

## **The Importance of Pluralism in Psychiatry**

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Psychiatry is important. It is important because millions of people around the world struggle with mental disorders and understanding such disorders can help alleviate a tremendous amount of suffering. Mental disorders are important because they are pervasive; they affect our thoughts, our desires, our feelings and our actions and in doing so they affect what we hold most dear and what we consider to be the core of human life: our mental life and our sense of self.

The history of psychiatry reflects the different explanatory claims predominant at different times in the field of psychiatry as well as the various different accounts of what we take mental disorders to be. The past century has seen shifts from the psychodynamic model of psychiatry on the one extreme, to the biological model on the other, with various other perspectives in between. These different frameworks are reflected in the different versions of classification and diagnostic manuals, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the *International Classification of Diseases (ICD)*.

Among the guidelines for ethical standards required in the psychiatric profession is the requirement that a psychiatrist's first responsibility is to the patient to whom he must provide competent medical care with compassion and respect for his dignity and rights. Two further requirements are that the psychiatrist is obliged to continue to study and maintain a commitment to medical education, making use of other health professionals when needed, and that the psychiatrist must make relevant information available to the patient.<sup>1</sup> In this paper I put forward some initial considerations in support of the idea that in order to address the needs of patients in the most effective way possible and to maintain the above ethical standards, we ought to maintain a pluralistic attitude in psychiatric research as well as practice. Instead of appealing to one ultimate model or form of explanation, psychiatry needs a

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<sup>1</sup> AMERICAN PSYCHIATRIC ASSOCIATION *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*  
<http://www.psychiatry.org/File%20Library/Practice/Ethics%20Documents/principles2013--final.pdf>, 2013, p.2

multifactorial model in which different perspectives are taken into consideration and, where possible, integrated in order to effectively address the complexity of mental disorders. Instead of seeing different factors competing as explanations we should see them as complementing each other and focus our research programs and our treatments in a direction that takes into account the multifaceted beings that we are and the various different factors that affect who we are. In the long run this will give us a better chance to tackle disorders of the mind and ultimately give patients the therapies that they need and deserve.

### **The DSM and The RDoC**

From the DSM-III onwards, mental disorders have been defined in terms of clusters of identifiable symptoms (syndromes) that occur together and follow a characteristic course with little or no reference to the causes of these symptoms. The introduction to the DSM-IV text revision explains why this is the case.

“There have been two fundamental approaches to formulating systems of psychiatric classification: etiological and descriptive...the etiological basis for most psychiatric conditions remains elusive...for this reason, a descriptive approach to classification has proved to be of greater utility”<sup>2</sup>

Just before the release of the latest version of the DSM, the DSM-5, its validity and its general direction, as well as that of the ICD-10, was questioned by proponents of a new approach in the National Institute of Mental Health (NIMH), the Research Domain Criteria Project (RDoC). The RDoC is a research framework that aims to uncover the component parts of mental disorders in order to find definite treatments to better clinically address patients’ needs.<sup>3</sup> In contrast to the DSM classification, the RDoC moves from a description of symptoms to underlying brain pathology, or, to put it another way, from symptoms reported by patients to biological signs that can be objectively identified, very much like is done in the rest of medicine. According to the RDoC mental disorders are “disorders of brain structure and

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<sup>2</sup> FIRST, M. and PINCUS H.A. *DSM: Fourth Edition, Text revision*. Arlington, VA: American Psychiatric Association, 2000.

<sup>3</sup> INSEL, T., CUTHBERT B., HEINSSSEN R., PINE D.S., QUINN K., SANISLOW C., WANG P. “Research Domain Criteria (RDoC): Toward a New Classification Framework for Research on Mental Disorders.” *American Journal of Psychiatry*, 2010, 167 (7): 748-751. NATIONAL INSTITUTE OF MENTAL HEALTH, “NIMH Research Domain Criteria (RDoC)” <http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml>

function that implicate specific domains of cognition, emotion and behavior”<sup>4</sup> and mental health research must be brain-based, focusing mainly on “neural circuits, their genetic and molecular/cellular building blocks, and the dimensions of functioning that they implement.”<sup>5</sup>

There has been growing dissatisfaction with the diagnostic categories of the DSM for a long time for a number of reasons<sup>6</sup> and so the attempt to break away from its nosology is welcome. However, despite the fact that a new direction in brain research will likely lead to new findings and, hopefully, a better understanding of how the brain functions, there are reasons to be skeptical about this new research direction when it comes to mental disorders. Given that the NIMH funds most research in psychiatry in the United States, there is the danger that social dimensions and the phenomenology of mental illness will be cast aside, or at least be given mere secondary importance, and that our attempt to understand mental disorders will take a predominantly reductive direction.

