



perception among psychiatrists that neuropsychiatry deals with purely organic problems and treats these problems using only physical treatments. Scheepers *et al* (1995) have noted this previously in their survey of in-patient admissions to the neuropsychiatric service in Bristol. Second, it may be that patients with psychological problems masquerading as physical problems are first referred to a neurologist rather than a psychiatrist. We conclude from this observation that neurologists in west Kent should be made more aware of the neuropsychiatry service, including the outreach clinic, and also that psychiatrists should be informed about the full scope of services that neuropsychiatry can provide.

There were 255 referrals in total from the West Kent Health Authority in the recent 4-year period studied. In a similar period prior to this there were only 87 referrals. The large increase in referrals to the service in the past 4 years has coincided with the outreach clinic's existence. Nineteen per cent of the 225 referrals were first assessed in the outreach clinic (the remaining 81% being seen in the Maudsley Hospital or King's College Hospital, London). This implies that the outreach clinic has not only provided a means of referral to neuropsychiatry but has also served to raise general awareness of the speciality as a resource for patients in west Kent.

This is further highlighted by comparison with the surrounding health authorities. There were only a small number of referrals in both 4-year periods from east Surrey and east Sussex, Brighton and Hove. It may be that they have access to local neuropsychiatric expertise or make referrals to other national centres, but we have no knowledge of this.

The increased use of the service in the west Kent area has occurred as a result of the collaboration between the Maudsley and secondary care services in Maidstone in the form of an outreach clinic. It is likely that a similar arrangement in other areas would have the effect of increasing the use of the service in those areas also. Of interest is the large increase in the number of referrals recently from the East Kent Health Authority despite the absence of an outreach clinic in that area. The high number of referrals from this area can, in part, be explained by the fact that 62 (32%) of the referrals in the past 4 years were made by a consultant neurologist in the area who has a specialist interest in epilepsy.

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- \*Feargal Leonard** Specialist Registrar, Department of Neuropsychiatry, The Maudsley Hospital, Denmark Hill, London SE5 8AZ, **Shahid Majid** Senior House Officer, Gatland House, Kent, **Kandiah Sivakumar** Consultant Psychiatrist, Priority House, Kent, **Brian Toone** Consultant Neuropsychiatrist, The Maudsley Hospital

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ALLAN BEVERIDGE

## Time to abandon the subjective–objective divide?

**“We don't see things as they are, we see things as we are”** (Anaïs Nin, 1969)

In the mental state examination, a standard method of describing the clinical encounter is to contrast the patient's supposedly 'subjective' account with the doctor's 'objective' description. In this model, the doctor is granted a privileged position: the clinician's perspective is taken to be superior to that of the patient. The doctor's objective approach is considered neutral, scientific and representing the truth of the matter. In contrast, the patient's subjective report is regarded as unreliable, distorted and potentially false. The lowly status of the subjective perspective is further emphasised by the frequent use of the accompanying prefix, merely.

On reflection, this dichotomy is an extraordinary one. It is held that the doctor is an authority on the patient's inner experiences. The doctor knows more about how the patient is thinking and feeling than the patient him-/herself. This belief ignores the preconceptions and prejudices that the clinician brings to the

interview. It ignores the impact that the interview has on how the doctor perceives the patient, and how the patient responds. In the physical sciences, it has long been recognised that the observer has an influence on what is being observed. As the physicist, Heisenberg (1958) commented:

'Science no longer confronts nature as an objective observer, but sees itself as an actor in this interplay between man and nature. The scientific method of analysing, explaining and classifying has become conscious of its limitations, which arise out of the fact that by its intervention science alters and refashions the object of investigation' (p. 29).

