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On the Nature of Mental Disease

The Psychiatric Humanism of Karl Jaspers

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Abstract: Karl Jaspers was a biological existentialist—that is the theme of this essay. He is often seen, in the tradition of Continental phenomenology, as opposed to scientific orthodoxy, such as the biological approach in psychiatry. A careful reading of Jaspers, especially in *General Psychopathology* (*GP*),[1] shows that this is not the case. His criticisms of biological approaches were all directed at a reductionistic method; he valued science and biology in medicine. His approach to spiritual and existential notions in his thinking built on, rather than negated, an appreciation for science. In psychiatry, his biologically-oriented views to many conditions are most clear, and the linkage he then makes with an existential appreciation of other psychiatric states shows us that Jaspers was neither a biological reductionist nor a phenomenological/hermeneutic radical. He was a pluralist, a thinker who held that different methods were needed in different settings, but he was not simply eclectic (another misconstrual), allowing for any and all methods in whatever circumstances. This analysis here is made in the context of his views on the nature of disease in general, and mental illness in particular.

– I –

What is (mental) illness? What is (mental) health? What is the proper role of the profession of medicine (and psychiatry)?

A common view is that medicine is a purely biological discipline, with no need to attend to mental matters or the individual as a person or anything apart from the diseased body. This is the so-called biomedical model, the dehumanized cold approach that is often criticized. The focus is on disease; all else is ignored. Psychiatry, on this view, is an almost spiritualistic profession, not really part of medicine, but there to handle behavioral problems that cannot be explained physically. This would seem to be an extreme, and hardly defensible, position. Yet as a practicing doctor, I can claim, rather unscientifically based on anecdotal experience, that a good chunk of practicing doctors think this way today, and a probably larger chunk have always thought this way. This view is in fact consistent with the basic philosophy of medicine underlying Thomas Szasz' view of mental illness as a myth. This view of medicine is also the straw man called "biomedical reductionism" which exists in reality, it is true, but also exists for sport as something to attack on the part of postmodernists of all stripes, social constructionists, followers of Foucault and his friends, as well as the predominant theory of contemporary psychology and psychiatry: the bio-psycho-social model. Each of these

[1] Karl Jaspers, *General Psychopathology*, 2 volumes (Baltimore: Johns Hopkins Press, 1998). [Henceforth cited as *GP*]

critiques is flawed in many ways, and much noise and debate goes on, but little clarity seems to occur.

The underlying question in this essay is what the work of Karl Jaspers can teach us about these different models of health, illness, and medicine, and whether he can point us to a solution.

– II –

Jaspers is widely seen as a holistic thinker. His emphasis on the human subject and on the limits of empirical science is often seen as implying an eclectic perspective. This interpretation of his thinking has especially taken root in those who approach his work on psychiatry and medicine from familiarity with his existentialist philosophical writings. The existentialist perspective privileges the individual, and when applied to medicine and psychiatry, it would seem logical that it should privilege the individual person or case over any emphasis on diseases or theories.

Yet this ethereal spiritualist anti-biological Jaspers is, in my view, a misreading of his thinking. I have suggested that a basic key to understanding Jaspers is the concept of pluralism, the idea of methodological consciousness, the notion that one must pay attention to one's methods in science, in medicine, and in psychiatry, that between fact and method no sharp line can be drawn, that no single method can be applied to all cases, but that there are better or worse methods (based on each method's strengths and limitations) that justify using one and not another for a specific condition or case. This is the pluralistic epistemology that underlies Jaspers' *GP*, which he specifically lays out in the two methods of *Erklären* and *Verstehen*. It will be seen that this basic pluralist concept underlies all his thinking, and that he is, at root, a biological existentialist.[2]

– III –

These contributions of Jaspers can be found in relevant sections of *GP*, such as chapter 12 ("Nosology: The Synthesis of Disease Entities") and the last 2 chapters of *GP* (Part Six, "The Human Being as a Whole," chapter 4: "The Concept of Health and Illness" and chapter 5: "The Meaning of Medical Practice").

