

Towards a hermeneutic shift in psychiatry

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Psychiatry is currently going through a crisis of confidence (1). Some medical commentators have even questioned the very credibility of the profession (2). There are many indicators of this crisis. For example, leading up to the launch of DSM-5 by the American Psychiatric Association last year, the chairperson of the DSM-IV task force raised serious questions about the validity of the whole DSM process (3), echoing earlier criticisms by the chairperson of the DSM-III (4). It is clear that psychiatry has been a particular target of the marketing strategies of the pharmaceutical industry (5), strategies that have led to the corruption of evidence-based medicine in general (6). Much-heralded advances in antipsychotic psychopharmacology are now revealed as “spurious” (7). Academic psychiatry’s attempt to transform itself into a sort of “applied neuroscience” (8) has consumed enormous resources but delivered very little for patients. A. Kleinman has called it an “extraordinary failure” and stated that “academic psychiatry has become more or less irrelevant to clinical practice” (9). In the U.S., where the practice of psychiatry has been most dominated by the DSM, neuroscience and the pharmaceutical industry, clinical work has become equated with the prescription of drugs. The *New York Times* carried a story in 2011 in which a psychiatrist spoke of having to train himself not to get too close to his patients and “not to get too interested in their problems” (10). Our discipline is in trouble.

There are several dimensions to the current crisis, but one of the most important difficulties is around the perennial question of what is an appropriate epistemology for psychiatry. What sort of knowledge can we have with regard to mental illness and what sort of expertise is possible? The current technological paradigm that dominates psychiatric thought (11) is based on the idea that episodes of mental illness arise from abnormalities in specific neural, or psychological, pathways or processes. Furthermore, it assumes that these can be grasped with the same sort of de-contextualized, causal logic that is used to explain problems of the liver or lungs. The authority of psychiatry and the power invested in it are often justified on the basis that it possesses, or is on the way to possess, a science that can predict outcomes, based on an accurate map of the underlying processes (12).

Therefore, debates about epistemology are not simply an intellectual exercise. Many psychiatrists feel that they cannot be “real doctors” unless their discipline is grounded in the natural science epistemology that guides the rest of medicine. In this short discussion, I do not intend to engage with the wider ethical and political dimensions of the current crisis; rather I simply wish to make the case that natural science methods reach their limits in the territory of mental

health and illness. This is largely a territory of meanings, values and relationships, an assertion now supported by a large body of empirical evidence about how psychiatric interventions actually work (11). I argue that, if we are to be truly “evidence-based” in our discipline, we need a radical rethinking of our guiding epistemology: a move from reductionism to hermeneutics.

MEANING, CONTEXT AND PRACTICE

Many people still believe that answers to the current crisis will emerge from an ever greater focus on neuroscience. The Research Domain Criteria (RDoC) project, a quintessentially technological view of the future, is being promoted as the way forward. It conceptualizes mental illnesses as brain disorders: “in contrast to neurological disorders with identifiable lesions, mental disorders can be addressed as disorders of brain circuits” (13). Furthermore, it assumes that “the dysfunction in neural circuits can be identified with the tools of clinical neuroscience”. However, others argue that there is also a need for “higher order” cognitive and computational approaches in addition to genetics and neuroscience in our attempts to map the mind and its disorders (14).

Central to all these approaches is the assumption that the mind is simply another organ of the body, or that it can be equated with the brain. In this understanding, “meaning” is generated *internally*, within “the brain” or “the mind” (15). It is viewed as something that emerges from a series of underlying neurological and/or cognitive processes, processes that are open to scientific investigation and explanation. Meaning, therefore, is something that can be explained fully in the terms of neuroscience or cognitive science models. This is what is meant by the term “reductionism”.

I believe that these approaches are simply inadequate. One of the major insights of 20th century philosophers such as Wittgenstein, Heidegger and Merleau-Ponty was the realization that meaning is not something that happens inside an individual mind or brain, but instead comes into our lives from the social practices that shape the world around us. It is in and through this world that we grow into human beings and come to know ourselves and others. Social practices generate a context in which our words, our experiences, indeed our lives, have a meaning. For example, the man or woman being tortured faces physical pain, the tearing of flesh and screams of agony; so too does a mother in childbirth. A pain questionnaire administered in both scenarios will record similar scores. And yet there is a major

difference. The *context* of motherhood is usually rich with love and hope; the suffering of childbirth has a positive meaning and can be integrated into the mother's life. This is seldom the case for those who endure torture. The context of their suffering is very different, despite the fact that in both cases the physical pain will have been mediated through similar centres in the brain and similar neurotransmitters will have been released. Even the most sophisticated neuroscience will not help us to understand the *meaning* of pain in the life of any particular person. And it is the meaning of the experience that will determine the longer-term outcome.

This is also true of most of the experiences with which our patients struggle. As psychiatrists, our work is about "making sense" of experiences such as low mood, suicidality, voices and paranoia. This requires attention to contexts and the use of empathy. With the tools available to us (listening, coupled with the specific insights of phenomenology, psychology, neuroscience and the social sciences, and the specialized insights given to us through our medical training), we can sometimes begin to grasp "what is going on" for our patients. This is rarely definitive and all psychiatrists have to live with ambiguity and uncertainty.

