

THE EPISTEMOLOGICAL BASIS OF PSYCHIATRIC CONTROVERSIES

Dear Editor, Prof. Kecmanovic (in press) raises interesting questions about several points of discord within the psychiatric enterprise. His paper has a great value because it reminds to clinicians and researchers that the philosophical basis of their model has always a strong influence on their practical activity, even in those (quite frequent) cases in which they are unaware of it, and take their model for granted, as a “simple” description of reality. The importance of a philosophical clarification in order to understand current polemics in psychiatry is intrinsic to psychopathology since its Jaspersian foundation and it is the major aim of more recent programs in philosophy of psychopathology (e.g., Aragona 2009a).

Because there is substantial agreement with Kecmanovic’s account on many arguments, I choose to focus on possible misunderstandings that deserve to be clarified.

Prof. Kecmanovic is right when asserting that the existence of so many contrasting models puts psychiatry at risk of being perceived as a non scientific activity, and that even the communication between psychiatrists is hampered if they scotomize the ideas and scientific achievements of those that do not share their own model. However, the exigency of one integrating paradigm to oppose fragmenting forces is at risk of conducing to a reductionist model (see for example the reductionist stance inspiring previous proposals of consilience models: Wilson 1998). Accordingly, the risk is that instead of Kendler’s frame of reference for multiple perspectives, the “conceptual centre” evocated in the script would act as an attraction force reducing all the different perspectives to a unique model, namely the biomedical model. I see such a risk because I notice in the argumentation about the scientific credibility of contemporary psychiatry the same arguments already advanced in the Seventies when the biomedical, neokraepelinian school imposed the North-American operative diagnostic criteria as the unique credible model in psychiatric nosology. At that time it was said that the existence of alternative models of psychiatric diagnosis, and the fact that psychiatrists trained in different schools were likely to diagnose the same patients differently, were a scandal putting at risk psychiatric credibility. Considering that after thirty years of DSM-based research the promises of that model have remained elusive (Kupfer et al. 2002) and that a return to a more historically-sensible psychopathological model has been recommended (Andreasen 1994), caution about replying the same schema for the present-day psychiatry should be suggested. In the end, the core of the problem is: what should we mean by “scientific” in this case? If the argument is that psychiatry is scientific because it is a branch of

medicine, then the reduction of our scientific ideal to the biomedical model is the logical consequence. To be sure, no cacophony can be expected if we eliminate dissonant models.

Following these premises, I will concentrate my comments on two points of Kecmanovic’s paper, because they are both related to the fundamental epistemological question that his article raises: how a scientific psychiatry should be conceived? The first point is related to Kecmanovic’s question about the place of psychiatry within the Kuhnian model: is psychiatry a pre-paradigmatic activity? The second one will focus on perspectivism starting from the ideas about psychopathology as a scientific discipline in the scripts of his founder, Karl Jaspers.

Kecmanovic (in press) rightly notes that psychiatrists (and, in general, mental health workers) hold sectarian models which are taken for granted and that are incommensurable to the rival ones; that they are close to information coming from other sources different from the proper school of thought; that they reconstruct the history of the discipline in accordance with their own model; that they are almost impermeable to the critics to their model (the proper weak points are usually not discussed and the validity of their model is never questioned); that they often write polemic papers against rival theories; that once having embraced a model, they rarely change side and that if they do it, it is more for “external” than for theoretical reasons. Well, this is exactly the picture of the state of affairs in a pre-paradigmatic phase, according to Kuhn’s (1962) model. Accordingly, “taken as a whole the disciplines concerned with the mind and with mental pathologies do not constitute a mature science. While the various branches of medicine are all subtended by a common basic science grounded on a unique and shared view of the human body functioning, the various disciplines studying the mental phenomena are based on different theoretical principles, see their field of study from different viewpoints, use different techniques of inquiry and presuppose interpretations and solutions which are widely heterogeneous” (Aragona 2006, p.34). However, having defined psychiatry as a pre-paradigmatic scientific activity according to the Kuhnian model of scientific development, we risk to pass unnoticed a fundamental assumption. In fact, the implicit idea is that psychiatry should conform to this model and that its current position is that of an immature science that in the future will be based on a unique scientific paradigm. This process will let all the other perspectives on the matter to progressively disappear from the scientific debate, being reconceptualized as non-scientific or proto-scientific cultural forms. This is the faith accompanying from its beginning any somatological

theory about mental illness (see on this Berrios & Marková 2002, particularly the technological alibi used to reassure the researchers and to maintain unaltered their foundational belief), so we are again reintroducing a covert reductionist assumption: there are many perspectives and many models because psychiatry is not yet truly scientific, once it will become scientific only one model will survive and the others will be eliminated from the scientific debate as no more pertinent. Is it a correct picture of psychiatry, or at the opposite the peculiar object of study of our discipline (the mental suffering of the human being) cannot in principle be fully reduced to the materialistic study of his brain? The plurality of models is a transient phenomenon, or the multi-perspectivist approach is intrinsic to psychiatry and thus unavoidable? Let us introduce here the methodological reflections of Karl Jaspers about the need of perspectivism in psychopathology. In Jaspers' view, the human being is the *Umgreifende*, "the encompassing that we are", of which a complete knowledge is and will always be impossible: "The individual as a whole never becomes an object which can be known. Human life cannot be systematized. Whatever the complete unity in which we think we have caught the individual, he himself has always escaped us" (Jaspers 1963, p.767). This does not contradict that the biomedical methods are fundamental in the explanation of psychopathological phenomena and that, as Kecmanovic remembers, they can coherently say something regarding any psychopathological phenomenon¹. However, psychopathology cannot be reduced only to the somatic medicine. According to Jaspers, "In fact the methods of almost all the Arts and Sciences converge on psychopathology. Biology and morphology, mensuration, calculation, statistics, mathematics, the Humanities, sociology, all have their application. This dependence on other branches of learning and the proper taking over of their methods and concepts are both matters of some importance to the psychopathologist, who is concerned with the human being as a whole and more especially the human being in time of sickness" (Jaspers 1963, p.36). These are the methodological roots of Jaspers' perspectivism in scientific psychopathology. Basically, the idea is that "The life of the human individual as a whole, if it is to be known scientifically, demands that all these methods be used and yet they cannot comprehend it entirely. But it would narrow psychopathology down too much if the scientific approach were confined to any one particular kind of testability. We should not try to reduce science to an isolated plane of similar knowable facts. Any one specific method provides the possibility for some knowledge of a scientific character" (Jaspers, 1963 p.769).

The most famous distinction in Jaspers' work is that between explaining biomedical causal relationships and understanding psychological motivations, a distinction that refers in different terms to the same Mind-Body problem acknowledged by Kecmanovic as a key problem in psychiatric controversies. However, the main point of perspectivism cannot be reduced only to this problem, because the thesis is epistemological² and more general. Reduced to its skeleton, it asserts that: a) a unique point of view can never be satisfying to study psychopathology; b) any perspective has its own scientific method and should not improperly transcend its own limits; c) any perspective studies scientific facts from its theoretical point of view, and thus "mere" facts independent from the theoretical perspective do not exist³; d) one can choose this or that perspective depending on its research interests, on the clinical relevance and so on (see on this the work of Schwartz and Wiggins quoted by Kecmanovic).