It is true that the RDoC does not ignore the role that ecopsychosocial factors play in the development of mental disorders but acknowledges their impact and, in this sense at least, it does not explicitly privilege one level of explanation over others. However, such factors are not represented in the RDoC matrix and when they are mentioned as possible future additions to the matrix, the focus is on specific events like childhood trauma and their relation to specific circuits, rather than as ongoing formative factors of mental disorders. By setting the research agenda in this way there is a clear danger that different explanations will play only a supporting role to the main explanatory role of neuroscience. In this sense, even though the RDoC is not explanatorily reductionist *tout court*, there is a strong underlying explanatory reductionist streak in it. The RDoC also promotes a methodological reductionist

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<sup>4</sup> INSEL, Thomas R. and LIEBERMAN, Jeffrey A. *Press Release: DSM-5 and RDoC: Shared Interests*, 2013, <http://www.nimh.nih.gov/news/science-news/2013/dsm-5-and-rdoc-shared-interests.shtml>

<sup>5</sup> NATIONAL INSTITUTE OF MENTAL HEALTH, “NIMH Research Domain Criteria (RDoC)” <http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml>

<sup>6</sup> First of all, neurobiological correlates for its diagnostic categories have not been found and its categories have been reified by convention rather than by data. (HYMAN, Steven, E. “The Diagnosis of Mental Disorders: the Problem of Reification.” *Annual Review of Clinical Psychology*, 2010, 6: 155-79.) Second, the binary categorisation of the DSM cannot accommodate effectively disorders that fall on a spectrum and there is an increasing sense that a dimensional approach is required for at least some disorders like, for instance, personality disorders. Third, the DSM is not successful in distinguishing normal responses to life circumstances from full-blown mental disorders- e.g. a normal response to loss or failure in the face of death or divorce as opposed to a case of depression.

tendency in research since its primary tool is neuroscience and its main method is that of decomposition. In addition to this, it is also reductive in the ontological sense that mental disorders are understood to be “disorders of brain function and structure”. So I think it is safe to say that the RDoC is, at heart, a reductively driven project. This, however, is problematic because there is no guarantee that it will lead to progress in the field of mental disorders. There are many reasons for this.

### **The limits of reductive explanations for mental disorders**

The search for reductive explanations so far has failed in the field of psychiatry. Barring Alzheimer’s and Huntington’s disease, for which biological markers have been found, we do not have reductive explanations for mental disorders. This is why mental disorders are still defined as syndromes rather than some physical pathology or cause. Extensive research has shown that although genetic and neurobiological factors are relevant to the etiology of mental disorders, there does not seem to be a direct causal link from one to the other. Instead, according to the widely accepted “stress-vulnerability hypothesis”, the onset and post-onset course of many disorders have environmental and psychosocial factors as contributing causes.<sup>7</sup>

In itself, this does not mean that reductions or clinically useful biomarkers are not there to be found. It can be argued that although these have not yet been found for mental disorders, reductionism as a methodological strategy has been very fruitful in other fields so it is plausible to assume that it will be fruitful in psychiatry also. And, since the RDoC changes the direction of research from an emphasis to neurotransmitters and localization to neural circuits, clinically useful reductions might still be achieved. However, there are reasons other than the current lack of reductions that make this questionable.

