Can psychiatry be retrieved from a biological approach?

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This article is written to counter the bias and domination of biological psychiatry, with the intention of stimulating a professional debate about its ideological basis.

A psychiatrist who had recently managed to obtain her first consultant appointment told me that she may be "irretrievably biological" in her approach to psychiatry. Many would regard this outcome of her training as acceptable (Guze 1989) but there are problems with a biological approach to psychiatry (Kaiser 1996). I am concerned about conformist pressures to adopt a biological approach in training and that a self-critical view is discouraged. The point of this piece is to highlight such bias and not to attempt to provide a full critique. The need for voicing alternatives seems to be increasing as biological psychiatry becomes more hegemonic (Klerman 1990). Of course, the biological hypothesis has always been present in psychiatry, but it is now rare for trainees to consider its implications.

The view that the phenomena of human existence can be understood in exclusively biological terms is obviously attractive. If psychopathology equals bodily dysfunction, aberrant behaviour and experience can be fixed in a natural substrate. Accountability for personal misfortune is shifted away from personal agency and the impact of relationships. The complexities of meaning are apparently made simple. Reducing relations between people to objective connections seems to make them more manageable. Biological psychiatry in its more expurgated version avoids radical reductionism by granting that environmental stressors are necessary precipitants of mental health problems on the basis of an antecedent "diathesis". Biological predisposition, however, is an overriding factor in this aetiological eclecticism. The basic assumption of biological psychiatry is that mental illness is due to a biochemical imbalance which can be corrected by medication. The implication is that personal conflict and responsibility are avoided.

Additional appeal of the biological approach comes from the apparent authority it provides for many practising psychiatrists in the clinical team. The understanding of basic bodily processes is knowledge that gives power to psychiatrists which is denied other clinicians.

Trainees should be able to question the primary assumption that the kinds of biochemical processes that produce mental illness are essentially different from those that create thoughts, feelings and behaviour amongst the "normal". What prevents them thinking critically about this hypothesis?

The bias of medical training

Medical training assumes a scientific mode of thinking. Medical students are not primed to realise that human behaviour may not follow rules of physical cause and effect. By the time trainees start psychiatric training they have been firmly indoctrinated in the belief that people can be explained and predicted. The weight of philosophical inquiry belies this view (Dilthey 1976). Students need to realise that it is legitimate to question whether an understanding of human nature can take the same form as the laws of natural science. It may come as a shock to medical students to be made aware of this potential because of the mindset which has been created by the unquestioning assumption that natural scientific methods can be applied to human behaviour. Even if students are not surprised, scientific education may have become so entrenched that it is too late for thinking to shift. I am, of couse, using science in the narrow sense of physical science. A broader definition of science would be the application of commonsense. It is in just this sense that medical training seems to be unscienific and mindless. I am aware that such a view will be dismissed as vague and uncertain.

Traditional medical education has fostered in students the notion that uncertainty is a manifestation of ignorance and weakness. Factual knowledge takes precedence over critical appraisal. The inevitable denial and avoidance that result when the limits of rationalism are exposed in clinical practice are reinforced by patients who may expect them to be certain. This vulnerability is made particularly acute in psychiatry when patients try to express their desires and self-destructiveness and describe their abuse and past traumata.

Clinical schools have sometimes said they want to recognise the importance of cultivating creativity and paying closer attention to students' emotional development. Unfortunately, guidance in developing techniques to handle issues raised by uncertainty do not feature prominently in most curricula. In our "post-modern world" there is some truth in the statement that natural science on which medical training is based has now a greater acceptance of subjectivity and uncertainty. It was never realistic, however, to expect that the introduction of social science and medical ethics to undergraduate training would encourage the necessary adjustments to thinking and practice. A more profound focus on the person is required in medical training from the start of training. Of course, I am not encouraging a dualism of mind and body. Biological knowledge needs to be integrated with personal understanding. Enlightened attitudes can only be developed by being open to the limits of medical practice.

A greater recognition of the anxieties experienced by all professional disciplines involved in the delivery of health care should facilitate better use of resources. This means clinicians must explicitly acknowledge and understand the importance of imprecision before such co-operation can be productive.