In conclusion, psychological perspectivism and pragmatism (intended as choosing this or that model depending on the relevance of specific scientific/clinical questions and on the most appropriate model to answer) are not two distinct models but two faces of the same medal. For those who accept the basic principles enlisted above, some possible shortcomings like those considered in Kecmanovic's work are avoidable: a) they value the interdisciplinary dialogue because they believe that many perspectives are all legitimate and complementary; b) they do not use all the perspectives contemporarily but choose the most appropriate(s) depending on the specific situation under study (thus avoiding both confused eclecticism and forced coexistence of models in any case); c) although utility is very important in a practical discipline like psychiatry, the notion of relevance does not need to be confined to it, depending more largely on the clinical and research questions.

Does it resolve Kecmanovic's problem? I think that the answer is not, because in his script the core of the difficulty (what should we mean by "scientific"?) remains controversial, divided as it is between two different views. At one side, the need of a unique, widely accepted, convincing and unequivocal psychiatric supermodel (Kecmanovic in press), as well as a unique agreed-upon definition of mental disorder (Kecmanovic 2011). Those who propose similar views usually do not accept to confine their work to the construction of a conventionalist consensus, they look for scientific models able to study nature as it is, to enucleate real diseases and to explain their real etiology. At the other side, Kecmanovic's clinical wisdom reminds us that "all those who have read the history of psychiatry know quite well that nothing is durable in the world of

¹ Jaspers writes that on this respect explanation is unlimited. However, in his view this does not apply to all the other methods, psychological understanding being for its nature limited.

² Due to reasons of space I do not consider here the ontological level, which in Jaspers himself is particularly problematic.

³ This idea of a theory-ladenness of scientific observations was already present in Jaspers' perspectivism and is in line with later epistemological work on it (e.g., Kuhn)

psychiatric ideas” (Kecmanovic, in press). Those who study the historical development of psychiatric concepts acknowledge that each historical period constructs its own psychiatric object of inquiry in terms of social, moral and aesthetic criteria (Berrios 2006); that even the current “atheoretical” mental disorders have been constructed “in a particular place (North America), in a particular era (the second half of the Nineteenth Century), in a particular cultural milieu (the encounter of neokraepelinian and neo-empiricist psychiatrists) and in reply to particular challenges” (Aragona 2009b, p.12); that the supposed observational basic stones of our nosography (the mental symptoms) are also constructed in the “emotional and epistemological” partnership between helper and sufferer “by the unique act of attaching meaning to certain experiences and behaviours” (Berrios 2006, p.471). Thus, in the end the tension is between a realist model that sounds scientific but is historically untenable, and a constructivist model which is better corroborated by the historical inquiry but that by acknowledging the unavoidable role of hermeneutics risks to be perceived as anti-scientific and radically relativistic. Maybe the time for a scientific constructivism reconciling these epistemological poles has come.

REFERENCES

1. Andreasen NC: *Changing concepts of schizophrenia and the ahistorical fallacy*. *American Journal of Psychiatry* 1994; 151:1405-1407.
2. Aragona M: *Aspettando la rivoluzione. Il DSM-V e oltre: le nuove idee sulla diagnosi tra filosofia della scienza e psicopatologia*. Editori Riuniti: Rome, 2006.
3. Aragona M: *Il mito dei fatti. Una introduzione alla filosofia della psicopatologia*. *Crossing Dialogues*: Rome, 2009a.
4. Aragona M: *The concept of mental disorder and the DSM-V*. *Dialogues in Philosophy, Mental and Neuro Sciences* 2009b; 2:1-14.
5. Berrios GE & Marková IS: *Conceptual issues*. In: D’haenen H, den Boer JA & Willner P. (Eds) *Biological Psychiatry*. John Wiley & Sons: Chichester, UK, 2002.
6. Berrios GE: *Introduction: the philosophies of psychiatry – conceptual history*. *History of Psychiatry* 2006; 17:469-486.
7. Jaspers K: *General psychopathology*. University of Chicago Press: Chicago, Illinois, 1963.
8. Kecmanovic D: *Why the mental disorder concept matters*. *Dialogues in Philosophy, Mental and Neuro Sciences* 2011; 4:1-9.
9. Kecmanovic D: *Conceptual discord in psychiatry: origin, implications and failed attempts to resolve it*. *Psychiatria Danubina* (in press).
10. Kuhn TS: *The structure of scientific revolutions*. University of Chicago Press: Chicago, 1962.
11. Kupfer DJ, First MB & Regier DA: *A research agenda for DSM-V*. American Psychiatric Association: Washington DC, 2002.
12. Wilson EO: *Consilience: the unity of knowledge*. Knopf: New York, 1998.
13. Kecmanovic Dusan: *Controversies and Dilemmas in Contemporary Psychiatry*. New Brunswick: Transaction Publishers, 2011.

Massimiliano Aragona

Professor of Philosophy of Psychopathology, Sapienza University of Rome, Philosophy Department, Rome, Italy

MENTAL DISORDER: FROM CACOPHONY TO CARTOGRAPHY VIA THE OXFORD SCHOOL

Dušan Kecmanović’s comprehensive review expertly summarises recent attempts by psychiatrists to define the concept of mental disorder. But there is a challenge implicit in his description of these attempts as a cacophony. In this brief commentary I outline a response to that challenge.

The response is essentially this: the problem of how mental disorder should be understood is a conceptual problem; there are resources for tackling conceptual problems in the Oxford School of linguistic-analytic philosophy; these resources show the different definitions described by Kecmanović as a cacophony, to be instead different parts of a complex map of meanings; a practical spin-off from this cartographic understanding of mental disorder is values-based practice; values-based practice links psychiatric science with the diverse needs of individual patients and their families.

Mental disorder as a conceptual problem

Psychiatry is unique among medical sciences in the extent to which the problems it faces are not just empirical (concerned with deriving data) but also conceptual (concerned with how we organise and make sense of data). At the heart of the conceptual problems of psychiatry as Kecmanović’s review so vividly shows is how mental disorder itself should be understood.

The new field of philosophy of psychiatry has developed as a response to the combined conceptual and empirical nature of psychiatric science (Fulford et al. 2003). Major areas of theory include the philosophy of mind and the philosophy of science to both of which Kecmanović refers in his review. Also important is phenomenology. Less well known perhaps but more directly relevant to understanding Kecmanović’s cacophony of mental disorder, is linguistic analysis.

Linguistic Analysis and the Concept of Mental Disorder

Linguistic analysis is a way of tackling conceptual problems that was developed in the middle decades of the 20th century by a group of philosophers working mainly in Oxford - hence it is often called 'the Oxford School'.

As a branch of analytic philosophy, linguistic analysis might be thought to be somewhat remote from the contingencies of day-to-day clinical work and research. But linguistic analysis includes a number of key ideas linking philosophical theory with psychiatric practice (Fulford 1990). Just three of these ideas are sufficient to support a cartographic understanding of mental disorder: 1) the distinction between higher- and lower-level concepts; 2) the limits of definition; and 3) logical geographies.

1) Higher- and lower-level concepts

'Mental disorder' is a higher-level concept in the sense that it subsumes a number of lower-level concepts. Thus 'mental disorder' subsumes for example 'delusion', 'phobia', 'obsession' and other psychopathological concepts. Each of these in turn subsumes still lower-level concepts: 'delusion' subsumes specific kinds of delusion such as 'delusion of control', 'grandiose delusion' and 'delusional mood'. Conversely, 'mental disorder' and 'bodily disorder' are both subsumed by the still higher-level concept of 'disorder'.

This rough ordering into higher and lower levels is a feature of all concepts. The everyday concept of 'time' for example, is a higher-level concept which subsumes 'clock', 'watch', 'minute', 'hour', 'rhythm' and so forth. Each of these concepts in turn subsumes even lower-level concepts: 'watch strap' for instance is subsumed by 'watch' which is in turn subsumed by 'time'.