In Part 6, chapter 4, "The Concept of Health and Illness" (779-790), Jaspers first makes the point that the only feature common to any understanding of illness is the value judgment inherent in it. This perspective automatically negates the positivistic/Szaszian view that physical illness is a fact, while mental "illnesses" are cultural values. Just as in contemporary philosophy, the distinction between fact and value has been increasingly questioned, and in philosophy of science even destroyed, so in any rigorous understanding of medical illness, it would seem that value must be allowed a role. Contemporary thinking in general thus agrees with where Jaspers was in 1911.

The fact that values inhere in medical illness does not imply that all such illness (and not just mental illness) is a myth of social construction. Rather, it may simply be a ho-hum fact: well of course, values are inherent in all human phenomena, including health and illness. Illness is a human phenomenon because it happens to humans, it is not an abstract entity.

Values are present in how we perceive pain, or why we decide to go to doctors or not, and so on. Of course, values are part of the illness process. But that does not mean that illnesses are nothing but values. The psychiatrist and philosopher William Fulford has pursued this topic in his work.[3] So the first step merely invalidates positivism, but it does not prove post-modernism or eclecticism. Jaspers goes on to describe health as "a normative biological concept" which is not, however, clearly articulated, he says.

This brings us to the question of how health and illness should be understood relative to each other. There seem to be two basic perspectives: either health is absence of illness (the narrow view, as discussed by Aubrey Lewis), or illness is absence of health (the broad view, for example of Leston Havens).[4]

– IV –

Perhaps the instinctive view in medicine is to view illness on its own terms, as a morbid process, without feeling a need to previously define health. There are many problems with this view, much discussed in the postmodernist literature in particular. Leston Havens has made informed critiques of this perspective in psychiatry, pointing out that this approach leads to overpathologization. You can read entire psychiatric hospital charts, he notes, and never find a single piece of good news! All aspects of patients' lives are viewed

[2] See S. Nassir Ghaemi, *The Concepts of Psychiatry* (Baltimore: Johns Hopkins Press, 2003).

[3] K. W. M. Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989).

[4] Leston L. Havens, *Approaches to the Mind* (Cambridge, MA: Harvard University Press, 1973).

as ill. Even the words we use are totalistic: the patient is schizophrenic or is depressed or is bipolar. If we were to view illness as something that happens to otherwise healthy patients, we would use the verb "to have"; the patient has bipolar disorder, but otherwise does not have a whole host of other entities, and by the way, the bipolar disorder only affects part of his psyche, not all of it. Havens makes the point that general medicine is much less pathologizing than psychiatry: when we go to the internist, we get some tests, the vast majority of which are normal, and we are reassured by those results. If a single result out of many is abnormal, we understanding the possibility of isolated illness in the larger context of greater health. In contrast, he argues, when was the last time a patient went to a psychiatrist and was told he was perfectly fine?

Havens suggests that psychiatry will not advance diagnostically until tests of normal functioning are developed, analogous to the effects of the reflex hammer and the tuning fork in advancing neurological diagnosis. Certainly, he makes many important points here, but the problems that arise if we take his view are also not minor, for then we have to define illness on the basis of health, which produces more problems than it solves. This view shifts the burden to defining what health is, and there are as many different views about the nature of health as there are about the nature of illness.

One might begin with the "official" definition of health, that of the World Health Organization: "a state of complete, physical, mental, and social well-being and not merely the absence of disease or infirmity." The psychiatrist Aubrey Lewis opposes this view.[5] A proposition could hardly be more comprehensive than that, or more meaningless. But to condemn it because it is meaningless is to ignore the history and complexity of the idea behind it—an ancient formula of unattainable wholeness of body, mind and soul, realized in the Golden Age but long since forfeited. Now if the various organs work well enough not to draw attention to themselves, and their owner is free from pain or discomfort, he usually supposes that he is in good health. The criterion is then a subjective one. But if he avails himself of the mass X-ray service and in consequence learns that his lung shows strong evidence of tuberculos diseases, he ceases to consider that he is in good health: the criterion he now adopts is an extraneous one, viz., the assertion of a physician who relies on objective or pathological data. It is evident that the physician's criteria of physical health are not the same as the patient's, and that, in practice, it is the presence of disease that can be recognized, not the presence of health. There are no positive indications of health that can be relied upon, and we consider everyone healthy who is free from any evidence of disease or infirmity.