TOWARDS HERMENEUTICS

I contend that good psychiatry involves a *primary* focus on meanings, values and relationships, both in terms of how we help patients as well as identifying from whence their problems arise (11). This is not to deny that psychiatry should be a branch of medicine, or that other doctors sometimes deal with problems of meaning. However, interpretation and "making sense" of the personal struggles of our patients are to psychiatry what operating skills and techniques are to the surgeon. This is what makes psychiatry different from neurology. When we put the word "mental" in front of the word "illness", we are demarcating a territory of human suffering that has issues of meaning at its core. This simply *demand*s an interpretive response from us. I think that many psychiatrists would recoil from the idea that they should train themselves to be *uninterested* in the problems of their patients, as the *New York Times* interviewee described (10).

Hermeneutics is based on the idea that the meaning of any particular experience can only be grasped through an understanding of the context (including the temporal context) in which a person lives and through which that particular experience has significance. It is a dialectical process whereby we move towards an understanding of the whole picture by understanding the parts. However, we cannot fully understand the parts without understanding the whole. The German philosopher H.-G. Gadamer suggested that the idea of hermeneutics is particularly relevant to the work of the psychiatrist (16).

By adopting a hermeneutic approach to epistemology, we can attempt to understand the struggles of our patients

in much the same way as we attempt to understand great works of art. To grasp the meaning of Picasso's *Guernica*, for example, we need to understand what is happening on the canvas, how the artist manages to create a sense of tension and horror through the way he uses line, colour and form. We also need to understand where this painting fits in relation to Picasso's artistic career, how his work relates to the history of Western art and the political realities of his day that he was responding to in the painting. The meaning of the work emerges in the dialectical interplay of all these levels and also in the response of the viewer. The actual physical painting is a necessary, but not a *sufficient*, factor in generating a meaningful work of art. A reductionist approach to art appreciation would involve the unlikely idea that we could reach the meaning of a painting through a chemical analysis of the various pigments involved.

CONCLUSION

I do not believe that we will ever be able to explain the meaningful world of human thought, emotion and behaviour reductively, using the "tools of clinical neuroscience". This world is simply not located inside the brain. Neuroscience offers us powerful insights, but it will never be able to *ground* a psychiatry that is focused on interpretation and meaning. Indeed, it is clear that there is a major hermeneutic dimension to neuroscience itself (17). A mature psychiatry will embrace neuroscience but it will also accept that "the neurobiological project in psychiatry finds its limit in the simple and often repeated fact: mental disorders are problems of persons, not of brains. Mental disorders are not problems of brains in labs, but of human beings in time, space, culture, and history" (18).

References

1. Pies R. Why psychiatry needs to scrap the DSM system: an immodest proposal. <http://psychcentral.com/blog/archives/2012/01/07/why-psychiatry-needs-to-scrap-the-dsm-system-an-immodest-proposal/>.
2. Angell M. The illusions of psychiatry. <http://www.nybooks.com/articles/archives/2011/jul/14/illusions-of-psychiatry/>.
3. Frances A. DSM 5: Where do we go from here? <http://www.psychiatristimes.com/login?referrer=http%3A//www.psychiatristimes.com%2Fdsm-5-badly-flunks-writing-test>.
4. Rubenstein S. Confidentiality of psychiatric manual's update draws gripes. <http://blogs.wsj.com/health/2008/12/29/confidentiality-of-psychiatric-manuals-update-draws-gripes/#comment-381755>.
5. Göttsche P. Deadly medicines and organised crime: how Big Pharma has corrupted healthcare. London: Radcliffe Publishing, 2013.
6. Spence D. Evidence-based medicine is broken. *BMJ* 2014;348:22.
7. Tyrer P, Kendall T. The spurious advance of antipsychotic drug therapy. *Lancet* 2009;373:4-5.
8. Insel TR, Quiron R. Psychiatry as a clinical neuroscience discipline. *JAMA* 2005; 294: 2221-4.
9. Kleinman A. Rebalancing academic psychiatry: why it needs to happen – and soon. *Br J Psychiatry* 2012;201:421-2.

10. Harris G. Talk doesn't pay, so psychiatry turns instead to drug therapy. http://www.nytimes.com/2011/03/06/health/policy/06doctors.html?pagewanted=all&_r=0.
11. Bracken P, Thomas P, Timimi S et al. Psychiatry beyond the current paradigm. *Br J Psychiatry* 2012;201:430-4.
12. Bracken P. Psychiatric power: a personal view. *Ir J Psychol Med* 2012; 29:55-8.
13. Insel T, Cuthbert B, Garvey M et al. Research Domain Criteria (RDoC): towards a new classification framework for research on mental disorders. *Am J Psychiatry* 2010;167:748-51.
14. Fulford KWM. RDoC+: taking translation seriously. *World Psychiatry* 2014;13:54-5.
15. Phillips J. The hermeneutic critique of cognitive psychology. *Philosophy, Psychiatry, & Psychology* 1999;6:259-64.
16. Gadamer HG. *The enigma of health*. Stanford: Stanford University Press, 1996.
17. Choudhury S, Slaby J (eds). *Critical neuroscience: a handbook of the social and cultural contexts of neuroscience*. Chichester: Wiley-Blackwell, 2012.
18. Rose N, Abi-Rached JM. *Neuro: the new brain sciences and the management of mind*. Princeton: Princeton University Press, 2013.

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