



The Biopsychosocial Model in Psychiatry: A Critique

S. Nassir Ghaemi

Tufts Medical Center

nghaemi@tuftsmedicalcenter.org

Abstract: In the United States, the basic concepts of psychiatry have involved the opposing dogmatism of psychoanalytic orthodoxy and biological reductionism. An alternative basic conceptual scheme, the biopsychosocial model (BPS), arose in the last decade and now represents the status quo. By providing a conceptual review of the strengths and limitations of the BPS in psychiatry, and identifying the limitations of the BPS model the author concludes that its limitations seem to outweigh its benefits. Suggestions for a non-eclectic pluralist model of psychiatry, based on the ideas of Karl Jaspers, are made.



Introduction

The history of psychiatry in the United States has been seen as a battle of dogmatism, particularly between psychoanalytic orthodoxy and biological reductionism.¹ Some still see psychiatry as basically fluctuating between these two dogmatic poles.² But this yin and yang of dogmatism reflects an underlying similarity: in their extreme forms, both approaches believe that they can understand the entirety of the field with one single method. They differ only on which method they propose. The most popular alternative,

which is today perhaps the conceptual status quo, is the biopsychosocial model (BPS), most identified with the work of George Engel.³

In this essay, I show that the BPS reflects eclecticism—an unprincipled mixing of many different approaches—and thus is both unscientific and not useful for the progress of psychiatry. In contrast to both dogmatism and eclecticism, I propose a return to the method-based psychiatry of Karl Jaspers, an approach that uses multiple methods in a principled way, based on scientific evidence, and without any a priori commitment to combining biological, psychological, and social approaches to understanding mental illness. It is not anti-reductionistic and holistic, as are the catchphrases of modern postmodernist attitudes that are critical of science. Jaspers combines science and

¹ Acknowledgements: I thank Leston L. Havens MD and Ross J. Baldessarini MD for comments on this manuscript. Paper presented at the 107th Annual Meeting of the American Philosophical Association, Boston, 2010.

² Tanya M. Luhrmann, *Of Two Minds: The Growing Disorder of American Psychiatry*, New York: Alfred Knopf, 2000.

³ George L. Engel, "The Need for A New Medical Model: A Challenge for Biomedicine," *Science* 196/4286 (1977), 129-36.

humanism in a way that postmodernist thinking, following Heidegger and Foucault, fails to do, and this postmodernist cynicism is reflected in the eclectic philosophy that represents the core of the BPS model as applied in psychiatry for the past three decades.

The Rise of the Biopsychosocial Model

Briefly put, the BPS model officially arose in the late 1970s in the work of the internist George Engel, but it has roots in other sources, such as Adolf Meyer's psychobiology⁴ and Roy Grinker's eclecticism.⁵ Indeed Grinker, unknown to many current readers but a contemporary of Engel, first formulated the term "biopsychosocial" in a lecture in 1954 (though not published until the 1990s),⁶ decades before Engel's usage of the term. (Grinker also published the term in the 1970, seven years before Engel's first publication on the topic. Yet Engel never publicly gave Grinker the priority and credit that Grinker deserved). As a leading psychiatrist and researcher, one could argue that Grinker's work is both more systematic and more psychiatrically profound than Engel's proposal for medicine.⁷ Nonetheless, given current usage, this essay will focus on George Engel's BPS model.

In the late 1970s, when Engel published influential articles on the BPS model, the idea caught on strongly in psychiatry, for political reasons as discussed below. It captured the temper of the times, which, after the 1960s countercultural period, was postmodernist and eclectic. The basic idea behind the BPS model was a rejection of biomedical reductionism. The view was that illnesses are multifactorial, with many causes; Engel held this to be the case for most medical illnesses, and his followers took the view that it was the case for all, or almost all, mental illnesses, certainly the standard

psychotic and mood conditions. This is still the basic presumption of most persons in the field of psychiatry, and, I think, it is a major obstacle to progress in identifying the causes of mental illnesses, as well as treating them scientifically.

