Psychiatrist: brain, mind or soul doctor?

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Cartesian dualism's separation of mind and brain has heavily influenced Western thought and implies a distinction between brain-based and mind-based psychiatry. Although focusing on the brain strengthens psychiatry's medical foundations and scientific legitimacy, it is not able to fully describe the nature of psychiatric illness. The patient's social context, personal values and unique perspective of their condition are lost in a narrow focus on the brain. These elements of psychiatry are captured in psychotherapy, social and phenomenological psychiatry but uniting these varying approaches to mental illness with a common focus has proven challenging. The concept of the soul unites the mind and body and could help psychiatry move beyond the limitations of dualism. However, psychiatry has struggled to incorporate the soul with its scientific grounding. Serife Tekin argues the 'multitudinous self' offers an empirically traceable model of the self. This pluralist model can accommodate the different approaches to mental illness and may offer a solution to the disagreements which stem from dualism. Rather than focusing narrowly on either the mind or brain, the art of psychiatry may be knowing which of many approaches to mental illness are most relevant in each patient. The psychiatrist is not a doctor of the mind or the brain. The psychiatrist is a doctor of the mind and the brain, which are united in the concept of the soul.

Twenty-first century psychiatry faces a challenge. In an era of increasing specialisation, it is difficult to unite the different understandings to mental illness with a common focus (Bhugra, 2014). Conflicting approaches to mental illness are a familiar issue. The whole process of psychiatric professionalisation has been characterised by the tension produced by its relevance to both the natural and social sciences (Berkenkotter, 2008). Internal disagreement undermines the foundations of psychiatry and may contribute to its poor public image and declining recruitment rates (Katschnig, 2010). In response to such challenges, some believe we should promote a biological psychiatry which studies and treats the brain to protect the discipline's scientific integrity (Jethwa, 2015). Others argue that these biological approaches neglect important aspects of psychiatry which help patients, harming its credibility as a practically useful medical discipline (Gardner, 2019). Such contradictory solutions to the issues psychiatry faces are a strong indication of its disunity. Much of the disagreement can be distilled into a fundamental question: is the psychiatrist a doctor of the brain, the mind or the soul? I argue that a narrow focus on either the mind or brain cannot fully capture the multifaceted nature of psychiatric illness. The concept of the soul offers a more helpful focus for psychiatry as it offers a pluralist framework which can accommodate the different approaches to mental illness, which all offer useful insights, without giving one primacy.

The Hardest Problem

The central problem in this discussion is captured by the intractable 'hard problem of consciousness' which asks how the physical processes of the brain can produce conscious experience (Chalmers, 1995). The Western attitude to this question is shaped by the work of René Descartes who argued that the physical brain and non-

physical mind are fundamentally different substances (Carter, 1983). Cartesian dualism was the dominant view of the mind-body relationship when modern Western psychiatry developed in the 19th century and forms its conceptual foundations (Berrios, 2018). Psychiatry's history is characterised by shifting levels of importance placed on each element of this dualism. Freudian psychoanalysis dominated in the early 20th century when brain based approaches had limited therapeutic value. The discovery of efficacious neuropharmacological agents in the 1950s caused a shift towards an understanding of mental illness as chemical imbalance in the brain (Miller, 2020). The disagreements that stem from dualism are a key part of the identity crisis psychiatry faces (Glannon 2020). Yet, despite its fundamental importance, the mind-brain problem has not been thoroughly assessed in recent psychiatric literature. There is a strong bias towards physicalist positions and alternative explanations of the relationship are misunderstood and caricatured (Moreira-Almeida, 2018). To resolve the divisions that arise from dualism, psychiatry should think critically about the potential relationships of mind and brain and not narrowly consider only physicalist positions.

Cartesian dualism's strict separation of brain and mind is unpopular on both sides of the split it created. For those who place primacy on treatments of the mind, it is thought to have created an objective but detached view of the physical world where the mind is not considered a legitimate object of scientific enquiry (Lipowski, 1989; Thomas, 2012). For those who see psychiatry as involving physical treatments of the brain, Descartes' 'dogma' is seen to have created a division between mind and brain that does not exist (Ventrilio & Bhugra, 2015). The distinction between mind and brain dissolves when one considers that psychotherapies alter neuronal activity in

ways similar to pharmacological treatments (Linden, 2006). Rejecting strict dualism and recognising the interdependence of brain and mind is important to psychiatric progress (Glannon, 2020). However, this doesn't entail a dogmatic subscription to physicalist positions which should also be avoided.

