

# The American Journal of Psychiatry

## Residents' Journal

March 2016

Volume 11

Issue 3

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# Humanities More Important Than Ever in the Era of Scientific Psychiatry

Vivek Datta, M.D., M.P.H.

We live in the era of scientific psychiatry. We have operational criteria, randomized controlled trials, evidence-based treatments, and a burgeoning research base into the neurobiological basis of mental disorders. We have been completely seduced by the narrow gaze of neuroscience. Technological interventions such as deep brain stimulation and other neuromodulatory treatments have excited the field. Finally, psychiatry appears to have the respectable veneer of science like the rest of the biomedical enterprise. What then is the problem?

Leon Eisenberg said it best: “The success of neuroscience has exacted costs. The very elegance of research in neuroscience has led psychiatry to focus so exclusively on the brain as an organ the experience of the patient as a person has receded below the horizon of our vision .... We have traded the one-sidedness of the brainless psychiatry of the first half of the 20th century for a mindless psychiatry of the second half” (1, p. 93).

In our quest for a rigorous scientific underpinning, psychiatry turned its back on the humanities and social sciences just as the rest of medicine was discovering how enriching these fields are (2). By privileging a neuroscientific discourse for understanding the range of human misery embodied in lived experience, we have reduced ourselves to neural circuitry and neglected the narratives, relationships, values, meanings, and assumptions inherent not only in our patient’s stories, but also in the model we have subscribed to. For the rise of

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neuroscience in psychiatry is the ascendance of a new narrative with particular values, meanings, and assumptions that largely go unchallenged. These values exist within a particular context: social, cultural, political, economic, and historical. It is no accident that the rise of biological psychiatry through the 1980s occurred alongside the rise of the politics of neoliberalism (3). A narrow focus on brain and biology obfuscated the wider causes of mental disorder in a socio-political climate that wished to divert attention from the mental health impact of Regan era policies.

The humanities offer us a tool for better understanding stories: those of our patients (4), those of ourselves, and those of our profession. An understanding of neuroscience and genetics will enrich psychiatry as we go forward, but a singular focus on the brain has led criticisms that psychiatry is reductionistic and medicalizes problems in living for pecuniary gain. Patients need to be understood in the context of their lives. We need to understand our patients.

Brain does not singularly nor linearly help us understand either mind or behavior. Psychiatrists can get a glimpse of mental illness through biographies, novels, poetry, art, film, and music. The humanities help us to focus on meaning, and meaning helps our patients to feel understood.

Most of all, however, the humanities allow us to be critical and reflective. In other fields of medicine, the doctor-patient relationship became the casualty of technological advancement (5), and there is reason to believe this is already happening in psychiatry. As such, the humanities are more important than ever in this era of scientific psychiatry.

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# Using Patient Writings in Psychotherapy: Review of Evidence for Expressive Writing and Cognitive-Behavioral Writing Therapy

Phaedra Elizabeth Pascoe, M.D.

Expression of thoughts and emotions has been a core aspect of psychotherapy dating back to its creation. Over the years, this expression has taken multiple forms, from traditional use of talking to writing, art, and music. Alternative forms of expression—writing in particular—have the advantage of being able to reach populations that may otherwise be unwilling or unable to engage in traditional psychotherapy. Some individuals feel comfortable writing about things they would not feel comfortable talking about (1). In addition, writing provides the benefit of being inexpensive and portable and often results in a product people can share with others.

Although writing has been used as a method of expression both in and out of psychotherapy for many years, Pennebaker was the first individual to systematically study the beneficial effects of writing with the development of expressive writing (2). Multiple therapies have incorporated writing since that time, including cognitive-behavioral writing therapy. The present article will review the evidence for expressive writing and cognitive-behavioral writing therapy.

## EXPRESSIVE WRITING

### Theoretical Background and Initial Study

In Pennebaker's theory of emotional inhibition (3), he hypothesized that individuals who have experienced traumatic events want to share their experiences with others for social support. However, feared or actual negative responses from others inhibit them from sharing their feelings and thoughts. Pennebaker theorized that this inhibi-

tion resulted in chronic low levels of stress, which placed individuals at increased risk of both physical and mental disorders. Pennebaker designed the expressive writing technique as a means for testing whether disclosing previous trauma was associated with decreased stress and subsequently improved physical and mental outcomes.

The initial study by Pennebaker and Beall (2) involved college students writing about either a previous trauma or a trivial topic. Students were asked to write for 15 minutes for 4 consecutive days. Assessments were completed before and 4 months after the intervention, including self-report of mood and different physical symptoms, such as headache, racing heart, and tense stomach. There was a significant decrease in the number of physical symptoms between the individuals who wrote about their trauma versus those who wrote about a trivial topic ( $F=3.05$ ,  $df=3, 38$ ,  $p=0.04$ ); however, there were no significant differences between the groups in terms of mood.

### Subsequent Research and Meta-Analyses

Since this initial trial, a large number of studies examining expressive writing for a variety of different populations and settings have been completed. The majority of studies examining psychiatric symptoms involve samples of individuals who have been exposed to either a major adversity, such as cancer (4, 5), or to significant trauma, such as sexual abuse (6, 7). There are a limited number of studies looking specifically at individuals with preexisting psychiatric diagnoses (Table 1). The studies on

expressive writing have generally used interventions similar to Pennebaker's initial study, with participants writing for 20–30 minutes for three to five sessions (4). Participants in these studies are usually given a prompt such as: "I would like for you to write about your very deepest thoughts and feelings about the most traumatic experience of your entire life. In your writing, I'd like you to really let go and explore your very deepest emotions and thoughts" (8).

There have been multiple meta-analyses examining the efficacy of expressive writing (9–11). An initial meta-analysis by Smyth (9) found a moderate effect size of expressive writing on physical health (Cohen's  $d=0.421$ ,  $p<0.0001$ ), psychological well-being (Cohen's  $d=0.661$ ,  $p<0.0001$ ), and biophysical measures (Cohen's  $d=0.681$ ,  $p<0.0001$ ) but not on health behaviors, such as sleep, drug use, and exercise.

