Holistic psychiatry without the whole self†

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Summary This article considers why whole-person care is often aspired to but remains problematic for psychiatry. One reason is that psychiatry wants to use ideas about the self in restricted senses rather than examine the idea as a whole. In particular, this includes wider issues that interconnect values to identity, which then ambiguously get raised in clinical practice, such as questions about who it is good to be. This issue is the context behind unresolved boundary disputes in mental health around well-being, spirituality, self-esteem and recovery, and reflects broader cultural tensions about the making of modern identity best understood in a historical context. It has impacts on service design, therapeutics and training. Suggestions are made about how the self can be approached in psychiatric practice.

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From a patient's perspective, seeing a psychiatrist may be an implicit acknowledgment of what they do not want to be like – depressed, panicky, overweight, the wrong gender. When patients see other health professionals with a pain, a rash or a cough they might not feel as though they are putting themselves as a whole person on the line in quite the same way. Psychiatrists appear to translate what may sound like an identity claim made by a patient ('I am depressed') into an attribute about the self, a type of pseudo-possession like a diagnosis or formulation – the patient has depression, or an anxiety, or an eating disorder. Whereas traditional healers in a non-Western setting may give accounts of distress that suggest identity itself is centrally at issue (e.g. 'You are possessed'), a Western-trained psychiatrist brings a different observational stance. The former account suggests an ontological claim, the latter offers a more disengaged instrumental approach.

This paper explores how psychiatry gets subtly drawn into, yet evades, these broader questions about the self and identity. To understand this evasion will be to understand something about the philosophical and cultural story behind what Taylor has called 'the making of modern identity'.[1,2] It raises questions about what this branch of medicine's subject matter really is, what underpins its uniqueness and what makes the project of holistic care so complex.

Underlying tensions

Although psychiatry is prepared to use concepts about the self in relatively restricted senses in diagnosis (depersonalisation, passivity phenomena, etc.) or in the search for biological correlates of mental states, it does not tend to examine the idea as a whole outside of the specialised field of the philosophy of psychiatry.[3] For example, the PsycINFO database has over 40 subheadings about the self, but no major subject term. More specifically, questions about what can be termed moral identity are put to one side, even when evaluative conceptions about the self appear to be at play at a clinical level, as illustrated in the opening paragraph. Moral identity involves questions like: 'What is it that makes humans the proper object of respect, gives life fullness, and makes life worth living?' For Taylor, the term 'moral' has wide reference, beyond duties, obligations, deciding what is right to do, but rather veering towards determining who it is good to be. This raises questions that go well beyond psychiatry but get reflected in some basic unresolved tensions within it.

Taylor's historical account of the making of the modern (Western) identity suggests that there is a particular dilemma for mental health practice – not the perennial puzzle about how minds relate to bodies, but whether differing characterisations of the self can be reconciled. Taylor's view is that the idea of the self cannot be approached as if it exists in a morally neutral space. From this he draws out a tension between seeing the self as a self-responsible agent disengaged from and acting instrumentally in the world and contrasting attempts to envisage it in broader, more holistic terms. The questions raised by this tension include whether there could ever be an adequate model of holistic care and how the so-called transformational agendas set out in the recovery, well-being, self-esteem and spirituality literatures fit into psychiatry.[4–6] These issues could be seen as boundary disputes about what should or should not be included in psychiatry,[4] but, perhaps more profitably, should be reframed as an issue about how identity questions are tacitly at the heart of mental health practice. The implications of Taylor's analysis therefore extend into psychiatric assessment and treatment as well as service design and training.

†See commentary, pp. 101–103, this issue.

The self: a history of modern identity

Taylor's philosophical history of the Western concept of the self is in one sense the history of secularisation: what might have been called the soul has now become termed the self.[1,2,7] He describes a pre-modern view of the self existing within a vision of the cosmic order. The pre-modern self was 'porous' to an outer world: meanings were not only located in minds but could reside in objects or agencies independent of us. In contrast, the modern self is more 'buffered'. The boundary between an inner self and the outer world has become more fixed. Values are projected out onto a reassuringly lawful but (possibly) indifferent universe rather than being seen as substantive features of an outer world. Meanings are found through inner exploration, enabling the self to become seen as a psychological concept largely identified as mental experience.

