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Psychiatry as a Technology of Empathy: A Perspective from Medical Anthropology

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Abstract

What does "empathy" mean in psychiatry? Based on studies in medical anthropology, I first examine how different forms of empathy have been shaped in biological, psychotherapeutic and psychopathological traditions. Secondly, I illuminate the ways in which mental illness can be understood as an "interactive kind," where a clinician's gaze can have a significant impact on the experience of a person with the illness as well as the phenomenon of the illness itself. Thirdly, I discuss changes brought about both by Japanese doctors' attempts to remedy the stigma of schizophrenia and the "neuroscientific turn" that has given rise to new ways of talking about the brain. Further discussing the rise of tojisha perspectives, I consider different directions that psychiatric forms of empathy may take in the future.

Keywords: empathy, medical anthropology, psychotherapy, biological psychiatry, psychiatric users

Introduction

What manner of empathy does psychiatry have? What exactly does psychiatric empathy mean? As a

medical anthropologist, I was reminded of this question when I heard how Masanari Itokawa, who has been leading genetic research on schizophrenia, began to learn about “Tojisha kenkyu” (self-supported research or the science of the self, used here to refer to the kind of research on mental health conducted by people with lived experience). Itokawa has been engaged in genetic research since he learned of his mother's schizophrenia, with the sole intention of relieving the suffering of people like her. When he decided to report the results of his research on psychiatry at a lecture for psychiatric tojishas/users at "Beteru no Ie" (Bethel House), he was at a loss as to how he should present his findings. This is because he realized that the scientific language that he usually uses casually in the laboratory could itself be harmful to users themselves 15). Itokawa is not alone. Many doctors and patients are now critically re-examining the language and practice of psychiatry, including Ikuko Natsukari 46) who examines psychiatry from the different standpoints of being a doctor, a family member, and a patient by reflecting on the conflicts of being raised by a mother with schizophrenia and her own experience of being a receiver of psychiatric care 19). Questions have begun to be asked regarding what kind of language and what kind of clinical practice can be experienced as more empathetic by those with schizophrenia and other mental disorders.

What is empathy in psychiatry? Is empathy necessary for psychiatry in the first place? Empathy is a new word that appeared in 1908 as an English translation of the German word Einfühlung 38). Nevertheless, empathy soon replaced the concept of sympathy, which had been central to philosophy and ethics in the 18th century, and became widely influential in 20th-century medical education and society as a term for "self-injection," "emotional involvement," "putting oneself in another's shoes and feeling another's pain as if it were one's own". In medicine, however, there is no need to emphasize empathic language when the cause of a disease can be easily identified by blood tests and the disease can be quickly cured with medication. Empathy is particularly important in clinical psychiatry, where, for many diseases, there are often no objective diagnoses by biomarkers and/or established cures, and the diagnosis and cure are largely based on verbal communication. For those who come to clinical psychiatry with discomfort or fear within and about themselves, it is in itself therapeutic to encounter a doctor who understands their anxiety that they themselves could not quite articulate, and to be provided with an explanation that makes sense to

them. Moreover, since Karl Jaspers defined the essence of psychosis to be incommensurability, physicians have used their five senses to determine the degree to which a patient's narrative is commensurable/understandable and to help in diagnosis. Such empathy is specialized knowledge unique to psychiatry and is an indispensable clinical method for diagnosis and treatment.

However, as a discipline that shares the ethos of modern science, which emphasizes reason rather than emotion, psychiatry has also examined the danger of emotion-based empathy. Indeed, emotions such as anger and hatred sometimes overtake reason and derail calm judgment, making them an extremely fragile basis for moral and political judgment (For instance, Bloom, who advocates "Against Empathy," asks whether the Holocaust could have been prevented if the Nazi Party members had only been more empathetic) 2). Furthermore, it is not uncommon for what appears to be empathy to be nothing more than a presumption based on a lack of knowledge, and this can be easily inverted into arrogance that (incorrectly) assumes an understanding. As Kosuke Kanemoto provocatively asks, the question arises as to whether empathy without understanding is possible at all 25)61). Particularly, when such false empathy is directed from the socially strong to the socially weak and takes the form of “speaking for the weak,” it may lead to the fixation of an inferior image of the weak 62). Psychiatrists are said to be "a profession that often unintentionally - sometimes out of naïve goodwill and sincerity - 'harms' patients" 53). In particular, the excessive emphasis on the impossibility of understanding (empathy) in the treatment of schizophrenia has inversely reinforced the stigma associated with the disorder. The history of psychiatric treatment of schizophrenia can therefore be read as a history of the search for more empathetic language and practice, as if to break the curse that has been placed on them. How can a language of empathy that overcomes negative images be created, and how can it become a method for self-reflection? In the 21st century, with the emergence of the "tojisha movement" (or psychiatric user movement) 34), how is the language of psychiatry beginning to be validated by tojishas/users themselves? I would like to consider these questions from a medical anthropological perspective.