Several years later, Mogk et al. (10) completed a meta-analysis that included a larger number of studies than the number included in the Smyth study ( $N=30$  versus  $N=13$ ), which were completed in a larger array of settings by a more diverse group of researchers (Pennebaker was listed as an author in 23% of the studies versus 62% in the Smyth meta-analysis). Both meta-analyses only included randomized controlled studies in which the control group was asked to write about a neutral topic. However, Mogk et al. only included studies that examined the effect of expressive writing at least 4 weeks after the last writing session. Four of the 13 studies included in the Smyth meta-analysis were excluded from the meta-analysis by Mogk et al.

**TABLE 1. Randomized Controlled Studies Comparing Expressive Writing Participants With a Control Group<sup>a</sup>**

Study	Psychiatric Diagnosis of Individuals Included in the Study	Location From Where Participants Were Recruited	Number of Participants/Percentage Completion	Duration and Timing of Expressive Writing	Timing of Assessments	Primary Outcome Measures	Summary of Results
Baikie et al. 2012 (17)	Mood disorders (85% of participants had depression, 21% had depression and anxiety)	Advertisement on website about depression	688/40%	Four 20-minute sessions over 2 weeks	After completion of expressive writing and after 1 month and 4 months	Center for Epidemiologic Studies Depression Scale, Depression Anxiety Stress Scale, Pennebaker Inventory of Limbic Languidness, overall health questions, Temperament and Personality Questionnaire (TPQ), and COPE Inventory (COPE).	Individuals receiving active interventions (expressive writing and writing about positive events) demonstrated significant improvement in the stress subscale of the Depression Anxiety Stress Scale compared to controls
Krpan et al. 2013 (18)	Major depressive disorder	Local advertisements	44/90%	Three 20-minute sessions over 3 days	After completion of expressive writing and after 1 month	Beck Depression Inventory and Patient Health Questionnaire 9 (PHQ-9)	Individuals using expressive writing showed significant decreases in depression compared to controls
Sloan and Marx 2004 (11)	PTSD	Introductory psychology college course	51/96%	Three 20-minute sessions over 3 days	After completion of expressive writing and after 1 month	Posttraumatic Stress Diagnostic Scale, Beck Depression Inventory, Pennebaker Inventory of Limbic Languidness, cortisol level	Significant decreases in PTSD symptoms, depression and physical symptoms
Smyth et al. 2008 (19)	PTSD	Trauma care agencies	25/96%	Three 20-minute sessions over 1 day	After completion of expressive writing and after 3 months	PTSD Symptom Scale Interview (PSS-I), Profile of Mood States (POMS), Post-Traumatic Growth Inventory (PTGI), cortisol level	No significant difference in PTSD symptoms between groups, individuals using expressive writing showed significantly larger reduction in tension and anger in comparison with controls
Meshberg-Cohen et al. 2014 (20)	Substance use disorders (more than 50% had comorbid PTSD)	Residential treatment facility	129/95%	Four 20-minute sessions over 4 days	After completion of expressive writing and after 2 weeks and 1 month	Posttraumatic Stress Diagnostic Scale, Center for Epidemiologic Studies Depression Scale, Pennebaker Inventory of Limbic Languidness, Brief Symptom Inventory (BSI), Positive and Negative Affect Scale (PANAS)	Significant difference between groups at 2 but not 4 weeks

<sup>a</sup> Writing was about a neutral topic among psychiatric populations.

In their meta-analysis, Mogk et al. found no significant effects of expressive writing on either physical or psychological health. It is difficult to apply these findings to individuals with psychiatric disorders because the majority of these studies used nonclinical samples, largely students. Mogk et al. completed an exploratory analysis that examined the six studies in the meta-analysis that included posttraumatic symptoms as an outcome. They found no significant ef-

fect on arousal, intrusion, or avoidance. Although these six studies were conducted with individuals who had been exposed to some type of trauma, only one of the studies included individuals diagnosed with posttraumatic stress disorder (PTSD) (11).

Frisina et al. (12) conducted a meta-analysis examining the effect of expressive writing on clinical populations, unlike previous meta-analyses that combined studies of clinical and

nonclinical populations. Of the nine studies included, four examined patients with psychiatric diagnoses and the remaining five examined patients with diagnoses of cancer, asthma, and rheumatoid arthritis. They found that expressive writing had a significant effect on physical health (Cohen's  $d=0.21$ ,  $p=0.01$ ) but not on psychological health (Cohen's  $d=0.07$ ,  $p=0.17$ ). No exploratory analyses were completed to examine whether the effect size differed

for psychiatric versus nonpsychiatric samples.

## COGNITIVE-BEHAVIORAL WRITING THERAPY

### Interapy

Lange et al. (13, 14) incorporated this research on expressive writing to develop a psychotherapy that integrated writing and cognitive-behavioral therapy (CBT). The theoretical basis for their therapy was that the three components crucial to the efficacy of CBT are exposure, cognitive restructuring, and social sharing and support (13). They utilized 1) structured writing assignments as a means for exposure, 2) therapist feedback and rewriting of assignments to facilitate cognitive restructuring, and 3) sharing of the final writing for garnering social support and connectedness.

Their therapy, called interapy, is completed entirely on the Internet. It includes three phases with a total of 10 writing assignments that are 45 minutes in length and occur over a 5-week period. Therapists read the assignments and then give feedback through the website between assignments. The first phase is self-confrontation, in which patients write four assignments about their previous trauma. The second phase is cognitive restructuring, comprised of four assignments with the goal of assisting patients in challenging automatic thoughts and gaining a new perspective on the trauma. The last phase is social sharing, with psychoeducation about the benefits of sharing and having patients write a letter to someone involved in the trauma or a person who is significant in their life.

