Dialogues in Philosophy, Mental and Neuro Sciences

Crossing Dialogues Association

ORIGINAL ARTICLE

The hybrid structure of psychiatry

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Research in psychopathology has tended to polarise between approaches that are either neurobiological on the one hand or social constructionist on the other. Currently, the neurobiological drive is particularly strong leading to a narrow and mechanistic conception of the nature of mental phenomena and underlying psychological processes. Taking an original and epistemologically justified approach, German Berrios and his school of psychopathology argue that the foundations of psychopathology need to be understood as hybrid in nature, that is, in the sense that deeply incongruous elements are jointly involved in the constitution and structure of psychopathology. This epistemological position entails the development of new approaches to the study of psychopathology, drawing not only on the neurosciences but importantly on history, cultural studies, hermeneutics, philosophy among others, and taking a transdisciplinary approach to making sense of mental phenomena.

Keywords: Psychopathology, Hybrid structure, Meaning, Configurators, Epistemology, Concepts

Dial Phil Ment Neuro Sci 2020; 13(2):36-42

INTRODUCTION

The year 2020 marks the 80th anniversary of the birth of German E Berrios. In celebration of this, a number of his students and colleagues produced a *Festschrift* (Marková and Chen, 2020) as a homage to a scholar and teacher whose immense and original contribution to psychiatry and related fields will continue to influence and inspire those who come after him. Amongst psychiatrists, there are many excellent clinicians, brilliant academics and imaginative thinkers but there are few who have attracted accolades from such a large, diverse and international body of researchers. In particular, it is the diversity of disciplines recognizing his contribution that is unusual. In many ways the work of Berrios defies characterization within one disciplinary field. Instead, and one of the hallmarks of the depth of his thinking is precisely the way in which he weaves together ideas and knowledge from different disciplines in order to help understand and push forward the boundaries of another. History is the thread that runs through everything for knowledge is rooted in history and our concepts can only be understood in their historical contexts and vicissitudes. However, philosophy, linguistics, hermeneutics, phenomenology, aesthetics, amongst others, as well as the medical/biological sciences are all necessary in the construction of narratives that can help explain aspects of our reality and, importantly, that can guide clinical understanding and management and steer research in legitimate directions. Psychiatry, as a hybrid discipline, not only lends itself to this approach but demands this for epistemological validity.

This paper deals with one of the core themes from the work of Berrios and his school of psychopathology, namely, the epistemological basis to psychiatry and its objects, mental disorders and mental symptoms. Explicating the epistemological basis to psychiatry is core because this forms the foundation on which our understanding of psychiatry and descriptive psychopathology is based. Furthermore, it carries vital consequences for the validity of research methodology in this field. Here we focus on the concept of hybridity, and the implications this carries for our understanding of psychiatry and its objects.

1. HYBRID STRUCTURE OF PSYCHIATRY AND ITS OBJECTS

Central to the epistemology of psychiatry is the concept of hybridity. This is the crucial cornerstone which distinguishes psychiatry from

other medical specialties and which confers its unique characteristics whose complexities raise ongoing challenges for our understanding and research. Indeed, problems in resolving these complexities are responsible for the continual polarities in thinking and research in this field. The Oxford English Dictionary (1989) defines hybrid as 'derived from heterogeneous sources; composed of different/incongruent elements'. Both aspects of this definition apply, and in a sense one follows from the other. However, it is worth for the sake of analysis to examine each aspect separately.

1.1 Derived from heterogeneous sources

This is most apparent when we consider the construction of psychiatry as a medical discipline. Psychiatry is the discipline that deals with the understanding, assessment and management of patients with certain afflictions, currently termed mental disorders. In contrast to medicine, it has a relatively short history in that it was constructed as a medical specialty at the beginning of the 19th century. Before that, behaviours and mental states subsequently viewed as mental disorders, were understood in a variety of ways including as something evil, something divine, as a blessing, as illness, as something supernatural and so on. Consequently, people showing such behaviours were managed in different ways including being ostracized, exiled, revered, imprisoned, and were treated by different sections of society including physicians, the church, families, communities etc. (Porter, 1997). It was as a result of complex socio-political processes in which the social institutions at the time participated to a greater or lesser degree that psychiatry came under the auspices of medicine (Berrios and Porter, 1995; Berrios, 1996). Whatever the reasons for madness becoming medicalised at this time, the crucial issue here is that it is the society, the specific culture and the particular historical period that determines whether the requisite behaviours/mental states were 'abnormal'. What is considered abnormal in one culture may not be in another, or similarly behaviours viewed as abnormal in one historical time are viewed differently in another (Kirmayer et al., 2015).