When it comes to individuals that exhibit symptoms of mental disorders, there

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<sup>7</sup> SCHAFFNER, K.F. “Psychiatry and Molecular Biology: Reductionistic Approaches to Schizophrenia” in *Philosophical Perspectives on Psychiatric Diagnostic Classification*. J.Sadler, O. Wiggins and M.Schwartz (eds). Baltimore, MD: Johns Hopkins University Press, 1994. KENDLER, K. S., HETTEMA, John M., BUTERA, Frank, GARDNER, Charles O., PRESCOTT, Carol A. “Life Event Dimensions of Loss, Humiliation, Entrapment, and Danger in the Prediction of Onsets of Major Depression and Generalized Anxiety.” *Archives of General Psychiatry*, 2003, 60: 789 –796. SUNDQUIST K., FRANK G., SUNDQUIST J. “Urbanisation and Incidence of Psychosis and Depression: Follow -Up Study of 4.4 Million Women and Men in Sweden.” *British Journal of Psychiatry*, 2004, 184: 293-8. VAN OS J., KENIS G., RUTTEN B.P.F. “The Environment and Schizophrenia.” *Nature*, 2010, 468: 203–212. BROOME, M.R., WOOLLEY J.B., TABRAHAM P., JOHNS L.C., BRAMON, E., MURRAY, G.K., PARIANTE, C., MCGUIRE, P.K., MURRAY, R.M. “What Causes the Onset of Psychosis?” *Schizophrenia Research*, 2005, 79, 23- 34.

is such a high degree of variation between them as well as in the same individual at different times that a reductive explanation might well be unattainable. Again, however, it can be argued that this is a result of the faulty classification system of the DSM in which research is currently entrenched and that, if we start looking from the bottom up beyond the DSM categories, underlying clinically useful regularities might be revealed.

Although this cannot be excluded at this point, there are other reasons to be skeptical about the RDoC agenda and the possibility of its success. One problematic point is the RDoC's understanding of mental disorders as disorders of brain function and structure. Though given supervenience there cannot be a difference in the mind without a difference in the brain and, as such, physiological mechanisms are necessary for a mental life of any sort, a deviation in brain function is not enough to identify or explain a disorder of rational behavior (disorders that affect the central, rational, capacities of the mind). What is further needed is an independent explanation of why the deviation is a disorder rather than just a difference or abnormality. The idea of something being disordered at a certain level implies that there also can be a kind of order at that level. But the mere presence of a deviation in physical structure does not necessarily imply the presence of a disorder - since for that we need a particular physical order (i.e. an order describable by physics plus a physiological description of the ways the physical parts are organised) which this deviance counts as disturbing. It is not clear that we have a description of such an order. In addition to this difficulty, in order to get an independent explanation why a deviance is a disorder will inevitably involve assumptions about what is normal and what is not. This is particularly difficult when it comes to psychiatry both because of the high degree of variation and heterogeneity between people suffering from disorders and between people that are considered normal and, also, because perceptions of mental disorders are highly contextual and cultural.<sup>8</sup>

This is not to dismiss the attempt to uncover underlying differences which may certainly lead to new discoveries. But the requirement that mental disorders be pathologies in the brain seems to be a doctrinaire requirement rather than a consequence of what we know. If some mental disorders are functional disorders of

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<sup>8</sup> KIRMAYER, Laurence J. and GOLD, Ian "Re-Socializing Psychiatry: Critical Neuroscience and the Limits of Reductionism" in *Critical Neuroscience: A Handbook of the Social and Cultural Contexts of Neuroscience*, S.Choudhury and J.Slaby (eds). Oxford: Blackwell, 2011.

rational behaviour in which a system fails to perform a certain function, then insisting on the presence of a physical pathology is unwarranted, since a person afflicted with a mental disorder may be simply working on faulty input acquired through learning, like in some instances of eating disorders, rather than have something physically wrong with his brain.

Another problem that is often bypassed by proponents of reductive views in psychiatry is the problem of the explanatory gap. The explanatory gap problem is the problem of bridging the divide between what we know about how the brain functions and what we know from psychology. How to connect functional descriptions of the mind to physiological descriptions of brain processes is something that still eludes us as much in cases of mental disorders as in cases of the mind's normal functioning. This means that even if we could find reliable physiological correlates for some mental disorders, we would still be unable to explain the correlation and form a complete multilevel explanation of them. This does not mean that there is no causal relation between variables at the two levels - the physical and the mental. If interventions on one level consistently produced the same effect on the other, we should accept a causal relation which we could, possibly, use for interventions.<sup>9</sup> But it does mean that such a relation would not be an explanatorily useful one. In other words, even if we could identify a physical pathology in the brain it would not be sufficient for explaining mental disorders.

