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Notes on a Few Issues in the Philosophy of Psychiatry*

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ABSTRACT

The first part called the Preamble tackles: (a) the issues of silence and speech, and life and disease; (b) whether we need to know some or all of the truth, and how are exact science and philosophical reason related; (c) the phenomenon of Why, How, and What; (d) how are mind and brain related; (e) what is robust eclecticism, empirical/scientific enquiry, replicability/refutability, and the role of diagnosis and medical model in psychiatry; (f) bioethics and the four principles of beneficence, non-maleficence, autonomy, and justice; (g) the four concepts of disease, illness, sickness, and disorder; how confusion is confounded by these concepts but clarity is imperative if we want to make sense out of them; and how psychiatry is an interim medical discipline.

The second part called The Issues deals with: (a) the concepts of nature and nurture; the biological and the psychosocial; and psychiatric disease and brain pathophysiology; (b) biology, Freud and the reinvention of psychiatry; (c) critics of psychiatry, mind-body problem and paradigm shifts in psychiatry; (d) the biological, the psychoanalytic, the psychosocial and the cognitive; (e) the issues of clarity, reductionism, and integration; (f) what are the fool-proof criteria, which are false leads, and what is the need for questioning assumptions in psychiatry.

The third part is called Psychiatric Disorder, Psychiatric Ethics, and Psychiatry

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Connected Disciplines. It includes topics like (a) psychiatric disorder, mental health, and mental phenomena; (b) issues in psychiatric ethics; (c) social psychiatry, liaison psychiatry, psychosomatic medicine, forensic psychiatry, and neuropsychiatry.

The fourth part is called *Antipsychiatry, Blunting Creativity, etc.* It includes topics like (a) antipsychiatry revisited; (b) basic arguments of antipsychiatry, Szasz, etc.; (c) psychiatric classification and value judgment; (d) conformity, labeling, and blunting creativity.

The fifth part is called *The Role of Philosophy, Religion, and Spirituality in Psychiatry.* It includes topics like (a) relevance of philosophy to psychiatry; (b) psychiatry, religion, spirituality, and culture; (c) ancient Indian concepts and contemporary psychiatry; (d) Indian holism and Western reductionism; (e) science, humanism, and the nomothetic-idiographic orientation.

The last part, called *Final Goal*, talks of the need for a grand unified theory.

The whole discussion is put in the form of refutable points.

Key Words: *Why, How And What; Eclecticism; Diagnosis And Medical Model In Psychiatry; Bioethics; Disease, Illness, Sickness And Disorder; Biological And Psychosocial; Critics Of Psychiatry; Mind-Body Problem And Paradigm Shifts In Psychiatry; Psychiatric Ethics; Social Psychiatry; Liaison Psychiatry; Psychosomatic Medicine; Forensic Psychiatry And Neuropsychiatry; Antipsychiatry; Blunting Creativity; Psychiatry, Religion, Spirituality, And Culture; Ancient Indian Concepts; Science, Humanism And The Nomothetic-Idiographic Orientation; Grand Unified Theory*

I. Preamble

I.A. Some Basic Premises: Silence and Speech - Problem of Life and Disease

I.1. The main heading needs to be clarified: 'Notes on a Few Issues in the Philosophy of Psychiatry'. What follows are *notes* without much of elaboration, and on *a few* issues, not all.

I.2. All discussion to follow is in the form of refutable points. The endeavour is to put forward the irrefutable, and then find out if it stands the critical scrutiny of peers.

I.3. Since this paper is a series of points/notes rather than a typical academic paper, it apparently may not offer a coherent argument or position. Rather it appears to present only a number of refutable assertions. On closer observation, however, the points/notes will not fail to offer a coherent position/argument

to the discerning. In terms of structure, it is similar to Spinoza's *Ethics* (Spinoza, 1927), Wittgenstein's *Tractatus* (Wittgenstein, 1998), or the *sutras* of Gautama's *Nyayasutras* (Jha, 1984). Such works need a *bhasya*, or commentary, to take over from where they leave.

I.4. Often the points may tease the reader, and leave him gasping for meaning. Sometimes, they appear profound, but inscrutable. Sometimes, certain points appear naïve, if not frivolous. At other times, too cryptic for comfort. All this may appear intentional, but is not necessarily so.

I.5. 'What we cannot speak about we must pass over in silence' (Wittgenstein, 1998, Section 7, p74). What we cannot speak about we must also acknowledge we cannot speak about. That requires breaching the silence. And then make efforts so that we can validly speak about. That requires effort. Silence is acceptable only in the interim. Silence of speech is complementary to effort and necessary to be able to effectively break it some time.

I.6. 'The solution of the problem of life is seen in the vanishing of the problem' (Wittgenstein, 1998, Section 6.521, p73). A similar proposition can be made about disease.

I.7. The solution to the problem of disease is seen in the vanishing of the problem (of disease).

I.8. Disease cannot vanish. *Diseases* can.

I.9. Some of the infectious ones have: small pox, for example.

I.10. Some of them disappear only to get a new name, as diagnostic formulations get refined, or etiological considerations enter diagnostic entities. For example, the present day attempt to re-label schizophrenia as 'hyperdopaminergic state of mesolimbic cortex' [causing positive symptoms] and 'hypodopaminergic state in the mesocortical tract [causing negative symptoms]' – both based on the Dopamine hypothesis of Schizophrenia]. While some may disappear empirically as well. For example, we say, 'There are no more cases of smallpox, etc.' (incidentally, smallpox may have disappeared as a disease entity, but its virus still exists in labs).

I.11. But *disease* cannot disappear. Preventive medicine can reduce it, and it should; treatment can cure/control it, but cannot eliminate it.

I.12. It is something like men come and go, but manhood remains. The universals remain, but the particulars come and go.

I.13. As we saw in I.8, although disease cannot vanish, the problems of disease can. This is the very basis of medicine, its very *raison d'être*. It treats the problems of a particular disease (clinical medicine); it can even reduce its occurrence (preventive medicine and allied branches), even if it cannot obliterate disease as an entity. This is equally applicable to psychiatry as a medical discipline.

I.B. Some and All of the Truth; Exact Science, and Philosophical Reason

I.14. 'The exact sciences do not encompass all of the truth but only the exact knowledge that is binding to the intellect and universally valid. Truth has a greater scope, and part of it can reveal itself only to philosophical reason' (Jaspers, attr., Shepherd, 1985).

I.15. In other words, science cannot know the whole truth, for which we need to supplement it with philosophical reason.

I.16. Varma articulates a similar thought when he says it is fatal to think that the scientific approach is the only one, because most of the important things do not lend themselves to the scientific approach (Varma, 1989).

I.17. With regard to I.14, for psychiatry, we are in dire need of exact knowledge, and knowledge that is universally valid. If such knowledge is not the whole truth, so be it. For, in the name of the whole truth, so much that can never be proved valid can gain currency.

I.18. And as regard I.16, while the scientific approach may not be the only one, it is the only one that can be empirically validated and refuted. And can, therefore, lead to progression of *verifiable* thought. This is how it has been with any scientific discipline down the centuries.

I.19. It is critical that psychiatry, which claims to be a scientific discipline, does not lose sight of this. It either gives up the claim of being scientific, or learns to follow the canons of science.

I.20. Further, with regard to I.16, it is true that most important things do not lend themselves to the scientific approach. So what do we do about it?

I.21. Develop the necessary tools to study them. And till such time, prefer not to comment on them. But accept them as valid only when so proved. In the interim, accept a state of suspended judgment, sometimes akin to suspended animation. That is the essence of a scientific approach.

I.22. 'A true scientist follows two cardinal rules. He is never unwilling to accept the worth of evidence, howsoever damning to the most favourite of his theories. Second, and perhaps more important, for want of evidence, he withholds

comment' (Singh and Singh, 2004). To give a simple example, if you were to ask a scientist, 'Does God exist,' he can, and must, neither say yes nor no. Until he gathers evidence either way, he remains in a state of suspended judgment.

I.23. Science has a limitation that it is aware of and respects. It is an admirable quality of science to realise it and to work within it. The same cannot be said of many other branches, including philosophical reason (see I.14).

I.24. Furthermore, as regard I.14, the truths revealed to such philosophical reason need scientific validation to provide ground for their acceptance. Till such times, they remain brilliant, but groundless.

I.25. And as far as *all the truths* go (see I.14), many so-called truths may turn out to be idle speculations, unproven, and more important, eternally unprovable.

I.26. Such 'truths' may kindly be forsaken, howsoever attractive they appear. For they often offer half-cooked solutions. And a sense of finality not in consonance with the existent state of knowledge, or the ignorance thus generated, and cloaked. More importantly, it stifles such further enquiry as has the potential to unravel this same 'truth' some time in the future.

I.C. Why, How, and What

I.27. A scientist looks at the 'how' of a phenomenon. A philosopher looks at its 'why'. This is almost a truism. For example, a scientist is concerned with *how* we are born. A philosopher is rather concerned with *why* are we born.

I.28. A philosopher starts with 'how' and ends in 'why'. For example, he understands *how* birth occurs but wants to know *why* it should occur at all. A true scientist must start with the philosophers' 'why' and end in 'how'. This means that a scientist must explain *why* birth occurs by evidencing *how* it is necessary for the perpetuation of the species. This 'how' can become the nidus for a new 'why' of the philosopher, which should be worked over to reveal a new 'how' of the scientist. For example, the '*how* of the perpetuation of the species' argument of the scientist becomes the nidus for the '*why* at all is perpetuation of life, or species, necessary' argument of the philosopher. The Hegelian dialectic of thesis-antithesis-synthesis. Till we can reach a state where the 'how' itself becomes the 'why'. Which means *how* birth occurs subsumes *why* it should occur. And then no new 'why' results. From our earlier example, no need to know *why* we are born (see also I.31).

I.29. Then speculation ceases. The role of the philosopher too ceases. In this, both science and philosophy actualise themselves.

I.30. Easier said than done.

I.31. What is the nature of a question that combines both 'how' and 'why'? It will be an integrated question - a 'what'. What is the nature of an answer that combines both 'how' and 'why'? It will be an integrated answer - again a 'what'. That may appear philosophically naïve, but is not.

I.32. By integrated, or a 'what', we mean it involves the empirical knowledge of the scientist combined with the speculative reason of the philosopher. Take the example quoted earlier of '*how* is a person born' and '*why* is a person born' (see I.28). The first is a scientific question, the second a philosophical one. If someone asks both, '*how* is a person born and '*why* is a person born', he is asking a composite question - '*what* is birth'. And the answer to such a question will be a composite or integrated one too: 'Birth involves... (physiological explanation)... Birth also involves... (trying to know why are we born, the purpose of life, the reason we are born as humans and not snakes/cockroaches, etc. - philosophical explanation)...' That is a composite answer. It often involves moving back and forth from the empirical to the speculative. In other words, someone seeking a composite answer to the phenomenon of *what* is birth must keep track of recent advances in understanding *how* birth occurs and combining that knowledge with recent advances in understanding *why* it should occur. And combining this knowledge with earlier knowledge of the *how* and *why* of birth. And doing it all in such a manner that it does not stifle further enquiry either into the *how* or the *why*. In other words, without propagating, in themselves and others, the fossilization of thought due to premature, or fore, closure of further enquiry.

I.33. This is not the 1950's Oxford view of philosophy (see J.L. Austin for example) as bits of philosophy being jettisoned from philosophy (e.g. psychology) and becoming sciences. It is rather science and philosophy coalescing at critical junctures to offer a more comprehensive grasp of the phenomena being studied.

I.34. The whole purpose, and business, of science is to make the need for the speculative as less as possible in understanding phenomena. In our earlier example, we find such answers to '*how* birth occurs' that pre-empt further questions as to '*why* it occurs'. To that extent science is eventually antiphilosophy. The purpose of philosophy is to aid this process by offering fresh speculation. To that extent, philosophy is essentially science-nurturing.

I.35. This may shock someone who believes science and philosophy are complementary, or at least should be. Mark the words *eventually* and *essentially*.

I.36. In our earlier example, of I.32, whenever science supplies an answer to '*how* birth occurs', philosophy offers a fresh speculation as to *why* the answer is incomplete, yet as there are many more questions still unanswered. And thereby prompts science to seek more complete answers by further robust evidential enquiry. Hence, philosophy is essentially science-nurturing.

I.37. Philosophy also sometimes forecloses the issue by offering answers itself, but in so doing it does a disservice both to itself and to the furtherance of knowledge. Philosophy by itself cannot give complete answers; science by itself cannot either. But with both acting their roles, science supplying the *hows* and philosophy the *whys*, the *whats* of phenomena may get unraveled ultimately. The philosophers of science have a strong role to play in reaching this ultimate destination, the *whats* of phenomena, provided they realize the stakes involved, and are ready to rise above their petty loyalties to schools and standpoints.

I.38. From I.34, we know science is basically antiphilosophy, while philosophy is basically science-nurturing. Which means philosophy is in the unenviable position of nurturing a branch that may ultimately destroy it - science may prove to be the Frankensteinian monster, the *Bhasmasura* of philosophy.

I.39. That is not a cause for alarm, for it is in such nurturing, and ultimate destruction, that philosophy will actualize itself. Provided science does not manage to annihilate mankind itself before this: (i) because of its value-neutrality; and (ii) because of the nefarious powers and processes it places in the hands of the unscrupulous.

