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Managing an Unorthodox Society by Orthodox Psychiatry: The Pitfalls

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Introduction

Do We Accept Unorthodox Behavior?

Any unorthodox activity by an individual person is looked upon by society as a symbol of deranged activity until and unless the motive behind that breach is clear and acceptable to society. No country is immune from the allegation where undue advantage has been taken on many occasions to label political opponents as suffering from mental derangement and have been diagnosed, treated, confined, and may be sterilized or killed by government agencies for their political gain. Wikipedia even lists the Government of India for enlisting the help of a renowned institute in relation to some agitation by a community in the year 2012. We all are aware of such atrocities committed in various big countries, like Germany, the USA, China, Europe, Russia and many more.

Do we think that situations like the Holocaust will never recur? Do we think that psychiatrists will not be called back again to help the faulty Governments? Do we think that today's psychiatry stands on a strong footing to deny labeling such rebellious individuals as not suffering from any kind of psychological disturbance? Do we think our classification system is robust and based upon solid knowledge?

I am no social reformer. Nor am I here to criticize the various Governments. My only purpose is to make psychiatry stand on solid footage so that it can help humanity in a better way. It would be wrong to assume that our diagnostic system has not been responsible anywhere. Why do we forget the terms like latent schizophrenia, autistic behavior, schizoid personality, borderline personality disorder, dissocial, etc., have/had been a part of our system?

So, what is mental illness?

People say that mental illnesses are easy to define reliably and their limits are relatively clear. The antonym of mental illness would be 'normal,' but then the scientists do not agree that the synonym of 'Normal' would be 'Mental Health.' For them, it is so because normal implies a reasonable rather than an optimal state of functioning. And one of the definitions of this mental health also accepts the doctrine of Freud, which states that it is the capacity to work and to love. A person having a hypomanic state has a better capacity to work and

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to love – Love the whole society – not only his family. Is he a mentally healthy individual? Thomas Szasz stated that normality can be measured only in terms of what persons do or do not do and that defining normality is beyond the realms of psychiatry.[1]

What is 'Ideal Mental Health'?

Jahoda (1958) identified six conditions associated with ideal mental health:

- A positive view of the self
- Capability for growth and development
- Autonomy and independence
- Accurate perception of reality
- Positive friendships and relationships
- Environmental mastery – able to meet the varying demands of day-to-day situations

Can a major population of any society fulfill the above criteria? And those who are not in tandem with the Govt. policies, do they not run the risk of being labeled not possessing good mental health? And don't be happy that in today's word, these atrocities are not occurring.

How Do We Perceive Unorthodox Behavior?

If we do not have any yardstick to measure the normality on what scale do we expect ourselves to be capable of accepting or rejecting an unorthodox behavior? A given person who hears the commanding voices is treated in what way by society? Has it not been dependent upon the influencing power of the person, time period of civilization, ethnicity, religiosity, and various other cultural factors? Psychiatric disorders may be one of those causes. Esquirol had once stated that he could predict the time of civilization by looking at the content of hallucinations.

Kraepelin himself had mentioned a few factors that make the diagnosis in mental diseases one of the most difficult tasks. I quote his description: "There are still other difficulties to be encountered in obtaining that fundamental knowledge necessary for a scientific classification of mental diseases. In the first place, it is almost impossible to establish a fundamental distinction between the normal and morbid mental state as was frequently discussed in our discussion of the general symptomatology . . .". The legendary had further stated- "If we want to serve the psychiatry, we have to first formulate the fundamental features, fundamental signs and symptoms and formulate a theory based on the available anatomical, biological, ethnological findings. We have to use certain measurable criteria to define our disorders and the same criteria should form the basis for formulating research studies."

Is It A Century Gone To Waste?

The last important publication by Kraepelin was in the year 1920. Kraepelin could not find the answer to his desire for a classification that was based on etiology. For the time gap, he had advised a diagnostic system that was based on clinical picture, course and outcome. His other goal was to search for the fundamental symptoms of each disease. A hundred years have passed since then. Has there been any fundamental change in our classificatory system? For diagnosing a disorder, we have made certain criteria which are totally based on symptomatology – symptoms which are psychological and subjective in nature and even those symptoms have been made the etiological factors for the causation of those disorders.

What does CTP state for hallucinations and schizophrenia:

"Etiology of hallucinations: These are to be found in diseases like schizophrenia."

And for,

"Diagnosis of schizophrenia: By the presence of specific hallucinations".

If we use a similar corollary in the field of general medicine, then can we say:

Etiology of fever: This is to be seen in cases of Malaria

And for diagnosis of malaria: By the presence of fever.