This process has involved a major introspective turn, which has obvious consequences for therapeutic professions but creates cross-pressures in the secular sphere. It has been described as involving a sort of 'disenchantment' of both the outer world and inner experience insofar as it portrays the universe as scientifically intelligible but mechanistic: in consequence, it has provoked a range of expressive protests against it from the Enlightenment on. We think differently about ourselves compared with our medieval forbears. It has led to a form of disengaged self, capable of objectifying inner worlds and outer realities, thereby achieving a kind of distance and self-possession that allows for rational action. There are consequences: the bond that links the idea of the good to identity is weakened and the self is experienced as more hermetically sealed and isolated as opposed to relational and interdependent. Containing frameworks (such as religious commitments) may try to preserve this sort of link but face the challenge of collapsing into explanatory accounts of human interiority (such as cognitive psychology) and being rendered as individual 'belief systems' or 'identity choices'. This can have an impact on the public practice of mental health work. Modern secular society could be said to manage a diversity of competing options within its public spaces and institutions to ensure that professions like psychiatry do not impose personal solutions on vulnerable individuals. Mirroring this disengaged stance, institutions such as the American Psychiatric Association offer guidance to professionals to act on the basis of neutrality and non-alignment.[8] This neutrality can be either welcomed as a form of sensible political tolerance that enables individuals to retain maximal freedom (limited by the caveat about not harming others), or else questioned on the basis that it amounts to a form of impoverishing ideology that pushes the issues of faith and moral identity into an entirely private sphere and therefore inhibits the possibility of common language about human wholeness, emancipation or worth.[9] The difficulty here may be in the consequence of deciding that some types of response to questions about self-worth – for example, religious questions – can only ever be matters of private adjudication and discernment. This might imply that there are some categories of truth claim that cannot be publicly reasoned with.[9] In this sense, delusions and religious belief risk sharing the same status: they could both be seen as matters of idiosyncratic private allegiance. Or it might imply that the only way of using treatment approaches rooted in spiritual traditions (such as the UK National Institute for Health and Clinical Excellence approved mindfulness-based cognitive therapy) is to downplay their background moral ontology. Interestingly, therapies like this explicitly borrow Buddhist practices articulated as psychological techniques, thereby side-stepping the full ontology behind them (ironically, the no-self doctrine) and implying that goals which are in some senses ultimate, such as enlightenment or salvation, could never be part of a therapeutic agenda. Some commentators see a sinister aspect to the psychotherapeutic adoption of Asian wisdom traditions, maintaining that Western psychological individualism creates forms of subjectivity based on ideals of consumer freedom that simply serve the market economy of psychotherapy and self-help.[10]

Holistic aspirations

This might remain an arcane philosophical debate were it not for some of the aspirational pressures that mental health work currently faces. Psychiatric practice strives to be holistic but finds ways of approaching the issue of a 'whole self' to be highly problematic. One solution has been to opt for an aggregated biopsychosocial approach. This has the benefit of orienting health practitioners to three component parts of the care process but it falls short of offering a unitary vision of human identity, ontology of the subject, let alone moral ontology. It also makes the outer boundary of mental health work less clear as agendas move out from reducing symptoms, problems and unmet needs, to promoting social inclusion, recovery, well-being and spirituality.[9,11] This describes a difference between an eliminative model (getting rid of what we do not want, for example, symptoms) and integrative holistic care. In other words, from this perspective there are contemporary pressures to consider who it is good to be, not just what it is bad to have. This might be resolved by an aggregated model that builds on ever more domains of human experience, such as the biopsychosocial–spiritual model.[11] But how many domains should there be and where would a duty of care end?

