1 The Need for a Model

1.1 INTRODUCTION

In her article 'Why Psychiatry Is the Hardest Specialty', Dew (2009) sketches the everyday difficulties of psychiatric practice. She writes, 'Being a psychiatrist means dealing with ambiguity all the time . . . I go to work and listen to someone describe a vague uneasiness felt for a lifetime. Then after about 45 minutes I'm asked to assign it a name' (p. 16). Of course, as Dew remarks, assigning a name to something does not make it true. But what she chooses to call it (depression, demon possession, or – a possibility that the author does not consider – non-pathological unhappiness) is not arbitrary: 'How I choose to conceptualize this person's complaint is not merely a matter of my own intellectual satisfaction; in addition to the implications for what treatment is applied, what I say will probably become an integral part of this person's life story' (p. 16). To make things even more complicated, we could add that this conceptualisation may even itself affect the course of the problems.

Dew explains the problem as a lack of a comprehensive view on (1) what is wrong with the patient and (2) what she as a psychiatrist is doing. Although she starts from the idea that psychiatrists are trying to 'make sense of someone else's brain', this conception obviously does not prove to be of much help in her practice:

> *I have to have some sort of model for what I'm doing*. So sometimes I think, 'She needs her serotonin levels tweaked, that's why she feels this way.' The truth is I don't really know why she feels this way. If I asked the right questions, I'd probably find something that happened in her childhood that could be considered traumatic. If not, I could probably find something in her current life that is

> a 'stressor'. I could develop a sense that this problem is more 'psychological' than 'biological' (as if thoughts and feelings weren't biological events and there were really two organs inside her cranium). The one thing I can't think, that I really can't tolerate at all, is that I don't know what's wrong and I don't know what I'm doing that is helping.
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> *(p. 16, italics mine)*

The idea of making sense of someone else's brain not only falls short of providing a model for what she, as a psychiatrist, is doing in practice but it also fails to encompass the various sorts of 'causes' or influences in play in psychiatric disorders. These range from traumatic experiences, relational conflicts, and dysfunctional neurotransmitters to genetic bad luck. It is already hard to figure out how each of these influences develops independently. But the hardest thing, according to Dew, is 'to imagine all of the causes happening together, responding to each other, making each other worse, compensating for each other, benefiting the person, harming the person, comforting the person, killing the person' (p. 17). She concludes, 'That's why psychiatry is the hardest specialty' (p. 17). What she lacks is a comprehensive view on her patients that would help her connect all the possible causes of their problems and the possible interactions between these causes.

In this book I want to address this problem and present a model that integrates the many phenomena that potentially play a role in the development and persistence of psychiatric disorders.

1.2 PSYCHIATRY'S PROBLEM OF INTEGRATION

Medicine is a discipline in which natural sciences and the life-world meet. In order to help people with their complaints, doctors will search for dysfunctions and treat these guided by applied knowledge from the natural sciences. They translate problems into medical diagnoses, and in so doing, they have to switch between the patient as

a person and the patient as an organism.[1] The tension between the patient as a person in his life-world and the patient as a body for scientific and medical investigation characterises the whole field of medicine. In psychiatry, however, matters are even more complicated. In somatic medicine, diseases can typically be regarded as alien intrusions, as external disruptions or at least as a problem of the body-as-an-organism only. Surely patients are involved as persons too; they need to cope with having this disease and maybe change their lifestyles. In psychiatry, however, the personal dimension goes much further, as psychiatric disorders pertain to the patient as a person. For it is not the

[1] Three terminological remarks. Firstly, I prefer to use the term *patient*, because it emphasises the passive element of being affected by something. *Patient* comes from the Latin *patiens*, which means 'one who suffers'. The term *client* has the advantage of stressing the rights of the person seeking psychiatric help. The downside of this term, however, is its suggestion of a business model and the client as an autonomous agent, free to choose between the options on offer according to her own will and insights. This picture of autonomous agency is already controversial in general, and it is certainly a distortion of those who turn to mental health care for help: their problems will often include an impairment in precisely the capacity to freely think, act, and feel as one deems right. The use of the term *patient* is meant to do justice to the vulnerable position someone with psychiatric problems finds. This of course does not deny the importance of taking the autonomy, experiences, and wishes of the patient seriously. It's an inherent difficulty in psychiatry to balance proper care and respect for patients' autonomy, avoiding both neglect and paternalism. I think it is unhelpful to stash these difficulties away and pretend this complicated patient–caregiver relationship is a simple client–provider relationship.