This problem stems in part from the nature of neuroscience, at least as we know it today. Neuroscience uncovers correlations of mental states to neural states and provides us with functional descriptions of cognitive systems. As such, it leaves out the phenomenal aspect of mental states, which in the case of mental disorders is part of the disorder itself. Though in medicine the reductive and third person method of attending to organs that perform a function has been quite successful, to conclude from this that a similar method is advisable in the case of the brain and the mind disregards the main difference between the two. In physical diseases like heart disease, diabetes, and inflammatory bowel disease, there is a clear sense in which the

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<sup>9</sup> CAMPBELL, John "Comment: Psychological Causation without Physical Causation" in *Philosophical Issues in Psychiatry* (eds. Kendler, K.S. and Parnas, M.D.) Baltimore, MA: The John Hopkins University Press, 2008: 184-196. KENDLER, K.S. and CAMPBELL, J. "Interventionist Causal Models in Psychiatry: Repositioning the Mind-Body Problem." *Psychological Medicine*, 2009, 39: 881-887.

patient's experience, the symptoms, can be separated from the causes of the disease. However, in psychiatric disorders first person conscious experience is very much part of the disease as well as the source of the patient's suffering. In this sense, the experience of the symptoms of mental illness is constitutive of the disorder in the way that the subjective experience of pain is constitutive of pain itself, so the distinction between signs and symptoms that can be applied in other fields of medicine is inapplicable in this case.

Yet another difficulty stems from the tools that neuroscience uses. As Kanaan and McGuire<sup>10</sup> have convincingly argued, there are difficulties with neuroimaging techniques - namely, choice of task, statistical power and analysis of findings - that bring into question the possibility of uncovering through them neural mechanisms responsible for mental disorders. In addition to this, there are reasons to question the main assumption underlying the use of such techniques, namely, that what we are searching for lies exclusively within the brain. This assumption is being questioned by currently developing models of cognition from cognitive science like the embedded, the enacted and the embodied models of cognition that not only see the mind as a socially and environmentally situated organ that is partially shaped by external factors, but also see cognitive functions as intimately coupled with the environment. Such models question the "classical sandwich model" that sees mentality as self-contained between environmental input and motor output and propose, instead, a model that for many cognitive and perceptual processes involves multiple feedback and feed-forward loops between the brain and the environment.<sup>11</sup> Though such models may not be applicable to all cognitive functions, since there is compelling evidence that cognitive dysfunctions are to be understood in relation to the ecopsychosocial environment in more than just a causal way and that greater system dynamics are at play<sup>12</sup> it is reasonable at this point to believe that the mechanisms we are looking for when it comes to mental disorders partially lie outside the head. If this is the case though, there is no guarantee that a primarily brain-based research program in mental health will be successful.

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<sup>10</sup> KANAAN, Richard A. A. and MCGUIRE P.K. (2011) "Conceptual Challenges in the Neuroimaging of Psychiatric Disorders." *Philosophy, Psychiatry and Psychology*, 2011, 18 (4): 323-332.

<sup>11</sup> VARELA F., THOMPSON E. and ROCH E. *The Embodied Mind*. Cambridge Mass.: MIT Press, 1993. ROWLANDS, Mark *The New Science of the Mind*. Cambridge, Mass.: MIT Press, 2010.

<sup>12</sup> KIRMAYER, Laurence J. and GOLD, Ian "Re-Socializing Psychiatry: Critical Neuroscience and the Limits of Reductionism" in *Critical Neuroscience: A Handbook of the Social and Cultural Contexts of Neuroscience*, S.Choudhury and J.Slaby (eds). Oxford: Blackwell, 2011.

So, given the currently available evidence, there is no guarantee that there are exclusively physical mechanisms that bring about mental disorders or that there are pathological mechanisms underlying all mental disorders. In addition, even if we could find some sort of a physical or cognitive mechanism underpinning a mental disorder it is not clear that we could connect it in an explanatorily useful way to the disorder at the cognitive and phenomenological level. In this sense, views that have the inbuilt assumption that physical mechanisms are there to be found and that they will be explanatorily sufficient for understanding mental disorders put the cart before the horse.