This viewpoint is consistent with Jaspers' thinking. Indeed, Jaspers critiqued three basic concepts of health, all of which he considered inadequate: (1) health as "harmony of opposing forces" which he dates to Alcmaeon, or being "midway between opposites" though he does not name Aristotle. He does not name Galen at all though this view was most elaborated by him. (2) the Hellenistic schools who valued health above all other values and thus made it the focus of their philosophies; the Epicureans wishing "contentment with a measured satisfaction of [reduced] needs" and the Stoics wanting to "destroy all passions for *ataraxia*." (3) And current views of health as "self-realization" (again without citing Aristotle's notion of flourishing, recently popularized again by Nussbaum).[6] Like Nussbaum, Jaspers points out that the Hellenistic philosophies were "a kind of therapy." The corresponding views of illness that derive from these concepts of health are as follows: (1) disharmony or "disintegration into opposites." (2) having too much affect or passion, (3) disingenuousness or "flight into illness" (as proposed by psychoanalysis) (*GP* 787). Jaspers views the first two ideas, citing Nietzsche, as bringing about "an impoverishment of the psyche" and he argues that the third viewpoint is empty (what it means to be self-realized is unclear).

To get beyond this dilemma, Jaspers emphasizes that we need to fully appreciate the value-based nature of assessments of health and illness. Jaspers argues that one either bases health on the application of value-norms or statistical norms. The value norm, based on some kind of ideal concept, seems to be in play more often than mere statistical norms, though. Jaspers cites the quip that "normality is a slighter

[5] All following quotations by Aubrey Lewis refer to his *The State of Psychiatry: Essays and Addresses* (New York: Science House, Inc., 1967). The original article was titled "Health as a Social Concept," page 539.

[6] Martha C. Nussbaum, *The Therapy of Desire* (Princeton, NJ: Princeton University Press, 1996).

degree of feeble-mindedness." He might have otherwise agreed with the psychoanalytic dictum that we are all neurotic, some more than others. Or perhaps he might have appreciated the medical observation that certain features, like height, weight, and blood pressure, vary greatly from nation to nation, thus changing definitions of what is normal or abnormal. Thus, if

> the average, that is, the attribute of the majority, is the measure for health, … therefore slight feeblemindedness [or neurosis, or slightly high blood pressure or slightly low height] is what is healthy. But slight feeblemindedness is a term for something "sick." Therefore something that is sick is also normal. Therefore healthy = sick. (*GP* 784)

Statistical average does not provide, thus, a means of defining illness and health without the use of value judgments.

And then we get, in medicine but more so in psychiatry, to the problem of inserting a human being into this picture, a person with feelings about whatever may be happening in his body. "The individual feels himself to be ill, knows or wants to know his illness, and adopts an attitude to his illness" (*GP* 782). It seems that the introduction of awareness, or what has come to be called "insight" in the terminology of psychopathology, leads to two types of false presentations that cloud our understanding of illness: There is the false negative, somebody is ill but does not realize that he is so: "There is…somatic finding without any awareness of illness…it is only with the help of the doctor's judgment that he can reach any medical insight." And there is the false positive, somebody thinks he is ill but is not: "or there are feelings of illness without any objective finding…the doctor finds nothing, calls them 'nervy' and dispatches them to the psychiatrist" (*GP* 782-783). Now this happens in medicine, but it happens more in psychiatry:

> With the psychic disorders the matter is altogether different and we are presented with a real problem. Either there is no somatic finding at all or the inappropriateness of the patient's attitude is part of the illness or there may be specific symptoms arising from a determination to be ill.