The limits of definition

Understood linguistic-analytically therefore the problem of defining mental disorder is not just a conceptual problem but a problem involving a higher-level rather than lower-level concept. Why does this matter? It matters because a further insight of linguistic analysis is that definition itself although often helpful as a way of clarifying the meanings of lower-level concepts breaks down with higher-level concepts.

The breakdown of definition with higher-level concepts explains Kecmanović's cacophony. The method of definition has been used successfully by psychiatrists in defining lower-level psychopathological concepts - particular kinds of delusion, phobia, etc., as in the PSE for example (Wing, Cooper and Sartorius, 1974). But such successes have led to the mistaken idea that definition can be applied equally effectively to higher-level psychopathological concepts. There are many varieties of definition of course: seven distinct varieties useful in different ways in psychiatry are

described in *The Oxford Textbook of Philosophy and Psychiatry* (Fulford, Thornton and Graham, 2006, pages 65/66). But Kecmanović's cacophony is sufficient evidence that definition as a whole breaks down when applied to the higher-level concept of mental disorder.

Again, it is important to be clear that the breakdown of definition with higher-level concepts is not special to psychopathology but applies to concepts of any kind. Thus, the lower-level concept of 'watch' for example, can be defined readily enough as 'a small instrument normally worn on the wrist and used for measuring time'. Whereas by contrast the definition of the higher-level concept of 'time' has eluded the best minds in philosophy and mathematics (and latterly in theoretical physics) for over two thousand years!

But now notice this. The definition of 'watch' just given depends on the concept of time (recall that 'watch' is subsumed by 'time'). So we are able to define the lower-level concept of 'watch' only because we are able to use the higher-level concept of time (in contexts of this kind) yet without being able to define it.

2) Logical geographies

The Oxford School recognised in our ability to use higher-level concepts a basis for exploring their meanings. The idea was that rather than just passively reflecting on the meanings of such concepts (as when we try to define them) we should actively explore how the concepts in question are actually used.

J. L. Austin, perhaps the clearest exemplar of this look-and-see way of doing philosophy, called it philosophical 'field work' (Austin 1956/7, 1968 edition, page 25). The idea behind philosophical field work is that what goes wrong when we try to define higher-level concepts is that we get stuck with a partial or incomplete view of their meanings - like being able to see only a local and limited part of what another Oxford philosopher, Gilbert Ryle (1949; 1963 edition, page 10), called their complex 'logical geographies'. Philosophical field work correspondingly provides a more complete view of the logical geography of a higher-level concept.

Ryle's metaphor of a logical geography thus gives us by extension a cartographic understanding of the work reviewed by Kecmanović. Understood on the one hand as competing attempts to define mental disorder this work is indeed cacophonous. Understood on the other hand linguistic-analytically, the different definitions of mental disorder described by Kecmanović each reflect different parts of the overall logical geography of the concept of mental disorder.

Using the map in practice

This cartographic understanding of mental disorder differs from both eclecticism and pluralism (as reviewed by Kecmanović) in being strongly theoretically grounded. It is closer to David Brendel's pragmatism (also

reviewed by Kecmanović): both are theoretically grounded (albeit differently) and both are in Brendel's terms practical, pluralistic, participatory and provisional. Linguistic analysis though with the development of what has become known as values-based practice takes psychiatry a step closer to an approach that as Kecmanović (page xx) requires 'respects the complexity of human beings'.

Values-based practice as its name implies is a partner to evidence-based practice. Based directly on Austinian philosophical field work (Fulford 1989, Colombo et al. 2003), values-based practice provides a process for matching the generalised research evidence supplied by evidence-based practice to the unique values – the unique needs, wishes, preferences and so forth – of individual patients. The first training manual for values-based practice, called 'Whose Values?', was developed jointly with service users (Woodbridge & Fulford 2004). The approach has subsequently been applied across a range of policy and service development initiatives in mental health (see websites below) and is currently being extended to other areas of health care (Fulford, Peile and Carroll, forthcoming).

Conclusions: Psychiatry First

In this commentary I have outlined some of the resources from the Oxford School of linguistic-analytic philosophy for responding to Kecmanović's challenge as a straight challenge to interpretation. His challenge though is tendentious. It implies that where psychiatry is cacophonous the rest of medicine is not.

A linguistic-analytic understanding reverses this 'psychiatry second' implication. It underlines the fact that the concept of 'bodily disorder' is no more readily definable than that of 'mental disorder': Kecmanović rightly reminds us that the biopsychosocial model was proposed originally by a gastroenterologist (George Engel) who illustrated it with a case of myocardial infarction; and a large part indeed of the debate about mental disorder can be shown to turn on differences of view about the meaning of bodily disorder (Fulford, 1989, chapter 1). Certainly, 'mental disorder' is the more problematic in use. But this shows only that psychiatry is a science like theoretical physics at the very edge of understanding. Psychiatric science moreover deals not as physics deals with particles but

with people. With the development of values-based practice therefore and its current extension into other areas of health care, a linguistic-analytic understanding of mental disorder replaces Kecmanović's 'psychiatry second' with a 'psychiatry first' in linking science with people.

REFERENCES

1. Austin, J.L. (1956-7) *A plea for excuses*. *Proceedings of the Aristotelian Society* 57:1-30. Reprinted in White, A.R., ed. (1968). *The Philosophy of Action*. Oxford: Oxford University Press, pps 19-42.
2. Colombo, A., Bendelow, G., Fulford, K.W.M., and Williams, S: *Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams*. *Social Science & Medicine*, 2003; 56:1557-1570.
3. Fulford, K.W.M. (1989, reprinted 1995 and 1999) *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press.
4. Fulford, K.W.M.: *Philosophy and Medicine: The Oxford Connection*. *British Journal of Psychiatry*, 1990; 157:111-115.
5. Fulford, K. W. M., Morris, K. J., Sadler, J. Z. and Stanghellini, G. (eds.) *Nature and Narrative: an Introduction to The New Philosophy of Psychiatry*. Oxford: Oxford University Press, 2003.
6. Fulford, K.W.M., Thornton, T., and Graham, G. *The Oxford Textbook of Philosophy and Psychiatry*. Oxford: Oxford University Press, 2006.
7. Fulford K.W.M., Carroll, H and Peile, E (forthcoming), *Essential Values-based Practice: Linking Science with People*. Cambridge: Cambridge University Press.
8. Ryle, G. (1949; Penguin Books, 1963) *The Concept of Mind*. London and New York: Penguin Books Ltd.
9. Wing, J. K., Cooper, J.E. and Sartorius, N: *Measurement and classification of psychiatric symptoms*. Cambridge: Cambridge University Press, 1974.
10. Woodbridge, K., and Fulford, K.W.M. 'Whose Values?' *A workbook for values-based practice in mental health care*. London: The Sainsbury Centre for Mental Health, 2004.