Before proceeding to those critiques, however, it is important to realize who Engel was and what he was doing. A theory is a reflection of the person who created it. One of the unique things about George Engel, the founder of the theory at the heart of modern psychiatry, is that he was not a psychiatrist. Rather, he trained and practiced internal medicine, and developed a special interest in gastrointestinal diseases, and he added formal psychoanalytic training for five years in the 1950s in the Institute for Psychoanalysis in Chicago (which, run by Franz Alexander, was the center of psychosomatic interest in the psychoanalytic world).⁸

The psychological component of the BPS was, for Engel, quite allied to psychoanalysis.⁹ This model was not meant to incorporate psychology broadly as a field (such as behaviorism, social psychology, or experimental psychology); rather, in the 1950s, when psychoanalysis was at the peak of its influence, psychology simply was assumed to be psychoanalysis. Although the BPS is viewed with extreme reverence among practitioners of social work, Engel put little emphasis on the social component of the model, except as related to the doctor-patient relationship primarily (with some secondary interest in the health care system as a whole). Little discussion can be found in Engel's main writings about the impact of society as a whole, or the larger roles of class or poverty or race, as is often the case in social work interpretations of the BPS.

Thus, Engel the man was an internist who sought to better understanding gastrointestinal illness through the use of psychoanalytic ideas. Some of his clinical views are clearly outdated due to their psychoanalytic orthodoxy: For instance, in 1956, he theorized that headaches in persons with ulcerative colitis were due to "strong conscious or unconscious aggressive or sadistic impulses." In ulcerative colitis, he argued,

⁴ Alfred Lief, ed., *The Commonsense Psychiatry of Adolf Meyer*, New York: McGraw-Hill 1948.

⁵ Roy R. Grinker, Sr., "A Struggle for Eclecticism," *The American Journal of Psychiatry* 121 (1964), 451-7.

⁶ Roy R. Grinker, Sr., "Training of a psychiatrist-psychoanalyst," *Journal of the American Academy of Psychoanalysis*, 22/2 (1994), 343-50.

⁷ See Roy R. Grinker, Sr., "The Sciences of Psychiatry: Fields, Fences and Riders," *The American Journal of Psychiatry* 122/4 (1965), 367-76. Roy R. Grinker, Sr., "Open-system" Psychiatry," *American Journal of Psychoanalysis* 26/2 (1966), 115-28. Roy R. Grinker, Sr., "An Essay on Schizophrenia and Science," *Arch Gen Psychiatry* 20/1 (1969), 1-24.

⁸ Peter A. Engel, "George L. Engel, M.D., 1913-1999: Remembering His Life and Work; Rediscovering His Soul," *Psychosomatics* 42/2 (2001), 94-9.

⁹ Edward Shorter, "The History of the Biopsychosocial Approach in Medicine: Before and after Engel, in *Biopsychosocial Medicine: An Integrated Approach to Understanding Illness*, ed. Peter White, Oxford, New York: Oxford University Press 2005, pp. 1-19. [Henceforth cited as HBA]

"Bleeding...characteristically occurs in the setting of a real, threatened, or fantasized loss, leading to psychic helplessness" (*HBA* 4). Engel would later move away from such simplistic psychoanalytic ideology, but he never left behind completely the psychoanalytic influences that were a key aspect of his intellectual formation.

The Fall of the Biopsychosocial Model 35 Years Later: A Report Card on the BPS

The BPS has strengths; else it would not have risen so high so fast. Its main strength is that it is not dogmatic; by allowing for any and all approaches, it is not, in theory at least, prone to excluding any method or claiming that any single method is better than another. Yet its weaknesses (see Table 1) flow from this very feature:

First, it is based on a simplistic conception of biology and disease. In this tradition, derived from positivism, the environment and personal experience is excluded, and biology is identified with genes and cells and molecules, conceived in isolation. Current views of biology and disease are much more broad, incorporating interactions of genetics and environment into the very definition of the biological.¹⁰ Perhaps Engel meant to promote this approach with the BPS label, but it could simply be called a biological model, properly conceived.