I.40. Academic philosophers need not be alarmed at this talk of ultimate destruction of philosophy. It is not happening that soon. Science is smart, but has many impediments to cross. Most of it is related to the inadequacies of its own methods, and due to the rigour it places on its findings. But if it does succeed, it will help actualise philosophy itself. Something like the father whose legacy lives on through his illustrious son.

I.41. By destruction of philosophy, we mean not the end of philosophical analysis, but the end of philosophical speculation. Philosophy as conceptual analysis will survive till the end of thought itself. But its other role, of offering speculative insights, may become redundant if science can pre-empt such a need some day.

I.D. Mind and Brain

I.42. The mind is the functional correlate of the structure called the brain. It has no existence aside and apart from it. All the functions of the mind are the result of, or connected to, the functioning of the brain. All attempts to prove otherwise are diversionary, even if well intentioned, and must be abandoned.

I.43. What exactly is the mind? The mind is the function of the brain, nothing more, nothing less.

I.44. What is the mind and what is the body? We must distinguish between structure and function. For example, a house has a structure - the walls. It has a

function - to shelter people, furniture, appliances, etc. Similarly, the body has a structure, which includes head, neck, thorax, abdomen and limbs. It has many functions: to think/sense (head), to connect (neck), to respire/circulate (thorax), to digest/evacuate/procreate (abdomen), to move (limbs). Within the head is a structure called the brain. Brain is connected to different parts of the body through neuronal structures passing through the spinal cord, cranial nerves, and the neuro-endocrine system. The whole functions of brain can be subsumed under the broad category called the mind.

I.45. The body functions are included in physiology. Similarly, the brain functions are included in the entity called the mind, or better 'brain neurophysiology'. The brain (structure) is connected to the rest of the body (structure). The mind (function), being a function of the brain, is connected to the physiology of the rest of the body, not to the body.

I.46. In fact, to avoid confusion over the varied meanings that the concept 'mind' has for different people down the centuries, the term 'mind' may be abandoned for the term 'brain neurophysiology', which better reflects scientific understanding.

I.47. If this is the materialist-physicalist position, fine! Just point out what's wrong with it, and how does it harm further advancement of psychiatry to think thus?

I.48. Is a disorder of the mind a disorder of the body or not?

I.49. Actually the question should be worded: 'Is a disorder of the *brain* a disorder of the body or not?' Thus put, the whole mystery dissolves. Of course it is. The brain being a part of the body, a disorder of the brain is very much a disorder of the body. Since what we call the 'mind', is just the function of this brain, a disorder of the mind is equally as disorder of the body, but of its physiology, or functioning.

I.50. A simple example of a disorder of the brain causing a disorder of the body is a paralytic stroke. A cerebro-vascular stroke causes disorder of the brain tissue. This results in reduced nerve impulses to bodily parts, and can cause weakness of the limbs, etc.

I.51. A disorder of the mind is actually a disorder of the brain, gross structural or subtle biochemical. A disorder of the brain manifests as a disorder of brain functioning, which we call a disorder of the mind. For example, hallucinations and delusions are *manifestations* of a disorder of the brain, and can, therefore, be called disorders of the mind. Such disorders of the brain are connected to disorders of the body, since the brain itself is dynamically linked to the body. For

example, when we are anxious (brain activity), we may have tremors, sweating, palpitations, etc. (body activity); when we are depressed (brain activity), we may have decreased/slowed movements (body activity).

I.52. So a disorder of the brain manifests as a disorder of the mind, which is intimately connected with the functioning of the body, and its disorder.

I.53. How do we know what is going on in someone's mind? By internal observation: studying his brain with neuroimaging studies, etc.; by external observation: careful observation of his behaviour and analysis of his thought processes, which are manifestations of brain functioning (mind) available for study by a trained outside observer.

I.54. How can we understand the individual experience of identity, and how do we enter into the world of another?

I.55. To understand an individual's experience of identity, we must first identify the brain centers that get activated when an individual thinks of his 'I-ness. Where is the center for personal identity in the brain, if any? What are the connections stimulated when a person is thinking of himself, or introspecting? And what thought processes are stimulated when one thinks of oneself, and its corresponding neurophysiological correlates?

I.56. A tall order, but this, and such, has to be the agenda for brain research in the future. Psychiatry can play a pre-eminent role here only if it knows the challenge it must accept, and the pitfalls it must avoid.

I.57. A question may be posed thus: How about mind existing without the brain: what about functionalism, AI, extended mind? The precise point is that brain may not be essential for mentality: may be instantiated in alternate physical structure? The answer is we are discussing *human* mind and *human* brain here. Many other forms of 'mind' and 'intelligence' are potentially possible. But they are of peripheral relevance to psychiatry.

I.58. 'Whether a mind can exist in the absence of a functioning brain is a theological question, not a scientific one.' (Kendell, 1993) What is subsumed under mind by the 'theologist' here is equally the function of the brain (and its appendages - the nervous system), albeit waiting to be unraveled.

I.59. When we talk of consciousness, we think of it as a cerebral phenomenon. We are aware of our surroundings, we are oriented to time, place, person, day, date, etc. We make intelligent conversation with others. These are cerebral events. But how does the cell 'know'? When does the gastric mucosa cell decide it has to secrete gastric juice? If this is cellular 'consciousness', it is obviously not a cerebral event, since it is mediated at the cellular level. The answer to this is

that such cellular 'consciousness' and intracellular mechanisms are connected with the nucleus and other cellular organelles, which are connected to the neuroendocrine system, and therefore eventually with the brain. Hence we can think in terms of 'creature consciousness' and 'cellular consciousness', and both are direct and connected brain activities respectively. Whatever else may be the meaning/s given to consciousness, and all the different theories connected with it -- and philosophical literature is teeming with it, down the centuries -- they all are known/unknown functions of the brain, its appendages and the neuro-endocrine system, many of them just waiting to be unravelled by scientific probing. Nothing more, nothing less.

I.60. Epistemology, metaphysics, and especially theology and philosophy of mind can supply many speculative insights, which will need scientific enquiry and validation to convert them into empirical knowledge. Without such validation, they may remain profound, but cannot become the basis of psychiatric theory or therapy.

I.61. For example, when Buddha said life is full of suffering (*dukkha*), and 'desire' or 'craving' (*tanha*) is the cause of suffering, he was offering a speculative insight (see also V.22 xiii). This must be validated by population studies. Suppose we studied 1000 people and found their life full of suffering, and 'desire' or 'craving' was its cause, then his speculative insight becomes converted into empirical knowledge. And this guides us to develop a method of therapy, or to formulate a psychiatric theory. Otherwise, it is a profound insight, but unvalidated, and cannot become the basis of any theory or therapy, howsoever attractive it may appear *prima facie*.

I.62. All bodily phenomena, mental included, involve physiological correlates, whether understood or otherwise. (In the case of mental phenomena, they are neurophysiological correlates.) All diseases, psychiatric disorders included, involve pathological correlates, whether deciphered or not. (In the case of psychiatric disorders, they are neuropathophysiological.)

I.63. The attempt to find biological determinants of behaviour in health and disease is a valid exercise. But it does not preclude finding psychosocial correlates as well.

I.64. The ultimate aim is to 'crack the code' of brain function in health and disease. This involves finding biological correlates of normality; and those of clinical-descriptive states, syndromes, and diagnostic entities under the broad category of abnormality. No waylaying of this agenda can be justified.

I.65. Some believe that, whilst undoubtedly there are correlates from mind to brain, there is no reason why the brain correlate should be neat and tidy and have

some meaningful structure. See Davidson on supervenience, for example, who believes in his 'anomalous monism' that 'causal relations hold between mental and physical events, and that all causal events entail the existence of *some* law of nature, while at the same denying that these laws can possibly relate mental and physical descriptions of an event' (Flew, 1984, p84).

I.66. The reason why there is no neat and tidy correlation is that we accept there may be none possible. The justification why laws of nature and causal relations are supposed to hold but cannot relate mental and physical events is that one cannot visualize such a correlation according to one's existent state of knowledge. It's like I cry, laugh, speak, see (all physical events), have a causal relation with mental phenomena, but still cannot accept that some law can possibly link the two. Is this 'anomalous monism' or 'anomalous reasoning'?

I.67. Even as the 'code' is cracked, the issue of how psychosocial factors impinge upon, modify, even regulate it, in health and disease - and in the transformation from health to disease and vice versa - remains a legitimate concern. Hence, there is no respite from the psychosocial, however biological psychiatry becomes. 'Even when we do "crack the code" of brain function (and this may happen fairly soon), we will still have to master the way in which input from personal and social sources interacts with individual, biopsychological systems' (Farrell, 1985; p14-15).

I.68. All attempts to separate the biological from the psychosocial are valid only in so far as they lead to robust evidential enquiry in their respective disciplines. And add to the corpus of objective refutable knowledge.

I.69. When used to settle scores, or prevent thinning in the ranks of followers, they fail the test of science.

I.70. For example, when psychologists, in trying to justify their presence in treating 'mental health problems', dismiss their medical conceptualization, and even the need and justification for psychiatric diagnosis itself (Kanfer and Saslow, 1965, p529; Tarrier, 2007), they are in danger of being a recent manifestation of the phenomenon outlined in I.69. Similarly, psychiatrists, in opposing drug-prescribing privileges of psychologists, manifest a similar urgency; and 'The claims of patient safety and public health, cited by both sides, are difficult to disengage from the more parochial economic concerns of the two professions' (Brooks, 2001).

I.E. Robust Eclecticism; Empirical/Scientific Enquiry; Replicability/Refutability; Diagnosis and the Medical Model in Psychiatry

I.71. Robust eclecticism is compatible with subscribing to any one strand of

thought in psychiatry - biological or psychosocial.

I.72. Robust eclecticism remains robust only as long as it accepts the worth of evidence from any quarter, even adversarial. It is the best antidote to scientific fossilization. But it is no substitute for robust empirical enquiry.

I.73. Eclecticism is an attitude. Empirical enquiry is a process. One cannot substitute for the other. But one can, and should, complement the other.

I.74. Empirical enquiry stands supreme in psychiatry. Nothing can replace it. It may be preceded by large exaggerated guesses but must be succeeded by unstinting critical enquiry. And a necessary analysis as to irrefutable conclusions from the existent state of knowledge. Such critical enquiry and analysis is as important as the empirical enquiry itself. It must lead to further empirical enquiry that refutes these apparently irrefutable conclusions. This is the inevitable, inexorable process of scientific progress in psychiatry. It is Popperian refutation/falsifiability in action (Popper, 1935/2004). And a necessary inbuilt self-correcting mechanism that inevitably results therefrom. This is the only valid way to add to the corpus of empirical knowledge. 'It is part of my thesis that *all* our knowledge grows *only* through the correcting of our mistakes' (Popper, 1963/2002; Preface to the 2nd Edn., first published in 1965).

I.75. Criticism can be made to the position forwarded in I.74 that this is a foundationalist view of knowledge uncritically accepted here, and throughout the paper, a rather old-fashioned rationalist view with irrefutable truths serving as the grounding of knowledge. For alternatives, one may want to consider, for example, Quine on coherentist theories of truth and his assault on empiricism (Quine, 1951).

I.76. There are two aspects to this criticism - one, a foundational view being uncritically accepted, which is based on an old-fashioned rationalist view that irrefutable truths are the basis of knowledge; second, the assault on empiricism of Quine *et al.*

I.77. As regard the first, if basing one's knowledge on irrefutable truths is old-fashioned, and rationalist, we plead guilty of being both. We wonder how else knowledge can be based, especially in a branch that claims to belong to the corpus of biomedicine. That irrefutable truths are not available in the present does not mean they are not possible in the future. In fact such a search is the very basis of scientific enquiry into any phenomena, psychiatry included. You negate this, and you negate the very foundation of science.

I.78. As regard the second charge, even if we accept the Duhem-Quine thesis (Duhem, 1954; Quine, 1969) that any theory can be made compatible with any

empirical observation by the addition of suitable ad hoc hypotheses, the thesis cannot deny either the empirical observation, or the need for a theory to explain it. It just means we should adopt as few ad hoc hypotheses as possible. And try and subject them to empirical observation as well at some time or the other. It also means that if the ad hoc hypotheses are found unacceptable, we may find the theory unacceptable, at least in its present form, and the assumptions that follow it. And either refute it, or modify it. It does not negate the empirical observations that led to it. And theories built on empirical observation need to be refuted on empirical grounds. Or by falsifiability. Not by negating the need for an empirical base to theorising, or empiricism itself. Psychiatry would do well to abide by this.

I.79. Confirmation holism of Quine states that evidence alone is insufficient to determine which theory is correct (Wikipedia, 2007), and that empirical data are not sufficient to make a judgment between theories.

I.80. But evidence is the only bedrock of any theory in science; and empirical data are necessary to construct a theory, at least in science, and especially so in psychiatry, which needs to establish its scientific credentials in biomedicine. And empirical data are necessary to adjudicate between theories based on empirical observation, as all theories in biomedicine have to be. Psychiatry cannot be an exception.

I.81. Empirical data are necessary, although not sufficient, to make a judgment between theories. It needs to be supplemented by robust reasoning, which is falsifiable. The self-correction that results therefrom is how science progresses. This is also how psychiatry will.