For information about conferences and other activities in the *Philosophy of Psychiatry*, see: *International Network for Philosophy and Psychiatry*: <http://www.inpponline.org/>

For information about values-based practice and a reading guide, see: http://www2.warwick.ac.uk/fac/med/study/cpd/subject_index/pmh/vbp_introduction/

K.W.M (Bill) Fulford

*Professor of Philosophy and Mental Health in the Medical School
and the Department of Philosophy, University of Warwick, England*

CHAOS THEORY OR TOLERANCE OF UNCERTAINTY

The profession of psychiatry, both in Australia and in many other countries is examining, thinking about, philosophising on its nature, and in many ways its future. Some anxieties underline this as they do for many specialities within the field of medicine – for instance ophthalmology and the rise of non-medical specialist in optometry; the battle for obstetrics between obstetrician and the holders of this territory of old, the midwives. For psychiatrists, who have moved to make mental health (or indeed “mental illness”) “everybody’s liveness”, they now find that not only their colleagues of old, psychologists, but also their colleagues, psychiatric nurses, social workers, non-government agency and carers are progressing their share of “the actions”. Many of these uncertainties are fuelled by antagonists, antipsychiatry movements. They also arise in the lack of full knowledge, based on good science, of the bases of many disorders, and the ongoing evolution of their categorical definitions. The development of DSMV, ICD II symbolise this. The practitioner, particularly if working alone, may see these changes, the demands of continuing professional education, the exponential development of pharmacological agents, and the righteous requirements for evidence based practice, as controlling and shaping his or her professional role, and the nature of psychiatry.

Dusan Kecmanovic’s paper identifying the uncertainties of, and conflict between, conceptual models as a basis for psychiatry is very timely. He explores the models that have evolved and their validity or the lack thereof, and hence the lack of a sound conceptual basis for practice. He discusses the commonly accepted biopsychosocial ‘model’ which is seen as an attempt to address all or several models in the one context, which he sees as failing. Some may disagree with his view on this. Evolving science, such as that dealing with gene-environment interactions, integration studies, and the technologies that so vividly depict the neuroanatomy, neurophysiology and neurochemistry of thinking, emotions, love and grief, may bring brain, mind, human nature, and humanity into acceptable conceptual understandings.

Many challenges face medicine more broadly: scientifically, ethically, morally. Psychiatry is increasingly linking into its medical background in ways that range from service systems of consultation liaison care, the role of depression in heart disease, through to psychiatric roles in emergency departments.

It is increasingly listening, assessing, acting, working with others and helping people with mental illnesses to recover and function in their lives. Psychiatric care has advanced vastly in Dusan’s and my own lifetimes. So perhaps we run the risk of undervaluing what has been achieved in this amalgam of conceptual frameworks guiding what we do.

As noted in this interesting paper, one of our great challenges is that our professional terrain is of the brain, and of the mind, and we believe we have to answer the eternal question of this, to make concrete, this human magic. And linked to these complex issues may be, as he suggests the many ideologies that may capture us: those of our teachers and leaders; those of our time; those that fit our beliefs; that excite our hopes. Like the science that informs our professions, knowledge is constantly expanding, is new, disappointing, exciting, everyday. It is impossible to keep up, and this may add to our insecurities. We think and philosophise, we seek to find the answer; a unifying single concept. Perhaps this is the dream that drives our thinking, as it does with physics, one answer, the gold, that makes the “bits”, the mosaic of life and living whole.

It is of interest, too, that others challenge the conceptual basis of mental illness and psychiatry and continue to question. Thomas Szasz’s writing this year reiterates his view about the concept of mental illness per se, views he has held for 50 years.

Ultimately of course the challenge is tolerating, living with and valuing uncertainty. It gives space, room for consideration, the nurture of questioning, thinking, feeling, exploring the options of possibilities; the potential for the future, the birth and fulfilment of hopes. And perhaps this uncertainty is a great gift for psychiatry, one we should value, nourish, build into thinking, stories, science, so as to better define and understand the continually evolving nature of the human species. We can develop science, wisdom and belief to address the challenges for person, people, society through birth, childhood, adulthood, old age and across diverse populations, as they struggle to overcome the suffering of diseases of the brain, the mind and the socioecological domains that we and they inhabit.

REFERENCES

1. Szasz, T: *The Myth of Mental Illness: 50 years later. The Psychiatrist. 2011; 35:179-182.*

Beverley Raphael

*Professor of Population Health and Disasters
Medical School University of Western Sydney, Australia*

RECLAIMING OUR ROLE AS HEALERS: A response to prof. Kecmanović

“My friend, your plan may work perfectly in fact, but it will never work in theory!”

One diplomat overheard chastising a colleague

“All creatures in this world are plagued by nothing other than suffering... disturbing the mind.” -

Ajahn Chah, in Living Dhamma

Like some diplomats, we professorial types often ruminate on important but rather abstract and theoretical issues. We are sometimes surprised when we learn that the general public is not nearly so preoccupied with these issues. In my view, the matter of psychiatry's diverse “conceptual models” - very thoughtfully analysed in Prof. Kecmanović's scholarly essay - is one such academic issue.

This is not to deny the potential benefits of a clinically useful, integrated model of mental function and dysfunction (Ghaemi 2003, Stein 2008, MacKinnon 2011) - perhaps emerging as a discipline I have called “encephiatrics” (Pies 2005). I also accept the view that our conceptual models may - and sometimes do - directly affect the outcome of our clinical care and treatment. Finally, there is little doubt that our conceptual models influence the direction (and funding) of psychiatric research.

And yet, and yet: I believe that the most pressing problems besetting American psychiatry do not stem primarily from the lack of a coherent “conceptual model.” Nor does Prof. Kecmanovic's “conceptual cacophony” greatly impede the conscientious psychiatrist's ability to do good, sound clinical work, on a day-to-day basis (Pies, 2010a). The lack of a univocal conceptual model does not mark psychiatry, in neo-Kuhnian parlance, as a “failed science” (McLaren, 2010), nor has psychiatry's profusion of conceptual models prevented significant advances in integrative research and treatment. For example, Dr. Aaron Beck recently summarized emerging evidence that “...the combination of a hyperactive amygdala and hypoactive prefrontal regions is associated with diminished cognitive appraisal and the occurrence of depression (Beck 2008).”

I believe psychiatry's main problem is that it has not sufficiently realized its primary ethical and clinical imperative: the relief of particular types of human suffering and incapacity. When we succeed in that endeavor, I would wager that any conceptual cacophony will recede to mere background noise - at least, for the general public and most clinicians. Finally, I want to advance the counter-intuitive claim that some of the “cacophony” in our conceptual disagreements belies a healthy and productive creative tension; and that, in some instances, psychiatry's sharp, internal divisions have actually inspired useful new treatment approaches.

Of course, it may be argued that psychiatry's lack of a single, unified conceptual model is itself the reason why our progress in reducing emotional suffering has been limited. This is a superficially plausible claim, similar to themes developed by some historians of culture and science. Thus, historian Henry Bamford Parkes observes that, “The happy and productive periods in the history of the West have been characterized by implicit faith in some general “frame of acceptance...” such as the frame of representative government in the 19th century (Parkes 1959). This “frame of acceptance” corresponds roughly to the concept of a scientific “paradigm” made famous by historian Thomas Kuhn. While any critique of Kuhn is beyond the scope of this commentary, the following may be stated with some confidence: the history of science and medicine are replete with examples of important discoveries and advances that occurred either in the absence of a preeminent conceptual model, or in direct opposition to it (roughly akin to Kuhn's “revolutionary science”). As the historian of science, Prof. Frederick Gregory, recently observed,

“... if history is our guide... a unified model is not necessary for (scientific) progress to occur. Perhaps the most glaring example from the biological sciences is the history of our understanding of evolution. Most (people) don't realize how contentious the field was until the appearance of the evolutionary synthesis of the late (19)30s and 40s... Yet look at how much was accomplished in the midst of these arguments by the laborious efforts of (researchers) in cell theory and genetics... Only because of their work was it possible (for the) fields of biology, paleontology and population genetics... (to) come together with molecular biology in the 1940s, to...(produce a) unified view...” (F. Gregory, PhD, personal communication, 6/26/11).