Lack of insight is part of mania and schizophrenia, and feigned symptoms can occur with malingering or drug seeking. Even when real mental illness occurs, no somatic findings really exist that help the practitioner. Thus defining illness—tough in general in medicine—is extremely hard in psychiatry.

Jaspers then adds the point that mental illness poses a further problem in that it is not merely a deficiency, something purely negative, but that it can have positive aspects, as with the creativity of famous mentally ill persons. "Analytic pathographies of outstanding personalities have shown that illness not only interrupts and destroys, but that something is achieved in spite of it and even more that it can be the actual condition for certain performances." What is special to man, his higher faculties, predisposes him to mental illness: "It is not mere chance therefore that poets have used symbols and figures of madness for the essence of human life in its highest and most horrible possibilities, in its greatness and decline" and he cites Cervantes and Shakespeare among others. Madness evokes "awe as well as horror". Plato: "A madness sent from the gods is more desirable by far than mere human reasonableness." Nietzsche: "How pallid and ghost-like [is]…so-called health" (*GP* 786). Mental illness reveals possibilities, Jaspers concludes, both negative and positive, which the healthy person conceals from himself. He approvingly cites an alienist, Peter W. Jessen, who in 1846 said "I have higher esteem for the mentally ill than for healthy persons."

Jaspers concludes that the general concept of illness cannot be well defined, and further that we do not need it. In his pluralistic mindset:

> As scientists we want to know: what kind of phenomena are possible in the human psyche? As practitioners we want to know what are the means whereby we can advance the very diverse desirabilities of psychic life? For these purposes we do not need the concept of "illness in general" at all and we now know that no such general and uniform concept exists. (*GP* 784-785)

He then contrasts the unscientific notion of being ill with the scientific notion of having an illness:

> The question "is there a morbid element or not?" contains a vestige of those old ideas according to which illnesses were Beings who took possession of people. We may say: this is an event which is unfavorable from such and such point of view…but if we term something as morbid in a general way we are none the wiser.

Later, Jaspers further clarifies the manifold concepts of health by emphasizing how not only can it not be a basis for understanding illness, but it also is not a basis for understanding the goal of treatment:

> What does the doctor see as his treatment goal? "Health" in some undefined senses. But for one person "health" means an unthinking, optimistic steady equilibrium through life, for another it means an awareness of God's constant presence and a feeling of peace and confidence…. while a third person believes himself healthy when all the unhappiness of his life, the activities which he dislikes, all that is inhospitable, is covered up by deceptive ideals and fictitious explanations. (*GP* 802)

In the end we cannot define health: "A precise definition of health seems pointless if the essence of man is his incompleteness." This gets back to the inherently pluralist nature of Jaspers' epistemology. He concludes that perhaps we cannot well define illness or health, alone or in relation to each other, partly because they go together, they cannot be separated, they are in a way the same. If illness means, "living creatures living off each other" or "radical changes of environment" or "mutations," then these things happen all the time. Thus, "being ill belongs to living as such." One might see Jaspers' own life-long and life-threatening severe lung disease as influencing his views. He approvingly cites Nietzsche yet again: "Healthiness as such does not exist." Jaspers again:

> Being ill is not only the lot of isolated exceptions in life but a part of living itself as an instant in its ascent and a risk to be overcome. Life proceeds by experiment and its course is at one and the same time success and failure. (*GP* 785)

Just as illness in general has no meaning, so too, Jaspers says citing Griesinger, mental illness "is not a general species"; it has to be structured, ordered, into concepts. Many are not "sick" at all, have no "morbid process," but have "some unfavourable constitutional variant," their personality (the statistical norm) that leads them to hospitals.

How then are we to define the specific mental illnesses that exist? First we have given up the notion of defining them based on views on mental health. We start, says Jaspers, with the phenomenon of insight:

> The concept of illness in psychiatry is characterized by the fact that the patient's attitude to his illness, his feeling of being ill, his awareness of illness, or the complete absence of both, is not something additional to be easily corrected as in the purely somatic disorders but always an integral part of the illness itself.