### **Pluralism in methodology, explanation and practice**

Because in psychiatry many different intertwining mechanisms at different levels are causally relevant to disorders and they are also context sensitive, looking for one kind of explanation will most probably fail.<sup>13</sup> So when it comes to explaining mental disorders what is needed is a framework that, on the one hand, brings together all the factors that are causally relevant and, on the other hand, addresses not only how mental disorders come about but also why they come about. Such an explanatory pluralism holds the best chance to bring together the different facets of psychiatry – i.e. the interest in the individual suffering patient, the interest in the patient *qua* biological organism who is affected by the larger ecosystem and sociocultural environment to which he belongs, the need to understand the disorder and the pragmatic interest to cure or prevent it, and so on.

To achieve such pluralism in practice we need mechanistic explanations that are not limited to the sub-personal level, but that are broadened to include psychological and social causes. However, though we want to retain the usefulness of mechanisms in scientific explanation, we also want to accommodate different kinds of explanations that are necessary in psychiatry, for instance, explanations in terms of successful interventions. For, as Cartwright<sup>14</sup> has argued, in the health sciences causes are important for instrumental reasons; we want to achieve a certain result – either to prevent or to cure - so our aim is to identify the variables that we can effectively

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<sup>13</sup> MITCHELL, Sandra D. *Unsimple Truths: Science, Complexity, and Policy*. Chicago: University of Chicago Press, 2009.

<sup>14</sup> CARTWRIGHT, Nancy “Causal Laws and Effective Strategies.” *Nous*, 1979, 13: 419-38.



intervene in in order to affect an undesirable outcome and hopefully change it to make a difference in a patient's experience.

A pluralistic framework that brings together different explanatory models and also aims at forming an explanation that integrates them in one explanatory framework can be found in Sandra Mitchell's "integrative pluralism".<sup>15</sup> In Mitchell's multilevel approach a full explanation will integrate different explanations at different levels – e.g. the neuronal, the computational and the personal level. This kind of pluralism has been proposed by some, the present author included, as the one needed in psychiatry.<sup>16</sup>

Upon further reflection, however, the requirement for integration has two main shortcomings. First, as we saw above, the integration of explanations at different levels may not be possible because the explanations at some levels may not be available or because we cannot integrate the different explanations that we have. Secondly, even where possible, in some cases integration may not be necessary. Integrating information from all levels can make the final explanation too cumbersome by including in it much that is irrelevant thus making it less useful.<sup>17</sup> It can also make the process of putting together such an explanation more time consuming and costly than it needs to be. Explanations are context and interest specific, so how good they are depends, among other things, on the questions they are meant to answer. Making integration a requirement ignores this aspect of explanations and can lead to inefficiency in the process of acquiring explanations and to defective final integrated explanations that include unnecessary or irrelevant information.

For this reason the pluralism required for psychiatry must be of another sort. It is a pluralism that welcomes integration where possible and where necessary, but that does not make integration a requirement. In such a pluralism what is required is that people working on different levels of explanation maintain a dialogue, remain up to date concerning work at different levels and, to the extent possible, cooperate.<sup>18</sup>

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<sup>15</sup> MITCHELL, Sandra, D. "Why Integrative Pluralism?" *Emergence, Complexity and Organization*, 2004, 6 (1): 81-91.

<sup>16</sup> KENDLER, Kenneth S. "Towards a Philosophical Structure for Psychiatry" *American Journal of Psychiatry*, 2005, 162: 433-440, VINTIADIS, Elly "A Frame of Mind from Psychiatry" *Medicine, Health Care and Philosophy*, November 2014, online first.

<sup>17</sup> GARFINKEL, Alan. *Forms of Explanation*. New Haven and London: Yale University Press: 1981, pp.56ff.

<sup>18</sup> Van Bouwel also proposes such pluralism and – very appropriately – calls it "interactive pluralism". (VAN BOUWEL, Jeroen "Pluralists About Pluralism? Different Versions of Explanatory Pluralism in Psychiatry" *New Directions in the Philosophy of Science*. eds. Galavotti, Maria Carla and Dieks,

The kinds of explanations we seek will also direct the research that gets funded. Given the state of our knowledge concerning the causes of mental illness, or, to put it bluntly, given that we do not know the causes of mental illness, at this point we should not only be open to different kinds of explanations but also be methodological pluralists in our pursuit of such explanations. This requires exploring different options and letting the data show us the level(s) of explanation appropriate to each case. This, in turn, means that we need to distribute funds to a plurality of different research projects rather than place all our eggs in one basket. Indicatively, possible research directions could include: thorough data accumulation, review and meta-analysis of symptomatology of different disorders, research on the effects of intervening in environmental factors that (can) act as triggering agents, research on the role that narratives play in the conceptualization of diseases and the effect that intervention in narratives can play in the course of a disease, research on how different environmental triggers like low socioeconomic status become embodied and affect mental health, and so on.