Secondly, I use the term *psychiatric disorder* rather than *mental disorder* or illness, because the term *mental* may suggest a Cartesian dualism that I want to stay clear of. An objection that has been formulated against the use of *psychiatric disorder* is that it may suggest 'that only psychiatrists are trained in the diagnosis and management of these conditions' (Stein 2010). That is a valid objection, and I certainly do not want to suggest that psychiatrists are the only experts, but still I find the Cartesian objection more weighty.

Relatedly, I speak of psychiatry as if this were a homogeneous field. In real life, those professionals who are concerned with treating patients with psychiatric problems are typically part of different services or organisational structures – such as social work, private or public psychotherapy practices, specialised clinics, psychiatric hospital wards, home care – and come from different disciplines. With my use of the term *psychiatry* as shorthand for this diverse field, I do not mean to imply that psychiatrists would be the alpha and omega of mental health care. In fact, the integrative approach to psychiatric disorders that I will present here precisely implies an acknowledgement of the importance of the other disciplines involved in mental health care, such as nurses, social workers, and psychologists, and rather calls for an integrative organisation of these diverse services.

liver, or the heart, or the lungs, or some other organ that is the problem; the problem, rather, concerns one's way of perceiving, thinking, feeling, behaving: experiences that make us who we are.[2] As a consequence, it is much harder for patients suffering from psychiatric disorders to distance themselves from their disorders.

In order to do justice to its complex field of investigation and treatment, psychiatry has always drawn on a combination of insights from the medical sciences and the humanities in general and from neurobiology, psychology, and philosophy in particular (see e.g. Jaspers 1913). Since the notion 'psychiatry' first emerged in the eighteenth century (Marneros 2008), theories about the exact nature of its objects of concern have continuously shifted their emphasis between those various disciplines: from phrenology, to psychoanalytical and anthropological conceptions, to the focus on the role of society and social structures in social and anti-psychiatry, to the paradigm of (neuro)biological psychiatry that has gained dominance during recent decades. Each of these paradigms advocates a very different understanding of what psychiatric disorders are. Should we understand them as brain diseases? From that perspective, patients' experiences are the result of one or more underlying problems in the brain. Research needs to be directed at finding these underlying mechanisms and, it is hoped that, we can subsequently find their biomarkers and develop interventions that target these mechanisms. Or, are psychiatric disorders, rather, the result of unresolved inner conflicts, as the more psychoanalytically minded would suggest? In that case, medication could possibly provide support, but it will not cure the problem. Or should we understand psychiatric problems as the expression in an individual of a social problem, as social psychiatry would argue? Or do psychiatric problems point to existential struggles, and should we focus on what stands in the way of patients' ability to engage with the world in a meaningful way?

[2] Some claim that psychiatric disorders are simply the problem of an organ too, namely the brain. Further on, I will discuss such neuroreductionist models and explain what is problematic about them.

These perspectives are so different that one gets the impression that there may be no way to reconcile them, with the result that one must instead choose between them. But the patient is both a biological organism and a person striving for meaning, and their social world seems to matter as well. How, then, should we understand the nature of psychiatric disorders? Should we indeed choose one of these perspectives, or could there be a way to reconcile them? This is no mere theoretical issue, for how we conceive of the nature of psychiatric disorders has important practical consequences. What is the problem, how can we assess it, and what could have caused it? – how one answers these questions will determine which treatments are preferred and which research gets funded. What should we focus on? Genes? The brain? Early attachment? Inner conflicts? Socioeconomic deprivation?

Besides, how one conceives of the relation between patients' experiences, their physiological processes, and their environment also matters for how one connects findings from (neuro)scientific research to psychiatric practice. Nowadays, psychiatry can profit from insights from genetics and epigenetics, from molecular biology and from neuroscience. Particularly the advancement of neuroscientific techniques like EEG, PET, and fMRI has greatly enlarged the pool of methods psychiatry has at its disposal. In fact, current research is mainly focused on tracking down deviations in the functioning of the brains of patients suffering from various psychopathologies. This has led to the collection of a huge array of data on the neurophysiological factors that are involved in psychiatric disorders: the brains of patients with a major depression show deviations in the levels of specific neurotransmitters (Nutt 2008). Schizophrenic patients show a decrease in grey matter and enlargement of the ventricles (van Os and Kapur 2009). Patients suffering from borderline personality disorder show abnormalities in their amygdala activity (O'Neill and Frodl 2012) and so on. With the increasing popularity of brain imaging techniques, more and more of these correlations between diagnosed illnesses and deviant brain processes are documented.