I.82. Occam's razor implies economy, parsimony, or simplicity, often or especially in scientific theories. It involves selecting the theory that introduces the fewest assumptions and postulates the fewest entities. In other words, 'one should choose the simplest hypothesis that will fit the facts' (Lacey, 1986). For biomedicine it also means diagnostic parsimony, which means that when diagnosing a given injury, ailment, illness, or disease, a doctor should strive to look for the fewest possible causes and clearest possible diagnoses that account for the greatest possible signs and symptoms in a given case. And parsimony in theorising that looks for greatest number of empirically verified claims and least number of unsubstantiated speculative leaps in a given theory. Clarity and simplicity are the desired goal, though it does not mean we unduly simplify issues for that only forecloses further enquiry, or seek illusory clarity for that only breeds didacticism. That is a pitfall teachers especially need to avoid in an evolving branch with imploding research evidence, as psychiatry at present is. Only empirically verified, replicated, and non-falsified hypotheses/theories can ensure this.

I.83. Psychiatry, and biomedicine in general, probably needs more of Occam's razor, and less of Quine *et al.*'s assault on empiricism.

I.84. Scientific enquiry is valid in psychiatry. Individual insights of therapists and researchers are valid only if backed by scientific enquiry, which stands the test of replicability and refutability - that is, by experimental population studies. 'Clinical insights, especially those based on individual cases, need to be supported by independent and objective methods' (Kandel, 1999).

I.85. By replicability we mean it is validated by studies at other centers and at other times. By refutability we mean it is presented as a finding that can be refuted by any other empirical enquiry.

I.86. Some believe that psychiatric diagnosis dehumanizes. Their concern is admirable, but their thrust is likely to be misplaced. Diagnoses do not dehumanise, attitudes to diagnoses do. Let's change attitudes, rather than find fault with the need to diagnose and treat, where advance will ultimately help change attitudes. Moreover, the agenda of those who believe diagnoses dehumanise is liable to get hijacked, and they themselves can get hopelessly waylaid.

I.87. Others like Kanfer and Saslow (1965) 'dismiss psychiatric diagnosis as being limited by issues of precision, consistency, reliability and validity to a "crude and tentative approximation of effective individual behaviours"' (Tarrier, 2007; quotes in "... " from Kanfer and Saslow, 1965).

I.88. Further, as regard I.86, diagnosis cannot replace individual and customised care. But the converse is equally applicable. In fact diagnosis complements individual and customized care. And the latter helps refine the diagnostic process.

I.89. As regard I.70, the medical model to psychiatric classification is both scientific and objective. It is also inadequate and needs refinement, not dismissal.

I.F. Bioethics and the Four Principles of Beneficence, Non-maleficence, Autonomy, and Justice

I.90. Bioethics is one important interlink between medicine, psychiatry, and philosophy. And an overlap between philosophical theory and medical advance (Warnock, 2007).

I.91. The foray of academic philosophers into this branch is understandable, and welcome. The major task for academic philosophers here is to supply heuristic models, and for psychiatrists to test them empirically.

I.91. The roles can be interchanged only under active surveillance. Expertise in one area is not generalizable to expertise in the other, or the whole enterprise. Just being a good psychiatrist does not mean someone can be a good philosopher or bioethicist, and vice versa. Transgression of expertise may be counterproductive unless the basic tenets of the branch are adhered to.

I.93. Beneficence, non-maleficence, autonomy, and justice (Beauchamp and Childress, 1989) are useful conscience keepers for medicine, in general, and bioethics and psychiatry, in particular. But they need (1) the utilitarians' detailed blueprinting; (2) the clinician's practical implementation; (3) the scientists/researchers' hard-nosed verification coupled with the activist's constant surveillance (and, of course, a well-primed legal system too).

I.94. Something similar to the three arms of governance. The utilitarian scientist/researcher is like the legislature, the clinician like the executive, and the conscience-keeper scientist/researcher/activist like the judiciary.

I.95. It is worthwhile to distinguish between these two categories of scientists/researchers. The utilitarian scientists/researchers are at the cutting edge of research and technology, while the conscience-keeper scientists/researchers are the necessary shields so the cutting edge moves along the straight and narrow path, and doesn't cut around indiscriminately.

I.96. This may appear somewhat naïve, but is useful as an explanatory model. The utilitarian scientist/researcher must provide actionable models. The clinician must implement them while dynamically interacting with the utilitarian to provide better models. The conscience-keeper scientist/researcher, with the activists and investigative medical journalists, must together monitor the activities of both the utilitarian and the clinician to ensure the agenda (of beneficence, non-maleficence, autonomy, and justice) does not get waylaid.

I.97. Beneficence is essential, non-maleficence obligatory; autonomy is relative, justice debatable.

I.98. Beneficence is the bedrock of medicine, non-maleficence its conscience. Justice its sentinel, autonomy its crowning glory.

I.99. Each is dynamically linked to the other. But in case of conflict, autonomy is the first that may need to be compromised; then justice, which may be temporarily suspended, although most reluctantly. (The legal position will be different for obvious reasons.)

I.100. That leaves behind beneficence and non-maleficence. Which is more essential between the two? Beneficence.

I.101. Beneficence can never be forsaken. Can non-maleficence be forsaken, then? It need not be. If properly implemented, non-maleficence is built into beneficence.

I.102. Non-maleficence assumes greater importance in research, beneficence in therapy, but beneficence cannot exclude non-maleficence. For beneficence cannot involve harm ever, although it may involve an element of hurt (Singh and Singh, 2006).

I.103. The essence of medical practice is: to cure sometimes, to comfort always, to hurt the least, to harm never (*Ibid*).

I.G. Disease, Illness, Sickness, and Disorder: Confusion Confounded but Clarity Imperative; Psychiatry an Interim Medical Discipline

I.104. Attempts to distinguish between disease, illness, and sickness (Susser, 1990; Gelder, Gath, Mayou and Cowen, 1996, p58) appear tenuous. For example, *disease* refers to objective pathology; *illness* is subjective awareness of distress; *sickness* refers to a loss of capacity to fulfill normal social roles (Gelder, Gath, Mayou and Cowen, 1996, p58).

I.105. But they need deeper reflection. Let us take three examples to clarify them.

I.106. Disease as objective pathology - 'He is suffering from a brain *disease*'.

I.107. Illness as subjective distress - 'I am feeling *ill* since morning because of fever'.

I.108. Sickness as inability to fulfill a social role - 'He cannot attend work since he is *sick*'.

I.109. 'It is possible to describe patients in terms of one, two or three of these terms. Most patients suffering from physical disorders can be said to be suffering from disease, illness and sickness. However, in many of the conditions dealt with by psychiatrists, only the terms illness and sickness are applicable, and in some disorders of personality and behaviour only the term sickness is relevant' (*Ibid*).

I.110. From the above, it must make clear why we said the distinctions appear tenuous, or hair splitting. But further analysis can help clarify issues.

I.111. Parkinsonism is a *disease*, a *sickness*, and an *illness*. A disease since it has objective pathology; an illness since there is subjective awareness of distress (at least until the later stages of profound cognitive decline), and a sickness since it involves an incapacity to fulfil normal social roles.

I.112. Schizophrenia is a *sickness*, often but not always an *illness*, and still to be proved a *disease*. It is a sickness since it involves an inability to fulfill normal social roles; an illness because often (although not always) there is subjective awareness of distress; and not still a disease because there is no proven universally accepted objective pathology.

I.113. Most psychiatric problems are sicknesses since they involve an inability to fulfill normal social roles. They are often also illnesses since there is subjective awareness of distress. But none are diseases as yet since there is no proven universally accepted objective pathology.

I.114. *This is the most important problem for psychiatry to tackle.*

I.115. This is also the major source of sustenance for the multitude of critics of psychiatry.

I.116. All branches of medicine pass through the process of first being referred as illnesses/sicknesses, and finally diseases.

I.117. This is a necessary and inevitable progression.

I.118. Psychiatry can be no exception.

I.119. The major task of psychiatry, therefore, is to prove its illnesses and sicknesses are also diseases. Then, it will truly become a branch of medicine. Till such time, it approximates, but does not fully become one.

I.120. The attempt to pick holes in the argument for the objectivity and reality of physical diseases is this connection, which by itself is a brave attempt at deflecting serious criticism away from psychiatry maybe great advocacy, but hardly likely to stand ground on serious reflection. For a disease will always need objective pathology, and a disease cannot be wished away by argument. If you were to have high fever, get epileptic fits, get a heart attack, or have sadness of mood/crying spells/suicidal ideation, you would hardly sit disputing whether it was for real. You would visit a doctor who could make a diagnosis and help you with treatment.

I.121. When it does prove its diagnostic categories are diseases, psychiatry will truly establish itself. And all antipsychiatry will die a natural death.

I.122. The process to achieve this is to find objective pathology for its different diagnostic categories.

I.123. Hence the importance of biology in psychiatry.

I.124. However, until this happens, psychiatry has the promise to become, but only approximates, a branch of medicine. *It is at an interim stage of development as a medical discipline.* This is an uncomfortable but necessary realization, which we may ignore at our own peril. The whole movement has now to be to convert an interim branch to a full-fledged one. Nothing short of this thrust must be accepted.

I.125. Certain thought processes appear practical in the interim. We will cite below one such example, which we must develop the ability to give up some day.

I.126. ICD 10 blissfully gets rid of all discomfort by using the term *disorder*. "The term "disorder" is used throughout the classification, so as to avoid even greater problems inherent in the use of the terms such as "disease" and "illness" (ICD-10, 1992, p5).

I.127. Now we know why denial is an effective coping mechanism. And Freud refuses to get exorcised. No one can escape it, including the present authors. For we used the term 'disorder' fairly commonly all through this paper.

I.128. If and when psychiatric disorders are found to be diseases, will they remain psychiatric entities; or will they get usurped by other branches, like it happened with GPI? And will then psychiatry die, as Torrey predicts? (Torrey, 1974)

I.129. That is a distinct possibility. Torrey makes a profound but unsettling statement. That is the reason for the discomfiture of many in the psychiatric establishment to his line of thinking. And his boycott.

I.130. But in doing so, psychiatry actualizes itself. Just as there is a possibility that philosophical speculation may die when all speculation is rendered redundant by the scientific approach of empirical enquiry. (See also I.43-I.50.)

I.131. In other words, if science can become the Frankensteinian monster of philosophy, biology can become the Frankensteinian monster of psychiatry.

I.132. Chances, however, are that psychiatry will reinvent itself. As will philosophy. Although toxic, metabolic or infectious pathology may be implicated in most psychiatric disorders; their diagnosis, management, and research need not fall outside the domain of the newly emerging branch, neuropsychiatry, and/or a new branch that will be a combination of psychiatry, neurology, and internal medicine.

I.133. What will happen to the psychosocial approach, then? Even this new branch, as mentioned in I.132, will not have a respite from the psychosocial, because the latter will always impinge on any manifestation of psychopathology. So, proponents of the psychosocial approach need not despair.

I.134. Will psychiatrists have a role to play only until psychiatric entities remain illnesses and sicknesses, and no role to play when they become diseases?

I.135. Chances are that their role will continue as neuropsychiatrists, and the artificial schisms between the different neurosciences will get obliterated (see also III.26 and III.27).

I.136. Will psychiatrists help to make psychiatric problems ascend from illnesses to sicknesses to diseases, and, in doing so, bring about the annihilation of their own branch?

I.137. The answer will be same as I.129, I.130, I.131, and especially I.132.

I.138. Is it possible that, fearing such eventuality, psychiatrists may never allow the problems they handle to get recognized as diseases?

I.139. Some may try, wittingly or unwittingly, but that is only possible by halting the march of the scientific process in psychiatry, or denying the medical model in psychiatry; both of which at present appear impossible to sustain on logical grounds. Hence, attempts to justify the psychosocial model are justified (Kanfer and Saslow, 1965, p529; Tarrier, 2007; see I.70), but not at the cost of denying the legitimacy of the medical model.

I.140. Until psychiatric problems are proved to be diseases, and even after they are, psychiatrists will have the following roles to play: (1) help reduce the illness and sickness dimension; (2) help prove, and treat, the disease dimension; (3) help treat the illness and sickness dimension even after the disease dimension is proved; (4) help tackle the illness and sickness dimension of all medical and surgical entities that have a psychological angle: that is, the whole basis of psychosomatic medicine and liaison psychiatry, which will survive until medicine as a branch does. Hence, the psychosocial approach cannot but remain a core activity in psychiatry, even as the biological gains greater currency.

I.141. The charge can be made that the idea that biology is somehow more objective and self-defining runs through this paper. Moreover, the status of biological changes as diseases relies on the notion of illness as perceived in society. How do I know a brain is wrong, without knowing that it came from a person who acted in a certain peculiar way? Disease does not generate its own status.

I.142. Now the answers. Yes, biology is more objective and self-defining than any other branch, especially in a specialty like psychiatry, which needs to firmly and justifiably establish itself as a branch of biomedicine. If not, then every transgression can be justified. And, yes, societal notions are very important

in what constitutes disease/illness/sickness, and what does not. If it were accepted by society that it is healthy to get a heart attack, or to hallucinate, or fall unconscious, or commit suicide, there would be no justification for biomedicine.

I.143. To the question, 'How do I know a brain is wrong, without knowing that it came from a person who acted in a certain peculiar way?' the answer would be: there is no need for this differentiation in most of biomedicine, because the person who acts in a peculiar way is available for study, as is his brain. What is needed, more than anything else, is to study what are the neurophysiological correlates of his peculiar behaviour with the malfunctioning of his brain. Only biology can provide this. Also, even if one wants to know how a brain is wrong, without knowing the person who acted in a peculiar way, there is no objective way except that which biology can possibly provide. When we carry out a double blind experiment, with PET/MRI scans, and/or neurochemical studies of normal/maladjusted subjects. The authors would like to be enlightened if there is any better.