In psychiatry, several critically important advances occurred in the absence of - or in frank opposition to - a dominant theoretical model of the mind or mental illness. Thus, John Cade's discovery (ca. 1949) of lithium's anti-manic effects did not arise from his (or anyone's) embrace of a univocal, conceptual model of mental illness, but from Cade's idiosyncratic experiments with guinea pigs! As historian Edward Shorter puts it, “Cade had stumbled into a discovery of staggering importance...” at a time when general medicine was focused on the cardiotoxic side effects of

lithium (Shorter 1998). Similarly, the revolutionary advance in our treatment of psychosis, as a result of chlorpromazine, arose from the efforts of the French surgeon, Henri Laborit, who was researching the calming effects of phenothiazine-antihistamines. Laborit did not require any over-arching “conceptual model” of psychosis or mental illness. Indeed, as Canadian psychiatrist Heinz Lehmann colourfully put it, during Laborit’s era, “...no one in his right mind in psychiatry was working with drugs. You used shock or various psychotherapies.” (Lehmann 1998). Almost contemporaneous with these developments, psychologist Albert Ellis and psychiatrist Aaron Beck developed their cognitive models of psychopathology as a direct result of disillusionment with the dominant psychoanalytic model.

Finally, let’s recognize that psychiatry is not the only field in medicine in which competing “conceptual models” exist. To cite but one example: in the field of pain management, “There does not exist an agreed-upon, unifying model of diagnosis and rehabilitation of pain-related occupational disability; rather, multiple, often competing and conflicting models currently operate...” (Schultz et al. 2000).

* * * * *

Prof. Kecmanović contends that “psychiatry abounds in conceptual models” and that this problem has contributed to the “tarnished image of psychiatry.” Alas, I agree that psychiatry has a “tarnished image” in several Western countries (Sartorius et al. 2010), and I will defer to Prof. Kecmanović as to why this may be so in Europe. However, with respect to the U.S, I believe psychiatry’s tarnished reputation has little to do with its profusion of conceptual models. Rather, our image problem results mainly from the perception that biological psychiatry is clearly the regnant “conceptual model”; and that various malign consequences have followed the overthrow of more humanistic models in psychiatry. On this view - baldly stated - biological psychiatry’s usurpation of influence has amounted to a *trahison des clercs*, with the following baneful effects:

- Psychiatrists have become mere “pill pushers”, having largely abandoned psychotherapy, and are uninterested in the patient’s inner life, psychological conflicts, etc.
- Psychiatrists are widely engaged in “medicalizing normality” by, for example, labelling ordinary grief as a “disorder”, labelling shy children as having “social anxiety disorder”, etc.
- Psychiatrists are unnecessarily medicating patients who are experiencing ordinary life stresses, existential dilemmas, or “problems in living.”
- Psychiatric medications are usually ineffective at best and harmful at worst.
- Psychiatrists have, by and large, have oversold the benefits of medication, and have colluded with the large drug companies (“Big Pharma”) in order to line their own pockets.

It is beyond the scope of this commentary to examine the validity of each of these claims; indeed, I do not fully endorse any of them, though I acknowledge that some contain more than a grain of truth. In any case, various versions of these claims have been proffered repeatedly by senior academic psychiatrists and other scholars in the U.S. (e.g., see Horwitz & Wakefield 2007, Szasz 2007, Carlat 2010, Frances 2010). A typical expression of these sentiments is provided by an American psychiatrist in private practice, Dr. Paul Minot:

“The prevailing biological model of psychiatry advances a view of mankind that reduces feelings to symptoms, dismisses thought altogether, and ignores human will - all in the service of an economically and scientifically corrupt industry geared toward the marketing of medical products. It promotes the fantasy of a quick fix for life’s problems, and buttresses this pipe dream with an elaborate body of pseudoscientific misinformation posing as medical fact.” (Minot 2011, italics added).

In my experience over the past 30 years, such perceptions are widespread, both in the general public, and among many psychiatrists. I do not believe these deprecatory views are merely “epiphenomena” of psychiatry’s failure to develop a unified conceptual model of the mind or mental illness. Rather, I believe these perceptions stem from a complex confluence of many factors, including but not limited to (1) Psychiatry’s inability, thus far, to develop robustly effective, well-tolerated treatments for several major disorders, such as schizophrenia, autism, and most of the severe personality disorders (despite our having effective treatments for bipolar disorder, panic disorder, etc.) (2) Psychiatry’s inappropriately close ties with the pharmaceutical industry in recent decades; (3) The decline in the use of psychotherapy among psychiatrists in the U.S., over the past decade (Mojtabai & Olfson 2008); (4) A lack of understanding, among the general public, of the risks and benefits of psychiatric treatments; for example, the erroneous belief that psychiatric medications are highly “addictive” or merely “cosmetic” in their effect (Sartorius et al. 2010); (5) Vituperative attacks on psychiatry by critics both within and outside the profession, often exacerbated by internet-based anti-psychiatry groups, and lurid depictions of psychiatry in the media (Pies et al. in press, Sartorius et al. 2010); and (6) Highly-publicized and often scathing critiques of the DSM-5 process and its underlying scientific premises, by well-known, senior psychiatrists (e.g., Frances 2010, Sadler 2011).

To be sure, this last issue is peripherally related to the “conceptual cacophony” Prof. Kecmanovic describes. However, I suspect that even the most coherent conceptual model would not greatly allay the public’s deep misgivings about psychiatry and psychiatrists.

So, in brief, what is required? On a concrete level, psychiatry needs to advance goals and initiatives that address each of the six factors noted; for example, by

(1) lobbying for more robust and better-funded research to develop more effective and better-tolerated treatments; (2) reducing the influence of pharmaceutical companies upon psychiatric education and practice; (3) ensuring that comprehensive psychotherapy training is a central part of psychiatric residency programs; (4) bolstering “outreach” and public education efforts, as well as improving communication with non-psychiatric physicians; (5) rebutting unwarranted attacks on psychiatry, while remaining receptive to constructive criticism from within and outside the profession; and (6) re-evaluating the policies, procedures of the entire “DSM” revision process, so as to avoid the debacles so widely criticized recently (Frances 2010).

On a more fundamental level, I believe we need to reclaim and reinvent our role as holistic healers - doctors who are as comfortable with motives as with molecules, and as willing to employ poetry as prescribe pills (Pies 2010b). When guided by sound evidence, this is not promiscuous eclecticism; but rather, polythetic pluralism. Most important, psychiatry must maintain a single-minded focus on our primary ethical and clinical mission: not the development of elegant conceptual models, but the relief of our patients’ profound suffering and incapacity (Knoll 2011).