Or by taking yet an another example:

Etiology of fever: It is to be seen in cases of typhoid

And for diagnosis of typhoid: It is to be diagnosed by the presence of fever.

And so on and on.

We have not applied the current available scientific knowledge in classification. We presume ourselves to be making psychiatry scientific – based on scientific evidence having biological, anatomical

etiological evidence. Our whole diagnostic is based upon symptoms which are psychological in nature but there has not been any evidence of biological correlation of those symptoms. And even to those symptoms, we have not assigned them the true representation. We do not go into psychological meaning of that feeling state to the person, rather we go by its presence or absence. And then, we are not applying the knowledge we have gained. The hallucinations and delusions which were of no significance to Kraepelin, have become the major thrust of significance. The credit goes to the Jasper, who had stated that, "The form of perception is incompatible with the form of imagination." A perception has a 'concrete reality' or 'perceptual quality' (Leibhaftigkeit) and was in 'outer objective space.' Our diagnostic system is heavily colored by symptoms. However, to none of the symptom we could assign them a quality statement of being 'Fundamental.' But because these are easy to be assessed, and hence helpful in assessing the effectiveness of pharmacotherapy and interrater reliability, these have replaced the attempts to awe for that fundamental quest of the causation and diagnosis of mental disorders. We are just waiting for the day when we shall be able to diagnose these disorders by some laboratory test.[1,2]

And for These Laboratory Tests We are Dependent upon What?

For any test to be performed upon any disease status, we are dependent upon some symptoms – which are psychological in nature and whose presence we are sure of makes the diagnosis. Hence, for what are we doing those laboratory tests? To search for a therapeutic molecule? But, the reality is that as those symptoms do not have a fundamental nature, all our attempts till date have been a kind of search in the dark. And even for doing those laboratory tests, we are dependant on doing some animal studies – the pitfalls of which also we shall be discussing.

Ding Dong's statements in the book- CTP, while criticizing the subjective descriptions of psychiatric symptoms, which have been stated as to be inherently less reliable, or at least less objective, had praised the present-day classificatory system and stated it to be "more directly measurable and quantifiable data . . . . A great deal of research in psychiatric diagnosis over the last 25 years has been concerned with increasing the reliability of observer-rated clinical symptom assessment. In many ways this research had had the desired impact – clinicians . . . . using . . . . structured interviews can come to a reasonable agreement on what symptoms patients are experiencing . . . ."

What is the goal of a classificatory system? Is it to formulate a system where many authors can concur or is it for the benefit of a patient and the clinician so that one can diagnose a disorder based upon etiology? And paradoxically, It appears more awkward if the same book, a few paragraphs earlier had stated that "the most important distinction between typical presentation of medical diseases and those of psychiatric disorders is the greater importance in psychiatric disorders of the patients sometimes idiosyncratic descriptions of his or her qualitative internal states, subjective experiences that are often difficult to describe in words. Many patients and clinicians often find it difficult to accurately communicate a fully comprehensible and reliable description of even familiar, somewhat universal feeling states.

What he says is important, not the meaning. I once had the opportunity to attend an International workshop held at Singapore, organized by a clinical drug trial company for training the psychiatrists in conducting a drug trial. The workshop had highlighted the machine-like attitude of defining the signs and symptoms – it was either present or absent – there could not have been any scope for peeping inside the mind of the patient. And the same workshop was being attended by many young non-clinicians – who could not be expected to have that clinical grasp of the patient's psyche. How much reliability of the findings of those trials can we be sure of?

My conscious had not permitted me to subject my patients to such types of trials. I am happy, so should you. While listening to a presentation in a conference, the author of a study of brain imaging techniques by PET scan reported a reversal of changes attributed to cognitive impairment of schizophrenia. And the molecule they used for this reversal was not any known antipsychotic molecule

but by mirtazapine. There is a mistake either at some steps. And one of the queries would be 'Is the cognitive impairment a feature of schizophrenia or was it not possible that the defect was caused by depression?' You have assumed the diagnosis, you have attributed the significance of some part of the clinical picture to that diagnosis and you have assumed the changes seen as re-enforcing your theory. Is there any scientific basis for that assumption? And one of the audience had very aptly asked the question, that, sir, when we shall be able to find any etiology of schizophrenia, and the answer we all know. It was the question we faced when we were studying psychiatry way back in the seventies and it is the question which still eludes the scientists.