I.144. As regard the statement, 'Disease does not generate its own status', it does. Positively. Disease exists. It may be generated due to one or more reasons. But it exists. And since it gives rise to distress, disability, and the possibility of premature death, it generates its own status. We may deny that role to our own eternal discomfiture.

II. The Issues

II. A. Nature and Nurture; Biological and Psychosocial; Psychiatric Disease and Brain Pathophysiology

II.1. A hugely contentious issue is of nature and nurture. Acrimony and camp following apart, for both sides, there is much to integrate and assimilate from their opponents.

II.2. Genes determine, and regulate, behaviour. And behaviour alters gene expression. Both are interlinked through and through. The major task of modern psychiatry is to unravel which determines what, and to what extent.

II.3. Opinion may be divided about the need for naturalized teleology in science. About 'whether Darwin's theory of evolution provides a means of eliminating teleology from biology, or whether it provides a naturalistic account of the role of teleological notions in the science' (Collin, 2003). The latter is more plausible, for Darwin gives justification for why some species survive due to naturalized teleological modification. It does not negate them.

II.4. Dawkins carries on from where Darwin left by specifying how genes carry out such modification and propagation.

II.5. Are these relevant to the philosophy of psychiatry? Significantly so, since genes determine behaviour, including the abnormal, and abnormal behaviour is the ground and substance, the very *raison d'être* of psychiatry. How the selfish gene (Dawkins, 2006) and the extended phenotype (Dawkins, 1999) concern prevalence/incidence of mental disorders, and how the extended phenotype impacts the environment around, including close relatives, can be a fascinating area of interdisciplinary study for biology, ethology, and psychiatry.

II.6. Memetics, an approach to evolutionary models of information transfer based on the concept of *meme*, needs close scrutiny in psychiatry too. This is because memes - like, for example, ideas, habits, skills, behaviours, inventions, songs, and stories - are like genes, that is, they are replicators. It is necessary to investigate whether this link between genes and memes can lead to important discoveries about the nature of the inner self (Blackmore, 2000).

II.7. Study extrapolation about the nature of the abnormal inner self is then a logical extension, and of significance to psychiatry.

II.8. Studies such as those of Horatio Fabrega need further attention (Fabrega, 2005), since they tend to study the links between psychiatric disorders as objective reality, their cultural determinants, and how they are perceived and understood during phases of biological and cultural evolution. 'If one assigns disorders some sort of "objective" reality (a scientific ontology), then one needs to explain what that corresponds to in cultural terms. Moreover, if disorders exist and have an evolutionary history, one has to formulate how they might have been perceived and understood during phases of biological and cultural evolution' (Fabrega, 2005).

II.9. What constitutes psychiatric disease is the external behavioural manifestation of abnormality correlated with a pathophysiological process in the brain, reversible or irreversible.

II.10. The aim of psychiatric research is to decipher all such correlates. Also needed is precision in diagnostic categories and developing fool-proof objective methods to verify/justify them.

II.11. The aim is also to make the irreversible reversible. The aim, moreover, is to prevent such reversible and irreversible processes.

II.12. Any peripheral or related discipline, philosophy included, that aids this process is welcome. Any waylaying of this essential thrust is to be firmly resisted.

II.13. Insights in psychiatric knowledge will come from many sources, especially the psychological, the psychoanalytic, the sociological, and the

philosophical. Breakthroughs will come mainly, if not solely, from biology (Singh, 2007). It is in how far the former supply heuristic experimentally verifiable propositions that their insights will be justified. And it is in how far biology validates/refutes these insights that it will supply those breakthroughs.

II.14. This does not mean biological breakthroughs cannot supply fresh biological insights. Or become the nidus for fresh psychosocial insights. And it also does not mean that psychosocial and philosophical insights cannot provide etiological and therapeutic breakthroughs by themselves.

II.15. This does not also mean biology alone will supply therapies. It will supply breakthroughs, and many therapies; but it does not have the sole prerogative over them.

II.16. Psychiatric treatment will always require an empathetic grasp of the patients' inner feelings; and a working knowledge, if not an intimate grasp, of the sociocultural ethos in which they occur. Unless, of course, all psychopathology is ultimately found rooted in, and more important, fully amenable to biological and psychopharmacological intervention. And psychiatric problems include only those with visible or demonstrable lesions of the brain, and exclude all other categories at present subsumed therein.

II.17. The inexorable march of biology in psychiatry is directed toward achieving some such ambition eventually. That is its major propelling force, and the essential cause for alarm in proponents of the psychosocial approach, even if it may not be so voiced or realized.

II. B. Biology, Freud, and the Reinvention of Psychiatry

II.18. This fundamental march of biology, as noted earlier (see I.119-I.132), was anticipated by Torrey in his *The Death of Psychiatry* (Torrey, 1974), when he speculated that psychiatric conditions would ultimately be found rooted in biology, their drug treatments found like in the rest of medicine, and psychiatry as a specialty would cease to exist.

II.19. Psychiatry has not ceased to exist; but the form in which it was earlier when he talked of it, has. That 'Psychiatry reinvented itself', and continues to evolve, is in no small measure due to the searching scrutiny of its internal critics as to its spirited adherence to robust empirical enquiry. These will sustain its march in the future (see also I.132-I.135).

II.20. The fundamental march of biology was anticipated much earlier by Freud himself when he said, '... we must recollect that all our provisional ideas in psychology will presumably some day be based on an organic substructure' (Freud, 1987a).

II.21. 'He was very well aware of the deficiencies of psychological descriptions in his times, even those given by himself, and felt a biological replacement would be appropriate' (Singh and Singh, 2004-2005).

II.22. The following statement should be an eye-opener to his committed followers: 'The deficiencies in our description would probably vanish if we were already in a position to replace the psychological terms by physiological or chemical ones... Biology is truly a land of unlimited possibilities. We may expect it to give us the most surprising information and we cannot guess what answers it will return in a few dozen years to the questions we have put to it. They may be of a kind which will blow away the whole of our artificial structure of hypotheses' (Freud, 1987b).

II.23. Biology is the engine and the fuel. Will psychoanalysis hold the steering, help change gears, and stop clamping on the brake?

II.24. 'What is the aspiration of psychoanalysis if not to be the most cognitive of all neural sciences? The future of psychoanalysis, if it is to have a future, is in the context of an empirical psychology, abetted by imaging techniques, neuroanatomical methods, and human genetics' (Kandel, 1998).

II.25. Well, that is the steering wheel to maneuver.

II. C. Critics of Psychiatry, Mind-Body Problem and Paradigm Shifts

II.26. Psychiatry will do well to listen carefully to foundational critiques of its branch and its processes, and evolve more precise empirical methods to counter them.

II.27. The major psychiatric disorders need precise diagnostic categorization correlated with precise neuropathological changes. Major energies need to be invested here.

II.28 The whole movement of antipsychiatry and/or criticism of psychiatry can be countered only by making psychiatric diagnosis more precise, and psychiatric therapy more humane (see also I.104-I.144).

II.29. Engaging in dialogue with critics is worthwhile, but not at the expense of the above.

II.30 The mind-body dualism is misguided, even if earnest. It may be a useful mode of thinking in philosophy, but it is detracting to the main pursuit of determining the etiology and therapy of psychiatric disorders.

II.31. The mind *is* the brain. And the brain, the mind. They are two sides to the same coin (see also I.42-I.67).

II.32. All paradigm shifts in psychiatry involved unjustified neglect of some worthwhile approaches. The psychoanalytic neglected the biological. The behaviourist neglected the psychoanalytic. The present biological/cognitive may make the error of neglecting both.

II. D. The Biological, the Psychoanalytic, the Psychosocial, and the Cognitive

II.33. If psychoanalysis has to survive, it must present testable hypothesis. Its empirical, single case studies format must be supplemented by (even, at times, supplanted by), or form a hypothesis for, rigorous experimental verification. Otherwise, its future is oblivion, or a fringe existence.

II.34. Neither biology can subsume the psychosocial approach. Nor the latter can write off the former. Both need their own methods to validate knowledge. Both also need to accommodate fresh insights from competing views, and accept refutation of even their most fundamental assumptions in the face of irrefutable, duly replicated evidence.

II.35. How do biological and psychosocial approaches gel? (1) Only under the overarch of ensuring comprehensivity of patient welfare; (2) so that each supplies insights to the other while carrying out self-correction; (3) and each accepts irrefutable evidence of its shortcomings, from whatever source it originates, internal or external.

II.36. A synthesis of cognitive psychology and neuroscience offers the greatest promise at present. A renaissance of scientific psychoanalysis coupled with perceptive neurobiology, which can translate those insights into testable hypotheses, holds the greatest promise for psychiatry in the future (Singh and Singh, 2004-2005, p5).

II. E. Clarity, Reductionism, and Integration

II.37. Clarity of research goals and findings is paramount. Presentation of such findings must ensure that language, personal biases/leanings, and personal agendas do not masquerade as evidence and undermine their fundamental purpose. 'It is a good morning exercise for a research scientist to discard a pet hypothesis every morning before breakfast. It keeps him young' (Lorenz, 1986).

II.38. All theorizing that is woolly or vague must be either refined or discarded.

II.39. There is no scope for paternal possessiveness or ego trips in the field of genuine theorizing.

II.40. Biological reductionism, overtly or covertly, rejects multilevel models, especially those that try to include psychological and sociological perspectives. Even if accepted, it is with the caveat, implicit or explicit, that all the 'real' causal effects occur at the level of basic biology (Bickle, 2003).

II.41. Okasha (2007) believes that 'the biological reductionist approach is too narrow to encompass the range and complexity of causal processes that are operative in psychiatric disorders' (pxxx). He espouses explanatory pluralism which alone can cater to 'Jaspers' twin demands for human understanding as well as scientific explanation' (Okasha, 2007, pxxx). There are many proponents of such explanatory pluralism, including Engel (1977), McHugh and Slavney (1986), Kendler *et al.* (2003), and Singh and Singh (2004-2005).

II.42. Reductionism is a valid approach in the study of psychiatric phenomena. But integration of the finding of disparate approaches is equally valid. As is explanatory pluralism.

II.43. So, reductionism or integration? Both. Reductionism as an approach. Integration as an attitude (Singh, 2007).

II.44. The approach cannot become the attitude. It can only guide it. And the attitude cannot become the approach. It can only prevent it from constricted world-viewing and dogmatism.

II.F. Fool-proof Criteria, False Leads, and Questioning of Assumptions

II.45. A fool-proof diagnostic criterion for mental disorders *does not* exist. But that does not mean it *cannot* exist. The whole process of diagnostic standardization and refinement is to remedy exactly this.

II.46. Realization of shortcomings does not make something unachievable. Or justify resignation. It should be a spur to more robust effort.

II.47. There are many a false leads, which will have to be explored and abandoned before progress in psychiatric research occurs. 'That white horse you see in the park could be a zebra synchronised with the railings' (Jellicoe, 1986).

II.48. The need to question even the most widely held assumptions is the hallmark of a good scientist. Nothing is taken for granted, not even the most obvious. Paradigm shifts occur only this way.

II.49. Had Freud not questioned the primitive biologists, he would not have given psychoanalysis. If the behaviourists had not found psychoanalysis full of holes, they would not have given behaviourism. If the cognitive psychologists and neurobiologists had not found both inadequate, they would not have given rise to the cognitive neurosciences.

II.50. The need is to first ask an apparently impertinent question. And to not rest till satisfied with an answer. If it results in your satisfaction, good. If it results in the questionee's exasperation, so much the better. 'This is the essence of science: ask an impertinent question and you are on the way to the pertinent answer' (Bronowski, 1986).

II.51. Asking a few impertinent questions would be the best thing to happen to shake up glib psychiatric theorizing.

II.52. It can start with what is written in these pages.

III. Psychiatric Disorder, Psychiatric Ethics and Psychiatry Connected Disciplines

III.A. Psychiatric Disorder, Mental Health, and Mental Phenomena

III.1. Psychiatric disorders exist only as symbols of psychological distress, disability, and possible premature death. They are heuristic assumptions (heuristic meaning serving to indicate or stimulate investigation; Flew, 1984, p147), and meant to reify (or concretize) those concepts of distress that can be subsumed under the broad category of mental abnormalities (see also I.104-I.144).

III.2. Every attempt to objectify subjective experiences, as is involved in psychiatric evaluation, is as mandatory as is presently inadequate. Its inadequacy should make us strive to make it more objective.

III.3. Absolute or perfect mental health is the absence of mental disorder plus a sense of wellbeing. In most cases, mental health is the control of mental disorder and the relative sense of wellbeing that results from optimal social functioning and personal equipoise.

III.4. All these concepts need to be translated into empirical models and rigorously validated and revalidated.

III.5. All mental phenomena have a correlate in brain functioning, known or unknown. All brain activity gives rise to mental phenomena, known or unknown. The key is to find the links between brain activity and mental phenomena. The key is also to make the unknown mental phenomena and brain activity known (see also I.42-I.67; II.30-II.31).

III.6. Psychotherapy needs clear-cut delineation and proof of biological changes induced in the brain. Refinement of objective processes like fMRI and PET scan will supply such proofs. Psychotherapists must not be averse to such validation.

III.7. Every new step in understanding psychiatric disorders must be: (1) clear improvement over the previous; (2) objectively verifiable; (3) provide grounds for its refutation; (4) should be capable of self-correction; and (5) should be perennially improvable. The ultimate aim is to progress from illness to sickness to disease (see also I.113-I.119).