Also, the BPS model does not appear to have a coherent conceptual basis as relates to the mind-body relationship.¹¹ Engel in later years appeared to view the BPS as reflecting a non-dualistic view;¹² his modern disciples have followed suit.¹³ However, rejection of

dualism does not entail the BPS model; other non-BPS approaches also avoid mind/body dualism.¹⁴ Further, Engel appears to reify the psychosocial components as different from the biological, as discussed above, and thus ironically his view could be criticized as dualistic.¹⁵

In addition, it is not clear that the BPS model adds much to the prior medical humanist model, especially as classically advanced by the tradition of William Osler.¹⁶ Engel tended to contrast the BPS model with biomedical reductionism, which he identified with lack of concern for personal aspects of patient experience. Yet Osler's model, while biologically reductionist, was simultaneously humanistic, having explicit regard for the patient as a person (in addition to the disease as a biological entity); this attention to the person was based on the humanities: on the arts and literature. Despite his disciples' attraction to the humanistic practice of the BPS approach,¹⁷ Engel claimed he was doing something altogether different: he denigrated the "art" of medicine, and wished to import the psychological and social sciences, not the arts and humanities.¹⁸ If much of the benefit of the BPS model lies in its humanistic consequences, then it needs to be shown how it surpasses the Oslerian medical humanist model.

Further, from the perspective of etiologies of illness, the BPS is true only if biology is conceived narrowly and positivistically, as discussed above. Yet then the model becomes trivial. It may be that all illness (as Engel claimed: not only mental illness) has biological, psychological, and social components. Engel used the example of diabetes. Here clearly a biological pathology is driven by psychological (overeating) and social (the ubiquity of fattening foods) determinants. In

¹⁰ See Eric R. Kandel, "A New Intellectual Framework for Psychiatry," *The American Journal of Psychiatry* 155/4 (1998), 457-69. G. Scott Waterman and Jaskanwar Batra, "Biopsychosocial Psychiatry," *The American Journal of Psychiatry* 160/1 (2003), 185; author reply 186.

¹¹ Marc J. Miresco and Laurence J. Kirmayer, "The Persistence of Mind-Brain Dualism in Psychiatric Reasoning About Clinical Scenarios," *The American Journal of Psychiatry* 163/5 (2006), 913-8.

¹² George L. Engel, "How Much Longer Must Medicine's Science Be Bound By A Seventeenth Century World View?" *Psychotherapy and Psychosomatics* 57/1-2 (1992), 3-16.

¹³ Glen O. Gabbard and Jerald Kay, "The Fate of Integrated Treatment: Whatever Happened to The Biopsychosocial Psychiatrist?" *The American Journal of Psychiatry* 158/12 (2001), 1956-63.

¹⁴ S. Nassir Ghaemi, *The Concepts of Psychiatry: A Pluralistic Approach To The Mind And Mental Illness*, Baltimore, MD: Johns Hopkins University Press 2003.

¹⁵ G. Scott Waterman and Robert J. Schwartz, "The Mind-Body Problem," *The American Journal of Psychiatry* 159/5 (2002), 878-9; author reply 880-1.

¹⁶ See William Osler, *Aequanimitas*, Philadelphia, PA: The Blakiston Company 1948. Paul R. McHugh, "William Osler And The New Psychiatry," *Annals of Internal Medicine* 107/6 (1987), 914-8.

¹⁷ Richard M. Frankel, Timothy E. Quill, and Susan H. McDaniel, eds., *The Biopsychosocial Approach: Past, Present, and Future*, Rochester, NY: Boydell and Brewer, 2003.

¹⁸ George L. Engel, "From Biomedical to Biopsychosocial. Being Scientific In The Human Domain," *Psychosomatics* 38/6 (1997), 521-8.

fact, one might be inclined to say that the chronic complex medical illnesses of our day (diabetes, coronary artery disease, hypertension) are classic biopsychosocial illnesses. Those illnesses share an etiological pattern with major mental illnesses (i.e., a complex but incomplete genetic basis combined with important environmental stressors).¹⁹ But if everything causes everything, one cannot fail to be right, while at the same time nothing informative is really being said.