In addition to explanatory and methodological pluralism, however, what is also needed is pluralism in psychiatric practice – for, ultimately, psychiatry is a branch of medicine, which needs to address the suffering of individual patients. This reveals another flaw in the RDoC agenda, for though it aims to ultimately giving patients better mental health care than is currently available, it is not clear how the new proposed direction of research will actually translate into better patient care. There is the danger that by giving priority to a neurocentric research agenda other aspects that may be just as important to mental disorders will be ignored without having any guarantee, or good reasons to believe at this point, that we are looking in the right direction. This not only leaves suffering patients in no better position than they currently are, but it also does so on no stable basis. Where relevant and available, of course, reference to neural underpinnings needs to be made. For although a thorough-going reductionism does not seem to be enough on its own to tackle the complexity of mental disorders, the reductionist methodology has offered valuable insights in terms of their neurobiological underpinnings - our understanding of which, albeit limited, has already changed our view of mental disorders and has helped us

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Dennis and Gonzalez, Wenceslao J. and Hartmann, Stephan and Uebel, Thomas and Weber, Marcel. Springer International Publishing, 2014, pp. 105-119.

find drugs to address some of the symptoms that such disorders exhibit. But that does not mean that the neural level must take center stage at the expense of the personal level of the patient's experience.

Although there is a general consensus in psychiatry that the etiology of mental disorders is multifactorial, in actual psychiatric practice, things are different. The biomedical model is the most endorsed model, especially for schizophrenia and bipolar disorder,<sup>19</sup> but for the vast majority of disorders there is still very much a division between professionals in the field between proponents of the biological model and proponents of versions of the psychodynamic model.<sup>20</sup> Also, though in the current practice of psychiatry there is no lack of lip service to the importance and role that social and environmental factors play on mental disorders, there is still, nonetheless, a strong reductionist inclination in psychiatry, which often results in a tendency to curtail psychotherapy as a therapeutic method.<sup>21</sup> Interestingly, studies show that choice of model depends on the disorder in question and that the predominant tendency is to have different explanatory models for different disorders.<sup>22</sup>

This lack of consensus in practice is in part due to the practical training of psychiatrists that to a large extent separates therapy from drug administration.<sup>23</sup> But arguably such a division is also, to a certain extent, the result of psychiatry's very nature. On the one hand psychiatry is a branch of science that seeks to explain and understand mental disorders and its causes by identifying objective, third person correlates of disorders. On the other hand, psychiatry is also a field of medicine and, as such, it aims to clinically address the suffering caused by disorders, understood as the first-person experience of patients. This makes for a difficult dynamic between a general scientific epistemological attitude and the task specific, pragmatic attitude required of the clinician. This also means that the adoption of a model may not stem

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<sup>19</sup> HARLAND, R., AANTONOVA, E., OWEN, G.S., BROOME M., JANDAU S., DEELEY Q., MURRAY R. "A Study of Psychiatrists' Concepts of Mental Illness." *Psychological Medicine*, 2008, 39: 967-976.

<sup>20</sup> LUHRMANN, T.M. *Of Two Minds: The Growing disorder in American Psychiatry*. New York, NY: Alfred A. Knopf, Inc., 2000.