III.B. Issues in Psychiatric Ethics

III.8. Involuntary hospitalization is unpleasant but unavoidable. While it cannot be used to incarcerate non-conformists (non-maleficence), it is a legitimate extension of beneficence, a necessary restriction of autonomy, and a means to provide justice, both to the patient and those afflicted by his suffering. 'It is a perversion and travesty to deprive those needy and suffering people of treatment in order to preserve a liberty which is in actuality so destructive as to constitute another form of imprisonment' (Peele, Chodoff and Taub, 1974).

III.9. Informed consent ensures autonomy and justice. But it cannot be the means to avoid beneficence, even as one ensures non-maleficence (see also I.93-I.103).

III.10. Confidentiality in psychiatric consultation and psychotherapy is sacrosanct and may be forsaken only so not to breach the Tarasoff Maxim: Protective privilege ends where public peril begins (Tarasoff vs. the Regents of the University of California, 1974). Here, non-maleficence trumps justice.

III.11. Except in the rarest of cases (e.g. *Samlekhana*), suicide is never justified. But rather than moral condemnation (e.g., Suicide is a sin) or legal strictures (e.g., Suicide is an offence against the state), it needs psychiatric treatment of the underlying cause (e.g. depression, or other psychiatric disorder), and redressal of the larger psychosocial issues that aid and abet it (e.g. social isolation and resultant poverty, social disintegration, etc.) (Singh and Singh, 2004).

III.12. While it is true that psychiatric labeling involves stigma, and increases such a person's difficulties in coping with social attitudes towards psychiatric disorders, it is equally true that psychiatric diagnosis is not simply a means to label deviant behaviour as psychiatric disorder. The element of the three Ds is an essential component of any medical diagnosis: distress, disability, and (possibly) death. And this is equally applicable to psychiatric disorders.

III.13. By ceasing to label a person sick/ill/diseased, the sickness/illness/disease does not disappear.

III.14. Often, the greatest good one can do to oneself is to accept one is sick/ill/diseased. As a corollary, the greatest harm one can do to oneself is to deny one's sickness/illness/disease.

III.15. The most fitting example of this is psychiatry and its disorders.

III.16. *Psychiatric research*, as all medical research, involves patients. Here, respect for person's autonomy and justice is paramount. All activities of the researcher must be guided by beneficence and non-maleficence, but the subject's autonomy and justice override these considerations when they conflict. For example, if the patient does not give informed consent (autonomy), the researcher cannot claim it is for his good (beneficence) and force him to submit to research.

III.17. In psychiatric *therapy*, beneficence and non-maleficence are paramount, and must override autonomy and justice when they conflict. In psychiatric research, however, autonomy and justice are paramount, and must override beneficence and non-maleficence when they conflict (see also I.93-I.103).

III.18. Sexuality and other intimacy issues between client and therapist are guided by non-maleficence, more than anything else. This subsumes autonomy and justice. Same is the case with physical manipulation of the brain, or child psychiatry. All disadvantaged and vulnerable sections need this to protect them from domineering caregivers and therapists. This is, however, no justification to avoid involuntary hospitalization in deserving cases.

III.19. Psychopharmacology has revolutionized modern psychiatry treatment, even as it has thrown up a number of credibility issues especially related to research misconduct and loyalty issues - patient welfare or profit.

III.20. Patient welfare and replicable studies are the only two pillars that ensure long-term welfare of all stakeholders in medical and psychiatric practice - researchers, manufacturers, publishers, caregivers and end users (Singh and Singh, 2007).

III.21. Misuse is an inherent danger in any use. Disuse is also a danger due to the fear of misuse. (This is especially applicable to involuntary hospitalization, ECT treatment, etc., wherein the concern with misuse is giving rise to disuse.) Both need to be addressed.

III.22. The psychiatrist has a larger responsibility to society, true. But only as an adjunct to patient welfare and scientific verifiability. And never as a means to override them. The psychiatrist must be specially careful that he does not become a convenient handle to enforce conformity on conscientious dissidents (e.g. political dissenters), social non-conformists (e.g. homosexuals), and interpersonal conflicts (e.g. labeling of a spouse in marital conflict to secure divorce/separation, etc.). Political and other misuse of psychiatry by vested interests become non-issues then. And only then.

III.C. Social Psychiatry, Liaison Psychiatry, Psychosomatic Medicine, Forensic Psychiatry, and Neuropsychiatry

III.23. It is easy to blame social processes as the fountain source of psychopathology. Problems arise when it no longer remains a convenient means to pass the buck. Or no strong evidentials back such insightful contentions. Part of the reason for the ineffectiveness of social psychiatry is being stuck in this groove.

III.24. Modification of social processes that germinate and perpetuate psychopathology is not the preserve of social psychiatry alone. But it cannot absolve itself of the lead role it must play, and the objective evidence it must produce to substantiate its claims.

III.25. Liaison psychiatry remains relevant only if appreciates the relevance of the medical model, but is prepared to transcend it. The same rule is applicable to psychosomatic medicine.

III.26. Forensic psychiatry is necessary, but psychiatric ethics is mandatory. While the former ensures autonomy and justice, the latter ensures beneficence and non-maleficence.

III.27. Neuropsychiatry is promising but guild-driven. It cannot supersede psychiatry and neurology, nor make them redundant, as of now, as they are equally guild-driven. Moreover, they carry out a justified division of labour, as of now.

III.28. Neuropsychiatry can harmonize psychiatry and neurology and explore their interconnections, which are numerous. A time may come when the interconnections themselves become the ground. Then, and then alone, the disparate branches of psychiatry and neurology will disappear and be replaced by neuropsychiatry. Much as this may be the wish and earnest desire of many of its proponents, including Yudofsky and Hales (2002), or Sachdev (2005).

IV. Antipsychiatry, Blunting Creativity, etc.

IV.A. Antipsychiatry Revisited

IV.1. Antipsychiatry attacks the basic premise of the objectivity and existence of psychiatric disorders. It believes there is nothing like a mental disorder and therefore there can be no justification for their classification. What are labeled as mental disorders are the product of social malady and establishment needs.

IV.2. Put rhetorically, there are no psychiatric patients. Society itself is the patient. And the psychiatrist himself is the symptom of a social disease.

IV.3. The answer to this is, *yes*, society generates psychopathology and needs correction. But those who suffer due to its processes need help too. The psychiatrist and his branch exist to help both.

IV.4. When the branch glosses over pathological social processes, or becomes a means to perpetuate it, then it and its followers become perpetrators of the social malady rather than its opponents.

IV.5. The branch runs the danger of glossing over pathological social processes in its present day obsession with biology to the neglect of the psychosocial.

IV.6. When psychiatrists collude with vested interests in politics, and even families, to help label nonconformity and dissent as disorder, psychiatry can become the means to perpetuate pathological social processes. Such misuse of psychiatry is not infrequent and needs to be firmly dealt with (see also III.20).

IV.7. That does not mean psychiatric disorders do not exist, or are a myth. In trying to prevent misuse of psychiatry, we cannot abandon its proper use. That amounts to throwing out the baby with the bathwater.

IV.8. Hence, while social maladies do generate psychopathology, and therefore need correction, their presence does not negate the presence of mental disorders, which equally exist.

IV.9. While the psychiatric establishment needs to proclaim the existence of psychiatric disorders, it does not mean they are a myth. It needs to do so simply because the psychological distress, disability, and premature death that result therefrom actually exist. Those who seek psychiatric help and are benefited will vouch for it.

IV.10. Ask the suicidal depressive who wants to live once again and gets back to family and work. Ask the schizophrenic who was deluded and hallucinating and becomes relatively symptom-free and gets back to leading his life. Ask the social phobic who can mix with others once again. Ask the bipolar, swinging from depression to mania, who gets stabilized to lead a relatively normal life.

IV.11. How can one simply gloss over all the good work done by establishment psychiatry by simply cataloguing its faults?

IV.12. And no one who criticizes what the psychiatric establishment does has any viable alternative to offer. Ask them what to do with the suicidal depressive, the hallucinating/homicidal schizophrenic, the mood swinging bipolar, and the severely restricted obsessive-compulsive or social phobic. They are speechless except for offering some archaic models, or skirting the issue and launching a fresh tirade against mainstream psychiatry.

IV.13. This way every establishment everywhere can be thrown out. The whole of medicine is culpable of perpetuating the labeling of distress, disability, and premature death as disease. We accept medicine as legitimate because it is the best means presently available to minimize them. Let someone provide a better alternative, or objectively disprove the benefits of modern medical treatments in general and of psychiatry in particular.

IV.14. The argument of the myth of mental disorders, and other such antipsychiatry arguments, thus, go way beyond their premises and lead to empty rhetoric. 'When the whole repertoire of criticisms and recommendations of antipsychiatry are analyzed, we find moral condemnation in place of scientific search for causes; social determinism in place of unbiased evaluation of the relative contributions of biological, experiential, familial and social factors; punishment in place of treatment; prejudiced denunciation instead of a critical receptivity toward different viewpoints, and dogmatic assertions in place of hypotheses which are open to refutation' (Roth, 1973, p378).

IV.15. However, antipsychiatry's pointer to the social processes which generate psychopathology is a worthy contribution to the field, as is its molting nowadays 'to promote radical consumerist reform' (Rissmiller and Rissmiller, 2006).

IV.16. It is in these two forms that antipsychiatry will actualize itself, rather than in trying to annihilate mainstream psychiatry.

IV.B. Basic Arguments of Antipsychiatry, Szasz, etc.

IV.17. The basic argument of antipsychiatry is that psychiatric disorders exist because the psychiatric establishment exists. This is a serious but fundamentally flawed charge.

IV.18. The psychiatric establishment exists because psychiatric disorders exist. And it is a one-way correspondence.

IV.19. The fundamental position of Szasz is also that mental disorders are defined by moral or evaluative rather than by factual or medical criteria. They are, in other words, moral rather than medical categories, which the psychiatric establishment wants to palm off as medical illnesses to justify their existence. Hence, mental illness is a myth (Szasz, 1960).

IV.20. What Szasz and his ilk have to realize is there is a moral judgment involved in any labeling, whether of a disorder in psychiatry or the rest of medicine. If it were good/proper to vomit blood, or fall unconscious, or live with broken bones, or develop heart attacks, no branch of medicine would be needed. Similarly, if it were good/proper to live with suicidal attempts/thoughts, to fear

meeting people so one remains confined to the house, to keep washing hands for hours, to believe one is the Almighty, or that the whole world is plotting/scheming against you, no psychiatry would be needed.

IV.21. Moreover, we must evaluate an entity within its frame of reference, 'Psychiatric disorders have a distinct shape, come in types and are inherent in *Homo sapiens*. To a social scientist, disorders exist by stipulation: contingent on a psychiatric frame of reference. Their materiality has meaning only in that framework' (Fabrega, 2005). Unless we wish to reject that frame of reference itself, which is possible as wish fulfillment, but not as a solution to real life issues that psychiatric disorders represent.

IV.22. As long as no organic basis is demonstrated, the problem appears purely moral. When it is, it becomes both moral *and* physical. The whole thrust of modern psychiatry is to find such physical correlates of its so-called 'moral' categories and demonstrate their moral *and* physical nature (see also I.113-I.121).

IV.23. And the distress, disability, and premature death are real entities; they actually happen in the conditions labeled as psychiatric disorders. There is no myth there, there is actual suffering. Ask any fully/partially recovered/remitted patient of depression, schizophrenia, social phobia, etc.

IV.24. We cannot gloss over reality to justify grand theories.

IV.25. Hence, it is legitimate to say that diagnostic categories do match real mental disorders. And mental disorders are symbolic representations of psychological distress, disability, and possible premature death (three Ds), which present as stable symptom clusters.

IV.26. The whole aim of psychiatry is to refine the process of diagnostic classification and related therapy to reduce the three Ds mentioned above. It has no existence, or justification, aside and apart from this.

IV.27. The aim, further, is to find underlying organic pathology that goes with psychiatric disorders, so that what are psychiatric *illnesses* and *sicknesses* today finally get acknowledged as psychiatric *diseases* (see also I.113-I.121).

IV.28. What Szasz and those of his ilk say is this is not possible, as mental disorder itself is a myth.

IV.29. What we say is mental disorders are illnesses and sicknesses, all right, it is still to be proved that they are *diseases*. Which will happen when we find the associated organic pathology. And associated pathognomonic signs. This process is on with some vigor. Till such time as we succeed, or fail, we suspend judgment either way. But continue to make earnest efforts to find such correlates.

IV.30. Why do we make earnest efforts at all? Why not accept we may never succeed, as Szasz and his ilk imply? Simply because the related three Ds exist for sure, and cannot be wished away by arguments.

IV.31. Unless we accept the argument that the distress, disability, and premature death related to psychiatric disorders do not exist, or if they do, are desirable. Let antipsychiatry prove it is so. Then, and then alone, they can undermine the foundations of mainstream psychiatry. Till such time, they run the danger of getting trapped in their own arguments.

IV.32. Starting with good intentions, but waylaid by their own arguments as they adopt unsustainable positions. And emotional attachment to intuitively compelling primary arguments, which cannot sustain the scorching gaze of reality and its problems.

IV.33. Witness how Szasz agreed to pay \$650,000 to the widow of a fellow psychiatrist who committed suicide after Szasz suggested that he discontinue taking lithium (<http://groups.google.nl/group/sci.psychology/msg/dd0224f00990c3b9?oe=UTF-8&output=gplain>). When you do not have an alternative in place, you better do not get convinced rhetoric can replace reality.