The challenge is to find a way to make these findings useful for psychiatric practice. Although the correlations that have emerged from this research are many, they have not led to the envisioned breakthroughs in psychiatric interventions and biomarkers for diagnoses and drug responsiveness. Little is known about the causal relations and possible mechanisms involved. The more we get to know about the functioning of our brains, the more complicated this turns out to be. In particular, the plasticity of the brain makes it an astonishing organ – and one that is notoriously difficult to study. For the application of research in neuroscience it is crucial to understand how brain processes are linked to experiences and to interactions with the environment.

It is by no means obvious how to relate such different aspects as physiological processes, experiences, existential concerns, and sociocultural influences and the different sorts of knowledge that they yield. This is what an integrative framework should help with.

1.3 THE USE OF MODELS

In both its practice and its research, psychiatry thus needs to find a way to integrate the different aspects of patients' problems. In practice, many of those working in psychiatry already work holistically in a pragmatic and eclectic way. Without using any explicit, overarching theoretical framework,[3] they aim to consider all the factors that cause and maintain their patients' problems. Such pragmatic approaches often function well enough. So why develop a framework at all? As Dew's example makes clear, one's view on the nature of psychiatric disorders influences one's decisions about treatment. If psychiatric disorders, for instance, are regarded as diseases of the brain, then solving patients' problems at their root involves changing their brains. If, on the contrary, psychiatric disorders are regarded as existential crises, treatment should be directed at addressing patients' existential concerns, not their brains. Likewise, one's view on which aspect(s) of

[3] I use the terms *framework*, *model*, and *account* in a loose, interchangeable way.

psychiatric disorders are most central will affect decisions on how funding for both treatment and research gets allocated. Besides, one's views on the nature of psychiatric disorders will impact one's views on the people suffering from them. Is depression a disease just like cancer? To what extent do we deem patients to be responsible for their problems? For psychiatric patients, their views on their disorder affect their very self-understanding. And the views of their family and friends and their therapists, nurses, and other professionals on psychiatric disorders concern them personally.

Still, one might ask why we should develop an *integrative* framework, and why it should be *explicit* rather than functioning implicitly in the background. The reason why the framework should be integrative is simply that if it does not account for how the diverse factors potentially at play in psychiatric disorders are related – it is of no help for solving the integration problem. A non-integrative framework can be useful in other ways, but not for the difficulty of connecting brain processes, patients' experiences, and the effects of social circumstances. As we will see in Chapter 2, there are different routes to integration, with the two main directions of reductionism and some form of holism.

An explicit integrative framework has several advantages. Given the impact of one's views on treatment, funding decisions, and (self-)understanding of patients, it seems a matter of decency to be able to explicate them in order to make them contestable. But there are more pragmatic reasons as well. In fact, the difficulties that Dew (2009) describes pertain precisely to the limits of practical pragmatism in the absence of a good theoretical grounding. An explicit integrative framework can help communication. In particular, it can provide (1) orientation, (2) treatment rationale, (3) a shared language for communication with all those involved, and (4) the means to explain treatment decisions to health insurers and society at large.

1.3.1 Orientation

A theoretical framework can be useful for a better understanding of what works and especially *how* and *why* it works that way. It helps to

know what one is doing and why one is doing it. An integrative framework helps us keep an eye on all the aspects of treatment, to switch between different ways of looking at the patient and his illness and to keep an overview. Is the patient unable to do something, or is he not trying hard enough? Is it primarily a physiological dysfunction, or do the patient's problems stem from social difficulties? Or is it a bit of both? How do these two interrelate? And even if we can point to an originating cause, how much use is this to improving the patient's current situation? Besides, such assessments are not just a matter of a proper diagnosis at the outset: during treatment, the emphasis may need to shift again.

