# Positivism, Humanism and the Case for Psychiatric Diagnosis

July 01, 2014 | Couch in Crisis [1]
By Ronald Pies, MD [2]

If you've never surfed the web for sites that critically examine psychiatry, I highly recommend it—though it's not for the faint of heart.

*If sick men fared just as well eating and drinking and living exactly as healthy men do . . . there would be little need for the science [of medicine].* —Hippocrates

*Canst thou not minister to a mind diseased?* —Shakespeare, Macbeth, V, 3

If you've never surfed the Web for sites that critically examine psychiatry, I highly recommend it—though it's not for the faint of heart. These Web sites vary from the viscerally enraged, to the politely skeptical, to the constructively critical, and everything in between. The worst antipsychiatry Web sites, in my view, are veritable bastions of bigotry, in which psychiatrists are subjected to invective and abuse that would never be tolerated if directed, say, at some ethnic or racial minority.[1] The best of the critical Web sites, in contrast, offer pointed but respectful criticism of psychiatric diagnosis and treatment. For example, the Foundation for Excellence in Mental Health Care[2] hosts some psychiatrists, psychologists, and other bloggers who often dissent from the psychiatric "Establishment" (whatever that is) but who usually do so with decency and respect. I often disagree with them, but these critics deserve attentive ears and open minds.

If you look for something resembling a philosophical position on the more vituperative Web sites, you usually find objections to psychiatric diagnosis and treatment based on one or more of 3 basic claims:

• Only physical (bodily) illness, demonstrated by the presence of a lesion or physiological abnormality, constitutes "real disease." Psychiatry doesn't deal with real diseases, but with invented ones; therefore, its diagnoses and "treatments" are bogus.
• Whatever their claims to science, psychiatric treatments are either useless or harmful.
• Psychiatry is inherently coercive; it stigmatizes people with pejorative labels and forces its (bogus) treatments on unwilling victims, who, in many cases, are hospitalized against their will.

To be sure, some who hold these views have had terrible experiences with psychiatry or psychiatrists, whether through incompetence or malfeasance. These folks are understandably bitter. They are usually not receptive to the evidence that psychiatric diagnosis and treatment (including psychotherapy), when carefully and respectfully rendered, can literally be lifesaving and can lead to a better quality of life for the afflicted patient.[3-5] Nor are these critics mollified by the fact that laws and rulings regarding involuntary commitment are the products of democratically elected legislatures and duly-established courts—not the inevitable outcome of a psychiatric diagnosis.[6,7] (If, as a society, we want change in this area of civil liberties, why not lobby legislators rather than excoriate psychiatrists?)

**The positivist prejudice**

As for the first claim—that only bodily lesions or demonstrable pathophysiology define real disease—I consider this a well-debunked vestige of misguided positivism, thoroughly covered in many essays and articles.[8-11] (Logical positivism, ie, logical empiricism, holds that a statement is meaningful only if it is empirically verifiable or logically self-evident. For more, see: http://www.philosophybasics.com/branch_logical_positivism.html.) But I was amused recently to find one blogger attributing to me a definition of disease that has been a foundational belief throughout the history of medicine; namely, that disease is best conceptualized as prolonged or intense suffering and incapacity—whether of known or unknown etiology, body or mind.

For most of the history of medicine, physicians hadn't the faintest notion of what was causing their patients' suffering and incapacity—and virtually never observed the microscopic pathophysiology that underlies many diseases. Were these physicians therefore not treating real states of disease? For example, did epilepsy become a real disease only after the invention of EEGs and MRIs? (By the way, the diagnosis of epilepsy, like that of migraine headache, has always been and remains a clinical one—based primarily on the patient's history, signs, and symptoms, as with most psychiatric disease).[12]

Alas, the positivist prejudice thrives in the enclaves of antipsychiatry. Now some of these critics reasonably raise the objection that "suffering and incapacity" may be the result of many things, such as floods, famine, terrorism, or extreme poverty—yet we do not typically call victims of such conditions "diseased." Fair enough—we need to limit the reach of our imperfect definition to situations in which obvious, noxious external factors (such as a visible knife wound) are not causing the suffering and incapacity.[11] But, contrary to my critic's flattering claim, I am hardly the originator of the "suffering and incapacity" criterion of disease. Indeed, in the edition of *Harrison's Textbook of Medicine* that I used when I was a resident, the following breathtakingly broad definition of disease is put forth:The clinical method has as its object the collection of accurate data concerning all the diseases to which human beings are subject; namely, *all conditions that limit life in its powers, enjoyment, and duration . . .* [the physician's] primary and traditional objectives are utilitarian—the prevention and cure of disease and the *relief of suffering, whether of body or of mind . . .* [italics added].[13]

So, nothing regarding lumps, bumps, lesions, or lab findings as prerequisites for disease—and, crucially, nothing limiting the disease concept to the body. Indeed, as the late psychiatrist Robert Kendell[14] observed, "The distinction between mental and physical illness is ill-founded and damaging to the interests of patients themselves, whatever kind of illness they are suffering from."
Some positivist critics of psychiatry also cherish the jejune notion that doctors in other medical specialties know precisely what "disease" is, and how to define it. Sorry, but this is nonsense on stilts! Consider the debacle that arose recently when the AMA—in its deliberations on obesity—requested an advisory opinion from its Council on Science and Public Health. The question before the Council was, "Is obesity a disease?" The Council's considered response was a lesson in both the limits of language and the merits of humility: "Without a single, clear, authoritative, and widely accepted definition of disease, it is difficult to determine conclusively whether or not obesity is a medical disease state."[15]
So much for the power of positivist thinking!