IV.34. And what saved him was the fact that, as a member of the APA, Szasz was eligible for the PRMS insurance coverage available to all APA members. Again, it is fine to take on the establishment, but it is often the establishment that comes to your rescue in your hour of need; not your rhetoric. Similarly, it is the establishment that comes to the rescue of the patient in his hour of need, not the rhetoric of antiestablishment forces.

IV.35. Labeling society as the patient is legitimate to draw attention to sociopathology in a dramatic manner. And doing something about it. In which process all, including psychiatry, have to be involved. But labeling society as the patient to discredit psychiatry and psychiatrists as perpetrators of this sickness is unwarranted, if not mischievous. Because that means we convert the drama itself into a reality.

IV.36. And why is it not a reality, and why is it unwarranted? Precisely because psychiatry *is* involved in reduction, not perpetuation, of such sociopathology. And how? By reducing the three Ds mentioned earlier.

IV.37. Crusading zeal makes use of hyperbole, true, but it must be careful it does not get waylaid by its own rhetoric.

IV.38. This section on antipsychiatry can be said to rely on an assumption that Thornton criticizes: that somehow physical illnesses are objectively 'real'

(Thornton, 2007). The issue may appear to be resolved by adopting his standpoint, so a lot of fears about the death of psychiatry, reduction of psychiatry to neuroscience, etc. will appear misplaced.

IV.39. Thornton skillfully does away with most arguments of antipsychiatry, fears about the death of psychiatry, or reduction of psychiatry to a branch of neuroscience by adopting an interesting argument: he criticizes the fundamental assumption that physical illnesses are objectively 'real'. If they are not objectively real, then where is the question of trying to make psychiatry objective, or real? Interesting, but rather, a stilted argument. Are the distress, disability, and premature death that can result from diagnostic entities not real? If Thornton suffers from a headache, is it not real? Is it just his imagination? Will he not rush to a doctor if he has high fever, vomiting, fractures his leg, bleeds profusely? Or shall we say, his running to the doctor itself is not real? [At no stage do the authors wish any of this ever happened to Thornton, or anyone else. Its just to exemplify the issue.]

IV.40. That would be justifying the old Advaita Vedantin position of everything being '*Maya*', a wonderful argument, but empirically groundless.

IV.41. It is important to decide first of all whether psychiatry is an empirical discipline or not. Philosophy is not only empirical. It has many strands. Some of its strands can survive even by rejecting empiricism. What we have to consider is whether psychiatry can survive by rejecting empiricism. And if it does, can it lay any claims to being a branch of biomedicine?

IV.42. Psychiatry must beware it does not become philosophy. It must only adopt *some* relevant methods of philosophy for its own advancement.

IV.C. Psychiatric Classification and Value Judgment

IV.43. Psychiatric classification is capable of being both scientific and objective (Boorse, 1976). Diagnostic categories do match real mental disorders. Hence, the medical model of psychiatry that Fink (1978), Boorse (1976), and many others, defend is legitimate, even if inadequate.

IV.44. 'There are facts about the world that determine what should be labeled as a mental disorder, but that at the same time, there is an irreducible element of value or normativity in deciding psychiatric categories' (Perring, 2005, while discussing Wakefield, 1992).

IV.45. See also IV.20-IV.22.

IV.46. The very concept of disorder involves a value judgment. Psychiatric disorders cannot be immune to this generalization. 'More fundamentally, illness

is itself a socially defined concept and involves value judgments which are liable to change from time to time and place to place' (Kendell, 1993; p5).

IV.47. Again see IV.20-IV.21.

IV.48. This is no substitute for finding organic pathology in psychiatric disorders, or the biological determinants of behaviour in health and sickness.

IV.49. If psychiatric disorder remains only a 'socially defined concept and involves value judgments which are liable to change from time to time and place to place', it can create apprehensions in the present or potential psychiatric patient, especially when he fears his values, cultural norms and mores may conflict with that of the psychiatric establishments. The following statement sums it up eloquently: 'I hold my mental health dear to me because I know that should it slip from my grasp the system that I may be subject to will diagnose me on the basis of its values, not necessarily my own or my culture's' (Adebowale, 2007).

IV.50. Minorities, the displaced or migrants, and in general the socially disadvantaged, may be specially predisposed to this, prone as they are to compensatory protectionist-isolatory maneuvers. The mentally sick may, wittingly or unwittingly, also become part of this minority group.

IV.51. One of the tasks before psychiatric therapy today is to be acutely aware of such needs, even as it strives in research to find culture-free and value-free substrates of mental phenomena. That will be the ultimate validation of the medical model in psychiatry.

IV.52. There can be a valid apprehension that 'moral, social and legal problems are increasingly being converted into medical ones... (and) psychiatrists have, through their concept of illness, encouraged a cult of irresponsibility and have provided criminals, delinquents and the generality of men with an excuse for misconduct' (Roth, 1973, while describing one of the criticisms of psychiatry).

IV.53. All moral, social, or legal problems that cause the three Ds, which present a stable objectively verifiable picture, and which can be cured/controlled/mitigated with therapy must fall under the ambit of medicine. Problems of a psychological nature will fall under the ambit of psychiatry. It is the three Ds that justify the disorder label, not the fact that they are moral, social, or legal. (And supplementing it with organic pathology, or pathognomonic signs, as and when it occurs, will confirm them as diseases.)

IV.54. As regard psychiatrists encouraging irresponsibility by finding an excuse for misconduct, the same charge can be placed on therapeutic abortion, or the treatment of AIDS, or all the sexually transmitted diseases, or the treatment

of an alcoholic driver in a mishap. If one carries out a moral judgment, we must allow all of them to suffer. Then there should be no recompense ever for a sinner. That would be a ridiculous argument.

IV.55. While psychiatry should beware it does not protect criminals, delinquents, etc., it must equally make people at large, and law enforcing agencies, aware that in certain mental conditions, a person may not realize the nature and consequences of his actions. A typical example is a schizophrenic who acts on his delusions and assaults someone, or a suicidal depressive who makes a suicidal attempt during a depressive phase. Treating helps them get rid of their delusion/suicidal impulse; putting them behind bars does not.

IV.56. Hence, while there is no excuse for misconduct, there is equally no excuse for psychologically naïve agencies riding roughshod and indulging in verbal vitriol, albeit because of ignorance or misguidance.

IV.D. Conformity, Labeling, and Blunting Creativity

IV.57. The charge is often made that psychiatry is specially used to force conformity in the culturally deviant by labeling them mentally sick. Further, it is also used to blunt creativity in the nonconformist.

IV.58. Let us take the first charge. It is not that the culturally deviant are labelled mentally sick. In that case all culturally deviant would have been labeled by now. It is rather that many cultural deviants, by the nature of their disposition and their activities, often land themselves in conflict with the social establishment around them. Some can survive, even prosper, due to such clashes. Some break down. It is in the case of the latter, if and when they develop psychological problems, which can be subsumed in a diagnostic category, and can be helped to recover, that a psychiatrist comes into the picture. This is a legitimate role, which can hardly be faulted.

IV.59. What can be faulted, however, is the misuse of psychiatry to bring about forced social conformity in social deviants, as happened in totalitarian regimes, for example, in the earlier USSR. This is not a legitimate ground for psychiatry, and establishment psychiatry has not defended it. Power to do good carries an inherent power to use it for evil as well. This is but one example, and makes us extra cautious in treating cultural/political deviants (see also III.20 and IV.6).

IV.60. As regard the second charge, psychiatry is not a means to blunt creativity. But some forms of treatment can interfere with creativity. Both are not one and the same.

IV.61. What this implies is that in cases (especially in the bipolar patient) where creativity is important, the psychiatrist will have to be extra careful with

monitoring doses/treatment, so that it is not affected. Or, if affected, it is the minimum. He will have to take an informed decision whether some symptoms may need to be allowed so that creativity does not suffer.

IV.62. Most importantly, he must develop therapies that interfere least with creativity. That is one important challenge for psychopharmacological research today and in the future. It is also one very important area for the psychosocial therapies to intervene in.

IV.63. Often those who are creative are so not *because of*, but *in spite of*, mental illness. In addition, often they continue to remain creative not because of, but in spite of, mental illness and treatment - and all the side effects and lifestyle modifications that ensue following a major mental illness.

V. Role of Philosophy, Religion, and Spirituality in Psychiatry

V.A. Relevance of Philosophy to Psychiatry

V.1. Philosophy supplies the means to critically evaluate concepts. It also expands the horizons to think beyond the obvious, to understand the intricacies of mental subjective states, to understand intuition and consciousness. But it has no objective tools to study its findings.

V.2. The task of psychiatrists interested in making philosophy more relevant to contemporary intellectual discourse in psychiatry is to find such objective tools and objectifiable concepts.

V.3. Collaboration with the cognitive neurosciences and neurobiology will supply them such tools.

V.4. Reifying (concretizing) philosophical insights will offer objectifiable concepts. Trial and error is inevitably involved in both processes (see also III.1).

V.5. We must also temper the philosopher's absolutism with the psychiatrist's utilitarianism (Singh and Singh, 1989, p89). We use the terms in their widest possible connotation here, wherein absolutism is also the opposite of relativism, and utilitarianism is also utility to self, here, the profession involved (Singh and Singh, 1989, p115). This, of course, is not how Hare (1984) would understand those terms (Singh and Singh, 1989, p115).

V.6. 'When moral conflicts arise, no one level account can solve the problem; if conflicts arise at one level, they cannot be resolved except by ascending to a higher level (Hare, 1984)' (Singh and Singh, 1989, p90).

V.7. 'At the intuitive level of thinking, the absolutist stance is appropriate; but it no longer remains sufficient when conflicts arise between them and/or with other circumstances. Then the critical level of thinking of the utilitarians alone will suffice. We select thereby the principles to be used at the intuitive level and adjudicate between them where they conflict (Hare, 1984)' (Singh and Singh, 1989; p90). For example, the absolutist's stance would be, 'It is wrong to tell lies'. But if there was a murderer at my door asking for someone inside, and he would believe me if I say he was not in there, then it would be proper for me to tell a lie. Why? Because saving a life is more important than telling the truth (adjudicating between two principles, both appropriate at the intuitive level; in so doing, the utilitarian's standpoint is helpful - the utility of saving a life is more important than telling the truth). An example of this in the present paper is from I.98 to I.102.

V.8. Many concepts of philosophy are attractive but peripheral to psychiatry. Metaphysical concepts are mainly such. Many others hold promise. Studies in logical thinking, in the epistemology of mental phenomena (Varma, 1989), and the principles of applied ethics, are mainly such.

V.9. Let us put it a little differently. Metaphysical concepts like God, Heaven, Hell, afterlife, etc. can be the concern of psychiatrists, but not of psychiatry. [Unless, of course, they are part of a patient's symptomatology].

V.10. Epistemological/logical/ethical issues can legitimately be the concern of psychiatry *and* psychiatrists.

V.11. Religion and spirituality hold an eternal fascination for some serious psychiatric thinkers. There are many concepts in both that intersect. But in so far as religion stresses the subjective at the expense of the objective, it cannot become a predominant force in psychiatric thinking. However, it can supply many insights into mental phenomena, which psychiatric research can explore with profit. But with its tools, its criteria, its methodology.

V.12. Similarly, psychiatry should beware of passing judgment on religious/spiritual phenomena without submitting them to critical enquiry. Neither dismissive and derogatory characterization, nor awe and reverence are justified. Only evidence should speak.

V.B. Psychiatry, Religion, Spirituality, and Culture

V.13. Psychiatry and related neurobiological research can help supply objective evidence for religious/spiritual phenomena, but all such evidence will remain piecemeal and inadequate. Only a grand unified theory of mind and consciousness based on neurocognitive verification, if and when it results, will be able to integrate and put forward a framework, which explains most,

if not all, religious/spiritual phenomena in a language modern psychiatry can understand. And philosophy/religion will have to accept, albeit with reservations (see also VI.1-VI.6).

V.14. In general, philosophy must couch its concepts in a manner psychiatrists can comprehend if it wants to make any lasting contribution to the field of philosophy of/and psychiatry. It must, further, be ready to allow those concepts to be couched in objectively verifiable terms.

V.15. Psychiatrists must expect philosophers to be expansive at times. They must extract as many as they can of reifiable/heuristic (*reifiable*, meaning concretized, used in a positive sense; *heuristic*, meaning serving to indicate or stimulate investigation) models that stand the test of objective scrutiny. They must, moreover, get themselves immunized to philosophers' exasperation at such elaborations (see also III.1 and V.4).

V.16. Where can religion and moral philosophy make a lasting impact on science, as also psychiatry? In taking care of science's value-neutrality. 'The essential value-neutrality of Science will have to be supplemented by the values that man has upheld for centuries as fundamental, and which religious thought and moral philosophy have continuously professed' (Singh and Singh, 2004). It is here that religion and moral philosophy can supply a number of testable hypotheses to science, in general, and normative sciences like psychiatry, in particular. The phenomenological-existential-humanist strand of thinking has a special role to play here. As has principles and ideals of different religions/philosophies, if and when converted into experimentally verifiable models of psychiatric care. Few such examples are the *Bhagwad Gita* as a model of psychotherapy; the Buddha's *Four Noble Truths and the Eightfold Path*; and Patanjali's *Ashtanga Marga* [see V.22 (ii, iv, xiii); V.22 (iv-vi), and V.27-V.29].

V.17. Unless the older concepts in the philosophy of mind, whether of the East or the West, get converted into empirically testable hypothesis, they are useless for modern psychiatry. Reverence and awe is one thing, proof and therapeutic validation quite another.