Another physicist, Schrödinger, made the point succinctly: 'the object is affected by our observation. You cannot obtain any knowledge about an object while leaving it strictly isolated' (see Boyd, 2000). If these considerations pertain in the world of modern physics, they surely have even more relevance for the human sciences, whose data is usually taken to be much 'softer'. In fact these concerns have been acknowledged in some areas of psychiatry. In psychoanalysis, the concept of



countertransference describes how a therapist's response to a patient can be distorted by his or her own emotional state and past experiences. In *General Psychopathology*, Jaspers (1963) proposed that the clinician should attempt to bracket off preconceived ideas and, by means of empathy, enter into the patient's inner world. Although this proposition is flawed in that it exhorts the doctor to aspire to an impossible state of neutrality, it does at least recognise that the attitudes of the psychiatrist affect the clinical assessment.

However, the objective approach remains dominant in clinical practice and is inculcated in medical school and beyond. The patient is viewed as an object – a faulty biological mechanism that requires the detached gaze of the clinician to determine where the faults lie. The objective approach values hard data and is concerned with measurement, whether it be of blood, urine, cerebrospinal fluid or brain density. If it cannot be measured, it is not considered important. Such a reductive model undoubtedly has its value, for example in simplifying complex clinical data. Problems arise, however, if the doctor is unable to see the patient as anything other than an object; if he or she loses sight of the patient as a human being.

Contemporary psychiatry has increasingly adopted this bioscientific approach. This is ironic, coming at a time when those in general medicine have been voicing their unease about the limitations of the bioscientific model. Weatherall (1994) and Lown (1997) have each warned that the preoccupation with technology has led to a dehumanising approach to patient care. They have emphasised that medicine is an art as well as a science. Saunders (2000) has attacked the view that the practice of medicine is the application of a scientific, value-neutral truth; clinical reality, he argues, is different. Practice varies widely between different medical communities, and neither evidence from randomly controlled trials nor observational methods can dictate action in particular, individual circumstances. As he writes:

'Evidence-based decision models may be very powerful, but are like computer-generated symphonies in the style of Mozart – correct but lifeless. The art of caring for patients, then, should flourish . . . in the recognition that what is black and white in the abstract often becomes grey in practice.'

If general medicine has qualms about the bioscientific approach to human suffering, then there is all the more reason for psychiatry to recognise the limitations of such an approach, dealing as it does with intangibles of mind and body relations. The core of the problem was eloquently described by Laing (1985) when he wrote:

'Psychiatry tries to be as scientific, impersonal and objective as possible towards what is most personal and subjective. The disordered suffering treated by psychiatrists has to do with what are our most personal and private thoughts and desires. No other branch of medicine has to contend with this domain so much. Nothing whatever in Western medical training exists to adapt students and young doctors to integrating the personal aspect into clinical theory and practice.'

Laing's writing can be seen as part of the existentialist tradition, which emphasised the importance of the individual. Søren Kierkegaard, the Danish philosopher, who is regarded as one of the first existential thinkers, wrote in opposition to the abstract rationalism of Hegel,

which he felt ignored the subjective side of man. Kierkegaard (1846) deliberately put forward the paradox that the subjective was the truth. He held that truth lay with the individual rather than in grand theoretical systems. Existentialism had some impact on psychiatry through the writings of Minkowski, Binswanger and May. These clinicians focused on the patient's individual experience. Rather than trying to squeeze their patients' descriptions of mental and emotional distress into some abstract schema, they endeavoured to see their patients as human beings with a unique inner world (May *et al*, 1958).

Psychology has also witnessed the conflict between the subjective and objective: between humanistic and behavioural schools of thought. This conflict has been examined by Matson (1973), who contends that behaviourism has been too dismissive of the mind and has attended only to outward behaviour. He quotes Watson as claiming:

'Psychology, as the behaviourist views it, is a purely objective, experimental branch of natural science, which needs introspection as little as do the sciences of chemistry and physics.'

In opposition to this assertion there arose the humanist movement in psychology, which was influenced by existentialism and its view that individual experience was paramount. Man could not be seen as some kind of biological automaton, passively controlled by the forces of the physical world.

These opposing views of man have a long history (Smith, 1997) and, as Polkinghorne (1983) has shown, they centre on the question: should the human sciences emulate the methods of the natural sciences or should they develop their own methods? Thinkers such as Dilthey, Brentano and Husserl have argued that human beings are different in kind from objects in the physical world and therefore require different methods.