Why is this issue so important? It highlights the fundamental difference in epistemological basis between psychiatry and medicine. Whilst the foundational basis underpinning medicine has centered, for thousands of years, in disturbance of the body, i.e. in the structure (and later on the function) of the bodily make up, thus involving physical matter, the foundational basis underpinning the new specialty of psychiatry is clearly very different. Here, it is behaviours and/or mental states that are identified as disturbed in some way. Such identification is based, as mentioned above, on the views of a society and culture at a particular time. The linking of such behaviours to the body only comes afterwards. Historical research shows that when such mental states and behaviours were brought under the umbrella of medicine at the beginning of the 19th century, psychiatry adopted the clinic-anatomical model in order to understand, research and manage patients (Berrios, 2008). This meant that, after being identified as such, the disturbed behaviours/mental states then viewed as mental disorders or madness were conceived as diseases and psychiatrists sought to identify signs and symptoms, akin to those in medicine, which would help localise the associated pathology in the body.

This very different foundational position in which society determined abnormality and clinicians then tried to understand it in disease terms meant that psychiatry had to develop as a hybrid discipline borrowing from both the natural sciences and the social sciences in order to constitute itself. Thus on the one hand, it had to reach out to the *natural sciences* in order to understand the abnormal behaviour as 'disease' with a corresponding search for organic explanations of problems (Ackerknecht, 1967). On the other hand, however, identifying and making sense of disturbed behaviour and the meaning behind man's actions in the context of the individual's history and circumstances, needed the help of the newly developing *social sciences* (Heilbron et al., 1998). Arising at that time as challengers to the natural sciences in seeking explanations for human beings and their place in the historical world (McDonald, 1993), the social sciences were thus from the beginning important constitutively in the development of psychiatry

as a discipline. This is the key difference in disciplinary structure between psychiatry and medicine and explains why psychiatry is deeply hybrid. Its origin is from both the natural and the social sciences which together and jointly create the understanding or knowledge that psychiatry holds about mental disorders. These are the heterogeneous sources that constitute the discipline and form its understanding of mental disorders. The heterogeneity is clear. One source deals with the material world, with methods designed to capture and explain what is there in the physical world, existing in time and space. The other source deals with a non-material world, a symbolic world of meanings where methods are designed to understand the meanings based on interpretation of actions, motivations, events, contexts, and so on. The hybridity of structure that characterises psychiatry and its understanding of mental disorders thus comes from the way that both the natural and the social sciences together form the discipline. Whilst medicine can also be conceived as a discipline in which both the natural and social sciences contribute, its origin lies firmly in bodily disturbance, that is, in material disruption. The contribution from social sciences comes secondarily and in an additive rather than integrative form as exemplified by the biopsychosocial approach.

1.2 Composed of different/incongruent elements

From a slightly different perspective though obviously related, we can look at the hybrid position in another way. Derived from the heterogeneous sources as described above, mental disorders are clearly composed of different and incongruent elements. What about mental symptoms? How can we understand their structure and composition? To answer this in relation to mental symptoms, it is important to consider how they are constructed. This has been detailed elsewhere (Aragona and Marková, 2015, Berrios and Marková, 2015) but the process will be briefly traced here.

Focusing on subjective mental symptoms, then by definition, these are symptoms of which patients are aware. Thus, irrespective of the original trigger – whether this be a distressed organic (e.g. neurochemical /neuronal insult) or non-organic signal (e.g. trauma, loss, other stresses, etc.), there has to be some experiential change in the individual. In order to make sense of such change individuals will have to draw on a variety of sources. For the sake of analysis, we can divide such sources into three main areas.

Firstly, factors around the development of the experiential change, such as rate, context and quality of the change will play a part. For example, a change in an internal state that builds up slowly, might draw on more sources such as memory, emotion, knowledge etc. to make sense of this change, than an internal state that changes very rapidly. Or something that is experienced as familiar might be more easily interpreted than something that is novel or alien which might require effort to make sense of and need additional sources (e.g. cultural factors, imagination, etc.) to construct.