<sup>21</sup> *Ibid.*

<sup>22</sup> HARLAND et al 2009. COLOMBO, A., BENDELOW G., FULFORD B., WILLIAMS S. "Evaluating the Influence of Implicit Models of Mental Disorder on Processes of Shared Decision Making Within Community-Based Multi-Disciplinary Teams." *Social Science and Medicine*, 2003, 56 (7): 1557-70

<sup>23</sup> LUHRMANN, 2000. GABBARD, G.O. and KAY, J. "The Fate of Integrated Treatment: Whatever Happened to the Biopsychosocial Psychiatrist?" *American Journal of Psychiatry*, 2001, 12:1956-63.

from a commitment to a certain view about the nature of the causes of mental disorders but it might be the result of the pragmatic aspect of a clinician's work. This can be seen, for instance, in the case of the increasing tendency to prescribe pharmacological therapy rather than administering psychotherapy to patients. Though there are cases in which such a tendency can be attributed to a bias for reductionist physical causality as some studies suggest,<sup>24</sup> this is not always the case. Such a tendency might be the result of practical concerns: prescribing medication and searching for drugs that will contain symptoms is less complicated, quicker, and has more immediate effects than addressing other relevant factors that can lead to long-term solutions. It is also, often, what patients themselves want. In general, etiology and treatment can, and do, come apart in clinical practice. For instance, though appealing to low serotonin levels in certain systems in the brain is an insufficient explanation for major depression, for largely unknown reasons drugs that raise serotonin levels in such systems have some effect on depressive symptoms and so can be manipulated for symptom reduction. This can lead clinicians to prescribe medication without committing them to the view that the etiology of the disorder is purely physical.

Another contributing factor to this separation in practice is that in the era of managed care financial concerns are central to the decision of what kind of therapy patients will receive and by whom it will be administered and some health care companies insist on the financial benefits of drug administration over psychotherapy.<sup>25</sup> This often leaves psychiatrists with few options as to what methods to use and pluralism is curtailed in practice.

Although pragmatic considerations cannot be ignored and will inevitably affect clinical practice to a certain extent, our limited knowledge when it comes to the causes and the nature of mental disorders, as well as the complexity exhibited by most cases of mental disorders, require that we be cautious about relying on one method or

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<sup>24</sup> DEACON, Brett J. "The Biomedical Model of Mental Disorder: A Critical Analysis of its Validity, Utility, and Effects on Psychotherapy Research." *Clinical Psychology Review*, 2103, 33: 856-861.

<sup>25</sup> Though it is still debated whether a dual therapeutic approach is best implemented, financially and otherwise, with one psychiatrist in charge of prescribing medication and administering psychotherapy, or with more than one professionals, strong arguments have been recently put forward that dual treatment performed by one person is, actually, more cost effective than separating treatments between a drug-prescribing psychiatrist and a therapist. (Also view of patient could be manipulated here!) See GABBARD and KAY 2001 and GOLDMAN W., MCCULLOCH J, CUFFEL B et al, "Outpatient utilization Patterns of Integrated and Split Psychotherapy and Pharmacotherapy for Depression." *Psychiatric Services* 1998, 49(4): 477-482.

model in our clinical approach. As the studies mentioned above show, it is clear that there is pluralism in clinical practice in the sense that there are many different views held by different clinicians in the field. However, the pluralism intended here is of a different sort. It is a pluralism in which different models or methods are available to the same practicing clinician to use when needed.

Apart from the use of different psychotherapeutic methods, I also have in mind conditions that benefit from dual treatment - meaning the combination of pharmacological treatment and psychotherapy. As far as we currently know, not all disorder benefit from dual treatment but some do, like schizophrenia, for instance. Studies show that patients suffering from schizophrenia that undergo family therapy in addition to taking their medication maintain improvement and have a lower relapse rate than patients who are only administered medication. In the case of schizophrenia studies also show that CBT when used with antipsychotic medication has a proven role in the management of positive symptoms of schizophrenia.<sup>26</sup> There is evidence that dual treatment also has positive results for major depression, substance use disorders, bipolar disorder and some eating disorders, but further studies need to be performed. However, since there is ample evidence not only that interventions at the physical level have mental effects but, also, that interventions at the personal level, i.e. psychotherapy, affect brain biology,<sup>27</sup> refraining from separating interventions at the two levels except if we have specific clinical reasons to do so seems the right direction to take.