REFERENCES

1. Beck AT: *The evolution of the cognitive model of depression and its neurobiological correlates*. *Am J Psychiatry*. 2008 Aug;165(8):969-77.
2. Carlat D. *Unhinged*. New York, Free Press, 2010.
3. Frances A: *Normality Is an Endangered Species: Psychiatric Fads and Overdiagnosis*. *Psychiatric Times*. July 6, 2010. Accessed 7/6/11 at: <http://www.psychiatristimes.com/dsm-5/content/article/10168/1598676>
4. Ghaemi SN: *The Concepts of Psychiatry*. Baltimore, Johns Hopkins, 2003.
5. Horwitz AV, Wakefield JC: *The Loss of Sadness*. Oxford University Press, 2007.
6. Knoll JL IV: *Psychiatry: Awaken and Return to the Path* - *Psychiatric Times*, March 21, 2011. Accessed 7/6/11 at: www.psychiatristimes.com/display/article/10168/182678.
7. Lehmann H. Quoted in: *Drug for treating schizophrenia identified, 1952. A Science Odyssey*. PBS/WGBH, 1998 Accessed 6/28/11 at <http://www.pbs.org/wgbh/aso/databank/entries/dh52dr.html>
8. MacKinnon DF: *Trouble in Mind*. Baltimore, Johns Hopkins University Press, 2011.
9. McLaren N: *Humanizing Psychiatrists*. Future Psychiatry Press, 2010.
10. Minot P: *Making sense of psychiatry*. Accessed 7/5/11 at: <http://makingsenseofpsychiatry.com/>
11. Mojtabai R, Olfson M, *National Office Trends in Psychotherapy by Office-Based Psychiatrists* *Arch Gen Psychiatry* 2008; 65:962-970.
12. Parkes HB: *The Divine Order*, New York, Alfred A. Knopf, 1969, p. 8.
13. Pies R: *Why psychiatry and neurology cannot simply merge*. *J Neuropsychiatry Clin Neurosci* 2005 (Summer); 17:304-9.
14. Pies R: *How “Objective” Are Psychiatric Diagnoses? (Guess Again)*. *Psychiatry (Edgmont)*. 2007 October; 4:18–22.
15. Pies R: *The Good Psychiatry Does: A Brief Review*. *Psychiatric Times*, Feb. 2, 2010a. Accessed at: <http://www.psychiatristimes.com/blog/couchincrisis/content/article/10168/1518165>
16. Pies R: *Psychiatrists, Physicians, and the Prescriptive Bond*. *Psychiatric Times*, June 2, 2010b. Accessed at: <http://www.psychiatristimes.com/dependent-personality-disorder/content/article/10168/1579874>
17. Pies R: *Has Psychiatry Really Abandoned Psychotherapy? Behind the New York Times Story*. *World of Psychology*. April 3, 2011. http://www.xydo.com/toolbar/17688488-has_psychiatry_really_abandoned_pschotherapy_behind_the_new_york_times_story
18. Pies R, Thommi S, Ghaemi N: *Getting It from Both Sides: Foundational and Anti-Foundational Critiques of Psychiatry*. *Bulletin of the Association for the Advancement of Philosophy and Psychiatry (AAPP)*, in press.
19. Sadler JZ, *Worrying About Greed*. *Psychiatric Times*, January 14, 2011. Accessed 7/6/11 at: http://www.psychiatristimes.com/dsm-5/content/article/10168/1778271?_EXT_4_comsort=nf
20. Sartorius N, Gaebel W, Cleveland H-R et al: *WPA guidance on how to combat stigmatization of psychiatry and psychiatrists* *World Psychiatry*. 2010 October; 9(3): 131–144.
21. Schultz IZ, Crook J, Fraser K: *Models of Diagnosis and Rehabilitation in Musculoskeletal Pain-Related Occupational Disability*. *Journal of Occupational Rehabilitation* (2000) 10: 271-293.
22. Shorter E: *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. Wiley, 1998, pp. 248, 255-56.
23. Stein DJ, *Philosophy of Psychopharmacology*. Cambridge, Cambridge University Press, 2008.
24. Szasz TS: *The Medicalization of Everyday Life: Selected Essays*. Syracuse, Syracuse University Press, 2007.

Acknowledgments

I would like to thank Prof. Frederic Gregory for his comments on the history of science; and Prof. James Phillips MD for his helpful critique of an early draft of this essay. However, all views expressed herein are my own.

Ronald Pies

*Clinical Professor of Psychiatry at Tufts University and
Lecturer on Psychiatry at Harvard Medical School, USA*

CONCEPTUAL CACOPHONY OR DIFFERENT PARTS OF A COMPLEX PUZZLE OF MENTAL DISORDERS: TRANSDISCIPLINARY HOLISTIC INTEGRATIVE PERSPECTIVE

Kecmanović's comprehensive review addresses some essential issues of contemporary psychiatry in a very challenging and thought-provoking way, but opens more questions than offers solutions. This topic is an important and timely issue, especially as it pertains to the upcoming release of DSM-V, the internationally influential diagnostic taxonomy for psychiatry.

What is needed now is an integrating framework that both explains existing knowledge and predicts future developments. My commentary will focus on paradigms and perspectives in contemporary psychiatry from transdisciplinary multilevel and multidimensional point of view.

Conceptual discord in psychiatry

Contemporary psychiatry has not yet been a coherent field of scientific theory as well as one unified and standardized practice (Jakovljević 2007, 2008). It is more an aggregative collection of different branches established on a loosely assembled set of various kinds of theoretical concepts about etiopathogenesis, conditions and meanings associated with mental disorders, all based on different kinds and strengths of evidence and it is being practiced in various ways with different treatment results. Many of the psychiatric schools, not only do not accept, but criticize the most basic tenets and treatment principles of the others. It is of great importance for further scientific credibility, professional maturation of psychiatry and increasing treatment efficiency to integrate neurobiological, intrapsychic, interpersonal, cultural, societal and spiritual processes in diagnostic and therapeutic considerations.

The holistic and integrative psychiatry as wishful theory and practice have been catchphrase and mantra repeated by many psychiatrists for many years, but still there has been no unified and generally accepted coherent theory of integration, nor has a practical clinical methodology for combining disparate treatment approaches been advanced. The biopsychosocial model has become the mainstream concept of the present-day psychiatry, but it is not fruitful enough because it is excessively broad and provides no real guidance to clinicians and researchers. Integration trends in psychiatry have progressed over the last 50-60 years from a rather singular emphasis on the integration of particular theories and therapeutic approaches, to parallel emphasis on the multiple actual process and principles of systemic integrating apparently disparate points of view and clinical methods (pluralism of Leston Havens, integrationism of Edward Hundert's neurobiology – see Ghaemi 2003; integrative mental health care of Lake).

Psychiatry should move from a pluralistic aggregative coexistence of many disciplines to a coherent transdisciplinary and comprehensive mental health science and practice.

Blessing or course

Kecmanovic is quite right: There are a great many concepts, theories and models in contemporary psychiatry. For pessimists and close minded psychiatrists that is a curse of conceptual cacophony. For optimists and open minded psychiatrists that is a blessing of different fragments of a complex puzzle of mental disorders. The multitude of current theories and models might be viewing different aspects of mental disorders, like in the story about six blind men groping an elephant in a dark room and coming up with the varying descriptions. From transdisciplinary holistic integrative perspective based on systems thinking it is quite possible that the vast majority of existing theories and models may be conceptually linked. Doing so can in essence allow psychiatry to get a better picture of the fabled (proverbial) elephant, or at least for the "blind men to begin talking to each other through dialogue instead through discussion, concussion and percussion.

Mental disorders appear complex, dynamic, unique and mostly obscure. These four characteristics refer also to what is termed mental health. Probably the major share of mental health reality as well as of reality of mental disorders remains hidden from direct detection by our senses. Scientific instruments are being developed to enable us to probe more deeply into brain, see ever tinier particles of matter and, through functional magnetic resonance imaging (fMRI), observe how regions of our brains are activated as we think, but the vast majority of our mental functions remain mysteriously hidden from direct view. A person's mind, the inner world of thoughts and feelings that presumably guide much of our behaviour, is one of the most obscure realms of all (Jaccard & Jacoby 2010).