Distinctly Medical or Medically Distinct?

Viewing mental illnesses as physical disorders of the brain provides an attractive model for treatment. It suggests that once we find the neurobiological essence of mental disorders, we can develop targeted therapies and give psychiatry the scientific integrity afforded to biological medical disciplines. Some argue that the challenges psychiatry faces arise from a neglect of psychiatry's roots within the medical tradition (Craddock, 2008). As well as harming disciplinary identity, neglecting the neurological underpinning of psychiatry disadvantages patients by limiting our understanding of their ailments and increasing stigma (Bullmore, 2009). There are fears that psychiatry may find itself made redundant if it fails to strengthen its links to related medical specialities (Oyebode & Humphreys, 2011). These views are not attacks on psychotherapy and its clear benefits, but rather are a call to promote a neuroscience-based psychiatry to prevent the discipline losing its medical grounding. These views suggest that the essential bridge between psychiatry and medicine will be found in a brain-based, biological basis for mental illness (Jethwa, 2015).

The efficacy of agents which increase monoamine neurotransmission in depression has led to the influential 'monoamine hypothesis'. However, it seems unlikely that a disorder as complex as depression can be reduced to a simple monoamine

deficiency but likely involves a complex interaction of genetics, biology and environment causing dysfunctional neuroplasticity or neurogenesis (Jesulola, 2018; Boku, 2017). A promising biological aetiology for depression points towards the role of inflammatory processes. One in four patients with depression have abnormal inflammatory markers and childhood trauma is found to contribute to a pro-inflammatory state in adulthood (Osimo, 2019; Baumeister, 2016). Depression may be an inflammatory disorder and the efficacy of antidepressant medications may be partly explained by their anti-inflammatory properties (Wallker, 2013; Więdłocha, 2018). Khandaker (2019) proposes that the inflammatory dysfunction seen in psychiatric disorders suggests that they are not simply mental disorders, but are the mental consequences of a multi-system inflammatory disorder. Such views place psychiatry firmly within the domain of biological medicine.

Understanding mental illness on the cellular level may provide novel therapeutic targets and the potential for precision medicine within psychiatry. This is the goal of the National Institute of Mental Health's research program the Research Domain Criteria (RDoC) (Cuthbert & Thomas, 2013). The RDoC is a response to the increasing disillusionment with the DSM and ICD nosologies. These models have helpfully given psychiatry a reliable common language, but their reliability does not ensure their validity. Their disease groups represent heterogeneous clusters of symptoms not related to any recognised pathological process and which blur into each other (Poland & Von Eckardt, 2013). The RDoC framework abandons the currently accepted psychiatric nosology and starts with research into functional brain circuits and considers mental disorders dysfunctions of those circuits (Cuthbert, 2015). The effect of the environment upon the development of these neural circuits is

a core feature of the RDoC approach. However, its aim is to translate these environmental influences into a mechanistic neurobiological language. This has been criticised as being too reductive and unable to capture all elements of psychiatric illness (Parnas, 2014; Lilienfield, 2014). Biological psychiatry and the RDoC programme are valuable research programmes, but should not be presented as all-encompassing frameworks for psychiatry.

Psychiatric legitimacy faces challenges which some argue are best overcome by forging strong links to biological medicine. Some go as far as suggesting that psychiatry *is* neurology and that their disease classifications should fuse (Zeman, 2014). Yet just because mental illness involves neural circuits does not mean they are simply disorders of those circuits. The fact that we cannot describe the nature of mental illness without using psychological terminology suggests they are not simply diseases of the brain (Graham, 2013). Furthermore, advocating too strongly for a neurochemical aetiology exposes psychiatry to commercial interests which simplistically suggest these enormously complicated conditions are reducible to 'chemical imbalances' reversible with a simple prescription (Charland, 2013). This is not a criticism of biological psychiatry, but is a warning against thinking that a biological psychiatry is all there is. Psychiatrists deal with disorders of emotions. Our emotional states are what give meaning to our existence and allow us to perceive the world in terms of our personal values. Biological reductionism attempts to reduce this deeply personal and value-laden perspective to an objective neurological fact (Thomas, 2012). Personal identity, social values, rationality and self-awareness are important elements of psychiatry which are difficult to capture in a reductive biological model (Parnas, 2014). Perhaps the threat that psychiatry faces is not just

being lost from medicine, but also becoming too ingrained in a biological paradigm and losing an important part of itself.