Lange et al. (14) completed a randomized controlled study examining the efficacy of interapy. Participants were individuals who went to the interapy website after learning about the trial through media coverage and completed online screening for participation. Of the 437 individuals who passed the screening, 184 committed themselves to the study. Participants were assigned to either a control group (being on a wait-list) (N=62) or to therapy (N=122). There was a high dropout rate in both arms of the study (N=30 in the control group;

N=44 in the treatment group). However, there were no significant differences between people who completed the study and those who dropped out of the study in terms of measures of trauma or psychological functioning prior to starting the therapy.

The results demonstrated that the improvement in the treatment group was significantly larger than that in the control group, with large effect sizes for intrusion (Cohen's  $d=1.28$ ,  $p<0.0001$ ) and avoidance (Cohen's  $d=1.39$ ,  $p<0.001$ ). These effects decreased slightly, although not significantly, at the 6-week follow-up. There were also significant decreases in anxiety, depression, somatization, and sleep problems, with large effect sizes for depression (Cohen's  $d=1.04$ ,  $p=0.0001$ ) and anxiety (Cohen's  $d=0.76$ ,  $p=0.001$ ).

### Subsequent Research

Cognitive-behavioral writing therapy was adapted for use in children with PTSD, with therapists completing the writing assignments in person with the children. An uncontrolled pilot study of this therapy found a significant decrease in PTSD and depression symptoms, in addition to a significant decrease in internalizing and externalizing behavior problems (15).

Van Emmerik et al. (16) completed a study examining the efficacy of CBT versus a structured writing therapy, which had been adapted from the interapy program for PTSD. Unlike the study by Lange et al. (14), patients were

recruited from a psychiatric clinic, and diagnosis was based on structured clinical interview versus online screening. In addition, writing assignments were reviewed during in-person therapy sessions rather than over the Internet. Similar to the Lange et al. study, there was a high dropout rate, although this was not found to be related to which treatment a participant was receiving. Participants in structured writing therapy and CBT groups did better than those in a control group, with significant reductions in intrusion, avoidance, depression, anxiety, and dissociative symptoms. No significant differences were found between structured writing therapy and CBT in terms of efficacy.

## CONCLUSIONS

Although writing has been incorporated into psychotherapy for many years, the effects of writing on physical and mental health have only been empirically studied in the last several decades through the development of expressive writing. Most recent meta-analyses have found limited to no benefit of expressive writing, although the number of studies on expressive writing in psychiatric samples is limited. Cognitive-behavioral writing therapy incorporates expressive writing and CBT. It involves individuals writing narratives about previous traumas, rewriting these narratives using cognitive restructuring, and then sharing revised narratives with others. Studies thus far have found cognitive-

### KEY POINTS/CLINICAL PEARLS

- The expressive writing technique was developed to empirically examine whether disclosure of previous adversities and traumas had benefit on physical and psychological health.
- Although there is mixed evidence, most recent meta-analyses on expressive writing have found minimal to no benefit of expressive writing, although there are limited studies examining expressive writing with psychiatric patients.
- Cognitive-behavioral writing therapy incorporates expressive writing and cognitive-behavioral therapy to help individuals write narratives of previous trauma, to assist them in altering these narrative using cognitive restructuring, and then to share these narrative with others.
- Multiple studies have found cognitive-behavioral writing therapy to be effective for posttraumatic stress disorder.



behavioral writing therapy to have similar efficacy to CBT in treating PTSD. Cognitive-behavioral writing therapy is a promising therapy and would benefit from further studies exploring the application of this therapy to other psychiatric disorders.

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# An Introduction to the Buddhist Underpinnings of Mindfulness-Based Interventions: Buddha-Nature and Intrinsic Goodness

David Saunders, M.D., Ph.D.

Mindfulness meditation has become an increasingly popular intervention for a panoply of psychological and medical afflictions (1). Although the subject of intense scholarly debate and frequent misunderstanding, “mindfulness” in these contexts has come to mean “paying attention in a particular way: on purpose, in the present moment and non-judgmentally,” which is the definition that will be employed in the present article (2–5). Mindfulness-based stress reduction (MBSR)—an 8-week course in which participants are taught mindfulness practices—is taken to be representative of the array of modern mindfulness-based interventions (6). It is widely known that Buddhist teachings lie at the heart of mindfulness-based pedagogy; rarely, however, are details discussed in the literature. When Buddhist underpinnings are addressed, they are typically bereft of any nuance or sophistication.

The present article is a review of the role that one particular Buddhist doctrine—*Tathāgatarbha* or Buddha-nature—plays in MBSR pedagogy. Referencing passages from the writings of seminal Buddhist figures and MBSR founder Jon Kabat-Zinn defends the notion that veritable Buddhist doctrine underpins mindfulness-based intervention. In this article, the topic is approached from the humanities, namely, the academic study of religion. It does not aim to *prove* that intrinsic goodness or Buddha-nature plays an empirical role in mindfulness interventions; rather, it seeks to provide textual evidence of a similarity between MBSR and Buddhist rhetoric. Additionally, the

relevance of the topic to contemporary psychiatrists and psychotherapists is discussed.

## BUDDHA-NATURE

The *Tathāgatarbha* doctrine, espoused by some but not all Buddhist traditions, holds that Buddha-nature, or *Tathāgata*, is a core feature of all sentient life. In other words, all beings have the potential to become a Buddha, or an enlightened being (7, 8). In a third-century Indian work, the *Tathāgatarbha Sūtra*, the Buddha is said to have held that all living beings “are endowed with virtues, always pure, and hence are not different from me” (9, p. 51). It is said in the formative thirteenth-century Zen text *Shōbōgenzō* that “The Dharma is not to be found externally; it is inseparable from oneself, and the self is inseparable from the Dharma. If you seek it elsewhere, you fall into illusion” (10, p. 41). And in the sixteenth century Tibetan text *Ocean of True Meaning*, it states: “Buddhahood is in one’s own body. Nowhere else does buddhahood exist. Those wrapped in the darkness of ignorance believe buddhahood to be somewhere outside the body . . . . Nowhere in the outer world will you ever find buddhahood” (11, p. 210).