Concepts, theories and models: the building blocks of understanding

Confronted by the field of complex, dynamic, unique and mostly obscured phenomena of mental disorders, how do psychiatrists and mental health researches manage to make sense out of mind-body-spirit world of psychiatry? To paraphrase Jaccard and Jacoby (2010) they do so by conceptualizing, that is, by using their mental processes to consider and sort their experiences and scientific results in terms of the

concepts they have acquired and stored in personal and collective memory. They also develop new concepts to describe things they had never previously experienced. "Concepts are the building blocks for all thinking, regardless of whether that thinking occurs in the context of everyday living, art, politics, sports, religion, or science... It is our concepts that enable us to achieve some basic understanding of the world" (Jaccard & Jacoby 2010). The most basic levels of understanding can be termed identification and classification. We understand something, in part, when we can identify and classify it. This is schizophrenia, that is bipolar affective disorder, etc. Schizophrenias differ in a great number of ways, in terms of onset, clinical pictures, course, treatment response, outcome. It is also the case with bipolar affective disorders, depressions, anxiety disorders and all other mental disorders. It is important to have in mind that concepts are generalized abstractions which encompass universes of possibilities, they are hypothetical, selective constructions, socially shared, reality oriented or functional, and at last, but not the least, most concepts are learned (Jaccard & Jacoby 2010). Hermeneutics as an explanatory framework of mental disorders claims that there are no objective facts but only varying interpretations of the subjective meaning of information (Lake 2007). Many concepts, theories and models are not competing ones, so the transdisciplinary use of two or more concepts in parallel in complementary and synergistic way is not only reasonable but also very useful in psychiatric treatment.

Multilevel and multidimensional modeling and person-centered theorizing: transdisciplinary holistic integrative psychiatry

There are many ways of thinking about the world, mental health and mental disorders.

Psychiatry, as a field of theory and practice, rests on philosophical questions and assumptions associated with historically influential systems of thought, like materialism, structuralism, functionalism, symbolic interactionism, evolutionism, humanism, systems theory and postmodernism. According to Ghaemi (2003), it is committed to certain views regarding what there is (mind-brain theories), how we know what we know about psychiatric realities (epistemology), and what we value (ethics). At conceptual level today's psychiatry can be divided in four approaches: dogmatic, eclectic, pluralist and integrationist (see Table 1).

Kecmanović's review still includes David H. Brendel's pragmatism with the four major approaches: practical, pluralistic, participatory, and provisional. At phenomenological level psychiatry has several partial or fragmentary identities related to its biologic, psychodynamic, and social subspecialties with many psychiatric schools. Which approach one espouses on these matters has important practical consequences (Ghaemi 2003). Dogmatists rigidly take one position or the other

in a reductionistic way: either neuroscience explains everything, or some psychological theory explains everything. Eclectists escape to take a firm position, simply claiming that it is all very complex. Pluralists agree with dogmatists in claiming that specific methods need to be applied purely, but they agree with eclectics that no single method is sufficient. Integrationists seek to describe a single approach that bridges the subject-object gap, but they are not limited to one approach, as in the various dogmatic schools "(Ghaemi 2003). Most psychiatrists are dogmatics in practice claiming to be eclectic in theory. The pluralist and integrationist concepts are the most promising. My preference is pluralistic, multilevel and multidimensional, person-centered theorizing approach that I use to note as transdisciplinary holistic integrative psychiatry.

Table 1. The Conceptual Status Quo in Psychiatry (Ghaemi 2003)

1. Dogmatism
▪ biological reductionism
▪ psychoanalytic orthodoxy
2. Eclecticism
▪ biopsychosocial model (Adolf Meyer, George Engel)
▪ agnosticism (DSM-III onward)
3. Pluralism
▪ Karl Jaspers's methodological consciousness
▪ Leston Havens's approaches to the mind
▪ Paul McHugh and Philip Slavney's perspectives of psychiatry
4. Integrationism
▪ Edward Hundert's Hegelian neurobiology
▪ Eric Kandel's neuroplasticity

Psychiatry: multi-paradigmatic or pre-paradigmatic

Disparate psychiatric branches are rooted in different modern and postmodern philosophical and scientific view points about the nature of human beings and the nature of psychiatric problems (see Raden 2004, Fulford et al. 2006, Jakovljević 2007, 2008). Their disparate diagnostic and treatment procedures emanate from applied mechanistic, formistic, contextual or systematic ways of information processing, thinking and understanding of mental health and mental disorders (Jakovljević 1996, 2007). Contemporary clinical psychiatry rests on a simplified form of Cartesian dualism that posits two fundamentally irreducible ontological categories: a physical body/ brain and an embodied nonphysical soul/mind (Lake 2007). Four hierarchically related paradigms embodying different assumptions about phenomenological nature of mental health and mental disorders can be recognized: the body paradigm, the mind-body paradigm, the body-energy paradigm and the body-spirit paradigm (Tataryn 2002).

Table 2. Seven Complementary Perspectives of Transdisciplinary Holistic Integrative View on Psychopathology and It's Treatment (modified McHugh & Slavney 1998)

Perspective	Basis assumptions	Practical implications
1. Disease Energy <i>What the patient has.</i>	Mental disorders are clinical manifestations of brain structure or function abnormalities. Energy resides at the most fundamental level of being. Psychological problems can be understood as manifestations of energy disruptions or energy fields/configurations symptoms.	Treatment corrugates altered neuroplasticity and brain dysfunction eliminating symptoms. Energy disruptions can be precisely diagnosed and treated. Psychopathology can be treated by addressing subtle energy systems in body
2. Dimensional Stress-diatheisis Vulnerability-resilience <i>What the patient is.</i>	Causes of mental disorders are the same stresses that affect all people, but result in cognitive or affective symptoms because of their relative level of intellectual or emotional functioning.	Distress and resulting symptoms are not „cured“ but avoided, Treatment involves cognitive skills training to improve future coping strategies (cognitive-behavioral therapy, supportive psychotherapy)
3. Cognitive <i>How the patient thins.</i>	Pathological behavior is related to conflicting cognitive strategies Misrepresentations and values. The much of mental disorder is created by errors or biases in thinking because our thoughts are main determinants of our actions.	Cognitive therapy converts maladaptive cognitions to more adaptive and useful strategies. When wrong, negative, self-limiting and self-defeating thoughts, beliefs or values are corrected mental health can be established again
4. Behavioral-Environmental <i>What the patient does.</i>	Mental disorders are caused by inappropriate or excessive responses to physiological drives Some abnormal behaviors result from psychiatric vulnerability in the context of anomalous early learning. Mental disorders are reflections of environmental disequilibrium and represent in fact maladaptive behaviour.	Treatment entails psychological and medical approaches to prevent, improve, or interrupt abnormal behaviors (psychopharmacology and cognitive-behavioral therapy) Environmental disequilibrium can be effectively prevented and treated by studying and modifying the environmental forces that impinge on the patient (nidotherapy).
5. Narrative <i>What is the patient's life story.</i>	Disturbing experiences result in distress and related cognitive, affective and behavioral symptoms that are subsequently incorporated into self-defeating «narratives». Life script is a person's unconscious life plan, an ongoing program for a life drama which dictates where the person is compulsively going with her/his life and the path that will lead there. The outcome of same disease may be very different within different life scripts.	Treatment relies on the reinterpretation, reframing and reconstruction of a life narrative that will give new meaning and direction to the patient's life regarding love, freedom, power, joy and purpose (narrative therapy). The most crucial is to help the patients to see how they contributed to their problems and distressing state ant how to avoid them in the future.
6. Systemic Cybernetic <i>Where the patient exist or belong.</i>	Mental disorders can be conceptualized within the systems like family, workplace, community, etc. The symptoms are punctuated as responses to structural relationship problems and interactions, ways of exercising control, etc.	The treatment addresses promotion of the healthier structural relationships and interactions within the system. According to the cybernetic model, the self is able to choose its moods, thoughts and behaviors as well as to switch off its past. It can use its brain as the mechanism of success or mechanism of failure.
7. Spiritual <i>What the patient believes in.</i>	Spiritual beliefs are of great importance to many patients and often improve coping and resilience during stressful periods. Spirituality pertaining to ultimate meaning and purpose in life, has clinical relevance.	Trust in providence which is love and wisdom, belief in power which is greater than oneself, which is a source of reassurance and hope, ability to find meaning in suffering and illness, gratitude for life which is perceived as a gift, ability to forgive have protective effects on mental health (spiritual therapy).