I. Empathy in Biology, Psychotherapy, and Psychopathology

How is empathy taught in psychiatric education? Tanya Luhrmann, an anthropologist known for her brilliant

ethnography of post-graduate training in psychiatry in the United States, describes how American residents learn "two kinds of empathy" 39). On the one hand, the empathy required in biological psychiatry, as in physical medicine, positions those who experience mental disorders as "poor victims affected by brain disease". The experience of mental illness may not be easily understood, but by "objectifying" it from a natural scientific perspective and understanding it intellectually, from a distance, it becomes much easier to conduct calm observation and intervention. Here, residents are even warned of the danger of being too “empathetic” based on a “commonsense psychology,” as that can sometimes lead doctors to overlook the possibility of underlying organic diseases 25)63). Using this (biomedical form of) "empathy" (that sees patients as victims of brain disease), it becomes easier for doctors to respond to even the most out-of-the-ordinary words and actions in a tolerant manner without placing a moral blame on the patient.

In psychotherapy, on the other hand, residents are thoroughly required to learn identification and empathy, which are the opposite of objectification and intellectualization. Through psychotherapy sessions, they learn firsthand how much their words and actions hurt patients and how much their words can sometimes help. For example, in a therapy session with a person with signs of borderline personality disorder, the resident became so emotionally involved that she is driven to the point of vomiting after sessions with the client 39). When a patient confronts them with unresolved conflicts, residents who lack insight and self-analysis, are driven by anxiety and aggression and unintentionally "act out" by scolding the client on the spot. Eventually, however, the residents come to confront their own sense of insecurity and reflect on their pain. Through this process, they also begin to feel and identify with the loneliness and despair of the patients. Furthermore, by experiencing the position of the "patient" in didactic analysis, they begin to recognize the importance of not only "cognitive empathy" through intellectual understanding, but also "affective empathy" through emotions and feelings. In other words, empathy in clinical psychiatry is a technique for understanding others that allows clinicians to reach a deeper level of objectivity through subjectivity. By contemplating the difficulties of empathy, residents acquire a "psychiatrist-ness" that differs from that of somatic medicine 32).

What about Japan, where psychoanalysis has not had much influence? In contrast to American

psychiatry, which developed outpatient psychotherapy based on dialogue largely with neurotic patients throughout the 20th century, Japanese psychiatry has cultivated psychotherapy for schizophrenic patients who are institutionalized in psychiatric hospitals for long periods of time. In addition, French and German psychopathology, which is based on biology but uses language as a tool to analyze psychotic experiences, was introduced to Japan before World War II and had a unique development in Japan under the influence of existential philosophy and phenomenology after the war. Indeed, psychopathology developed as a critical reflection on biological psychiatry, which was too indifferent to the inner world of schizophrenic patients. Behind this was the historical background of the concept of "schizophrenia" at the end of the 19th century, when psychiatry was introduced to Japan. The concept of schizophrenia was initially based on the model of progressive paralysis and was assumed to be an "incurable disease" associated with an excessively pessimistic prognosis 57). The fact that the place where the course of the disease was observed was not in the community but in a residential psychiatric hospital where severely ill patients were gathered was also a disadvantage. The possibility that such an artificial environment could have a negative effect on the prognosis was not sufficiently examined, and the results of hospital observations were taken as if they were the "natural history of the disease". Eugenics, which is now denounced as pseudoscience, also had the detrimental effect of treating the disease as an inherited pathological mutation from the normal human form. Osamu Kan, who worked at Matsuzawa Hospital in the 1930s, lamented that the mentally ill were now regarded as "animal-like beings" that had "nothing to do with normal people" 17), and it is unfortunate that the source of such a distorted image was modern scientific discourse 59). Even after the war, the stigma was further reinforced through scandals surrounding large-scale institutionalization, lobotomies, and drug-assisted restraints. As Yuji Okazaki pointed out, its negative legacy persists in clinical practice in the 21st century.

Schizophrenia has long been considered a chronic progressive disease, and many medical professionals, including psychiatrists, still believe so. A vicious cycle has often formed in which the negative results of explanations and treatment practices based on a pessimistic view of the disease are seen as signifying a poor prognosis, confirming their own

hypothesis 50).