Many within this tradition make the stronger claim that we do not *have* Buddha-nature, but rather we *are* Buddha-nature. This position is not merely semantic, but rather underscores the immanence of Buddha-nature. It is not that all sentient beings have the Buddha-nature (or contain a *Tathāgata*), but rather, all sentient beings *are* Buddha-

nature, or the *Tathāgata* (12). From this perspective, to say that a sentient being has or does not have Buddha-nature is a categorical mistake: all beings, without exception *are* Buddha-nature according to these traditions.

Altogether, these passages evince several core features of the doctrine of Buddha-nature. First, all beings inherently possess the enlightened qualities of the Buddha. Second, one does not need to look *outside* of oneself for these virtuous characteristics. Third, it is deleterious to the Buddhist path to attempt to find enlightenment outside of one’s own being. Finally, there is no Buddhahood anywhere but within oneself—it is the mind itself. While there are a number of different iterations of the Buddha-nature doctrine in the Buddhist world, these features hold true in most contexts.

## INTRINSIC GOODNESS IN MBSR

The mindfulness-based stress reduction course consists of eight weekly teacher-led meditation instruction sessions. Daily mindfulness practices are assigned, 30–60 minutes in duration, building up to a full day of intensive silent practice. Most contemporary mindfulness interventions are structured in a similar way. Conceptual and methodological difficulties within the mindfulness literature abound, though research is still in its infancy. Nevertheless, mindfulness-based interventions are indicated in a number of settings, with some of the strongest data supporting the use of mindfulness-based cognitive therapy for major depressive disorder relapse (13).

The passages below suggest that MBSR rhetoric relies on the assumption that all participants are intrinsically good. Innate goodness is often construed as one's "true self," rather than the damaged, stressed, or depressed person that many believe themselves to be. The notion of intrinsic goodness is important for at least two reasons. First, it assures practitioners that they do not need to cultivate any special qualities that they do not already innately possess. Second, participants merely need to reveal intrinsic virtues, rather than build them. The goodness is innate, always present, common to all and effortless to achieve, to the extent that we do not need to cultivate any qualities to attain it. In the context of psychiatry, innate goodness is of theoretical value because many patients with mood, anxiety, and personality disorders suffer from conscious and unconscious perceptions of self as unworthy of love, intrinsically bad, or damaged. By foregrounding intrinsic *goodness*, mindfulness-based interventions provide an antidote: a stable sense of well-being that precedes and undermines these maladaptive notions of self. A deep understanding of innate goodness can allow patients to safely construct a more adaptive, less pathological sense of self that is fluid, resilient, and worthy of affection.

In MBSR rhetoric, the wonderful qualities of our truest self need only to "be nurtured to unfold and be discovered . . . you don't need to get anywhere . . . . You only need to really be where you already are and realize. In fact in this way of looking at things *there is no place else to go*, so efforts to get anywhere are ill conceived" (14, p. 94). Indeed, MBSR requires diligence, commitment, and perseverance when the practice becomes difficult during long periods of meditation. However, as one becomes more adept, it becomes a decidedly effortless process as conceived in certain Buddhist traditions (15). In fact, effort eventually becomes an impediment to practice. For one's intrinsic goodness needs to be "nurtured" rather than constructed, "discovered" rather than built, and left to unfold naturally from within rather than laboriously assembled (4).

In MBSR teachings, one's intrinsic goodness is often painted as a refuge for times of sorrow and stress. Participants are instructed to trust in this innermost identity as a means of alleviating anxiety, stress, and discomfort. When we feel at our worst, we need to rely on it: "Times of great emotional upheaval and turmoil, times of sadness, anger, fear, and grief, moments when we feel hurt, lost, humiliated, thwarted, or defeated, are times when we most need to know that the core of our being is stable and resilient and that we can weather these moments and become more human in the process" (14, p. 429).

Despite the emotional turbulence intrinsic to the experience of being human, the innermost core of one's identity, so MBSR teaches, is intrinsically good, wholesome, and pure. Moreover, it can serve as a teacher during times of personal upheaval. Consider the following Kabir poem referenced by Kabat-Zinn:

My inside, listen to me, the greatest spirit,  
the teacher, is near,  
wake up, wake up!  
Run to his feet—  
He is standing closer to your head  
right now. (16, p. 50)

One's true self is taken to be present at all times—to be revealed, not constructed. Kabir implores the reader to recognize the teacher within oneself rather than searching afar. The implication in MBSR, of course, is that one already has all the qualities one needs to be happy. If we can just realize that we

are intrinsically good, the true but dormant self can and will awaken, as long as we let it.

## CONCLUSIONS

A comparison of Buddhist writings on *Tathāgatagarbha* and MBSR writings on intrinsic goodness suggests a considerable degree of overlap. And in fact, Kabat-Zinn, founder of MBSR, practiced in the Zen and Tibetan traditions before developing his program. In both instances, in any case, the inner goodness of the practitioner is foregrounded, betraying the enlightened mind within all human beings.