There are other ways to integrate values into mental health theory by focusing mental health practice on the concept of persons rather than simply on brains, minds or social functioning and so avoiding some of the shortcomings of this aggregated approach. Person-centred approaches are explicitly value based and suggest that personhood is revealed by enactment rather than any form of static definition.[12] Of course, it is possible to have a philosophical stab at saying what a person is, at least from a descriptive, phenomenological perspective. These approaches assert that a person should not be considered as a thing alongside other things: persons are better described as 'body-subjects', relational, inducted into language communities, defined by self-narration and characterised by first-person subjectivity.[13,14] On this reading (following Jaspers) mental health practice is about helping individuals find contextual understanding as well as explaining the contingent causes of their illness. It legitimises the use of value terms alongside descriptive analysis in diagnoses such as personality

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disorder or addiction.[15] Mental disorder is then read as personal disorder. Psychiatrists would presumably be 'personal disorder specialists'. A practice example here might be the person-centred Tidal model.[16] This suggests that given the optimum receptivity of a proper in-patient environment, people will have the inner resources to self-narrate their way into health and recovery. To approach suicidality as personal disorder in this way brings a different theory of change and different theoretical basis of hope compared with the traditional diagnostic model. Temptingly holistic though this may sound, many aspects remain problematic: it may offer a narrative view about what the term 'whole person' encompasses, but, like the biopsycho-social approach, it does not address what it is about a person that makes them irreducibly valuable or who it is good for them to be.

Perhaps these issues get raised by the well-being agenda. This agenda suggests that mental health workers promote values of enhanced control, increased resilience and social participation.[17] This is what Taylor would call affirmations about ordinary living, the post-Reformation humanism that values universal solidarity, the world of work and relationships. His analysis suggests that we cannot separate questions about identity from questions about value and worth. Psychiatrists get involved in helping people who see themselves as worthless to find reasons to be alive. Their professional comfort zone may be about eliminating distress or reducing symptoms on the basis of diagnostic formulation, but it may now also involve appealing to framework values about this affirmation of ordinary living – the occupational therapy values about purposeful activity and the humanistic psychology ethics of authenticity. In practice, the boundary might not be so clear between where the scientific pursuit of well-being stops and the start of any privately formulated quest for deeper or higher claims about what it is that makes life worth living. Psychiatrists may feel more professionally at ease in the world of immanent meanings by reminding people at risk of suicide about the existence of loved ones, not the existence of God.

Grounding ourselves

Perhaps the sensible way forward is to avoid the grandiose aspirations of a holistic care agenda. Unfortunately, a disengaged instrumental approach can give rise to other cross-pressures. For example, mental health therapeutics strives to be person centred yet then gets shaped by the oddly impersonal language of intervention and technique. Experience becomes objectified; the complexities of human desire get reduced to a list of conceptually manageable needs and are then itemised on care plans. Evidence-based practice becomes a type of procedural ethic telling us what pragmatically it is good to do, not, of course, who it is good to be. Psychotherapy distils its active ingredients into a repertoire of competences and skills and delivers them in as pure a form as possible via manualised protocols. Practice becomes codified and the care process is valued not as an end in itself but only insofar as contingently driven outcomes are achieved. Assessment protocols give particular emphasis to a view of self as an agent and privilege the values of autonomy and choice (rather than, for example, social harmony or social justice).

Instrumentalist perspectives give an industrialised shape to service design; knowledge gained from research is expressed in procedural forms via the intermediate step of evidence-based guidance. This clinical knowledge base is operationally expressed in subspecialisation, referral pathways and eligibility criteria. This may have the unintended consequence of obscuring a holistic, whole-system perspective – the corporate identity as it were – which is instead experienced as fragmented. This may explain attempts to find counterbalance, for example by recovering a vision of the generalist (as someone who works to integrate the system),[18] by attempts to re-centre the experience of the service user (in the service user movement) and to develop stepped care models in a variety of contemporary mental health programmes.