**The existential-humanist perspective**

The existential-humanist perspective in psychiatry is widespread not only among many nonphysician mental health specialists but also among many psychiatrists. One radical version of the existential-humanist perspective is the notion that psychiatric illnesses are really nothing more than problems in living—amenable not to psychotropic medications, but to psychological explorations of the patient's world view, coping mechanisms, spiritual outlook, and social supports. The most famous proponent of this view was undoubtedly the late Dr Thomas Szasz. In the following passage from his 1960 essay, "The Myth of Mental Illness," Szasz combines a form of the existential-humanist perspective with a quasi-positivist perspective.I use the word "psychiatry" here to refer to that contemporary discipline which is concerned with problems in living (and not with diseases of the brain, which are problems for neurology). Problems in human relations can be analyzed, interpreted, and given meaning only within given social and ethical contexts. . . . The foregoing position which holds that contemporary psychotherapists deal with problems in living, rather than with mental illnesses and their cures, stands in opposition to a currently prevalent claim, according to which mental illness is just as "real" and "objective" as bodily illness.[16]

For Szasz, as for many existen-tial therapists, so-called mental illnesses are really problems arising from "conflicting human needs, aspirations, and values."[16] Now, as it happens, I am a long-time proponent of the existential-humanist perspective in general; that is, of the view that asserts the primacy of personal responsibility; the importance of one's way of "being in the world"; and the relevance of philosophy, linguistics, literature, and religion in our approach to psychological problems.[17,18]
Some of my formative influences included Viktor Frankl, Rollo May, James Hillman, and Karl Jaspers. In very broad terms, these philosophers and psychologists (Jaspers, of course, was a psychiatrist) emphasized not only causal explanations for illness (what Jaspers, following Wilhelm Dilthey, called *erklären*) but also psychodynamic and intention-based understanding (*verstehen*).[19,20] In clinical terms: when Mr Jones is depressed, it's not enough to posit low serotonin levels in his brain (which may or may not be the case); we must understand what gives Mr Jones's life meaning and purpose, and how these have been undermined by social, psychological, and spiritual impediments in his life. I heartily agree—but all this is in no sense a refutation of diagnosis in general, or of psychiatric diagnosis in particular. And, no: I do not necessarily mean the categorical diagnostic model found in the DSMs, which admittedly has many limitations, as I and others have noted.[21,22] Diagnosis,

etymologically, simply means “discernment” or “knowing the difference between” one thing and another.[23] We need not use DSM-5 categories, but we must know and recognize the difference between depression and anxiety, delirium and dementia, mania and hypomania, psychosis and derealization, etc. Moreover, we need to recognize that the “problems in living” trope has its own limitations. Consider this passage from writer William Styron’s autobiographical book, *Darkness Visible: A Memoir of Madness*.Death was now a daily presence, blowing over me in cold gusts. Mysteriously and in ways that are totally remote from normal experience, the gray drizzle of horror . . . takes on the quality of physical pain. . . . [the] despair, owing to some evil trick played upon the sick brain by the inhabiting psy-che, comes to resemble the diabolical discomfort of being imprisoned in a fiercely overheated room . . . there is no escape from the smothering confinement . . . the victim begins to think ceaselessly of oblivion . . . the faith in deliverance, in ultimate restoration, is absent.[24]

Note the phrase “totally remote from normal experience.” To describe such a severe major depressive episode as a “problem in living” is to trivialize almost unbearable suffering with a vapid euphemism. Styron’s condition was disease in as valid and robust a sense as when “disease” is used in reference to cancer. Indeed, in a recent piece in *Psychiatric Times*, pediatrician Elizabeth Griffin poignantly described her own depressive illness in terms of its profound suffering and incapacity.I couldn’t pay my bills on time. I couldn’t clean my house. I lost 60 pounds in a year without trying, because I couldn’t eat. I quit opening my mail and answering my phone. I completely isolated myself, and I sat at home weeping. . . . The time finally came though, when . . . I could not complete my charts. I could not concentrate. I hid in my office, crying at times.[25]

Eventually, Dr Griffin buys a gun and nearly turns it on herself—but, thankfully, she resists. Still, she writes, “I do think that depression might kill me someday.” She beautifully characterizes major depression as “. . . overwhelming and overpowering: it crushes its prey.” For her, as for many severely depressed people, depression is not a mere “problem in living” but a terrifying gateway to dying. Ironically, the existential-humanistic perspective, if applied indiscriminately to all psychiatric disorders, is a form of reductionism—no less procrustean than an exclusive fixation on “brain chemistry” or neurotransmitters.
Of course, not all the problems psychiatrists see and treat are instances of disease. We treat individuals and families dealing with normal grief and loss.18 We treat ado-lescents struggling with their sexual identity. We treat some who are simply searching for meaning in their lives. But we are also members of a medical discipline, whose patients often suffer from life-threatening illnesses. To be sure, many of them will face ignorance, prejudice, and discrimination when their condition is revealed to others. But this is reason to educate and inform the public, and to advocate on behalf of our patients’ vital interests—not to shirk our medical responsibilities or apologize for our diagnoses.
****Logical positivism (or Logical Empiricism) holds that a statement is meaningful only if it is empirically verifiable or logically self-evident (eg, the statement, “All bachelors are unmarried males”). For more,* please click here.

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