This similarity between Buddhist and MBSR pedagogy is important and relevant for at least three reasons. First, Buddhist apologists should take note that its teachings remain central, though implicit, to this popular contemporary meditation program; on the other hand, secular enthusiasts should take solace in the fact that the language used by MBSR instructors nevertheless remains agnostic. Second, the intertwined relationship between Buddhism and MBSR—an ostensibly secular, scientific, and Western phenomenon—effaces a number of unquestioned dichotomies in popular conceptions of medicine: East and West, science and the humanities, secularism and religion. The boundary between science and religion may be more porous than typically assumed. Finally, while it is widely known that mindfulness-based interventions are "Eastern" or "Buddhist," clinicians should be aware that such facile ref-

## KEY POINTS/CLINICAL PEARLS

- The *Tathāgatagarbha*, or Buddha-nature, doctrine holds that all sentient beings are innately endowed with the qualities of Buddhahood.
- Mindfulness-based stress reduction also embraces the notion that human beings are intrinsically good and has well-established ties to Buddhist thought and practice.
- The notion of Buddha-nature is a core, though unstated, feature of mindfulness-based stress reduction.
- The secular presentation of the doctrine of Buddha-nature in mindfulness-based stress reduction challenges a number of unquestioned dichotomies in modern medicine: science vs. the humanities, West vs. East, and secularism vs. religion.



erences have deeper doctrinal roots. While not all psychiatrists and psychotherapists will use mindfulness in practice, it has become widespread enough to merit the basic understanding that veritable Buddhist principles, including *Tathāgatagarbha*, lie at the heart of contemporary mindfulness practices.

Dr. Saunders is a first-year resident at the Yale Child Study Center, New Haven, Conn.

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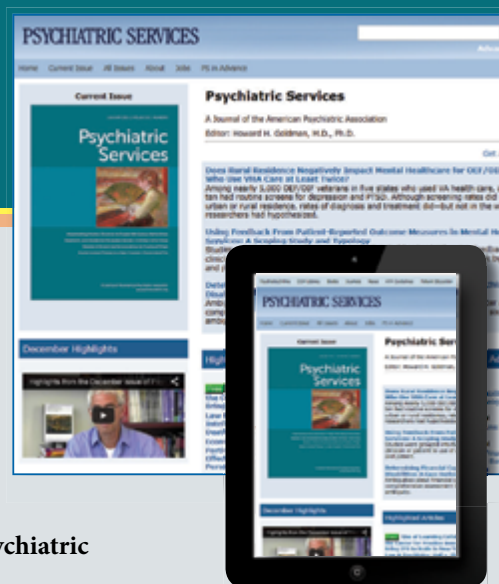
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# Mental Disorders and Naturalism

Awais Aftab, M.D.

One of the central questions in the philosophy of psychiatry is whether the diagnosis of mental disorder is a matter of natural facts or social norms (1). The debate exists as part of a larger debate on the concept of “disease,” which is relevant to all of medicine (2). Naturalism (or objectivism) maintains that concepts of health and disorders are predominantly driven by objective natural categories of biological function and dysfunction, which may interact with social values and norms but exist independently of them (3). A naturalist view of disease maintains that a harmful departure of organ systems from “natural functions” constitutes “disease.” All naturalists contend that the determination of biological dysfunction is an objective scientific matter; some naturalists (such as Boorse) argue that determining whether a malfunction is detrimental to human well-being is also an objective matter, but most naturalists (such as Wakefield) concede that it is determined by normative considerations (2). The opposing philosophical position is constructivism (or normativism), which argues that the disease concept is normative and denies that a biological dysfunction can be identified independently of human values. For naturalists, diseases are objectively malfunctioning biological processes that cause harms; while for constructivists, diseases are harms with an associated biological process that is identified as dysfunctional only because it causes that harm (2). There are others who belong to neither camp who argue that there is no general concept of disease in medicine coherent enough to be analyzed (4) or that a conceptual understanding of disease is irrelevant to most clinical decisions (5). While the development of medicine has benefitted tremendously by a focus on discrete disorders under-

pinned by specific pathologies with specific treatments (6), these developments are still amenable to a constructivist account, and naturalism by itself is a post hoc philosophical account with little prospective utility in the development of medical specialties.

## NATURALIST ACCOUNTS OF MENTAL DISORDER

There are three main naturalist approaches to mental disorders in literature.

### Szasz’s eliminativist account.

Thomas Szasz (7) is an intriguing case, as he is naturalist about physical disease but a constructivist about mental disorders. Szasz has a very strict objectivist concept of disease as demonstrable anatomical or physiological lesions. His argument is that disease requires a physical lesion; the mind is non-physical; ergo, the mind cannot be diseased (7). He argues that mental disorders are instead problems in living, human conflicts, and unwanted behaviors. Szasz is also a “simple naturalist” in the sense that he sees disease as a failure of physiology, regardless of its impact on functioning (2). The flaw in Szasz’s argument lies in the assertion that biological dysfunction can only manifest in physical lesions. It has been successfully argued that a structurally and functionally intact brain can instantiate a variety of mental patterns, including dysfunctional ones (3). This is aside from the fact that a number of neurobiological abnormalities have now been discovered for most, if not all, conditions we call mental disorders.

### Boorse’s biostatistical account.

Christopher Boorse (8, 9) holds that mental disorder can be defined entirely in a scientific and objective manner

without recourse to value judgments. He defines health as normal species functioning, which is the statistically typical contribution of all the organism’s parts and processes to the organism’s overall goals of survival and reproduction, and disease is a statistical deviation of functioning below normal species functioning (8, 9). Statistical typicality is measured with respect to a reference class, consisting of all the individuals belonging to the same age group, sex, and race. There are several problems with this account (10, 11). First, in conditions currently held to be mental disorders, statistical rarity is neither necessary nor sufficient (major depressive disorder, for instance, is widely prevalent). Second, psychological and behavioral traits are often normally distributed, and there is no non-arbitrary cut-off in statistical terms. Third, there is no objective value-free way of determining which reference classes should be used, and it is unclear if there is such a thing as human species typical functioning (12). Boorse’s account also leads counterintuitively to a number of conditions being labeled as diseases. For instance, Cooper (13) has argued that a woman’s suppression of her fertility by oral contraceptive pills will be considered as a disease state per Boorse’s account, even though ingesting contraceptives is not a disease.