Moreover, its boundaries are unclear. Thus one critique of the BPS is that, at least as advanced by Engel, the BPS leaves aside the realm of existence, personal meaning, and spirituality.²⁰ Engel's perspective, it must be recalled, was highly influenced by psychoanalysis, and he also was committed to seeing the BPS in the traditional scientific paradigm, i.e., as a scientific theory. In practice, applications of psychological methods in using the BPS often vary based on the biases of the practitioner, and certainly existential or spiritual psychological approaches are infrequently used in psychiatry. While these considerations may seem to wander from psychiatry to religion or philosophy, it is relevant that the BPS does not guide us as to which psychological theories are relevant. Further, one might interpret the social component of the BPS an interventionist model (as often proposed by colleagues in social work),²¹ or perhaps a more academic psychology approach emphasizing life event correlates of illness,²² or perhaps a public health approach looking at structural social factors (class, race, poverty) rather than individual ones.²³ All these interpretations of the social aspect of the BPS could be supported, and again the BPS can be stretched in any direction. The BPS gives

permission to do everything, but no specific guidance to do anything. In an analogy suggested by McHugh & Slavney,²⁴ the BPS is like a list of ingredients, as opposed to a recipe. To cook a meal, it is not sufficient to simply know the list of ingredients. One also needs to know how much of each ingredient, and in which order. The BPS only lists relevant aspects of psychiatry, but it is silent as to how to understand those aspects in different conditions and in different circumstances.²⁵

- | |
|---|
| <ol style="list-style-type: none"> 1. Based on a falsely narrow concept of biology 2. Conceptually inconsistent about the mind/body relationship 3. Not more beneficial than Osler's medical humanist model 4. If true, it is trivial 5. Unclear boundaries 6. Can confuse treatment versus etiology 7. Poor model to address costs and managed care 8. Presumes psychiatric superiority to other mental health disciplines 9. Poor teaching tool when simplistically applied 10. Limited resistance to rebirth of biological dogmatism |
|---|

Table 1

Limitations of the biopsychosocial model in psychiatry: Ten theses

Simplistic interpretations of the BPS frequently confuse treatment versus etiology. Often it is assumed that all three components must go hand in hand: thus genetic causes should lead to biological pathogenesis and psychopharmacological treatment, whereas environmental causes should lead to psychosocial pathogenesis and psychotherapy. Of course, the matter is much more complex. Often causes are genetic but treatments environmental (even in the most genetic conditions, like phenylketonuria, the treatment can be environmental: diet restriction). At other times, causes are environmental but treatments biological (a person who has mainly eaten Twinkies for decades and has developed severe coronary artery disease may require surgery, rather than anti-Twinkie psychotherapy). The BPS flounders when a one to one correlation between type of cause and type of treatment fails to hold, since the result is that clinicians are left with even less guidance on what means what. If an illness is

¹⁹ Kenneth S. Kendler et al., "The Structure of The Genetic And Environmental Risk Factors For Six Major Psychiatric Disorders In Women. Phobia, Generalized Anxiety Disorder, Panic Disorder, Bulimia, Major Depression, and Alcoholism," *Archives of General Psychiatry* 52/5 (1995): p. 374-83.

²⁰ Eugene M. Abroms, "Beyond Eclecticism," *The American Journal of Psychiatry* 140/6 (1983), 740-5.

²¹ Richard B. Francoeur, Carol K. Copley, and Pamela J. Miller, "The Challenge to Meet The Mental Health And Biopsychosocial Needs of The Poor: Expanded Roles For Hospital Social Workers in A Changing Healthcare Environment," *Social Work In Health Care* 26/2 (1997), 1-13.

²² Joel Paris, "The Etiology of Borderline Personality Disorder: A Biopsychosocial Approach," *Psychiatry* 57/4 (1994), 316-25.

²³ Lisa F. Berkman and Ichirō Kawachi, eds., *Social Epidemiology*, Oxford, New York: Oxford University Press 2000.