The Bio, the Psycho and the Social

Biological psychiatry and the RDoC programme aim to demonstrate that mental illness are real entities bound in neuronal dysfunction and give psychiatry scientific legitimacy (Tabb, 2019). However, it is important not to take this too far and neglect the social component of psychiatric diagnoses. Even if mental illness are just brain disorders, the decision to classify the behaviours of a certain brain state as disordered is a normative social judgement (Kigma, 2013). The goals of a discipline shape the form of knowledge it produces and the knowledge that it leaves behind. A narrow biological focus risks neglecting the important social element of mental illness (Fallin, 2018). A purely brain-based approach risks dehumanising psychiatry as the unique, socially-situated individual is lost in the search for replicable scientific objectivity (Tripathi, 2019). To prevent this, some promote a social psychiatry based in the community which focuses on the socio-political influences on mental health and prioritises prevention (Srinivasa, 2018). Closer collaboration with social sciences could offer a deeper understanding of the way a patient's social context shapes their mental life (Strauss, 2019). With this focus, changing harmful social situations or encouraging societal integration could be considered therapeutic interventions (Preibe, 2016). The impact of the COVID-19 pandemic on mental health presents an immense challenge to psychiatric services and demonstrates the way that shared social experiences shape mental health. A biological model, focused on dysfunction of individual brains, cannot capture the impact that COVID-19, the climate emergency or an increasingly divided society have on mental wellbeing, which

require an understanding of the social context these issues arise within (Kesner & Horáček, 2020). To fully understand mental illness, psychiatry needs to look beyond the brain.

In response to the limitations of the biomedical model, George Engel (1977) described the biopsychosocial model which aimed to unite the social element of illness with its biological and psychological components. One of the main strengths of the biopsychosocial model is that it highlights the inseparability of biological and psychosocial factors. Epigenetic research reveals an aspect of this inseparability, showing that the expression of a biological predisposition to mental illness relies upon environmental factors (Uher, 2014). Early life adversity and lower socioeconomic status is associated with increased methylation of the SLC6A4 serotonin-transporter gene which predicts a heightened threat response from the amygdala. Such findings may represent a biological marker of social adversity which predisposes to mental illness (Swartz, 2017; Provenzi, 2016). Research into the mechanisms which unite social and biological causes of mental illness may provide a richer understanding of its treatment and prevention (Kular & Kular, 2018). The interconnectivity of the brain and its social environment shows that, although an understanding of neuronal processes is hugely important, it cannot give us the full picture. The language of neurobiology alone cannot explain why a patient's serotonin transporter genes are methylated as this requires an understanding of the social context the patient exists within. Social psychiatry is not in opposition to biological psychiatry, but approaches mental illness in a different way.

Soulful Psychiatry

Etymologically, ‘psychiatry’ translates as the treatment of the ‘soul’. However, Western psychiatry has distanced itself from the concept of the soul and its spiritual connotations (Johnston, 1998). Cartesian dualism cut the connection between mind and body which was characteristic of the soul which has resulted in a shift from the ‘soul’ to the idea of the ‘self’ (Duvall, 1998).[1] The pre-modern conception of the self was intimately connected to the external environment and the things that brought meaning to life. The modern ‘self’, in contrast, is internalised and considered to be distinct from the scientifically measurable external world (Crossley, 2012). We have moved towards an understanding of the soul which is detached from the external world and understood in isolation from its environment. This is problematic as it neglects the fact that an individual is intrinsically shaped by the environment they exist within and that a full understanding of their soul requires an understanding of their social context.

The concept of the self is central to psychiatry. Mental illnesses impact self-identity and the ownership of one’s thoughts or emotions. People with psychiatric disorders are often literally defined by their illness. We do not just say that a person *has* schizophrenia, we also say that they *are* schizophrenic – or depressed, bipolar, psychotic, bulimic, anorexic, autistic – which implies a degree of permanence (Reynaert & Gelman, 2007). Our emotions give personal meaning to our existence and altering these responses pharmacologically has complicated effects on the self (Svenaeus, 2013). Despite its fundamental importance, psychiatry has not meaningfully addressed the concept of the self and its complex relationship to

[1] I use the terms ‘soul’ and ‘self’ interchangeably.