A good framework also helps to relate scientific findings on the heterogeneous aspects of psychiatric disorders – for psychiatric research, too, is splintered. Biological psychiatry, for instance, investigates which brain networks show deviations in patients with schizophrenia (Alexander-Bloch et al. 2013) and phenomenological psychiatry investigates questions like the changes in the experience of time for depressed patients (Fuchs 2001; Wyllie 2005; Ghaemi 2007), while social psychiatry, for instance, investigates the family dynamics that drive patients to anorexia (Minuchin et al. 1978/2009). Even if these outcomes are intended to contribute to an integrative approach, not much integration is achieved as long as there is no guiding idea for how to connect these elements.

1.3.2 Treatment Rationale

This follows from Section 1.3.1: if one knows what one is doing and why one is doing it, one has a treatment rationale. An integrative framework can shed light on how intervening on one aspect (e.g. sleep) affects other aspects (e.g. mood). The use of a framework does not mean that one definitive treatment pops up just by looking at the framework; rather, it helps to keep an overview of all influences that could play a role and could be intervened on and to change course if the intervention is not having the intended effects.

1.3.3 Communication

A good, integrative framework aids communication. Given that there are various, very different perspectives on the nature of psychiatric disorders – as primarily physiological, or sociocultural, or existential problems – these different perspectives also imply different types of language and different frameworks for explanation. One easily ends up talking at cross purposes if one interlocutor adopts a physiological and the other an existential perspective. An integrative framework should offer a common ground and a perspective that bridges these differences. In this way, different types of expertise can be connected – both amongst various health care professionals and between health care professionals, and patients and family.

1.3.4 Justification

Mental health care professionals need to be able to justify their treatment decisions to the insurance companies that pay for it. If one wants to defend a holistic approach against economising tendencies, one will have to argue for it. For that, a solid theoretical grounding is indispensable. And it's not just insurance companies that require explanation and justification. After all, it is in the end a political decision of how many funds will be allocated to mental health care and to research. What do we need that money for and how do we use it to improve the situation of patients suffering from psychiatric disorders? A good framework can provide the premises for answering these questions.

Simply put, the primary function of a theoretical framework is thus that it helps one to know what one is doing and why one is doing it. Now any model faces the difficulty of finding the right balance between structuring, ordering, and simplifying on the one hand, and encompassing all the relevant aspects and relations on the other hand. There is both the risk of the model being too complicated, therefore offering no help in structuring the complexities of reality, and the risk of oversimplifying reality; leaving out relevant aspects or connections. What are the relevant aspects of psychiatric disorders that an

integrative framework should take into account? What is it that needs to be integrated?

1.4 DISCERNING THE DIMENSIONS INVOLVED IN PSYCHIATRY

In what follows, I suggest that we can discern four main dimensions of psychiatric disorders as indispensable for understanding the nature of psychiatric disorders. These are the experiential, the physiological, the sociocultural, and the existential dimensions. Each of these can in turn be further specified, but these are the main elements. The first three dimensions more or less reflect the elements of the biopsychosocial model. I take it that these are generally accepted as relevant aspects of – or, depending on one's view, influences on – psychiatric disorders. I want to add one more aspect to this list: the existential dimension.

The *experiential* dimension refers to patients' experiences.[4] These experiences are both the starting point and the final measure of any treatment. A good understanding of patients' experiences is therefore a crucial part of psychiatric practice.

The physiological dimension includes genetic, anatomical, biochemical, and neurological aspects of psychiatric disorders. Despite the diversity of these aspects, they group together in the sense that

[4] I speak of the *experiential* dimension rather than of the *psychological* dimension for reasons of clarity. The notion 'psychological' encompasses a wide range of phenomena and categories, ranging from unconscious processes, to behaviour, to the concept of personality. Because of this potpourri, *psychological processes* can refer to both first-person experiences as well as third-person descriptions, or categorisations of these experiences. Avoiding the term *psychological* forces one to be more precise about what exactly one is referring to. In particular, I want to distinguish between the experiences of the person and an observer's perspective on these experiences. The experiential dimension refers only to the first. From the enactive perspective that I will be developing here, these diverse phenomena and categories that now fall under the heading of 'psychological' can be accounted for in a different way. For instance, unconscious processes can be understood as patterns of interaction that the person is not aware of. *Behaviour* refers to a person's interaction-patterns as described from an outside perspective. And *personality* can be understood in terms of engrained interaction patterns, following a history of coupling which shapes a person's current preferred kind of interactions.