Similar cross-pressures exist in psychiatric training. The vagaries of the old apprenticeship model have gone but along with it developmental ontology, a perspective on the personhood of the trainee. The apprenticeship model involved a process of becoming what was admired or seen as worthy in the trainer. Everyone remembers a good teacher. At a psychological level this is about internalisation. It implies a process of personal formation and narrative.[19] In its stead is a model of the practitioner that offers the reassurance of standardised quality: the trainee, however, is at risk of being reduced to an aggregate of skills and competences that can be reliably measured, instrumentally shaped to purpose and appropriately placed on the workforce map.

Although these examples of a disengaged instrumental mode of life show a huge range of practical benefit, as an orientation to life this model may be perceived as emptying it of meaningful depth, fullness or wholeness in the field of therapeutics, service design and training. In its utilitarian form, so often found in large organisational cultures such as the National Health Service in the UK, it can be seen as a driver of bureaucratic modes of existence with little room for high purpose or creativity, such as the pursuit of vocations to heal, the striving to redress injustice or the search for artistic fulfilment.

Some conclusions

There are no philosophically uncontested questions about what is meant by identity and this paper is not a systematic review of the differing opinions on the topic. However, Taylor's analysis of our secular age usefully suggests one issue. We want to have it both ways – to be holistic (but naively sidestep questions about what wholeness is) but to act instrumentally.[2] Put another way, psychiatry tries to be person centred yet scientific, as if this was an unproblematic task. These tensions are best seen as part of a wider secular predicament in the context of the story of the modern self. It leaves the task of trying to deliver care that is empirically grounded yet capable of meaningful depth.

Two suggestions might be worth making in response. Attending to the internalised shame of patients may provide one legitimate but circumscribed way through some of these cross-pressures that can enable psychiatrists to take

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'identity' issues with both an evaluative and scientific seriousness. This is because shame involves global evaluations about the self.[20,21] We might never have a settled view about our identity, but we may be clearer about who we do not want to be. Indeed, that is how many psychiatric presentations begin. This is not just about social stigma. It comes to be about the ontology of the subject, because to be ashamed is to be an undesirable self, a self one does not want to be. It also may bring a distinctive sensibility to the issue of insight. Shame provokes hiding rather than self-disclosure. Unsurprisingly, correlations between psychopathology and shame are extensive and some mental illnesses, such as depression and borderline personality disorder, have been considered to be shame-based syndromes.[22] Much psychiatric care can start from this departure point, which is so often disclosed in the language of presenting complaint. This may also help to avoid atomising the concept of self, seeing it as a thing alongside other things, ultimately capable of being itemised into component parts. We are made by others and others are the making of us in every biopsychosocial sense. We may have undesirable bodies, be socially unattractive and be riddled with the hallmarks of internalised shame (self-criticism). Yet the separate biological, social and psychological dimensions of the 'body-subject' can give rise to shame-based experiences and narratives, which orient therapeutic practice, sometimes in an eliminative direction – focusing on what we do not want to have, for example symptoms or unmet needs, but sometimes in a more integrative direction – focusing on who it is good to be.

I suggest a second complementary step forward may be to re-personalise the training of psychiatrists to promote education (what gets led out) as well as instruction (what gets put in). Psychiatrists need to know something of the assumptions behind their own moral ontology to be able to map out their own personal and professional boundaries.[19] This will require devising new forms of the educative reflective process, perhaps via a long-term formative relationship with a peer group or mentor. Currently, trainees have to present clinical material in case-based discussion groups. This provides focused opportunities to reflect on the interplay between professional roles and personal experience but there are no requirements to create longitudinal developmental perspectives taken over the whole 6 training years.

Taken at face value, language about mental illness can suggest a moral status, not simply deficient mechanism. This does not imply that people who have a mental illness have done wrong or are bad, but that they may be making evaluative claims about their identity which they struggle to resolve without professional help. Many of these claims relate to the daily realities of ordinary living, the life of relationships and purposeful activity to which they want to be restored. But some of these claims and questionings may be uncommonly deep: our task as psychiatrists is in trying to understand the multifaceted implications of hearing our patients say they are not who they want to be.

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