories are possible: "scientific" and "hermeneutic". Epistemologists starting from Immanuel Kant as well as great modern-day thinkers like Popper,[16] Kuhn[17] etc. have all emphasised that, for the advancement of knowledge, there is a need to follow "hermeneutic" theories much before any "scientific" theory is available.

Even in hard sciences, a hermeneutic theory would be made use of. A classic example is "bosons" or "God particles", which is a hermeneutic concept we have had in Physics, much before the laboratory-study-based evidence for the same became available.

So, when we look for a theory to improve the understanding of our patients' predicaments, it does not matter whether it is "hermeneutic" or "scientific". What we must look for is whether it is a good theory. And we can make-out whether a theory is good, by looking for the following qualities:

a. It must aid our understanding of the subject being studied.
b. It must stimulate helpful questions.
c. It must open possibilities for observing the phenomenon from new paradigms, or conducting experiments that would further improve our understanding.[18]

The wisdom of Sigmund Freud is that, he realized that a theory is needed to explain every aspect of human nature, even though enough "scientific data" is not available yet. And he had no hesitation to formulate his theory of "Psychoanalysis", making use of "hermeneutics" to a considerable extent.

Today, a section of clinicians does not value the usefulness of dynamic theories. This is probably because of their inability to critically analyse their own professional work and realize the fact that without a dynamic theory to empower them, their management of many patients would not be good enough. They hardly realize the fact that in conditions like psychoneurosis, deviant sexual behaviour, personality disorders, psychosomatic conditions and also many relationship problems, their biology-based management approach seldom yields satisfactory results.

Psychiatrists with sensitivity are required to value subjective experiences of their patients. Only by learning about the manner in which unconscious forces work and how psychic determinism produces very unique predicaments in every human being, would one appreciate the importance of dynamic theories. The concept that "past is prologue" to all sorts of strange states in patients needs to get integrated into the thinking of all psychiatrists.
In the nineteen-sixties, trainees like this scribe had no difficulty in accepting such concepts which are part of "hermeneutic theories" by Freud and others. Maybe, one reason was that, findings from biological research on mental disorders were rudimentary in those days. But, more than that, it was because dynamic theories helped us to understand all sorts of strange phenomena that manifested in our patients, in a better way.

In contemporary practice also, only by having a psychodynamic theory, which has immense explanatory power, a practitioner can understand every kind of predicaments of their patients. Without a theory, the danger is that we would be forced to take defensive stands and distance ourselves from patients. It has been stated that, "for a practical understanding of the human being, sometimes it is the language of psychology, and sometimes it is the language of physiology and biochemistry that is more apposite".[19]

Commenting on the unnecessary polarization between biological and psychodynamic approaches within psychiatry, Glen Gabbard stated that medications were part of the dynamic psychiatrists' therapeutic armamentarium and that a sophisticated knowledge of transference, countertransference and resistance was extraordinarily helpful in the practice of pharmacotherapy.[15]

Let posterity not judge present-day practitioners as narrow-minded reductionists who failed to have an "inside view" of their patients. Who would want to be counted as psychiatrists who merely labeled their patients on the basis of some narrow biological concepts, quite mechanically? Let us continue to make use of various profound ideas and concepts formulated by doyens in our chequered history. After all, in a bygone golden era, concepts from dynamic theories enabled psychiatrists to understand human nature in health and disease in a much better manner.

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