He then states his famous un-understandability criterion, which has been misunderstood by many to be seen by Jaspers as pathognomonic of mental illness (or psychosis), whereas he makes clear that it is only the first step to deeper understanding of the patient and the patient's illness:

> In the observer's case the starting-point is something which cannot be meaningfully understood whether this is a disordering of the meaningful connections by abnormal mechanisms or something "quite mad," that is a radical breakdown of the possibilities of communication…. Differential diagnosis rests on distinguishing the different kinds of un-understandability, slight symptoms which to the lay person do not appear at all morbid can be the indicators of a most serious and destructive process whereas florid phenomena (states of excitement, called furor) can be symptoms of a relatively harmless hysteria. In the patient's case, the starting point is what he suffers…. These starting-points for defining illness are not reliable. There is no concordance between the phenomena as first observed and the nature, severity, and trend of the disease-process. The psychopathologist, therefore, penetrates to deeper levels by a number of methodical observations and by discovering what phenomena cluster together and the way in which they run their course, etc. As a result we now find three concepts of disease. (*GP* 788-789)

Here we see how Jaspers had incorporated the teaching of his predecessor at Heidelberg, Emil Kraepelin: the clustering together of phenomena, their course, etc., these were how Kraepelin taught nosology. Jaspers did not reject this, contrary to many of his later followers in the Heidelberg school (like Kurt Schneider). Rather, Jaspers added his *Verstehen* method as a necessary predecessor to the external observations of symptoms and course that were the method of the Kraepelinian school. The two approaches, *Verstehen* and *Erklären*, go hand in hand, the one ceding way to the other as appropriate. Using this method, Jaspers describes three kinds of mental illnesses:

> (1) as a somatic process; (2) as a serious event which breaks into healthy life for the first time and procures a psychic change; a somatic base is suspected for this but as yet not known; (3) as a variation of human life far removed from the average and somehow undesired by the affected person or by his environment and therefore in need of treatment. (*GP* 789)

Jaspers then refers to chapter 12 on nosology where he described the specific psychiatric conditions that fall into these categories, a description which deserves some attention as it presaged our current psychiatric nosology, and since it further shows us how Jaspers' ideas help us to better appreciate psychiatric diagnosis, rather than simply serve as a means to reject the idea of diagnosing anyone at all.

An ideal schema would have to satisfy the following requirements:

> It must be such that any given case would have only one place within it and every case should have a place. The whole plan must have a compelling objectivity so that different observers can classify cases in the same way. We abandon the idea of disease-entity and once more have to bear in mind continually the various points of view (as to causes, psychological structure, anatomical findings, course of illness and outcome) and in face of the facts we have to draw the line where none exists. Such classification therefore has only a provisional value. It is a fiction that will discharge its function if it proves to be the most apt for the time. There is no natural schema that would accommodate every case. (*GP* 605)

With those caveats, Jaspers proposes a nosology quite similar to the big shift in 1980 with *DSM-III* in modern US psychiatry. He proposes dividing psychiatric conditions into three main groups: Group I, "Known somatic illnesses with psychic disturbances" (such as cerebral tumors, meningitis), coincides with *DSM*'s "Axis III" which describes psychiatric conditions secondary to known medical illnesses. Group II, "The three major psychoses" (genuine epilepsy, schizophrenia, and manic-depressive illness), corresponds with the major mood and psychotic disorders on *DSM*'s "Axis I" of primary psychiatric conditions (with epilepsy now moved to Axis III, since a cerebral basis has been established for it). Group III is the "Personality disorders," which corresponds to *DSM*'s "Axis II" also defined as personality disorders. Heuristically, with the caveats given previously, Jaspers goes on to accept Kraepelin's definition of the distinction between schizophrenia and manic-depressive illness based on the outcome criterion as the main factor, i.e., invariably poor outcome with schizophrenia and frequent recovery with manic-depressive illness. This too is a distinction that mainstream psychiatry dropped in most of this century in favor of psychoanalytic theories, but to which the field returned in 1980 with the neo-Kraepelinian nosology of *DSM-III*.

