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Guest Editorial

The Sources of Knowledge in Psychogeriatrics

Whether called psychogeriatrics, old-age psychiatry, geriatric psychiatry, geriatric psychology, or mental health of the elderly, the clinical disciplines focusing on the mental health problems of older individuals are increasingly becoming recognized as subspecialties of their parent disciplines. Although the rate at which this is occurring is variable, interest is spreading worldwide and will continue to grow.

Perhaps the single greatest important justification for the growth of psychogeriatrics as a subspecialty is the accumulation of a unique database relevant to the mental health problems of older individuals. This is evidenced by the large number of textbooks on geriatric mental health, the increasing membership of the International Psychogeriatric Association and other national societies, and the increasing number of journals whose primary focus is on late-life mental health and illness.

Where does this knowledge come from? This is a crucial question because developing a consensus on what knowledge is important to a field is a necessary step in the growth of that field.

One century ago, the sociologist Max Weber distinguished between two types of knowledge. This distinction actually goes back to Aristotle. The philosopher and psychiatrist Karl Jaspers adapted this distinction to psychiatry, labeling the two types of knowledge "explanation" ("Erklärung") and "understanding" ("Verstehen"). The first type of knowledge, and the one most recognizable, is what might be called empirical or "scientific" knowledge. It is knowledge that can be confirmed by performing research that meets criteria for validity and rigor. Because the methods of science evolve, the types of studies done and the methods used have changed over time. Although there is a debate about whether a single "scientific method" exists, explanatory knowledge depends on the ability to test and refute hypotheses *prospectively*. Undoubtedly, hypotheses about late-life mental disorder will continue to be tested. The results gained from these studies will remain important sources of knowledge for increasing the database of psychogeriatrics.

The second form of knowledge, understanding, is gained through the empathic method and depends on the methods of empathy, meaning, and narrative. The ultimate validation of this method is an agreement among the people holding the idea that this knowledge is valid. For example, if a clinician and a patient agree that failing health is a

source of demoralization, then this is "true" from the empathic point of view. If other clinicians or individuals come along to challenge this view, no scientific test can developed to challenge the belief. Even if the patient's mood improved after an antidepressant were prescribed, there is no way to prove that, for this individual, the empathic interpretation was incorrect.

It is a mistake to consider "scientific" knowledge better or more valid than "empathic" knowledge. The sources and the purposes of each type of knowledge are different and each has its strength and limitations. For example, although a scientific explanation can guide care in a rational direction, it also removes the individual person from the equation. Sometimes, a data-centered approach is desirable and appropriate, but for many aspects of life, empathic understanding is more informative and more helpful to the individual.

There is a third type of knowledge that can be distinguished from these two—I will call it "spiritual" or "religious" knowledge. The sources of this knowledge are religious texts and legends, long-held traditions, and generations of leaders. This knowledge differs from the prior two in that it is "given" knowledge, that is, knowledge whose truth is established by the source from which it comes. In the scientific method, validity is confirmed on the basis of studies that test ideas that *can be disproven*. In the empathic method, the ultimate truth is whether a particular individual or situation can be best understood by the participants as having a specific meaning. In the spiritual model, correctness is defined as meeting the precepts of the original source of the knowledge.

Knowledge from each of these sources will remain important as psychogeriatrics matures. Understanding the culture and religion of others can help practitioners appreciate spiritual knowledge even when the practitioner does not share those beliefs. The limitation of spiritual knowledge is a tendency to denigrate knowledge from other sources. Empathic knowledge can be gained only from the interaction relationship between individual people and practitioners. The bond that forms, sometimes called the "therapeutic relationship," will remain a central core of psychogeriatric practice. The danger of this method is the mistake of extrapolating from one or many individuals to all or most people. Knowledge gained through the scientific method will advance the care of individuals by demonstrating the likelihood of a given outcome. The limitation of explanatory knowledge is that it loses the person.

The skillful clinician balances all three types of knowledge and is able to utilize each when appropriate. It is this ability that sets the professional apart from the lay person and necessitates the involvement of mental health practitioners in any healthcare system.

Peter V. Rabins, MD, MPH
Department of Psychiatry
and Behavioral Sciences
Johns Hopkins University
School of Medicine
Baltimore, MD, USA