V.18. Even as we cannot afford to neglect culture-specific behaviours in health and disease, we must try to delineate culture free modes of behaviour in health and disease too.

V.19. While culture-specific behaviours must be emphasized in psychiatric therapy, culture-free behaviours are the focus in psychiatric diagnosis and classification. Together, they make for a composite picture. (Both culture-specific and culture-free behaviours are important in psychiatric research, and also in comprehensive understanding of psychiatric phenomena.)

V.20. The final goal is to extract culture-free determinants of behaviour in health and disease that can provide universally valid models in psychiatry therapy and research.

V.C. Ancient Indian Concepts and Contemporary Psychiatry

V.21. A number of well-intentioned forays into ancient Indian thought, and their relevance to contemporary psychiatry, deserve to be placed in perspective.

V.22. There are certain revered concepts of ancient Indian thought that hold great fascination for the thinking psychiatrist. Some of these are:

i. The concept of mind in Indian philosophy (see Chennakesavan, 1991) and in Ayurveda (Venkoba Rao, 2002);

ii. Yoga and its eightfold path '*ashtanga*' - *yama* (restraint), *niyama* (discipline), *asana* (body posturing), *pranayama* (breath control), *pratyahara* (withdrawal), *dharana* (fixed attention), *dhyana* (contemplation), and *samadhi* (complete tranquility, or renunciation);

iii. Concepts like *stithaprajna* (stable intellect), *svabhava* (temperament), and *svadharma* (individual's duties) of the *Bhagvad Gita*;

iv. Gita and its teachings as 'a masterpiece of psychotherapy touching upon every aspect of mental functioning' (Venkoba Rao, 1980);

v. Samkhya concept of *Gunas* (qualities) - *sattwa*, *rajas* and *tamas*;

vi. Concepts derived from the *Karma* theory and their incorporation in psychotherapy (Venkoba Rao, 2001);

vii. Upanishadic thought and probably its most brilliant successor - *Advaita Vedanta*;

viii. Psychological concepts like *manas*, *citta*, *buddhi*, *ahankara*, *vritti*, *antahkarana*, *samskara*, *sreyas*, and *preyas*; as well as psychophysiological ones like *vata*, *pitta*, and *kapha* (the somatic *dosas*) and *rajas* and *tamas* (the mental *dosas*);

ix. Ancient ideas of mind, mental health, and *unmad* (insanity) in Ayurveda, and in the writings of Susruta, Caraka, and Bhela;

x. *Kapha*, *pitta*, and *vayu* (translated roughly as phlegm, bile, and wind) and their imbalance as causative of diseases;

xi. Life as divided into four kinds by Caraka: *sukha* (happy), *duhkha* (unhappy), *hita* (good), and *ahita* (bad) (Dasgupta, 1973, Vol. II, p277);

xii. Concepts like *atman*, *Brahman*, and *punarjanma* (rebirth), along with *moksa*, *kaivalya*, *Jivanmukta*, *sanyasa* (and other forms of final release), which recur all through ancient Indian thought;

xiii. The doctrine or *dharma* taught by the Buddha summed up as the four noble truths, 'corresponding to the traditional form in which a physician expresses his conclusions about a patient' (Smart, 1972; p417): (a) the concept life being full of *dukkha* (suffering); (b) caused by craving and grasping (*tanha*); (c) which *dukkha* can cease when *tanha* ceases; and (d) the Eightfold path to bring it about (*ariya attangika magga*): right views, right aspirations, right speech, right conduct, right livelihood, right effort, right mindfulness, and right contemplation. This model needs clinical corroboration (see also I.61);

xiv. Also the concept of *karuna* (compassion) in Buddhism as a model for psychotherapy, both for the therapist and the client, and the concept of *nirvana*, which is knowledge and attainment of the ultimate truth, and the peace, insight, serenity, and freedom that goes along with it;

xv. Concepts from Jainism: the ideal of *ahimsa* (non-injury or non-violence); practice of austerity to annihilate *karmic* matter: for example - extreme asceticism, fasting as a means of self-purification; as also the ideal of death by fasting (*samlekhana*), which was reportedly followed by Mahavira himself. Also the concepts of *anekantavada* (or relative pluralism) and *syadavada* (or qualified skepticism), both of which accept the plurality of approaches and understandings, as the forerunner of a healthy eclectic attitude for contemporary times (see also I.71-I.73);

xvi. Sikhism and its emphasis on the word of the gurus - *guruwani*, the *Adi Granth*; the worth of self-respect, sacrificial living, equality, and brotherhood as in the teachings of Guru Nanak; and the ability to synthesize the best from diverse religious streams like Hinduism and Islam that the *Adi Granth* represents - again a form of robust eclecticism;

xvii. The four *asramas* of life according to the Hindu tradition, namely *brahmacharya*, *grahastha*, *vanaprastha*, and *sanyasa*; and the four *purusharthas*, namely *artha*, *kama*, *dharma*, and *moksa*. Models of therapy based on, or incorporating, these concepts.

xviii. Concepts of sexuality enunciated in treatises like the *Kamasutra* (Trans. Burton, 1962) as forerunners of the present day attempts at sexual emancipation and education; and

xix. Twentieth Century Indian philosophers and their thoughts on religion, spirituality, and mind - among them Sri Aurobindo, Ramana Maharshi,

Ramakrishna Paramhansa, Swami Vivekananda, J. Krishnamurti, Rabindranath Tagore, Mahatma Gandhi, S. Radhakrishnan, etc. (see Lal, 1989; Mahadevan and Saroja, 1985). And many more in their wake in today's times as well.

V.23. This is but a representative sample of ancient Indian concepts and their current proponents and reinterpreters. The list can be multiplied.

V.24. A number of irrelevant among these concepts need to be deciphered and forsaken, as a number of others need serious exploration as to contemporary relevance.

V.25. Let us take an example. When Caraka says: 'The mind being afflicted and the understanding disturbed, the mental dosas are provoked, reaching the heart and obstructing the ducts through which the mind operates, they initiate insanity' (*Caraka Samhita*, 1949; attr. Venkoba Rao, 1978), his statement 'reaching the heart and obstructing the ducts through which the mind operates', etc. needs to be quietly consigned to the dustbin of history. Similarly, when Bhela says, 'The original cause of *manas* and the energy of all the senses and the cause of all feelings and judgments (*buddhi*), the *citta*, is situated in the heart', (Dasgupta, 1973, p341), or when Susruta claims that Ayurveda was composed by Brahma before he created all beings (*Susruta-Samhita*, I.I.5; attr. Dasgupta, 1973, p273), it deserves only archival importance.

V.26. But when Caraka offers a classification on *unmad* (insanity) as those caused by:

i. Imbalance of 'bodily humors': *vatonmad*, *pittonmad*, *kaphonmad*, and *sannipathonmad*; and

ii. Imbalance of 'mental humors': *rajasonmad* and *tamasonmad*

we need to make experimentally verifiable models of each and test them empirically, and then accept or reject them, whatever.

V.27. Similarly, the four noble truths and the eightfold path of Buddha (see V.21 xiii) needs empirical testing to determine whether they offer practical models of psychiatric care.

V.28. Moreover, a statement like the *Gita* and its teachings are 'a masterpiece of psychotherapy touching upon every aspect of mental functioning' (Venkoba Rao, 1980), needs to be accepted as an insightful hypothesis to be validated by empirical studies. Is it really a masterpiece of *psychotherapy*? Does it offer a *valid* model of psychotherapy? Can it touch upon *every* aspect of mental functioning?

V.29. How do we accept this as valid knowledge except by constructing models of care based on it? And then comparing and contrasting them with existent models. Say, the Gita model of psychotherapy in depression, personality disorder, or anxiety, compared with the Psychodynamic model, or the Cognitive Behavioural model.

V.30. Indian psychiatrists' attempts to understand ancient Indian concepts and their relevance to contemporary psychiatry have been intensely patriotic/reverential but feebly scientific.

V.31. Their well-intentioned forays have not spawned interest in developing experimental models to test insightful hypotheses.

V.32. A similar phenomenon is seen in contemporary Indian philosophical thought, wherein majority of attempts to study ancient Indian thought have been equally intensely reverential but feebly critical/analytic.

V.33. When we revere, or are patriotic, we attempt to idolize and praise. We cannot find faults, or tend to paper over them. In fact finding fault is akin to rejection of the idolized. Critical evaluation is then impossible.

V.34. This is the bane of contemporary Indian thought. Especially when it handles ancient Indian thought.

V.35. As different from this, Western thinkers have not desisted from critical evaluation of their greatest predecessors. Only that which stands the critical scrutiny of peers is accepted, and that too provisionally.

V.36. Reverence leads to followers. And fossilization.

V.37. Critical evaluation leads to *enlightened* following. And progression of thought.

V.38. While the majority of Indian thinkers doing research in ancient Indian thought remain in awe of it, and therefore fixated on reverence, the majority of Western thinkers about ancient Western concepts quickly learn to forsake awe (sometimes too quickly), and proceed to critical analysis.

V.39. Progression of thought is only possible with critical analysis. That is the essence of the scientific attitude.

V.40. Lack of critical thinking is a serious lacuna in contemporary Indian philosophical approach to ancient Indian concepts and their contribution to contemporary philosophy.

V.41. Lack of critical thinking is also a serious lacuna in contemporary Indian psychiatric thinking about ancient Indian concepts and their contribution to contemporary medicine in general, and psychiatry in particular.

V.42. The necessary progression in mindset - from reverence to critical sifting and analysis - is essential if experimentally verifiable models of care have to evolve from the writings of the great masters of the past.

V.43. Contrary to the belief of the follower, this may be the greatest service he does to his master.

V.D. Indian Holism and Western Reductionism

V.44. It is also mentioned, almost as a truism, that Indian thought is holistic, synthetic, as opposed to the Western, which is reductionist and analytic (Varma, 1993).

V.45. There are many reductionist-analytic strands in Indian thought, just as there are many holistic-synthetic strands in Western thought. There is Indian materialism, not only Carvaka, as there is Kantian synthesis of empiricism and rationalism, Western holism/eclecticism, etc.

V.46. But the predominance of religion (and belief) in Indian thought, and of science (and verification) in the West has given rise to such predominance.

V.47. Holism is necessary as an *attitude*; reductionism is necessary as an *approach*. Holism is necessary to synthesize and integrate diverse strands of knowledge. But reductionism is needed to produce new knowledge. Which is then synthesized and integrated.

V.48. Does not synthesis/integration itself produce new knowledge? It produces new *understanding*, which can aid and abet production of new knowledge. Knowledge here is used in the restricted sense of an empirically verifiable, experimentally provable entity.

V.49. Hence, while the holistic attitude helps in therapy and understanding of mental phenomena, the reductionist approach helps in research, in evolving new knowledge that can be validated and refuted.

V.50. Both approaches are valid within their respective domains. It is invidious to think of one as superior to the other, or exclusive of the other. This is the essence of the correct eclectic approach.

V.51. Holism cannot become the *approach* (for example, in research). And reductionism cannot become the *attitude* (for example, in therapy).

V.52. See also II.E above and V.E below.

V.E. Science, Humanism, and the Nomothetic-Idiographic Orientation

V.53 'What is the difference between a lay intelligent observer and a scientist? A lay intelligent observer would try to find out the individual variations and peculiarities of abnormal behaviour as it manifests in different individuals and different cultures. A scientist will try to decipher the commonalities in the abnormal behaviour across cultures and peoples so he can find stable symptom clusters that can be labeled as diseases/syndromes, etc. Which then help him decide a plan of therapy and delineate the course and outcome of the said disease/syndrome' (Singh, 2007).

V.54 'It is a mistake to stress individuality so much that commonalities are obliterated. For that is counter-scientific' (Ibid).

V.55. It is also a mistake to stress commonalities so much that individualities are obliterated. For that is counter-humanistic.

V.56. The orientation necessarily has to be a blend of science and humanism. Where universally valid scientific knowledge serves individual patient welfare. And individual patient welfare serves to promote further universally valid scientific knowledge. Not as difficult as it seems, provided research integrity and patient welfare remain the watchwords. Holism at its best.

V.57. This holism also has to be nomothetic-idiographic, wherein norm laying gels with individuality, the standardized gels with the personalized (IGDA, 2003a,b).

V.58. The nomothetic-idiographic orientation is valid. But their integration must not blunt the legitimate thrust of their respective disciplines.

V.59. In case of a conflict between science and humanism, science gets precedence in research, while humanism gets precedence in therapy. But science cannot override justice and autonomy while furthering research.

V.60. When does science override justice? When it overrides the sanctity of the scientific record, when it plays into the hands of powerful manipulators, when it promotes scientific misconduct in its various forms.

V.61. When does science override autonomy? When it overrides informed consent, when it carries our surreptitious procedures on uninformed gullible patients.

V.62. Similarly, humanism cannot override beneficence and non-maleficence.

V.63. When does humanism override beneficence? When concern for individual patient's rights deprives him of freedom from sickness - the whole basis of the antipsychiatry movement.

V.64. And when does humanism override non-maleficence? When care for the individual patient goes with blind trust in the therapist, which exposes the patient to potential maleficence by an ethically compromised therapist.

V.65. See also I.93-I.102, and III.16-III.17.

V.66. Often, however, conflicts between science and humanism are conflicts less of branches and more of individual interests. That realized, and exposed, the problem often evaporates. The guilds of establishment psychiatry and the crusaders of antipsychiatry become redundant.