### Wakefield’s harmful dysfunction.

Jerome Wakefield (14, 15) has proposed a hybrid evolutionary account of “harmful dysfunction,” which requires a value criterion, as well as a factual criterion. For a condition to be a mental disorder, it has to be harmful as judged by the standards of the person’s culture, and there has to be a biological dysfunction independent of any values (14, 15). Wakefield defines dysfunction as a failure of a natural mental or behavioral mechanism

to function as designed in evolution (14, 15). There are several problems with this account as well. The dysfunction associated with mental disorders may emerge from a mismatch between evolutionary design and the environment, rather than a failure of the evolutionary design per se, and we cannot distinguish between the two. Furthermore, Wakefield's account is highly revisionist. It re-labels many conditions we now consider disorders as non-disorders and places many conditions out of the realm of disorder altogether. For instance, whether the ability to read and its problems should be included in the realm of medicine depends on what exact causal role it plays in our evolutionary history (3). Furthermore, if it is shown that a particular DSM disorder does not have an underlying evolutionary design failure, but it nonetheless leads to distress and disability warranting treatment, we gain little by not calling it a mental disorder. Wakefield's approach turns the diagnosis of mental disorder into an indeterminate hypothesis about evolutionary causes, making a diagnosis of mental disorder unreliable and impossible in the clinic, and a hypothesis that is for all DSM disorders uncertain and controversial (12).

### **DSM-5 DEFINITION OF MENTAL DISORDER**

DSM-5 defines mental disorder as a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (16). DSM-5 further clarifies that mental disorders are usually associated with significant distress or disability in social and occupational activities. (There are exceptions, such as the DSM-5 diagnostic criteria for pyromania do not include the criterion for clinically significant distress or impairment.) Culturally appropriate reactions to stressors are not considered mental disorders. Socially deviant behavior and conflicts between the individual and society are also not considered mental

disorders unless they result from a dysfunction in the individual (16).

### **PROBLEMS WITH MENTAL DISORDER**

DSM-5 states that in the absence of clear biological markers, it is not possible to identify boundaries for pathology based on symptomatic criteria alone, and therefore the criterion for clinically significant distress or disability is utilized (16). This criterion conceptually conflates pathology with disability, which is problematic from the point of view of naturalism.

In the DSM-5 definition, the clinical syndrome constituting mental disorder is considered to be reflective of a psychological/biological/developmental dysfunction, but the diagnostic criteria for the vast majority of mental disorders are clinical with no reference to underlying biological/psychological processes. (There are some exceptions; for example, diagnostic criteria for narcolepsy include low CSF hypocretin levels, and frontotemporal neurocognitive disorder requires imaging or genetic support, etc.)

Boundaries of mental disorders as defined by DSM are subject to human interests given the criterion of clinical significance, making it difficult for them to correspond to the natural world (16). "Clinical significance" is a universal characteristic of mental disorders

in the DSM; however, it is not explicitly defined (although DSM-5 encourages the use of the World Health Organization Disability Assessment Schedule and information from family members and third-parties for the purpose) (16). Bolton (12) explains that a study of the literature surrounding the development of DSM reveals that it refers to the idea that the kind and severity of the condition is such that these problems are brought to psychiatric attention (17, 18). He notes: "[T]he idea behind these expressions is the recognition that the conditions listed in the manuals ... are the kinds of problems people bring to the clinic" (12, p. 13). This raises important philosophical considerations with regard to "folk psychiatry" (19) and the social organization by which these problems are brought to psychiatric attention rather than elsewhere.

### **PROBLEMS WITH NATURALISM**

The primary challenge for naturalism is the problem of establishing a satisfactory objective, scientific distinction between normal and abnormal human functioning, and this becomes even more problematic when it comes to issues of mental health and mental disorders. As we have discussed, none of the leading naturalist accounts of mental disorders are satisfactory. Furthermore, aside from psychiatry, there are a number of medical disorders, such as

### **KEY POINTS/CLINICAL PEARLS**


- Naturalistic accounts of mental disorder define disorder as biological dysfunction, which can be determined as a matter of objective natural fact, without recourse to social or moral value judgments.
- DSM conflates pathology with disability and diagnosis with need for treatment. It does not define dysfunction and makes little to no reference to underlying dysfunction in diagnostic criteria. The boundaries of disorders are based on clinical significance. All of these are problematic from the point of view of naturalism.
- The primary challenge for naturalism is the problem of establishing a satisfactory objective, scientific distinction between normal and abnormal human functioning, and none of the leading naturalist accounts of mental disorders (by Szasz, Boorse, and Wakefield) are satisfactory.
- Many medical disorders (such as fibromyalgia, irritable bowel disease, tension headache) cannot be adequately conceptualized in naturalistic terms, which brings into question the utility of naturalism.

chronic fatigue syndrome, fibromyalgia, irritable bowel disease, and tension headache, that share problems similar to those in psychiatric disorders with regard to absence of clear biological markers and lack of well-defined underlying biological dysfunction (20), which does not fit in a naturalist account. In essence, many of the medical disorders cannot be adequately conceptualized in naturalistic terms, which questions the utility of naturalism, and the expectation that psychiatric disorders should conform to naturalistic accounts remains without sufficient justification.

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# Diagnosis and the Structure of Scientific Revolutions

Jacob William McBride, D.O.

The term “paradigm” carries many meanings in today’s discourse. In Thomas Kuhn’s *Structure of Scientific Revolutions* (1), he uses the concept of a paradigm to describe how scientific fields undergo crisis, upheaval, and eventual revolution. A full understanding of this process and how it relates to the history of our field is necessary to understand how psychiatry has changed and may change again.

In Kuhn’s model, a paradigm is the intellectual structure that describes a whole scientific discipline’s worldview (1). These large bodies of theories must be matched with actual observations about nature, and Kuhn calls this matching process “normal science (1).” Normal science describes the day-to-day work of most scientists. When their daily toil produces a fact that doesn’t fit the theory, an anomaly emerges. As anomalies accumulate, paradigms are thrown into crisis, as experts and neophytes alike question the current paradigm’s ability to describe nature. Out of this conflict, new paradigms emerge. Through debate and political struggle, one paradigm becomes dominant and completely supplants the old one. Old textbooks are discarded, new curricula are written, and the past, present, and future of the field become dominated by the new paradigm.