Secondly, sources relating to the individual and their socio-cultural background will be important. Factors such as past experiences, personality traits, personal biases and outlooks, levels of education, media influences, peer pressures, social contexts, language skills and many more, will all contribute in shaping the experiential change into an articulated ‘symptom’. For example, a history of past similar experiences or knowledge of others with what seem like similar experiences, might facilitate interpretation of some states such as depressed mood or anxiety. A tendency to introspection might generate more detailed and colourful expressions of some experiences. The level of education or interest in reading might determine the range of vocabulary an individual has to describe what he/she is experiencing. The family, societal and cultural background of the individual will also help to structure and colour the interpretation he/she makes of the internal state. In a society where it is frowned upon to express feelings explicitly, a particular experience might be understood and described in cognitive rather than emotional terms. Or, a culture lacking in obvious ways of articulating emotional distress, might encourage descriptions of specific experiences in somatic terms such as fatigue, pain etc. Thus, in the same way that

individuals will report on an external event in different ways, they will likewise interpret and make sense of changes in their conscious states according to their personality and socio-cultural background.

Thirdly, interactional forces are also important in making sense of a particular internal state. Here, for example, the dialogical encounter may be vital in contributing to the shaping and articulation of the mental phenomenon. Thus, whether in communication with a clinician or with someone else, a nebulous, initially strange experience that the patient may have difficulty in capturing might, through the encounter itself, become crystallised into a specific 'symptom' as the mutual exchange may offer descriptions or meanings which resonate with the patient. Likewise, in some cases it might be that noticing a particular response in the interlocutor (e.g. the clinician may appear more interested or understanding in relation to certain terms) might encourage the use of a specific description by a patient which subsequently becomes fixed as a symptom. Similarly, in the interaction with the environment and context, sense may be 'constructed' of a particular internal experience.

The analysis above shows plainly the hybrid structure of the mental symptom. In the first place, there has to be a neurobiological element since all mental states are realized in the brain and thus any mental activity will be underpinned by neuronal activity. This biological element will therefore be one of the constituents of any mental symptom. In the second place, we have a very different element, one that can be understood as 'meaning', since this has been shaped by the sorts of configurating factors identified above. Furthermore, it is evident that this 'meaning', in contrast to the neurobiological element, is constituted not only through the multifarious factors configurated by the individual but, through the interactional factors, it extends beyond them into the social and physical environment in which the individual is situated.

2. IMPLICATIONS OF HYBRIDITY

The hybrid structure of psychiatry and its objects raises many challenges for our understanding of this field and for research. One of the main questions that emerges, on this epistemological position, is how can such heterogeneous sources and incongruous elements be integrated? The difficulties in answering this are evident in the continued polarization of approaches to understanding psychiatry and its objects. At one pole lies the social constructionist approach where mental disorders are viewed through the lens of the social sciences, conceived as the product of changing forces in societies and cultures, reflecting the outlooks and values of the time. This approach searches for underlying societal motivations for the creation of labels to categorise the behaviours deviating from the 'normal'. At the other pole lies the neurobiological approach where the natural sciences drive understanding of mental disorders and these are viewed as disruptions of neurobiological structures and processes. In current times, the neurobiological approach is particularly prominent with research efforts directed at exploring possible neurogenetics, neurocognition, neuroimmunology, neural correlates and so on, underlying mental disorders. This is exemplified in its extreme form by the RDoC programme of research (Insel et al., 2010) and leads to a mechanistic conception of mental disorders (Marková and Berrios, 2015). This is not to say that either approach ignores the contribution of the other, and indeed the umbrella of the biopsychosocial approach is generally used to emphasise this. The polarity however lies in the conception of the origin of mental disorder lying either with the social sciences or with the natural sciences respectively. The hybrid position in which the origin of mental disorders is seen as a joint process of construction from both the natural sciences and social sciences, is left with the problem of trying to reconcile such diverse sources and make sense of how the material and non-material can be brought together.

Similarly, in relation to mental symptoms and their constitution from incongruous elements, we encounter the problem of integration. On the one hand there is the organic element, *neurobiology* which is the material element, forming the medium through which we can exist and function. There is no disputing that our brains and nervous systems are necessary

for the functioning of our mental processes. This element is composed of matter, is present in time and space and fixed within one individual. On the other hand there is *meaning*, a fluid-like non-material element that carries both personal and collective (family, peer, societal, cultural) components. This element is non-material, non-tangible and is present in different time-space configurations. It is not fixed within one individual but extends beyond them to indefinite extents. Both these elements, incongruous as they are, are necessary and are intertwined to jointly form the clinical phenomena, i.e. mental symptoms and mental disorders, which are described and captured by the language of psychopathology. One question that arises concerns the extent to which the neurobiological element and the 'meaning' element contribute to the salience or *sense* of a particular symptom (Marková and Berrios, 2015). It seems likely, given the heterogeneity of mental phenomena that this will vary considerably. Determining whether the sense of the symptom is carried by the organic or by the meaning element is an important question since this would carry therapeutic implications. This would need further theoretical as well as empirical research to help resolve.