Jaspers' acceptance of affective disorder/ schizophrenia distinction in the nosology debate was based on the distinction between conditions with which one could empathize, those in whom meaningful connections could be made, and those which were not understandable. He felt that this distinction would provide one of the few organizing principles for nosology:

> The most profound distinction in psychic life seems to be that between what is meaningful and allows empathy and what in its particular way is ununderstandable, "mad" in the literal sense, schizophrenic psychic life (even though there may be no delusions). Pathological psychic life of the first kind we can comprehend vividly enough as an exaggeration or diminution of known phenomena and as an appearance of such phenomena without the usual causes or motives. Pathological psychic life of the second kind we cannot adequately comprehend in this way. Instead we find changes of the most general kind for which we have no empathy but which in some way we try to make comprehensible from an external point of view.... The affective illnesses appear to us to be open to empathy and natural but the various types of "madness" do not seem open to empathy and appear unnatural. (*GP* 577-578)

Jumping back to the next to last subchapters of the final part of *GP*, Jaspers notes that mental illnesses as somatic processes reflect

> the basic attitudes of medicine and the natural sciences which only accept the somatic as the decisive factor…. In fact there is a field of organic cerebral disease where the demand for a somatic basis can be gratified and where the psychic events are symptoms of a known physical event. But the difficulties which remain are by no means negligible. In scarcely a quarter of hospital patients do we know the organic basis for the disorder.

One might comment that in Jaspers' era, most of these patients had general paralysis of the insane, known by then to be neurosyphilis, treatable by 1927 with malaria therapy (the only Nobel Prize given to a psychiatrist for treatment), and cured by the 1950s with penicillin (thus the most powerful psychotropic ever discovered). It is noteworthy that here Jaspers flies directly in the face of postmodernism and social constructionism: some mental disorders are physical diseases; they are not all simply cultural pheonomena. On the other hand, Jaspers obviously argues against a positivistic mind-brain identity as well.

The second category of suspected somatic illnesses are defined by their psychic (rather than unknown somatic) features, and here Jaspers places the "psychoses in the three hereditary groupings," or the main illnesses of psychiatric practice – schizophrenia and manic-depressive illness along with severe melancholia. We would want to identify psychic basic functions that are disturbed to better classify these conditions, but since those psychological

functions have not been well described, we have "a multitude of theories and a host of descriptions" (*GP* 790). The third group consists of "the unwanted variations of human nature", where "the concepts of natural science are indispensable but do not suffice and everywhere we find a gulf between man and beast." These represent the personality conditions.

One way to summarize the mental illnesses might be to conflate these three categories to two: biological illnesses (the known or suspected somatic forms) and problems of living (either due to personality extremes or also simply due to extreme life events or a combination of the two). Using Jaspers' pluralistic approach, the first type of illness may be best analyzed with *Erklären*, and is to be treated as in the medical tradition with somatic means (medications); the second type of illness is best understood with *Verstehen*, and is to be treated either outside of the medical field (through religious, spiritual, or other psychic means) or through psychotherapies. In either case, treatment of some kind is given, but the right kind of treatment needs to be chosen for the right kind of condition (pluralism).

– V –

Jaspers concludes his discussion of health and illness in this way. He then writes the final section on "The Meaning of Medical Practice" (*GP* 790-822), apparently as a means of describing how these treatments can then be provided, the somatic as well as psychotherapeutic treatments in psychiatry. In fact, most of this section is actually given to explaining the nature of psychotherapy, perhaps because he viewed the traditional concepts of somatic medical practice as already well known, while psychotherapy was a novel concept in his era.

