



# The Importance of Multiple Perspectives in Psychiatry



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Submission: 📅 May 25, 2018; Published: 📅 June 26, 2018

## Introduction

In clinical practice, there are times when it is especially wise to explicitly formulate a detailed understanding of a patient and his or her disorders. Such times would include the beginning evaluation at the start of treatment; a time of transfer of care to another professional; and those occasions when progress in treatment has plateau'd, yet the patient's current status remains sufficiently psychopathological that it is unacceptable as a treatment endpoint.

Such a formulation, or reformulation, is useful to insure that all important aspects of a patient are considered in further treatment, so that nothing in particular is overlooked. It is particularly important to recall that psychiatry recognizes multiple dimensions in psychopathology, indicating various foci, for example, on mind, or brain, or behavior, or interactions. This entails considering the different groups of factors that can be impacting the patient. We can say that psychiatry is a "biosychosocial" [1] discipline, or one that calls for a "systems theory" [2] model. But in the case of a full formulation, one from differing perspectives, what is involved? What dimensions need to be looked at? From a very general point of view, we can recall the interplay of mind and body, of environment and behavior, but what might be considered more specifically?

As a start, consider the medical model [3]. This calls for consideration of the pathology pattern as a medical illness. This would be an occasion for a diagnostic evaluation or reevaluation. This approach is most commonly employed by psychiatrists, but not always by non-psychiatrists. It includes a history of signs and symptoms. Then it involves a delineation and description of observed behavior and speech, in quality, in time pattern and intensity, as well as the subjective symptoms that the patient articulates. The particular focus is on abnormal thoughts, feelings and behaviors. This is a matter of "empirical" or "clinical" or "descriptive" psychiatry, derivative of the approach of Kraepelin, [4] often referred to as one of "phenomenology." The Kraepelinian approach looks for patterns, syndromes, and today it can specifically suggest correlations with underlying neurology, especially neurotransmitters, and neuromodulators, thereby offering an approach to treatment. The medical model offers as its goal relief or reduction in suffering. Recent advances make it possible to also consider brain circuitry.

It can be useful to formulate a patient's symptoms as interplay of neurotransmitter systems. Hyperdopaminergic function [5] can relate to psychotic symptoms, movement symptoms, excessive pleasure seeking, dysregulated lust, and risk-taking. Hypodopaminergic function can underlie anergia or passivity; it can also involve attentional and cognitive problems. Dopaminergic dysfunction can also be a

basis in compulsive or addictive behavior and drug taking. Norepinephrine [6] can be seen as a neurotransmitter of flight or fight, contributing to panic attacks, performance anxiety, and other anxieties, as well as depression. Serotonin [7] can be seen as performing a "soothing" or coping function, problematic in the stress of depressive or anxious conditions. It also can underlie hallucinosis and satiety functions. Histaminic dysfunction can underlie alertness problems, and weight gain [8]. Cholinergic deficiency can underlie memory problems, and problems with executive function [9].

Orexins can be involved in problems with alertness and sleep, as well as motivation [10]. Opioid neurotransmitters [11] can be involved in problems of pleasure or pain, as well as addiction, and they play a role in depression. It may be useful to review standard medication approaches, with their augmentation strategies. For example, major depression, bipolar disorders, schizophrenia, and anxiety disorders, in the case of the treatment-refractory patient, have published approaches and algorithms [12]. A patient's genome can be assessed easily by a saliva sample with respect to DNA involved in the enzymes of drug metabolism, and also the structural proteins of a number of neurotransmitter receptors [13]. A full consideration of possible biological treatments would certainly include electroconvulsive therapy [14], transcranial magnetic stimulation [15], and direct current stimulation [16].

However, there is another usage of the word "phenomenology," derived from the point of view elaborated by Jaspers, [17] and this is an alternative dimension. This involves an effort to delineate the subjective, internal experience of the patient, to articulate the patients' full inner world. Such offers us a firm basis to relate it to objective symptoms. In addition, a more thorough understanding

of the patient's motivation can develop. It is a key to developing empathy. It is also often useful in developing a firmer alliance with the patient, as one inquires about his inner life and meaning, and it demonstrates one's interest in this.

Consider also a further dimension, the psychodynamic point of view [18].

In many ways this can be considered an elaboration of the phenomenological point of view of Jaspers, but it goes beyond it, in offering a model which can provide a dynamic and structural understanding of the patient's psyche [19]. It strives to break each thought and emotion down to its most basic elements, characterizing the patient's fundamental goals and wishes in primitive terms, and then relating derivative objectives and intentions of the patient. However, there are conflicting fundamental primitive and derivative fears, as well. And then it calls for identifying the efforts of the patient to limit his own awareness, in the form of "defense mechanisms". Finally, there is a compromise formation of them all, underlying the expressions of symptoms and behavior. An additional feature of the psychodynamic point of view entails the development of a life history, especially childhood, which point to psychological forces that have influenced the patient in both early life and later, in the persistent motivational patterns.

Additionally, consider an interpersonal point of view. This would include an articulation of the social and cultural forces [20,21] as well as the relational experiences that have impacted the patient. More specifically, one considers matters such as minority status, immigration, ethnicity, and social involvements. Family dynamics [22] may be very significant, and this is where one may find a systems perspective especially relevant. Also, the dynamics of the patient's current major relationship need to be factored, with attention to the quality and depth of the relationship [23]. Finally, as an interpersonal perspective, an assessment of the relationship between therapist or doctor and patient is important [24].

A behaviourist [25] point of view can be very useful. A perspective of behaviour modification involves attending to reward and punishment aspects that may be involved in a patient's behavior, and that function to reinforce or to discourage. This may not be so simple, since the nature of reward and punishment may be not be stereotypically pleasant or painful, and may be counterintuitive, yet may function as reinforcement or punishment. Likewise, assessments of maladaptive cognitions, and association behaviors may be useful [26]. The approach of dialectical behavior therapy can also be considered [27]. Aspects of addiction [28] may be relevant in a number of behaviors, pointing the way to therapeutic approaches. A multidimensional framework may enrich a particular treatment approach, and may suggest new avenues of treatment or. It can certainly assist in optimizing patient care.

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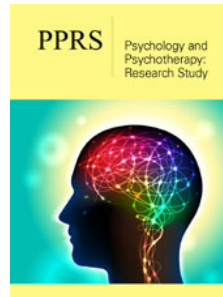
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