Thus, overcoming the adverse effects of the biological theory of schizophrenia became the driving force of psychopathological inquiry in the latter half of the 20th century. Especially since the 1960s, this field has gained excellent interpreters of illness, translating the internal world of schizophrenics, through its own distinctive language, into something one can empathize with. Building on the tradition of Masashi Murakami, Toshiki Shimazaki, and Shiho Nishimaru, who had already introduced this field to Japan before and during World War II 48), doctors such as Bin Kimura and Tadao Miyamoto, who were also familiar with European phenomenology and existential philosophy, created new schizophrenia theories one after another 36). They discussed, for example, the unique mode of existence of schizophrenics who prefer intellectualization and abstraction to emotional exchange, and vividly depicted their ambivalent mentality of awe and longing for something that looms over them with subtle discomfort, their acuse sense of being shaken by the world, and their religious experience in which they feel that the truth is revealed to them 41). In dialogue with philosophy, esthetics, and religious studies, they also rewrote the cultural meaning of the schizophrenic experience by examining the possibilities of human beings in extreme conditions and the creativity and sanctity of illness 12).

II. Mental Disorders as Interactive Kinds

Why, then, did early psychopathology not necessarily work to dispel the stigma of mental disorders? While the social and institutional factors of the time were far more significant, I would like to consider the limitations of this perspective based on the "interactive kinds" theory of Ian Hacking, a philosopher of science. In the philosophy of science, it has been argued that there are two kinds of objects of science. The object of natural science, on which biological psychiatry is based, is usually assumed to be a "natural kind" that exists in nature regardless of the involvement of the observer. For example, the "atom" is arguably a phenomenon that can be observed universally and objectively, regardless of who names it or what they call it. In schizophrenia theory, physicians have tried to investigate the cause of the disease as something that exists outside the observer - a "natural kind" (Hacking calls it a "non-responsive kind"). In doing so, physicians have tried to eliminate their own feelings and subjectivity as much as possible, and

observe objectively and neutrally 4). However, the experience of mental disorders is a troublesome phenomenon for scientists because it deviates from the natural kinds model that is an ideal model of natural science. This is because, unlike atoms, people suffering from mental disorders are beings with "minds (kokoro)". Therefore, mental disorders, while they can be diseases with biological etiology, and can be understood as a "non-responsive kind," they can also be a "responsive kind" – or an "interactive kind" - that can easily be changed by the observer's or society's gaze (Hacking's theory has been influential and given rise to various philosophical debates over the strict meaning of the concept, but here I would like to focus on its usefulness for clinical analysis 10)11)).

In the interactive kinds, the experience of illness can vary greatly depending on how the observer (physician) names the phenomenon of illness and what kind of empathetic gaze he or she directs - and how the person being observed perceives the observer's gaze. Psychiatrist/medical anthropologist Robert Barrett shows how a patient learn to be a "schizophrenic" through his interactions with medical professionals by analyzing conversations in psychiatric practice 1). As the patient explains the history of his illness to the doctor, he gradually removes matters that were important to him but not of interest to the doctor (such as his friend's death and a religious experience) and instead focuses on the parts of his story that the doctor showed interest in (namely, hallucinations and delusions). In the process of repeating the same narrative to various professional staff and gradually internalizing it, the patient becomes a typical "schizophrenic" fixated on his pathological experiences. Despite this interactive process, when the illness is documented in the medical records, no consideration is given to the interactive aspects of the diagnosis, and schizophrenia as a product of dialogue is transformed into an independent natural kind, reinforcing the physician's view of schizophrenia as a "disease".

In other words, what was lacking in early psychopathology was a clearer recognition of interactivity and a mechanism for incorporating the voices of patients. Because psychopathology was initially developed as a method of scientific observation and intellectual insight by physicians, rather than for dialogue with patients and their self-care, the alienating effects of highly abstract verbal objectification were not fully recognized 40). Especially for those who experience schizophrenia, which develops during adolescence and young adulthood when the self-image and social identity are yet to be fully formed,

when they are suddenly thrown into destructively chaotic experiences 27), the gaze of the doctor in the confined space of the psychiatric hospital is so influential that it may begin to rewrite and define patients' sense of self. Therefore, what has been criticized in the anti-psychiatry movement since the late 1960s was the danger of "creating and refining delusions in collaboration with the doctor" through medical examinations 45). When the author began conducting research in psychiatry in the 1990s, concerns about the harmful effects of this practice were still strong. I met doctors who continued to see patients who had been "emptied out" by the erosion of their healthy parts through the repeated discussions with their previous doctors who had excavated their secrets and focused too much on the pathological aspects of their experience. The language of early psychopathology did not fully overcome the cold and detached, difficult-to-understand characteristics of its terminology, which, as Itokawa points out, was translated from German and English and created its own rigidity and distance, such as "personality desolation," "emotional numbing," and "genetic predisposition". The sometimes-excessive emphasis on the difference and otherness of psychoses may have had the effect of reinforcing in doctors "a solemn psychiatric view of illness with a strange mixture of resignation, determination, and sense of mission".