First, he contrasts the two extremes of "therapeutic nihilism" and "therapeutic over-enthusiasm," the first over-relying on knowledge for its own sake and seeing medicine as a pure science instead of as an art, the second believing wrongly that "something should be done or attempted in all circumstances" and that "practice only needs aptitude, not knowledge." In fact, Jaspers would come out on the side of the hard-headed proponents of evidence-based medicine (EBM) in today's debates about the role of science in medicine: "In the long run…effective practice can only be based on the certainties of knowledge." Practice needs to depend on science, on real knowledge, not just experience. Yet practice, while dependent on science for its methods, has to look elsewhere for its aims. Its goals, its view of health as an illness, are based on its values; science cannot provide those values.

Jaspers is arguing that practitioners of psychiatry needed to pay attention to their own value systems in the course of giving treatments. Why were they treating? What goals were they pursuing? They could not cover up these values with scientific pseudo-explanations. This problem, so prevalent in the positivistic era in which Jaspers lived, may be lessened somewhat in today's postmodernist atmosphere, but it remains a problem, this misapplication of science:

> Things are expected from science which it cannot provide. In this age of superstitious belief in science, science is used to conceal unanswerable facts…. A form of pseudoscience may be used to express something that is by no means known but only wished for.

Jaspers is especially making this point in relation to psychotherapies, which enact value systems to a much greater extent than in somatic medicine. He then goes into an analysis of what is entailed in psychotherapies, concluding that the root of all of them is the doctor-patient relationship, which again connects psychotherapies to all medical therapy, since that relationship is present in even somatic treatments. However, in psychotherapies, the entirety of the treatment is that relationship:

> What is left as the ultimate thing in the doctor-patient relationship is existential communication, which goes far beyond anything that can be planned or methodically staged. The whole treatment is thus absorbed and defined within a community of two selves who live at the possibilities of Existence itself, as reasonable beings…. Doctor and patient are both human beings and as such are fellow-travellers in destiny…. There is no final solution.

He concludes then that psychiatric treatment ranges on a spectrum where "the widest polarities lie in whether a doctor turns to what can be discovered by science, that is to the biological event, or whether he turns to the freedom of man." The distinction is essential, and it is not a matter of preference. Where biological disease is present, existential empathy with the freedom of man has no place; and vice versa. The doctor needs to know which method to use when, and he needs to know how to use the methods. One approach involves treating with drugs, the other requires existential collaboration: "Life I can treat, but to freedom I can only appeal."

– VI –

By turning to a discussion of existential methods in psychotherapy, Jaspers is addressing the key problem with defining illness, as he does, without reference to health, the constant complaint of pathologizing, of overdiagnosis, social construction, abuse of power, etc. The corrective to this risk is to remember that diseases, though real objective entities in the natural world, happen to individual human beings, free men and women, with feelings about having or not having disease. And, sometimes, there is no disease at all, but only problems of individual free human beings, in which case, thinking again pluralistically, the disease model does not apply.

Thus, today if Jaspers were active as a psychiatrist, I think he would be prescribing medications for diseases such as narrowly defined schizophrenia and bipolar disorder, and even severe depression, but I think he would also be cognizant of the positive aspects of mental illness, and of the many presentations of psychopathology that do not have biological roots. Yet he would disparage the dogmatic oversimplification of those who think that because some psychopathology is non-biological therefore all (or most) psychopathology is non-biological.

In the end, I think Jaspers is promoting a pluralistic model of psychiatry that is nothing more nor less than a proper understanding of science applied to psychiatry and medicine, and thus it is completely in keeping with the work of that other great physician William Osler—the concept of medical humanism.[7] The idea here is that one takes a biologically reductionist model of disease, and applies it where appropriate, but always with a humanistic awareness of the importance of the person, the individual, who has the disease. No disease wipes out the person, and no understanding of person is adequate by itself when a bodily disease is present. This too was an old view: Osler overtly resuscitated the Hippocratic view that medicine consisted of three factors: the patient, the disease, and the doctor. This Hippocratic tradition had been lost in two millennia of subservience to a theory about health and illness—Galen's humoral dogma. That theory had been enough, no talk of persons and diseases and doctors was needed. After the Galenic theory was proven wrong, Osler took modern medicine back to the ethically and scientifically sound Hippocratic approach.