²⁴ Paul R. McHugh and Phillip R. Slavney, *The Perspectives Of Psychiatry*, Baltimore: Johns Hopkins 1983 (1998).

²⁵ Niall McLaren, "A Critical Review Of The Biopsychosocial Model," *Australian and New Zealand Journal of Psychiatry* 32 (1998), 86-92.

predominantly biological and genetic in etiology and pathogenesis, psychotherapeutic treatment could still be defensible, and vice versa. The scientific evidence does not support a direct line from etiology to treatment, even though, in my experience, clinicians often simplistically interpret the BPS that way.

Another problem is that BPS proponents often advocate combination psychotherapy plus psychopharmacology treatment in general. This result is of course, to be expected from such a broad theory, since more specific guidance is not forthcoming. Providing a rationale for combined treatment may be the main reason why this theory has been so attractive. Obviously, there are drawbacks to constant combination treatment. From the policy perspective, if some therapies (including medications) are sometimes not necessary, then this approach is fiscally wasteful and expensive. Further, psychiatry as a profession has not been able to engage with managed care on the front of costs,²⁶ in my view, partly because the BPS does not provide us any rationale on how to limit costs. (Engel argued that the BPS should provide such larger social guidance). It might be suggested that the BPS is not meant to be a cookbook of therapeutics, which raises the question of what it is that we want from a conceptual model of psychiatry. I would suggest that a model should provide a rationale for the basic approaches taken to treatment, though it need not itself provide the details of such treatment. Some might suggest that empirical studies now demonstrate the benefit of combined treatment. Yet, discussions of such literature are usually quite selective. The BPS model would predict that combined treatment is the most effective treatment in general, i.e., most of the time. Yet the available research, which is still rather limited, suggests that combined medication/psychotherapy treatment may be effective in some cases or conditions,²⁷ but not in others.²⁸ This selective efficacy is hard to reconcile with the BPS.

The emphasis on combination therapy among some BPS adherents becomes a justification of psychiatry as a guild. After all, only psychiatrists, among mental health professionals, can provide combination therapy (medications and psychotherapy), since others cannot prescribe. This fact may explain in part why psychologists and nurses have battled to gain prescribing privileges. If the BPS is accepted, they cannot be "real" biopsychosocial practitioners unless they can prescribe. Yet many psychiatrists do not have special expertise in psychopharmacology, and recently trained psychiatrists, as has often been discussed in the psychiatric education literature,²⁹ have less and less expertise in many psychotherapies. In contrast, clinical psychologists receive extensive training in psychotherapies, and social workers study and practice social interventions at length. Indeed, it takes a great deal of effort to be a very good psychopharmacologist or psychotherapist or social worker, with the highest level of expertise often gained in only one diagnostic or treatment subtype. Specialization has happened in the mental health professions, although generalists also exist and have a role as well. Yet one might ask whether, conceptually, it is necessarily better to have combined treatment from one person or separate treatment from highly trained persons in different specialties. Empirically, the matter has not been studied.

Another weakness is education. In many settings, the BPS has not served well in the teaching of medical students and psychiatric residents. Even in prominent academic centres relatively simplistic scenarios apply in which a case will be presented, and the teacher will ask the students to describe the case in three facets: bio, psycho, and social. Often, two of the facets are rather weakly explored, and the student, for whatever reason, leans toward one particular aspect of the case. Or alternatively, no facet is explored in any depth. Proponents of the BPS might object that in their institution, they may do a better job, and this may in fact be the case.³⁰ It is not irrelevant; however, that the

²⁶ Thomas Detre and Margaret C. McDonald, "Managed Care And The Future of Psychiatry," *Archives of General Psychiatry* 54/3 (1997), 201-4.

²⁷ Martin B. Keller et al., "A Comparison of Nefazodone, the Cognitive Behavioral-Analysis System of Psychotherapy, and Their Combination For the Treatment of Chronic Depression," *The New England Journal of Medicine* 342/20 (2000), 1462-70.

²⁸ Ellen Frank et al., "Three-Year Outcomes for Maintenance Therapies in Recurrent Depression," *Archives of General Psychiatry* 47/12 (1990), 1093-9.