The DSM provides psychiatry and its allied fields with a structure that guides the field, serving as psychiatry’s paradigm. DSM-I and II, based largely in psycho-dynamic and psycho-social theory, provided the grounding for normal science to occur. As normal science was conducted, however, many anomalies arose: The line between mental illness and health was unclear and, to some critics, arbitrary (2). Furthermore, the diagno-

## A paradigm in crisis invites the alternative lines of inquiry that precede scientific revolution.

ses had low reliability, and advances in brief psychotherapy and psychopharmacology challenged the psychodynamic model (3). Spurred on by the work of Robins and Guze in diagnostic reliability and the National Institute of Mental Health Research Diagnostic Criteria, a rival paradigm emerged conceptualizing mental illnesses not as a psychological state but as “discrete, operationally-defined disease categories (3).” The DSM-III represented the victory of the latter paradigm, a victory that entailed profound and near-total reorientation of psychiatry’s research, resident training, and clinical practice.

Successful paradigms adapt to explain anomalies, and versions of the DSM subsequent to DSM-III reflect this. In an attempt to adapt to the previous DSM’s failures, each iteration modifies disease categories to allow the current paradigm to better fit facts observed in research and clinical practice. The predictions of our current paradigm, however, continue to yield anomalies rather than confirmations of theory. The paradigm aspires to disorders that separate well, but comorbidity, subsyndromal diagnoses, and broad unspecified diagnostic categories are common (4). The genes associated with psychiatric disorders correlate poorly with the current DSM’s disorders. Treatments relate poorly to diagnostic categories as

well. The antipsychotic quetiapine, to name one example, has been shown to be effective for diverse indications such as bipolar disorder and schizophrenia. Kuhnian theory predicts that as anomalies mount, our field will approach crisis. A paradigm in crisis invites the alternative lines of inquiry that precede scientific revolution. Advances in biology may allow for a paradigm that divides psychiatric disorders into etiology-based groups, rather than the current symptom-based syndromes (5). Another alternative is to describe disorders along a spectrum rather than the current discrete categories. The information age allows still another alternative, as big-data strategies may allow for theory-free approaches. Over the past decade, a plethora of data-sharing consortia have arisen to share and mine functional MRI and other data in the hopes of achieving a “connectome,” a complete neural map (6). With such a map, especially if coupled with behavioral correlates as the Human Connectome Project aspires to, a new theory can be built from the ground up (7). Should any of these lines of inquiry prove superior in theory, practice, or convenience, they may lead to the rise of a new paradigm and eventually to scientific revolution.

Dr. McBride is a fourth-year resident in the Department of Psychiatry at University Hospitals Case Medical Center, Cleveland.

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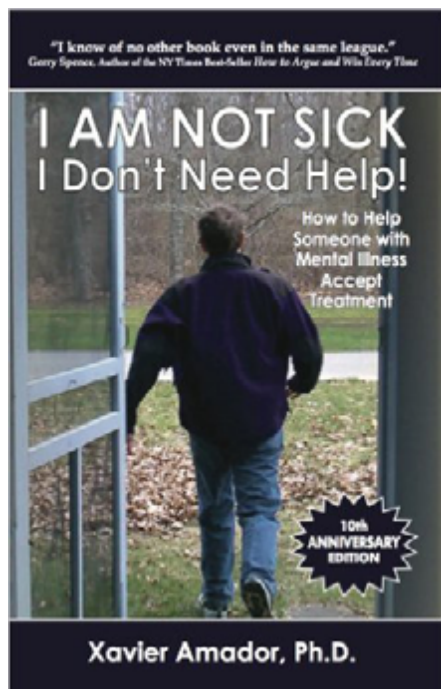
# I Am Not Sick, I Don't Need Help! How to Help Someone with Mental Illness Accept Treatment

M.M. Naveen, M.D.

Renowned clinical psychologist and founder of the LEAP Institute, Dr. Xavier Amador has written eight captivating books filled with masterful insights. For the busy psychiatry resident who can only choose one, my recommendation is *I Am Not Sick, I Don't Need Help!* This easy read is packed with useful tips and provocative ideas. The 10th anniversary edition of this international best-seller was released in 2012 and includes six new chapters and the latest research on anosognosia.

Anosognosia refers to a “lack of insight.” Functional imaging studies demonstrate a correlation between frontal lobe deficits and anosognosia, and research has found neuroanatomical abnormalities in up to 15 subregions of the frontal lobe in chronic schizophrenia patients with this condition. There is a well-established association between poor insight and negative symptoms of schizophrenia; however, Dr. Amador posits that links also exist between poor insight and positive symptoms.

In this book, Dr. Amador takes great effort in emphasizing how a lack of insight is not due to denial, defensiveness, or stubbornness, but is rather a symptom of chronic mental illness. He clarifies several myths, such as insight leads to demoralization, depression, and suicide. He encourages readers to avoid arguing with a person who lacks insight and notes that “a cycle of confrontation and denial always ends in avoidance.”



by Xavier Amador, Ph.D., Vida Press; 10th Anniversary Edition edition (2011), 254 pp, \$21.95.

Throughout the book, Dr. Amador shares principles of LEAP and explains how this effective tool can be used to gain the trust of someone who lacks insight. LEAP stands for Listen, Empathize, Agree, and Partner. The cornerstone of LEAP is reflective listening, and Dr. Amador excellently notes that “if you want someone to seriously consider your point of view, be certain he feels you have seriously considered his” (p. 57). He points out that a common ground exists, even between the most

extremely opposing positions and that it is tremendously important to find it. He illustrates the example of a patient who disagrees about the need to take medications but is able to agree to a goal of staying out of the hospital and how consistently taking medications can help to achieve that. Another principle, which relates to LEAP, is called the “three As.” With this, Dr. Amador encourages readers to Apologize for a difference in opinion, to Acknowledge the existence of different perspectives, and to Agree to disagree.