This humanism is individual and existential; it is not captured by another scientific discipline (like psychology or sociology) tacked onto the discipline of biology (as George Engel argued), and thus the biopsychosocial model does not do it justice. It is not captured by any single non-biological theory of medicine or psychiatry (e.g., psychoanalysis). It is best understood through an appeal to literature, to the uniqueness of humanity and of each individual human being, which is best approached, though never completely captured, in poetry and fiction.

Osler divided medical knowledge, then, into two parts: scientific and humanistic. The scientific part related to diseases, and was based on the sciences of pathology, laboratory medicine, and clinical observation. The humanistic part related to understanding the persons who suffered from diseases, and was based on literary wisdom and worldly experience with the feelings and wishes of human beings.

The idea of medical humanism might best be provided by an anecdote. When I was a visiting medical student in 1989 in London, I followed a neurologist at King's College one day on his morning appointments. I and five other British medical students stood behind him while he sat at his desk, and the patients would enter one by one. One day, during a break between patients, he turned to us and asked, "Who can recite a poem to me?" No one could (or perhaps, dared). He turned, disgusted, and remarked, "How can you expect to be good doctors if you know no poetry? Understanding poetry is about understanding human beings. And if you don't understand human beings, you can't be a good doctor, no matter how much scientific knowledge you possess." He taught me that day the basic lesson of medical humanism—that science is not enough to be good physician; since we deal with persons and not just bodies, we need to learn to relate to individual human beings, and the best repository of knowledge about this topic lies in human literature (fiction, poetry, and the humanities in general). That day, our teacher was passing along the tradition of Osler. In fact, this tradition for decades was formalized in Osler societies at individual medical schools, where students

[7] William Osler, *Aequanimitas* (Philadelphia, PA: The Blakiston Company, 1948).

would engage in reading of poetry and works of literature with relevance to medicine.[8]

None of this entails a dismissal of science—of positivism yes—but not of science properly understood. For medicine, in Osler's view, was an art based on a science, not just an art, and not just a science. Without science, medicine would be empty; without art, it would be irrelevant.

Despite the claims of postmodernism, Osler offered another choice: he similarly rejected a cold inhumane approach to medicine, but he offered the biomedical model plus the art of medicine as an alternative.

I suggest that Karl Jaspers' pluralism also led to this conclusion; he did for psychiatry what Osler did for medicine, though Jaspers emphasized an existentialist philosophy as something in addition to literature that would provide the humanistic element needed for psychiatric practice in particular.

His existentialism was a biological existentialism, not a social constructionist, postmodernist, anti-medical perspective (Jaspers was not Heidegger). Too often, phenomenology and existentialism get conflated with anti-science and non-biological perspectives in medicine and psychiatry. This need not be the case, and this approach is certainly different from what Jaspers stood for. In medicine and psychiatry we need to be biological, because we are dealing with physical diseases, but we also need to be existential, because we are dealing with individual persons at all times (whether they have diseases, or whether they only have problems of living). The two perspectives are not opposite or exclusive, as many seem to assume.

The Jaspersian/Oslerian option would allow us to keep the standard scientific model of biomedicine while emphasizing a humanistic and existential orientation to the needs, values, and desires of individual human beings. This is not to say that scientific research in psychology and social sciences may not aid such person-based approaches, but rather that such scientific work will not exhaust the complexity of humanity. At some level, we would have to admit that human beings could not be captured completely by the methods of science, that there is another kind of knowledge—literary, philosophical, intuitive—that can inform us about our lives and our loves. Without needing to add the BPS model or psychoanalytic theory or other philosophical or psychological dogmas, we can add a humanistic wisdom rooted in Socrates and Hippocrates and Shakespeare and Cervantes and Goethe, and Nietzsche and William James and Walker Percy and James Joyce and Reiner-Maria Rilke and William Faulkner, and even Jalaluldin Rumi: What an excellent medical model, and what an excellent vision of psychiatry, that can be.

[8] For instance, Robert Coles for years has taught a highly successful course at Harvard Medical School titled "Literature and Medicine."