Even if understanding how integration between heterogeneous sources and incongruous elements remains elusive at present, the recognition of the hybrid structure underlying mental disorders and mental symptoms is essential not only to help improve our clinical understanding of these problems but because it is the epistemological foundation on which legitimate research can be undertaken. For example, it becomes apparent that research methods in psychiatry cannot be modelled entirely on research methods in medicine which are themselves modelled on the natural sciences. New methods need to be devised, ones that can address the complexities of the hybrid objects.

Hybrid objects thus need to be understood as complexes of matter (organicity) and meaning. Research into 'meaning' remains one of the crucial areas for investigation. What is the nature of meaning, this nebulous non-material component of psychiatric and psychopathological phenomena? How might this be explored? Leaving aside questions of ontology, from an epistemological perspective, meaning has content, and the content has to be configured in some way. It goes without saying that these two aspects of meaning, namely, content, i.e., what it is about, and configuration, i.e., what factors and processes are involved in the creation of the content are interrelated or inseparable. Nevertheless, in the process of analysis, we should be able to make a methodological distinction between them in order to understand how they are organized and how they are interrelated.

Exploring the content of meaning is a particularly intricate endeavor. This is because meaning itself is complex and multilayered. As such, it entails an approach that draws on different sources such as history, psychology, culture, linguistics, anthropology, hermeneutics and many others. Different hybrid objects will demand different approaches to be taken in this respect. Thus, elucidating meaning in subjective mental symptoms will require foci of interest that will be different from those when exploring meaning relating to mental disorders and different again from those in relation to other psychopathological phenomena. For example, in a clinical situation, clarifying the meaning of presented mental phenomena whether subjective or objective, will involve more of psychological sources and will be directed towards individual circumstances within a particular socio-cultural background. The context of the presented phenomena (Barrera, 2020; Chen, 2020) and the interactional factors involved (Marková and Berrios, 2019) will be particularly important. On the other hand, researching the meaning element in relation to psychiatric disorder or in relation to descriptive psychopathology, will draw much more on different kinds of sources, such as historical (Berrios, 1994, 1996), cultural (Luque and Villagrán Moreno, 2020), hermeneutical (Aragona, 2020), philosophical (Berrios, 2006), and combinations of these and others (Holguín Lew, 2020) and so on.

Focusing on the meaning element of hybrid objects in psychiatry is vital and necessary. As was shown earlier, the foundational basis to psychiatry and its objects is crucially different

to that of medicine. In psychiatry, because of its hybrid structure, the meaning element plays a significant role in the construction of its objects. Hence, in order to build our knowledge of psychiatry and its objects and consequently to improve clinical care, meaning in terms of its composition, configuration and relative role needs to be explicated. How can we access this meaning? In relation to psychiatry and descriptive psychopathology, meaning is carried by our concepts. Thus concepts form the roots of the discipline and its language, descriptive psychopathology. Conceptual exploration therefore remains a primary and critical research tool in this area (Marková and Berrios, 2016). In order to understand what we mean by mental disorders, by mental symptoms and signs, we need to understand the concepts that constitute them and specifically the meaning conveyed by them. In turn this means understanding how the concepts were created. As Berrios (2011) has shown, concepts result from the historical convergence of i) terms (names), ii) theoretical accounts/explanations and iii) the referents (objects of interest). All of these individual components, however, can change as languages evolve, as explanations and theories are modified and as the ways in which referents are identified change in light of continually transforming contexts. Since, often enough, changes will affect the components independently, discontinuities will arise. For this reason, throughout history, we find that the same term has been used to name different concepts, or, different terms have been used to name the same concept. Similarly, referents have been indicated by different concepts. Conceptual exploration thus demands transdisciplinary research as the biographies of concepts need to be mapped over time and in the context of changes that take place in societies and cultures, and through the interaction of the diverse factors that govern them. Whilst such a research approach in recent times may be termed historical epistemology (Feest and Sturm, 2011; Braunstein et al., 2019; Marková, 2021), it is an approach that has from the beginning formed the basis of the work of Berrios (Kirkby, 2020).

3. CONCLUSION

In contrast to medicine, psychiatry is a deeply hybrid discipline, jointly created through the interaction of the natural and social sciences. Mental disorders and mental symptoms are correspondingly hybrid in structure, constituted by the integration of a material element, neurobiology, and a non-material element, meaning, whose reach extends beyond the individual to the wider socio-cultural world. This hybridity places psychiatry in a different epistemological position to medicine and carries implications for our understanding and for the development of research methods that are unique to this field.

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