III. Empathy in Japanese Clinical Practice for Schizophrenia

How can we change the language of psychiatry to that which is comfortable and empathetic for the patient? In psychopathology and psychotherapy since the anti-psychiatric era, various attempts have been made to overcome its own self-criticism. In psychoanalysis, the adverse effects of translating foreign words into technical terms that create their own reality have been pointed out; for example, Joji Kandabashi illuminates the power of the unconscious by discussing how certain technical terms such as "resistance" and "defense" that are war-metaphors would create in a therapist a desire to break through the resistance. In order to avoid setting the tone for therapy as a place of such confrontation, Kandabashi proposes to rephrase "resistance" as "unfamiliarity" and "defense" as "ingenuity" to imagine patients' autonomy and creativity 21)23). Clinical practice using everyday language by Takeo Doi et al. 6) and Japanese clinical language by Osamu Kitayama et al. 31) were also attempts to change technical terms into more culturally friendly ones. In addition, the schizophrenia theories of Japanese psychoanalysts during this

period have produced provocative and intriguing ideas that were new to psychoanalytic world outside. These include Doi's "secrecy" theory, which emphasized the importance of protecting patients who are already frightened by the experience of their self being revealed to the outside world and assuring them that it is okay to not reveal everything to their doctors, 5) and Kandabashi's "use of self-withdrawal" that calls attention to the protective and creative aspects of being withdrawn from society 20) . On the other hand, the psychopathology of the new era by Satoshi Kato, who incorporated a psychotherapeutic perspective into psychopathology and discussed the role of the physician as a "secretary" who listens to and writes down the patient's narrative, 28) and Kunifumi Suzuki 58) and Takeshi Utsumi 60) who explored the historical significance of schizophrenia, continues to attract intellectuals beyond psychiatry. Their greatest contribution lies in the fact that, without reducing its complexity and heterogeneity of schizophrenia, they have tried to translate the rich semantic world of schizophrenia into something commensurable 29) while continuing to question the possibility of empathy for others who are different from oneself 33).

Furthermore, there has been a change in the symptomatology of schizophrenia, where traditionally attention has tended to focus on the pathogenesis of the disease. Hisao Nakai, who has reshaped psychiatric approaches to treatment by focusing on the process of recovery of patients, has described the fierce struggle between hope and despair that takes place in the seemingly aimless minds of patients. By using such easy-to-understand words as "cocoon period," "downy hair of the mind," and "lump of impatience," Nakai captures the mental dynamism of people on the road to recovery 44). Nakai's treatment theories, such as "consideration of whether the patient feels lonely when the auditory hallucinations are gone, pointing out that it is not polite to deny delusions out of hand, and the term 'secondary gain from illness' refers to the fact that the patient is not yet in a situation where he or she feels secure enough to be cured," 49) have softened the way doctors perceive schizophrenia. Nakai's words, supported by a "high degree of ordinariness," in which he described the pain of mental illness not only in terms of physical exhaustion and brain fatigue, but also in terms of "mental fatigue", 53) were easier for patients to understand and made other people more empathetic to those suffering from psychiatric disorders.

In Japan, while the toxicity of words

and their "explosiveness" have often been pointed out within psychiatry and beyond 44), some psychiatrists have actively incorporated traditional medicine and its approaches to the body such as feeling and diagnosing through palpation and using nonverbal techniques 22). The author, who conducted research in a Japanese psychiatry department after observing Canadian psychiatry for a few years, found it refreshing when she encountered the mind-body monistic approach in Japan, which seems to combine both approaches of "starting from the body and going to the mind, while also starting from the mind and going to the body" 54) 18). The residents were taught that, after asking about psychological hardships and family conflicts, they should finish the interview by asking about the body such as bowel movements, appetite, and sleep. At various university hospitals, psychiatric hospitals, and clinics, the author met many doctors who smoothly led their patients to recovery by directing their attention from the "mind" to the "body," which is easier for patients to grasp and intuitively understand. The patients also seemed to steadily regain their autonomy by enhancing their sense of self-sensor and self-control over their bodies. In particular, focusing on changes in the autonomic nervous system during the recovery period of schizophrenia and viewing the illness not only as a brain disease, but also as a whole-body disease, seems to work as a form of self-care that is easily accepted by the patients.