What I found most enjoyable about this book was reading the stories of actual patients. And by far my favorite patient was Henry, Dr. Amador's older brother who suffers with chronic schizophrenia. Dr. Amador paints an honest picture of how he struggled through the early years of his brother's illness and the frustration he experienced in dealing with Henry's lack of insight. It is quite moving to read about how the relationship between these two brothers changed after Dr. Amador began practicing the principles he now preaches to others.

Every budding psychiatrist hopes to one day display a library of books in his office. No such library would be complete without *I Am Not Sick, I Don't Need Help!*

Dr. Naveen is a first-year child and adolescent psychiatry fellow at the University of Maryland/Sheppard Pratt, Baltimore.

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- Collaborate with the Editor-in-Chief in selecting the 2017 Senior Deputy Editor, Deputy Editor, and Associate Editors.
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- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2016, or a fellow in an ACGME fellowship in July 2016
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- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

### Requirements

- Must be an APA resident-fellow member
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For all positions, applicants should e-mail a CV and personal statement of up to 750 words describing their a bit about who they, their reasons for applying, as well as any ideas for journal development to Katherine.Pier@mssm.edu. The deadline for applications is 4/15/2016.

# Residents' Resources

Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

*\*To contribute to the Residents' Resources feature, contact Hun Millard, M.D., M.A., Deputy Editor (hun.millard@yale.edu).*

## MARCH DEADLINES

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
AACAP Pilot Research Award for Child Psychiatry Residents & Junior Faculty  <b>Deadline: March 30, 2016</b>	AACAP	Offers \$15,000 for child psychiatry residents and junior faculty who have an interest in beginning a career in child and adolescent psychiatry research. Recipients have the opportunity to submit a poster presentation on their research for AACAP's 64th Annual Meeting in Washington, DC, 2017. The award also includes the cost of attending the AACAP Annual meeting for 5 days.	Enrolled in a child psychiatry residency or fellowship or have a faculty appointment in an accredited medical school but no more than 2 years' experience following graduation from training Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health. AACAP member	Department of Research, Training, and Education at 202-587-9664 or research@aacap.org	<a href="http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Pilot_Research_Award_Child_Psychiatry_Residents_Junior_Faculty.aspx">http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Pilot_Research_Award_Child_Psychiatry_Residents_Junior_Faculty.aspx</a>
AACAP Pilot Research Award for General Psychiatry Residents  <b>Deadline: March 30, 2016</b>	AACAP, Supported by Pfizer	Offers \$15,000 for general psychiatry residents who have an interest in beginning a career in child and adolescent mental health research. Recipients have the opportunity to submit a poster presentation on their research for the AACAP 64th Annual Meeting in Washington, DC, 2017. The award also includes the cost of attending the AACAP Annual Meeting for 5 days.	Candidates must be enrolled in a general psychiatry residency Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health. AACAP member	Department of Research, Training and Education at 202-587-9664 or email-research@aacap.org	<a href="http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award.aspx">http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award.aspx</a>
AACAP Pilot Research Award for Learning Disabilities for Child Psychiatry Residents and Junior Faculty  <b>Deadline: March 30, 2016</b>	AACAP, Supported by the Elaine Schlosser Lewis Fund	Offers \$15,000 for child and adolescent psychiatry residents and junior faculty who have an interest in beginning a career in child and adolescent mental health research. The recipient has the opportunity to submit a poster presentation on his or her research for the 64th Annual Meeting in Washington, DC, 2017.	Enrolled in a child psychiatry residency or fellowship or have a faculty appointment in an accredited medical school but no more than 2 years' experience following graduation from training Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health. AACAP member	Department of Research, Training, and Education at 202-587-9664 or research@aacap.org	<a href="http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award_for_Learning_Disabilities.aspx">http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award_for_Learning_Disabilities.aspx</a>
AACAP Pilot Research Award for Attention Disorders for CAP Residents and Junior Faculty  <b>Deadline: March 30, 2016</b>	AACAP, Supported by the Elaine Schlosser Lewis Fund	Offers \$15,000 for child and adolescent psychiatry residents and junior faculty who have an interest in beginning a career in child and adolescent mental health research. The recipient has the opportunity to submit a poster presentation on his or her research for the 64th Annual Meeting in Washington, DC, 2017.	Enrolled in a child psychiatry residency or fellowship or have a faculty appointment in an accredited medical school but no more than 2 years' experience following graduation from training Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health. AACAP member	Department of Research, Training, and Education at 202-587-9664 or research@aacap.org	<a href="http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award_for_Attention_Disorders.aspx">http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award_for_Attention_Disorders.aspx</a>

## Author Information for *The Residents' Journal* Submissions

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*The Residents' Journal* accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

To submit a manuscript, please visit <http://mc.manuscriptcentral.com/appi-ajp>, and select a manuscript type for *AJP Residents' Journal*.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
- 3. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice

questions based on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.

- 4. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 5. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 6. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This

article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.

- 7. Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 8. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 9. Book Review:** Limited to 500 words and 3 references.

**Abstracts:** Articles should not include an abstract.

## Upcoming Themes

*Please note that we will consider articles outside of the theme.*

### Social Media and Psychiatry

If you have a submission related to this theme, contact the Section Editor  
Spencer Hansen, M.D.  
(shansen3@tulane.edu)

### Psychiatry in the General Hospital

If you have a submission related to this theme, contact the Section Editor  
Kamalika Roy, M.D.  
(Kroy@med.wayne.edu)

### Addiction Psychiatry

If you have a submission related to this theme, contact the Section Editor  
Rachel Katz, M.D.  
(rachel.katz@yale.edu)

\*If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Rajiv Radhakrishnan, M.B.B.S., M.D., Editor-in-Chief (rajiv.radhakrishnan@yale.edu).