mental illness (Crossley, 2012). Some patients see their healthy state as their authentic self and the effect of their illness on their behaviour as inauthentic. Some consider any psychological change induced by medications as inauthentic. Others identify positively with their illness (Erler & Hope, 2014) This final group pose a challenge that psychiatry is unable to deal with if it remains focused on the disease model. If psychiatry adheres solely to the disease model, where patients are considered to have a problem which requires therapeutic intervention, it is unable to meaningfully help those who positively identify with their psychiatric condition. To overcome this challenge, Rashed (2020) argues psychiatry needs to incorporate the concept of *social insight* to patient encounters. In contrast to *illness insight* (the understanding that one is afflicted by a disease which needs treatment), *social insight* encourages the patient to understand how their behaviour and its social consequences led to the clinical encounter. This is reminiscent of the work of anti-psychiatrist Thomas Szasz who argued that mental illnesses are not truly 'diseases' but are better understood as forms of social behaviour. Rather than focusing narrowly on the disease model, understanding some psychiatric symptoms as behavioural responses to social situations moves psychiatry away from the cold language of intervention and disease, towards one of meaning, integration and understanding (Moncrieff, 2020). However, this places psychiatry in the difficult position where it has to have the conceptual tools to help patients who are seeking treatment for an illness and those who identify positively with their 'psychiatric' behaviours.

Psychiatry has struggled to incorporate the concept of a soul with its scientific grounding. However, Tekin (2019) argues there is an understanding of the self which

is empirically traceable: the ‘multitudinous-self’. It is divided into 5 interlinked parts: the physical ‘ecological self’, which interacts with the environment; the ‘interpersonal self’, composed of social relationships; the ‘temporally extended self’, grounded in memories of the past and anticipation of the future; the ‘private self’, with privileged access to first-person phenomenological experience; and the ‘conceptual self’, the interaction of the other components which represents the self to the self. The multitudinous-self offers a framework which accommodates the different approaches to mental illness. The ecological self is the object of biological psychiatry; the interpersonal self is the focus of social psychiatry; phenomenological psychiatry explores the experiences of the private self; the conceptual self encapsulates the patient’s perspective. Focusing on the multitudinous-self (rather than the mind or brain) may help move psychiatry past the limitations and disagreements which stem from dualism and unite the different understandings of mental illness with a common focus.

This model raises the question of how the distinct components of the soul, and their respective research programmes, are related. How far should we aim to unite them into a single unified framework? Gijsbers (2016) argues that the project of integration can go too far. The unique perspective, values and goals of each approach to psychiatry are their strength and trying to define one approach in terms of another devalues them. In the philosophy of science, contextualist pluralism describes the position which recognises that a single scientific approach is unlikely to offer a full explanation of any phenomena, but different approaches, each with their own perspective and values, are needed for a clear picture (Longino, 2015). Such a model is attractive for a discipline as complex and multi-faceted as psychiatry

(Dupré, 2015). The soul, understood as the multitudinous self, offers an attractive pluralist framework for psychiatry. It is able to accommodate distinct research approaches and the patient's understanding of mental illness, which all have their own value, without giving one primacy.

Conclusion

Cartesian dualism's separation of brain and mind inevitably returns us to the doomed question of whether the psychiatrist is a doctor of the brain or mind. Brain based psychiatry risks neglecting the integral social component of mental illness, yet focusing solely on the mind weakens psychiatry's medical foundations and therapeutic potential. The reality is that psychiatry is not 'mindless' or 'brainless', but involves both – the challenge is finding a way to unify them for the benefit of patients (Lipowski, 1989). This was the goal of the biopsychosocial model, but this has been criticised as an overarching paradigm as its bio, psycho and social components are studied in isolation and their interactions not fully explored (Steinert, 2020; Ghaemi, 2009). Perhaps psychiatry does not need a single overarching paradigm. The art of psychiatry may be knowing which of many approaches is most relevant to each individual patient (Parker, 2020). The soul is an attractive focus for psychiatry as it unites a person's biological constitution and social context with their personal perspective on their psychiatric symptoms. It recognises that the varying understandings of mental illness all have value and, even if they cannot be fully integrated, all can be directed towards the patient and their care. Placing the whole patient as the locus of concern in this way is a literal realisation of patient centred care. In sum, the psychiatrist is not a doctor of the mind or the brain. The psychiatrist is a doctor of the mind and the brain, which are united in the concept of the soul.

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