Body paradigm is a framework in which biological psychiatry and psychopharmacotherapy operate. The mind and mental functions develop as the genetically programmed maturation of the brain and neural circuits responding to ongoing experiences. The mind exists primarily as a by-product of brain activity and mental disorders are consequences of the disturbed brain functioning. The widely spread view that mental disorders are caused by imbalance at the level of neurotransmitters is complemented by model of neuroplasticity dysregulation. Effective treatment of mental disorders works by modifying structural and functional neuroplasticity and abnormal brain functions.

Mind-body paradigm is a framework in which the mind-body medicine operates. Acute and chronic stress is associated with dysregulation of hormones, immune dysfunctioning and neurotransmitter imbalance that manifest as cognitive, affective and behavioral symptoms of mental disorders. Increasing integration of mind-body practice with conventional treatments will probably result in significant improvements in patients' autonomy, improved outcomes and reduced mental health costs.

Body-energy paradigm is based on scientifically validated forms of energy or information that are directed at the body/brain. Energy exist in various states and forms, with some more easily detectable than others (zero-point energy, life-fields). Representative energy-information treatment modalities that have been scientifically accepted by modern psychiatry are electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), neurobiofeedback, vagal nerve stimulation, bright light therapy. Some recently introduced conceptual models assume that thoughts exist in fields, negative emotions are rooted in energy configurations, and psychological phenomena are fundamentally quantum physics events or processes (Gallo 2005).

Body-mind-spirit paradigm is based on the beliefs that mind, body and spirit are three mutually interconnected ontological dimensions/domains of human beings in health and disease. This approach relies on the body-spirit, mind-body and body-energy paradigms integrating them.

Monoperspective or Multiperspective approach

From an integrative and holistic perspective, mental health and mental health disorders are manifestations of complex dynamic interactions between psychological, somatic, physical, social, and spiritual factors at multiple hierarchic organization in space and time (Lake 2007). Following this concept, a modification of the McHugh & Slavney's four perspectives model is applied in THIP by adding cognitive, systemic/cybernetic and spiritual perspectives (Table 2). A conceptual framework for transdisciplinary holistic integrative psychiatry

should provide a common language for describing mental disorders and mental health in a more complete way addressing biological, psychological, social, cultural, energy-informational and spiritual meanings and causes of medical and psychiatric symptoms. The clinical content and logical structure of the multidimensional and multiperspective transdisciplinary approach will evolve over time in response to conceptual advances in medicine and humanistic disciplines, emerging clinical methods, and new research findings pertaining to existing and treatment methods.

Conclusion

Psychiatry is interdisciplinary situated at the interface of social, psychological and biological sciences. It utilizes insights from various humanistic disciplines, psychology, sociology, philosophy, axiology, ethics, anthropology, as well as from neuroscience, biology, pharmacology, physics, neurology and other medical specialties (Fulford et al. 2006, Bruene 2008). Although psychiatry, as a specialty of modern Western medicine, is a quintessentially modernistic project and a paradigmatic application of Enlightenment aspiration (Lewis 2000), it has become more than only medical discipline. Psychiatry is a heterogeneous profession, a "broad church" (Craddock & Craddock 2010) that accommodates an enormous range of disparate discourses and different practices (Lolas 2010). Psychiatry should become a specialized profession (Lolas 2010), not reduced only to a medical specialty. Medical psychiatry or psychological medicine is an important branch of a transdisciplinary specialized profession looming on the horizon. I fully agree with Martin Bruene: "Not only does a psychiatrist need a profound knowledge of internal medicine and neurology, but psychiatry is at the core of human experience and behaviour, not only in terms of deficiency and impairment, but also in terms of resource activation, encouragement and support to develop perspectives for a patient's life... An evolutionary synthesis of the proximate and ultimate causes of mental disorders can greatly contribute to this endeavour". Transdisciplinary holistic integrative psychiatry provides a new conceptual framework for improving quality of life and protecting mental health as well as for defining and treating mental disorders in more complete, complementary and successful way addressing its biological, psychological, socio-cultural and spiritual aspects (Jakovljević 2008). The obvious fact is that psychiatry has gained in scientific and professional status by the tremendous increase of knowledge and treatment skills. Psychiatry today has the historical opportunity to shape the future of mental health care, medicine and society.

References

1. Bruene M: *Textbook of Evolutionary Psychiatry*. Oxford University Press, New York, 2008.
2. Fulford KWM, Thornton T & Graham G: *Oxford Textbook of Philosophy and Psychiatry*. Oxford University Press, New York, 2006.
3. Gallo FP: *Energy Psychology – Explorations at the Interface of Energy, Cognition, Behavior, and Health*. CRC Press, Boca Raton, London, New York & Washington, D.C., 2005.
4. Ghaemi SN: *The Concepts of Psychiatry: A Pluralistic Approach to Mind and Mental Illness*. The Johns Hopkins University Press, Baltimore & London, 2003.
5. Jaccard J & Jacoby J: *Theory Construction and Model-Building Skills – A Practical Guide for Social Scientists*. The Guilford Press, New York & London, 2010.
6. Jakovljević M: *The brave new psychiatry: Beyond modernism, antimodernism and postmodernism in psychiatry*. *Psychiatria Danubina* 2007; 19:122-129(a).
7. Jakovljević M: *Contemporary psychopharmacotherapy in the context of brave new psychiatry, well-being therapy and life coaching*. *Psychiatria Danubina* 2007; 19:195-201 (b).
8. Jakovljević M: *The brave new psychiatry: A pluralistic integrating transdisciplinary approach in theory and practice*. *Psychiatria Danubina* 2007; 19:262-269 (c).
9. Jakovljević M: *Integrative brave new psychiatry of the person, for the person, by the person and with the person – The postmodern turn*. *Psychiatria Danubina* 2008; 20:2-5.
10. Kecmanović D: *Conceptual discord in psychiatry: origin, implications and failed attempts to resolve it*. *Psychiatria Danubina* 2011; 23:210-222. (in press)
11. Lake J: *Textbook of Integrative Mental Health Care*. Thieme, New York – Stuttgart, 2007.
12. Raden J (ed): *The Philosophy of Psychiatry – A Companion*. Oxford University Press, New York, 2004.
13. Tataryn D: *Paradigms of health and disease: A framework for classifying and understanding complementary and alternative medicine*. *Journal of Alternative and Complementary Medicine*, 2002; 8:877-892.

Prof. dr. Miro Jakovljević, MD, PhD

Department of Psychiatry, University Hospital Centre Zagreb, Croatia