This is in sharp contrast to the Western tradition of psychotherapy, which regards the body as lower to the higher mind. In classical psychoanalysis, the emphasis is on the control of the body/emotions by the mind/reason, using "words", which are supposed to distinguish humans from animals. In contrast, what was cultivated in Japanese clinical practice was an alternative philosophy that worked from the body to mind 30). Such an approach of discussing brain healing from the perspective of changes in both mind and body not only worked empathetically with patients, but also seemed to draw unexpected strengths from them as it allowed them to scoop up the spring water of traditional therapeutic culture 42).

By retelling this theory of mind-brain therapeutics with a biological foundation, can we change the language of psychiatry as a whole to be more empathetic in the future? 8)24) In this regard, it is worth noting the possibility that the language of biological psychiatry itself has undergone a major transformation following the rise of neuroscience, which has been called the

"neuroscientific turn" 43). This is due to the fact that since the 1960s, with the advancement of brain imaging technology to visualize the functions of the living brain, the understanding of the brain itself has begun to be described in more dynamic terms, far removed from the genetic pessimism of the early 20th century 52). Furthermore, the increasing use of psychotropic drugs has led to the spread of a "neurochemical self" view of human beings, in which the mind is imagined to be alterable in any way by neurotransmitters 51). On the other hand, as mental disorders such as depression, developmental disorders, and dementia have become generally known, there is a growing recognition about the "spectrum" of mental disorders, in which a qualitative disconnect between normal and abnormal is no longer assumed, but rather everyone is positioned on a quantitative continuum between the two extremes. Efforts to take advantage of brain plasticity are also becoming more widespread as treatment methods, such as medical education for developmental disorders and dementia rehabilitation by speech-language pathologists 13). One may wonder if, in contrast to psychoanalysis that presumes the existence of a "true self" to be discovered in the realm of the unconscious, the language of biological psychiatry may not erode self-consciousness in the same way as psychoanalysis, as it perhaps lacks that kind of depth and remains instead on the surface of the "self." We need further investigation on the actual effect of the biological language of psychiatry, however, to determine if it actually helps decrease stigma and improves patients' self-image 37).

Conclusion

In fact in Japan, the image of psychiatric patients is also currently undergoing a major transition. In the past, the focus of clinical practice was on schizophrenic patients who were diagnosed at a young age and institutionalized for long periods of time before they had time to develop a social identity. Therefore, the emphasis was on how to protect their sensitive inner world and how to speak for them. However, the increasing numbers of depressed patients are changing the landscape of psychiatry as they are mostly those who come to psychiatry with a strong social/work identity and have led an adaptive life. They are users who would not be satisfied with the status of being passive "patients", who instead actively gather information on their own and take for granted autonomous decision-making for their treatment 3). In the face of these patients, psychiatrists are beginning to

search for a way of dialogue that respects the will of the patient rather than one-way empathy. Attempts to guarantee mutual feedback in groups that transcend the doctor-patient relationship, such as open dialogue, are utilizing the dynamism of empathy among multiple participants in treatment 55).

On the other hand, the manner of empathy is also being fundamentally changed by the voices of tojishas/users. Particularly in the realm of developmental disorders, users are beginning to talk about how their behaviors that were once described as "sensory insensitivity (hypoesthesia)" were actually protection against excessive signals due to "hypersensitivity." In such ways, they are beginning to re-examine psychiatric knowledge and rewriting symptomatology 26). The rise of the study of psychiatric users by users themselves, represented by Bethel House and the Tojisha-Kenkyu Lab led by Shin'ichiro Kumagaya at the University of Tokyo has generated a "language recovery movement." Using self-diagnoses such as "schizophrenia 'mind-being-read-by-others' type" and "schizophrenia dashing-out type" have changed psychiatric language into something more self-affirmative 14). Coproduction studies, in which the psychiatric users are positioned as equal research partners 35)57), and the medical anthropological inquiry of Shigeyuki Eguchi and others, who introduced Arthur Kleinman's "illness narratives," are also building their own unique modes of dialogue 7). In order to question what kind of words and practices are empathetic for patients, it will be necessary to transform clinical practice into a place of collaborative process of scientific hypothesis building, testing, and validating with users themselves 9)16)47). Clinical psychiatry with this form of democratic scientific inquiry will open up new possibilities for empathy as the basis for "Tojisha-gaku," as Shigenobu Kamba promotes in the Paradigm Shift Group of the Japanese Society of Psychiatry and Neurology.

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