Do those scientist, even for once, ever think that there is some mistake somewhere in their methodology? Is it not because of diversion from the stand of our predecessors that even after more than a hundred years of research, the statement for schizophrenia in the above-stated book is, "Although its phenomenology is fascinating, its pathophysiology and etiology remain unclear, and people with the illness suffer greatly. . . . No one knows which of the modern neuroscience methodologies or knowledge areas will ultimately address schizophrenia pathophysiology."

Making schizophrenia-related behaviors in animals has been particularly challenging. Some symptoms, such as delusions and hallucinations and disordered thoughts and speech, cannot be modeled. However, behavioral assays that model some features of schizophrenia, such as locomotor agitation, sensitivity to psychostimulants, social interaction abnormalities, and cognitive impairment, have been developed. Patients with schizophrenia have differences in cognitive performance. There are many animal study models that prove the efficacy of antipsychotic molecules in reversing the dysfunction of executive function produced by dopamine agonists. How much credit should be given to this phenomenon? Is cognitive impairment a fundamental feature of schizophrenia?

More than a hundred years earlier "go on analyzing the brain to the minutest possible biochemical status, but can you still predict with certainty if the individual harbors homicidal intent"?

A Symptom or Sign Serves Three Purposes

- Face validity, whereby we presume the diagnosis.
- Construct validity, whereby we predict the psychopathology and the mechanism that has led to the disorder.
- And we can also say, predictive validity, whereby we presume the severity of the disorder and the prognosis.

The Same Three Principles are used in Animal Research Methods

- Predictive validity: This refers to the extent to which the effects of drugs in an animal assay will predict their efficacy for symptom alleviation in humans.
- Face validity: The extent to which the behavior under study resembles the human behavioral process that it is intended to model.
- Construct validity: Refers to the extent to which the assay reproduces the etiology and pathophysiology of the disorder that it is intended to model.

Are We on the Right Path?

Neither the face validity of a symptom is pathognomic of diagnosis in psychiatry, nor do the animals have any behavioral correlate to human beings.[3] If the basic principle of face validity of a symptom or sign is not correct, can we design or interpret the findings from this research in the right direction?

Do We Design our Psychopathology on the Basis of these Anatomical Findings?

In the anatomical findings from the brain, one study in the brain system that organizes coping processes that control our experience and behavior stemmed from the work of Heinrich Kluver and Paul Bucy of marked taming of monkeys produced by excision of their temporal lobes. The study had also found that not only taming but also other "basic instincts": fighting, fleeing, feeding and sex – were also dramatically altered by the removal of the amygdala. Have we tried to formulate our diagnostic system on the basis of this important observation?

Similar questions for emotional disorders.[4-6] We have six known basic (Innate) emotions. The big six emotions are happiness, sadness, fear, surprise, anger, and disgust (Paul Ekman). However, I have been proposing four types.[4] Nevertheless, have we made the classification of emotional disorders on the basis of these innate emotions? Mood disorders are disorders of emotions, then why only we find the two states of elation and depression as being caused by these disorders?

Lesson not Learned

A Swedish study done by Paul Lichtenstein and colleagues in 2009 was conducted on more than 2 million nuclear families, which were identified from the Swedish population and hospital discharge registers.[7] The authors had concluded that they "found evidence that schizophrenia and bipolar disorder partly share common genetic causes, which challenges the nosological dichotomy between schizophrenia and bipolar disorder." And a similar finding has been reached in animal study models on genetics, which states that schizophrenia & bipolar disorder share a common genetic etiology and indicates that different polymorphisms in genetic susceptibility loci may result in distinct phenotypic consequences.

Hence, the big question remains.

Have we applied these observations in adopting our diagnoses and classificatory system?

Patients have not changed, nor their clinical picture. It is we whose views have rather. Description of signs and symptoms in psychiatry have remained fairly constant over the centuries, and it is by their particular constellation that we diagnose a disorder. However, the meaning associated with them, their diagnostic utility, and the form with which they have been associated have not remained constant. That is one of the reasons that various terms which we have been accustomed to, have been found to be missing from newer classifications. A case in example is for the term 'Neurosis' which we find missing from newer classificatory systems. We have to accept that The studies done on animal models require an equivalent subjective and objective representation of the signs and symptoms, which is not possible most of the time. We have to find out the psychological meaning of those psychological symptoms – not hypothetical ones but meaning based on solid evidence. The diagnosis in psychiatry is not an issue of a yes or no phenomenon. We have to take into consideration the various other variables like constellation, heredity and cultural factors in giving shape to a symptom.

For the future, If we want to serve and save psychiatry, then we have to first formulate the fundamental features, fundamental signs and symptoms and formulate a theory based on the available anatomical, biological, clinical and ethological findings. We have to shed away some firmly held concepts that we have stuck to for the last hundred years.

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