V.67. Philosophical analysis, and resultant understanding, helps in resolving seemingly irresolvable contentions of cliques - both in psychiatry and antipsychiatry.

V.68. As we said at the beginning of this essay, 'The solution to the problem is seen in the vanishing of the problem' (Wittgenstein, 1998, Section 6.521, p73).

VI. Final Goal

VI.A. A Grand Unified Theory

VI.1. The ultimate aim of psychiatric theorizing and research is to find a grand unified theory that will explain all mental phenomena, in health and disease.

VI.2. All piecemeal approaches are valid only as stop gaps to this destination, never as the only reality. Hence, statements like 'Our strongly held desires to find *the* explanation for individual psychiatric disorders are misplaced and counterproductive' (Kendler, 2005) need to be accepted as the reality of today, to be countered by systematic research to find exactly such an explanation.

VI.3. No foreclosure, no giant leaps; just a string of evidences to a final resolution.

VI.4. The present maze-like complex findings in most major psychiatric disorders only camouflage an essentially simple solution that awaits discovery.

VI.5. Just as Einstein integrated a string of evidences/theories before him to give his essentially simple theory of relativity, we need the genius of a synthesizer to make sense of the burgeoning scientific research in psychiatry and extract the essential simple solution that lies within handshaking distance.

VI.6. As we get to know it finally, we may be surprised at the naïveté of it all.

Concluding Remarks

1. Disease cannot vanish. *Diseases* can. This is the very basis of medicine, it is very *raison d'être*. It is equally applicable to psychiatry.
2. For psychiatry, we are in dire need of exact knowledge, and knowledge that is universally valid. Although the scientific approach may not be the only one, it is the only one that can be empirically validated, and refuted. Psychiatry, which claims to be a scientific discipline, should not lose sight of this. It either gives up the claim of being scientific, or learns to follow the canons of science.
3. A scientist looks at the 'how' of phenomena. A philosopher looks at its 'why'. What is the nature of a question that combines both the 'how' and the 'why'? It will be an integrated question. A 'what'. What is the nature of an answer that answers both the 'how' and the 'why'? It will be an integrated answer. Again a 'what'. By integrated, or a 'what', we mean it involves the empirical knowledge of the scientist combined with the speculative reason of the philosopher.
4. Science is basically antiphilosophy, since its fundamental thrust is to reduce the need for speculation, and speculation is fundamental to philosophy. Philosophy is basically science nurturing, since it offers insights for science to objectively verify and accept/refute. It also plays the role of being the conscience of science, because it shows the path and often prevents it from getting waylaid. While playing this role, philosophy sometimes appears to be antiscience since it is critical of science's unbridled power. Actually it is science nurturing.
5. The mind is the functional correlate of the structure called the brain. It has no existence aside and apart from it.
6. Theology and philosophy of mind can supply many speculative insights, which will need scientific enquiry and validation to convert them into empirical knowledge.
7. Robust eclecticism is compatible with subscribing to any one strand of thought in psychiatry - biological or psychosocial. It remains robust only as long as it accepts the worth of evidence from any quarter, even adversarial. Eclecticism is an attitude. Empirical enquiry is a process. One cannot substitute for the other. But one can, and should, complement the other.
8. Diagnosis cannot replace individual and customized care. But the converse is

equally applicable. In fact diagnosis complements individual and customized care. And the latter helps refine the diagnostic process.

9. Beneficence is essential, non-maleficence obligatory; autonomy is relative and justice debatable. Beneficence is the bedrock of medicine, non-maleficence its conscience. Justice its sentinel, autonomy its crowning glory.
10. Most psychiatric problems are sicknesses, since they involve an inability to fulfill normal social roles. They are often also illnesses, since there is subjective awareness of distress. But none are diseases as of yet, as there is no proven universally accepted objective pathology. This is the most important problem for psychiatry to tackle.
11. The major task of psychiatry, therefore, is to prove their illnesses and sicknesses are also diseases. Till this happens, psychiatry has the promise to become, but only approximates, a branch of medicine. *It is at an interim stage of development as a medical discipline.* This is an uncomfortable but necessary realization.
12. Genes determine, and regulate, behaviour. And behaviour alters gene expression. Both are interlinked through and through. The major task of modern psychiatry is to unravel which determines what, and to what extent.
13. Insights in psychiatric knowledge will come from many sources, especially the psychological, the psychoanalytic, the sociological, and the philosophical. Breakthroughs will come mainly, if not solely, from biology.
14. Psychiatric treatment will always require an empathetic grasp of the patients' inner feelings; and a working knowledge, if not an intimate grasp, of the sociocultural ethos in which they occur.
15. Biology is the engine and the fuel. Will psychoanalysis hold the steering, help change gears, and stop clamping on the brake?
16. The mind *is* the brain. And the brain, the mind. They are two sides of the same coin.
17. How do biological and psychosocial approaches gel? (i) Only under the overarch of ensuring comprehensivity of patient welfare; (ii) each supplies insights to the other while carrying out self-correction; and (iii) each accepts irrefutable evidence of its shortcomings, from whatever source it originates, internal or external.
18. Reductionism is a valid approach in the study of psychiatric phenomena. But integration of the finding of disparate approaches is equally valid. As is explanatory pluralism.

19. So, reductionism or integration? Both. Reductionism as an approach. Integration as an attitude.
20. All mental phenomena have a correlate in brain functioning, known or unknown. All brain activity gives rise to mental phenomena, known or unknown. The key is to find the links between brain activity and mental phenomena. The key is also to make the unknown mental phenomena and brain activity known.
21. In psychiatric *therapy*, beneficence and non-maleficence are paramount, and must override autonomy and justice when they conflict. In psychiatric *research*, however, autonomy and justice are paramount, and must override beneficence and non-maleficence when they conflict.
22. Social psychiatry must back up its insightful contentions with strong evidentials. Liaison psychiatry remains relevant only if appreciates the relevance of the medical model, but is prepared to transcend it. The same rule is applicable to psychosomatic medicine. Forensic psychiatry is necessary, but psychiatric ethics is mandatory. While the former ensures autonomy and justice, the latter ensures beneficence and non-maleficence. Neuropsychiatry is promising but guild-driven.
23. What Szasz and his ilk have to realize is there is a moral judgment involved in any labeling, whether of a disorder in psychiatry or the rest of medicine. If it were good/proper to vomit blood, or fall unconscious, or live with broken bones, or develop heart attacks, no branch of medicine would be needed. Similarly, if it were good/proper to live with suicidal attempts/thoughts, to fear meeting people so one remains confined to the house, to keep hand washing for hours, to believe one is the Almighty, or that the whole world is plotting/scheming against you, no psychiatry would be needed.
24. Psychiatric classification is capable of being both scientific and objective. Diagnostic categories do match real mental disorders. Hence, the medical model of psychiatry that many defend is legitimate, even if inadequate.
25. While psychiatry should beware it does not protect criminals, delinquents, etc., it must equally make people at large, and law enforcing agencies, aware that in certain mental conditions, a person may not realize the nature and consequences of his actions. A typical example is a schizophrenic who acts on his delusions and assaults someone, or a suicidal depressive who makes a suicidal attempt during a depressive phase. Treating helps them get rid of their delusion/suicidal impulse; putting them behind bars does not.
26. Often those who are creative are so not *because of*, but *in spite of*, mental illness. Moreover, often they continue to remain creative not because of, but

in spite of, mental illness and treatment; and all the side effects and lifestyle modifications that ensue following a major mental illness.

27. Religion and spirituality hold an eternal fascination for some serious psychiatric thinkers. There are many concepts in both that intersect. But in so far as religion stresses the subjective at the expense of the objective, it cannot become a predominant force in psychiatric thinking. However, it can supply many insights into mental phenomena, which psychiatric research can explore with profit. But with its tools, its criteria, its methodology.
28. Unless the older concepts in the philosophy of mind, whether of the East or the West, get converted into empirically testable hypothesis, they are useless for modern psychiatry. Reverence and awe is one thing, proof and therapeutic validation quite another.
29. Indian psychiatrists' attempts to understand ancient Indian concepts and their relevance to contemporary psychiatry have been intensely patriotic/reverential but feebly scientific. As different from this, Western thinkers have not desisted from critical evaluation of their greatest predecessors. Only that which stands the critical scrutiny of peers is accepted, and that too provisionally. This necessary progression in mindset - from reverence to critical sifting and analysis - is essential if experimentally verifiable models of care have to evolve from the writings of the great masters of the past.
30. It is also mentioned, almost as a truism, that Indian thought is holistic, synthetic, as opposed to the Western, which is reductionist and analytic. The predominance of religion (and belief) in Indian thought, and of science (and verification) in the West has given rise to such predominance. Holism is necessary as an *attitude*; reductionism is necessary as an *approach*. Holism is necessary to synthesize and integrate diverse strands of knowledge. But reductionism is needed to produce new knowledge, which is then synthesized and integrated.
31. The orientation necessarily has to be a blend of science and humanism. Where universally valid scientific knowledge serves individual patient welfare. And individual patient welfare serves to promote further universally valid scientific knowledge. Not as difficult as it seems, provided research integrity and patient welfare remain the watchwords. Holism at its best.
32. The ultimate aim of psychiatric theorizing and research is to find a grand unified theory that will explain all mental phenomena, in health and disease.

Take Home Message

There are many areas of connect between philosophy and psychiatry. Philosophy can offer insights into mental phenomena for psychiatry to objectively

verify. Psychiatry must progress from being an interim medical discipline to becoming a full one. It will do so only by finding biological determinants of behaviour in health and illness. A grand unified theory to explain mental phenomena is the final goal.

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Questions That This Paper Raise

1. 'Science is basically antiphilosophy and philosophy is basically science nurturing.' Why can both not be nurturing of each other?
2. 'Disease cannot vanish. Diseases can.' When can disease vanish, and well-being flourish?
3. 'Eclecticism is an attitude. Empirical enquiry is a process.' What if their roles are interchanged?
4. 'The major task of psychiatry, therefore, is to prove their illnesses and sicknesses are also diseases.' Will only biology help here?
5. 'Insights in psychiatric knowledge will come from many sources, especially the psychological, the psychoanalytic, the sociological, and the philosophical. Breakthroughs will come mainly, if not solely, from biology.' What about breakthroughs from other sources and insights from biology?

6. 'Reductionism as an approach. Integration as an attitude.' What if their roles are also interchanged?
7. Unless the older concepts in the philosophy of mind, whether of the East or the West, get converted into empirically testable hypothesis, they are useless for modern psychiatry. How do we do that?
8. 'This necessary progression in mindset - from reverence to critical sifting and analysis - is essential if experimentally verifiable models of care have to evolve from the writings of the great masters of the past.' Is not reverence itself necessary to understand phenomena? Which areas of enquiry are most suited for a move from reverence to critical enquiry?
9. 'The orientation necessarily has to be a blend of science and humanism.' How much of each, what when they conflict, how can they blend seamlessly?
10. The ultimate aim of psychiatric theorizing and research is to find a grand unified theory. Is it at all possible? Such grand ideas are doomed to failure. Why at all attempt it?

[Authors' Postscript: A Parting Thought, and Some Explanatory Notes:

1. A paper such as this can arouse two extremes of reactions. There are some who may find this paper well worth the effort, others may want to forget all about it. While both reactions are understandable and legitimate, more relevant would be to tear apart and analyze which of its points are relevant, and which need rejection; and why.
2. The paper adopts a certain format of presentation because it best suits the assertions that it presents. This is no comment on the usual style in which academic papers are presented.
3. To those who may feel the writers think they are Wittgenstein, or it is an imitation, we wonder whether anyone, Wittgenstein included, enjoys sole proprietary rights to presenting papers in a certain format.
4. To those who find this paper poorly written, badly argued, and rather naïve in its outlook, we plead guilty on all charges. It is not well written, if a typical academic paper format is what makes a paper well written, for it only presents points to be refuted, if possible. It is badly argued, for it mainly presents assertions and conclusions of arguments, and many actionable points, rather than pure arguments. It is rather naïve in its outlook, for we believe a naïveté that charts the course is preferable to arguments that enmesh and cause inaction. Of course the course should be worth charting, and well delineated. How this paper errs in so doing, would be worth knowing from our peers.

5. The charge can also be made that despite being a paper on philosophy and psychiatry, it seems to be ignorant of most recent philosophy. Being ignorant and not quoting, or commenting on, are not identical. The purpose of this essay is to raise certain foundational issues with regard to psychiatry and its sub-disciplines, and its relation to many other branches, especially philosophy. The purpose is not necessarily to enter into a polemic with recent writings in the philosophy of psychiatry. This is no comment on the need for, or preoccupations of, the latter.
6. Some may not be sure if this is a final version: this reads like an essay plan for several papers and does not offer a coherent argument and position. This is the final version, as of now, which of course can expand into several papers over a length of time. It does not offer a coherent position/argument, because it presents several assertions to be worked over, by the author and contemporaries, if psychiatry has to make solid ground as a rigorous empirical discipline in biomedicine. If it wishes to reject its empirical base, if it rejects the very need to establish itself as a branch of biomedicine, if it wishes to keep floundering, or if it wishes to continue with presenting arguments for the sake of arguments, then these assertions may be kindly forsaken.
7. Some of you may get irked at the sheer audacity of making such a grand project of a paper. Especially the sweeping generalizations, the dogmatic assertions, and the occasionally brusque comments. If you can stop getting irked, and can manage to give it a second read, things may not seem that bad after all. For you, as a reader/thinker, have at least sometimes realized the worth of an initially rejected idea.]

About the Author



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