The myth of biological psychiatry

By the time doctors begin psychiatric training, they are enmeshed in medical indoctrination. There should be little surprise then about their unthinking acceptance of the biological model of mental illness. "Chemical imbalance" explains aberrant behaviour and feelings, as if it understands it. Medication is the simple response and the foundations of trainees' worldview shake if the hypothesis is not true. The belief is so fundamental to the edifice of psychiatry that paradigms about neurotransmitters and receptors do not shift despite contrary pharmacological evidence. Most psychiatrists in their clinical work still think they are correcting dopamine imbalance in their treatment of schizophrenia with neuroleptics, despite the abandonment of the hypothesis by pharmacologists and the widespread acceptance of atypical neuroleptics onto the market. The amine hypothesis still figures at least in the background of psychiatrists' use of antidepressants, encouraged by pharmaceutical companies' rationales for the development of their products. Of course, I am not dismissing psychiatry's base in medicine, which, for example, is useful for understanding the common physical complaints of psychiatric patients.

Lack of self-criticism in psychiatry is stifling. Recognition by a trainee that there may be more factors than "chemical imbalance" involved in a patient’s problems may be dismissed as interesting "psychodynamics". Failure to produce the correct diagnosis in the MRCPsych clinical examination is given more weight than an attempt to understand the patient’s problems, albeit in no more than one hour. When have trainees had demonstrated to them the power of suggestion, rather than the effects of medication, or had any acknowledgement of the influence and power of using medication? Doctors with a designated interest in the mind should be expected to be more aware than other specialities of the power of the placebo. And if so, they might realise that habituation to medication is likely to be common, perhaps particularly with drugs which are thought to improve emotional states. This recognition would help trainees to appreciate why so many people have difficulty discontinuing medication, and would provide an alternative explanation to recurrence of disease when symptoms present themselves on terminating treatment.

Authoritarian attitudes are not conducive to self-criticism. Challenge to the structure of training is marginalised. Creating unhealthy, defensive doctors cannot be in the interest of patients. Narcissistic impulses will have to

be renounced along with ideas of omnipotence, although there should be no fear that patients will no longer need services.

And besides, how does a doctor relate to other disciplines who sense their vulnerability but have not the authority to challenge it? After all, it is the doctor who has knowledge about the body and other disciplines do not have accredited training in this field. Even if they can see the bizarreness and absurdity of biological psychiatry's claims, they may be missing some information. In a power struggle it suits the psychiatrist to keep them thinking this way.

Alternative Psychiatry

The only solution to this predicament that I can see is that medical training should become interdisciplinary and psychiatric training adopt a Neo-Meyerian model (Double 1990). Entrenched vested interests make this outcome highly improbable. Trainees should be aware of the modern recent history of psychiatry. Although Adolf Meyer's views never perhaps dominated psychiatry, they were a powerful influence in the first part of the century before they were eclipsed with the introduction of the plethora of modern psychotropic medications. Meyer argued with Kraepelin, suggesting a psychogenetic explanation for dementia praecox, so trainees should take courage if they appreciate that schizophrenia or any other mental health problem can be understood in terms of their patients' life experiences.

Meyer's psychobiology is open to psychotherapeutic ideas, but distinct from them. Meyer played an ambiguous role in the acceptance of psychoanalysis in America (Leys 1981). He favoured commonsense use of language, rather than the theoretical conceptualisations of psychoanalysis. Both Meyer and psychoanalysis agreed on a dynamic interpretation of mental illness based on an understanding of psychological factors. Such a critique of modern psychiatry needs to be incorporated into medical training. Although psychotherapy and counselling are more readily recognised as an alternative to biological psychiatry, Meyer's social perspective goes beyond the voluntary individual practice of psychotherapy.

It seems I am proposing an antipsychiatric project and I think it is if psychiatry's definition is ruled by biological psychiatry. I say this in an attempt to bring my message home rather than to allow it to be marginalised. Critical psychiatry needs to organise itself so that future generations of trainees are given more awareness of options in their practice of psychiatry (Critical Psychiatry Network Website 2000).

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