This debate is particularly acute in the arguments concerning the mind–body problem. Those from a physicalist perspective, who see mind as but an epiphenomenon of matter, are also dismissive of subjective experience. The physicalists argue that mental events can ultimately be explained in terms of physical processes. A current version of the physicalist perspective is the so-called eliminativist view, which sees the notion of mind disappearing altogether. The grand march of neuroscientific discovery will extinguish the last remnants of the mental as it will be discovered that all aspects of the mind can be explained in terms of neurobiology. At the other pole are those who argue that human consciousness and subjectivity are more than merely the secondary off-shoots of brain activity. Mental life cannot be reduced to matter. Important aspects of being human, such as the need for meaning and value, and the notion of free will, cannot be accounted for by a purely materialist philosophy.

While some may agree with Horgan (1999), whose latest book, *The Undiscovered Mind: How the Brain Defies Explanation*, concludes that the mind–body problem is a mystery that is beyond our capacity to solve, these philosophical positions are not just of scholarly interest. They influence clinical practice and affect how doctors treat patients. A physicalist-inclined doctor



will see his patient as a dysfunctional, neurobiological mechanism and prescribe physical interventions such as drugs, electroconvulsive therapy or psychosurgery. A doctor from the other end of the philosophical spectrum, one who holds that human experience cannot so easily be reduced to brain biology, may be more likely to emphasise talking to the patient rather than using medication.

This is, of course, a parody of most doctors' attitudes, and clinicians usually operate somewhere in the middle of the spectrum or move along it in response to their patients' needs. However, Havens (1973), in his discussion of the different models used in psychiatry, argues that the conflicting aims of these models often create tensions for the clinician. He contrasts what he calls the objective–descriptive model, derived from Kraepelin, with the existential approach. In the former, the doctor is trying to elicit signs and symptoms in order to make a diagnosis, whereas in the latter the focus is on how the patient feels.

The influence of existential thought can be traced to the present day with the rise of narrative-based medicine, which holds that the patient's history should be seen as a story unique to the individual. By telling his or her story, the patient attains meaning and an understanding of personal misfortune (Greenhalgh & Hurwitz, 1998). The newly-emerging interest in the medical humanities also stresses the limitations of the traditional disease model and seeks to demonstrate that the arts can help clinicians attain a deeper understanding of their patients (Evans & Greaves, 1999). Literature, which recounts individual experience, enables doctors to see the unique and personal aspects of their patients – what Downie (1994) has called 'whole person understanding' – rather than perceiving them as just being a bundle of signs and symptoms.

However, there are concerns that an overemphasis on subjective, existential factors will lead to a neglect of bioscientific knowledge. Fulford (1999) has argued that psychiatry needs to operate in both the world of facts, as represented by science, and the world of values, as represented by the humanities. To remain in only one world impoverishes clinical practice. Aware of these dangers, Greenhalgh (1998) has attempted to reconcile the narrative approach with the biomedical one. Likewise, Eisenberg (2000), in his discussion of the tendency of psychiatry to be either mindless or brainless, has argued that a balanced approach should be adopted. Like many others, he concludes that the great challenge for the future is to integrate the neurobiological with the social and psychological.

Whether or not this is achievable is open to debate. Some commentators, like Polkinghorne (1983) and Charlton (1990), have argued that such a project is fundamentally flawed, because the various explanatory

systems – physical or psychological – represent descriptions of different aspects of reality and cannot be assimilated. Whatever one's perspective, it may be time to discard the terms objective and subjective. If one believes that integration is attainable, the dichotomy should be abandoned because it represents an artificial divide – what the neurologist Damasio (1994) has called *Descartes's Error*. If, on the other hand, one believes that integration is impossible because the competing schemas, though different, are all equally valid, the objective–subjective dichotomy should, once again, be rejected because it privileges one side – the objective – as representing the truth of the matter. Either way, the dichotomy appears to be untenable and unhelpful.

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**Allan Beveridge** Consultant Psychiatrist, Queen Margaret Hospital, Whitefield Road, Dunfermline, Fife KY12 0SU