

VIEWPOINT

Psychiatry's Myopia—Reclaiming the Social, Cultural, and Psychological in the Psychiatric Gaze

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Over the last 50 years, outcomes for individuals with serious mental illness (SMI) in the US have worsened. Individuals with schizophrenia die 20 to 25 years sooner than those without SMI,¹ and—although it was unthinkable 50 years ago—many find themselves incarcerated or homeless because of their psychiatric disease. Explanations include stigma, welfare state contraction, and limited access to evidence-based treatments. Less scrutinized is the role of clinical psychiatry. We suggest that clinical psychiatry's taken-for-granted, everyday beliefs and practices about psychiatric disease and treatment have narrowed clinical vision, leaving clinicians unable to apprehend fundamental aspects of patients' experiences.

This narrowed vision has persisted in the 2 decades since McHugh and Slavney² compellingly argued that clinical psychiatry must embrace a nonreductionistic, multivalent approach to psychiatric disease and treatment and turn away from monocausal approaches, whether biological or psychological. After the antipsychiatry critiques of the 1960s and 1970s, psychiatrists rightfully argued that psychiatric disease is as real as any other disease. Lost in this assertion is the complex nature of all diseases, rooted in the body but profoundly shaped by the psychological, social, cultural, and clinical-scientific contexts in which a particular individual experiences a particular illness. Fully understanding disease requires that we contend with the logic, causal networks, and interactions that operate within and between multiple levels of factors, from the molecular to the social, cultural, and historical. McHugh and Slavney summarize how psychiatric disease presents a case apart: “[I]n contrast to cardiologists, psychiatrists cannot go directly from knowing the elements of the brain (neurons and synapses) to explaining the conscious experiences that are the essence of mental life. At the frontier of brain and mind, wherever that may be, the words we use change from tangibles (neurons and synapses) to intangibles (thoughts, moods, and perceptions)...Unlike cardiologists, psychiatrists are unable to go directly from the molecular structure of a bodily organ to the functional results of that organ's action.”^{2(p30)}

Nothing inherent in the biomedical paradigm precludes such a broad understanding. A scientific, evidence-based approach to understanding psychiatric disease and treatment should account for the nature of mental illness as simultaneously constructed by social judgments of what is normal and pathological, subjective experiences, and biology. The limits of current clinical frameworks that guide practice for those with SMI are not because of overreliance on biomedical paradigms. Rather, clinical psychiatry has failed to systematically address the reality of mental illness as a liminal object, its multilevel nature, and how it is lived in everyday life.

Ironically, prior to our contemporary biomedical paradigms, all disease was understood through a theory-driven disease model based in humoral medicine that conceptualized disease as a disrupted balance among bodily, behavioral, and environmental factors. Beginning in the 1800s, physicians increasingly located disease in specific organs, then tissues, cells, and finally genes and their molecular interactions. We now take for granted that diseases, including psychiatric ones, can best be understood and treated using refined analyses of their component parts.

Throughout the 19th and much of the 20th century, shifts in disease models had little consequence for how psychiatrists cared for patients with SMI. No matter what label psychiatrists affixed to patients entering state hospitals, they cared for patients as if afflictions were simultaneously of the brain, mind, and functioning in the social world. Following World War II, treatment changed dramatically as state hospitals across the country closed. These changes were fueled not by clinical evidence but naive faith in the therapeutic powers of community care, state governments' inability to sustain hospital networks, and the passage of legislation creating Medicare and Medicaid. Our current system of fragmented, sporadic community care is the legacy of these transformations. The spectacular growth of the neurosciences, retreat from psychoanalysis, enormous success of the *DSM-III*, and marketing and financial success of antipsychotic and antidepressant drugs combined to create clinical paradigms in which psychiatric diseases and treatments approximate the specificity of antibiotics for infectious diseases.

Since philosopher Ernest Nagel's formal elucidation³ in 1949 of reductionism in science, philosophers, life scientists, and physicians have discussed its place as a method and mode of explanation. While reductionism underlies commonsense ideas of disease and treatment, it has come under increasing scrutiny within medicine. Federoff and Gostin argued that modern approaches “premised on fundamental biological discovery, elucidation of underlying mechanisms, and delivered as evidence-based medicine”^{4(p994)} are “neglecting the dynamic interaction of all elements and how they affect the system as a whole.”^{4(p994)}

As genomics, proteomics, and other powerful tools have uncovered greater complexity underlying biological processes, life scientists also have discovered the limits of reductionism. “The more complex the organization of a system,” writes philosopher of biology Marie I. Kaiser, “the more its parts are integrated and interdependent on each other, the more limited are the insights into the system one can achieve by...reductive methods....The less adequate appear reductive expla-

nations that refer exclusively to lower-level, internal entities (the parts of the system).^{5(p471)}

Despite compelling arguments in medicine and psychiatry against clinical reductionism, we parse patients' diseases into signs and symptoms that yield to pharmacological and/or time-limited psychosocial treatments that address parts of psychiatric disease while failing to address the most human and tragic ravages of SMI. By mistaking the parts for the whole, clinical psychiatry has aided and abetted the social alienation; social, medical, and psychiatric abandonment; and neglect inflicted on those with SMI over the last half century.

Kendler⁶ has cogently argued for a psychiatric science that is nonreductionistic, attends to multiple levels of causation, is agnostic about the relative importance of these levels, and attends to both third-person explanations and first-person understandings. We need a similar approach to clinical practice, in which we do not confuse humane doctoring with the prescription of psychotropic medication for an individual with psychosis living in unhoused squalor or jail shackles.

Kendler⁷ writes, "We are 'stuck' with the dappled causal world for psychiatric disorders."^{6(p937)} We need frameworks for clinical practice that explicitly take into account this reality and see patients' diseases not as we want them to be constituted, but rather as a real,

lived experiences inextricably embedded within social, psychological, and biological contexts.⁸ Clinicians do not confront patients who are fragmented and not contextually bound. Their social and psychological alienation, impoverishment, and violations of social norms are integral to their psychiatric disease. Biopsychosocial and biological approaches are equally susceptible to a reductionism that perpetuates a system of mental health care that fails to address the fundamental realities of SMI in everyday life. We need new paradigms of clinical practice to effectively address SMI in vivo, in which what matters most to patients—loss of meaning, impoverishment, social isolation, and/or disabling symptoms—is also what matters most to clinicians. An empirically based, integrative approach will give clinicians the scientific justification and ethical imperative to insist that homelessness and incarceration are unacceptable either as locales for alleged treatment or outcomes for those with SMI. An expanded clinical gaze will remind us that responsible treatment requires more than prescribing a single modality, such as a psychotropic drug, but instead addressing multiple levels of interacting factors, including families, living situations, social networks, and what makes patients' lives meaningful. Perhaps then, we can help undo some of the forces that have made those affected with SMI subject to some of the worst human rights and public health crises.

ARTICLE INFORMATION

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