Such pluralism requires that a psychiatrist be able to use different approaches (individually or in combination) where appropriate. In turn, this means that psychiatrists must be trained in a variety of practices, including integrating psychotherapy and medication, and it requires flexibility on their part if the situation or the patient requires it. What the patient wants must be a priority because the informed consent of the patient is not only an ethical requirement in psychiatry, but it

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<sup>26</sup> PHAROAH F., MARI J.J., RATHBONE J., WONG W. "Family Intervention for Schizophrenia." *Cochrane Database of Systematic Reviews* 12. Art. No.: CD000088. DOI: 10.1002/14651858.CD000088.pub3, 2010, TURKINGTON D., DUDLEY R., WARMAN D.M., BECK A.T. "Cognitive- Behavioral Therapy for Schizophrenia: A Review." *Journal of Psychiatric Practice*, 2004, 10: 5-16.

<sup>27</sup> FUCHS, T. "Neurobiology and Psychotherapy: An Emerging Dialogue." *Current Opinions in Psychiatry*, 2004, 17: 479-485, SCHMID- SCHONBEIN, C. "Improvement of Seizure Control by Psychological Methods in Patients with Intractable Epilepsies." *Seizure*, 1998, 7: 261-270, MAYBERG H.S., SILVA J.A., BRANNAN S.K., TEKELL J.L., MEHURIN R.K., McGinnis S., JERABEK P.A. "The Functional Neuroanatomy of the Placebo Effect." *American Journal of Psychiatry*, 2002, 159 (5): 728-37.

is also essential for the patient's collaboration and full participation which is required for efficient therapy. One of the cornerstones of a successful patient-doctor relationship in psychiatry is building a relationship of trust. One of the ways that this is achieved is by instilling in the patient the feeling that he is understood, listened to and respected which then can lead the patient to disclose information that he might not otherwise disclose due to shame, guilt or social stigma.<sup>28</sup> To achieve this, a therapist needs to not only know the biological aspects of a disorder but also to acquire a comprehensive understanding of the patient and decide on the approach to be used after taking into consideration all aspects of the particular situation and everything that goes into the patient's experience. This includes understanding the life experiences of the patient but also his values, goals and narratives - that is, the cultural and explanatory models through which the patient, and his cultural context, makes sense of the world and his particular condition.<sup>29</sup> Understanding how these work may also allow us to intervene in the loops that reify disorders.<sup>30</sup>

The important thing is that when faced with the complexity of a clinical situation psychiatrists need to have a broad scope of options to draw from in trying to help the patient rather than being committed in advance to one method thus risking ignoring important factors in the patients' condition and treatment. This should be the case even if, in the end, the situation requires that only one approach or model is used. Finally, such an approach to therapy will be in line with the ethical requirements for psychiatric practice mentioned in the beginning of the paper: the individual patient is the priority, he is informed of all the options open to him and the psychiatrist is knowledgeable about them and competent in their practice.

## **Conclusion**

Although pluralism is given plenty of lip service, it is not the status quo in psychiatry today. In this paper I have suggested that, given our lack of understanding of the causes and the nature of mental disorders, rather than focusing in one direction,

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<sup>28</sup> GABBARD and KAY, 2001.

<sup>29</sup> KIRMAYER, L. J., & BHUGRA, D. "Culture and Mental Illness: Social Context and Explanatory Models" in I. M. Salloum & J. E. Mezzich (Eds.), *Psychiatric Diagnosis: Patterns and Prospects*. New York: John Wiley & Sons, 2009, pp. 29-37. For the importance that the meaning attributed to life events by people plays in rates of major depression see also KENDLER, K.S. "The Dappled Nature of Causes of Psychiatric Illness: Replacing the Organic – Functional/Hardware- Software Dichotomy with Empirically Based Pluralism" *Molecular Psychiatry* 2012, 17 (4): 377-388, pp. 11-12.

<sup>30</sup> *Ibid.*

as the NIMH runs the risk of doing, we should be open to pluralism in explanation, methodology and practice. To achieve this the mental health sciences need to maintain a dialogue not only with the brain sciences but also with disciplines that have the psychosocial environment as their object of study as well as disciplines that address peoples' point of view and the narratives with which people makes sense of the world - such as different fields of sociology, anthropology and ethnography. In addition, understanding mental disorders in a multilevel and interactive way addresses the complexity and the uniqueness of patients and their mental disorders, is consistent with the emerging view of the mind as intimately connected to its environment and, lastly, allows psychiatry to exist as an independent science that productively cooperates with neuroscience to better understand and help patients.