²⁹ Lisa A. Mellman, "How Endangered is Dynamic Psychiatry in Residency Training?" *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 34/1 (2006), 127-33.

³⁰ Gerald M. McDougall and B. Reade, "Teaching Biopsychosocial Integration and Formulation," *Canadian Journal of Psychiatry* 38/5 (1993), 359-62.

BPS can be, and often is, simplistically interpreted such that one only attains a relatively superficial understanding of a case. The problem may not be poor use of the BPS, but rather inherent flaws based on the over-inclusiveness of the model and its poor boundaries, as described above.

The German philosopher G.F.W. Hegel argued that all theories, if taken logically to their full conclusion, would end in contradictions, often producing the opposite of what they intended. The BPS suffers from this Hegelian tragedy. It began as a way to avoid dogmatism. But it has ended in a new dogma; for, due to its broadness and vagueness, it provides weak arguments against dogmas, and it provides little resistance to other forces in society that propound their particular dogmas. A case can be made that the strongest such forces in contemporary American society are the insurance and pharmaceutical industries.³¹ It is in their economic interest to propound a biologically oriented psychiatry,³² one in which disease labels are used widely and treated with medications (which is cheaper than psychosocial interventions for the managed care insurance industry,³³ and the source of profits for the pharmaceutical industry).³⁴ While it is not itself a cause of these forces, and thus does not deserve blame, the BPS model has failed to stem the devolution of psychiatry into more and more positivistic and reductionist biology. While the leaders of the profession proclaim fealty to biopsychosocial eclecticism, the reality on the ground is biological dogmatism. As the president of the American Psychiatric Association, Steven Sharfstein, put it to great applause in his April 2004 address to the annual convention, "We have let the biopsychosocial model become the bio-bio-bio

model."³⁵ Perhaps one need not blame psychiatrists, but rather the inherent limitations of theoretical eclecticism. The recovery movement,³⁶ enshrined now as the philosophical basis of President George W. Bush's 2003 New Freedom Commission on Mental Health,³⁷ is a reaction, overtly directed against this perceived rise of biological dogmatism in psychiatry.

Political Uses of the Biopsychosocial Model in Psychiatry

The seeds of the decline of the BPS began in the political uses to which it was immediately put. The BPS promised an end to the increasingly bloody conflict between the biological and psychoanalytic schools. In the 1970s, the rise of psychopharmacology put the biological school in psychiatry on the attack. The framers of DSM-III rather overtly saw psychiatry as an objective medical discipline, and they framed their work in the traditional medical model as put forward by Emil Kraepelin in the early twentieth century. Yet, while pushing for a return to Kraepelinian nosology, this group (called "neo-Kraepelinian") was willing to back off on a commitment to (or perhaps belief in or hope for) a clear biological etiology to psychiatric disorders. The "neo" in neo-Kraepelinian stands, to a great extent, for this difference:³⁸ Kraepelin strongly believed in an almost completely biological etiology and pathogenesis of major (though not minor) mental illnesses.³⁹ Those who resurrected his nosology in the USA in the 1970s were willing to be atheoretical about this topic. They wanted to give up the psychoanalytic or Meyerian commitments of DSM-II, but they were also willing to avoid a biological commitment in etiologies.

³¹ Ray Moynihan, Iona Heath, and David Henry, "Selling Sickness: The Pharmaceutical Industry and Disease Mongering," *British Medical Journal* 324/7342 (2002), 886-91.

³² David Healy, *The Creation of Psychopharmacology*, Cambridge, MA: Harvard University Press 2002.

³³ Asken, M.J. and D.W. Florence, "Keeping the 'Care' in Managed Care: The Importance of The Therapeutic Relationship and Psychosocial Factors in The Managed Care Setting," *Physician Executive* 21/11 (1995), 22-5.

³⁴ Marcia Angell, *The Truth About the Drug Companies*, New York: Random House 2005.

³⁵ David Hathcox, "Sharfstein Challenges Psychiatrists To Help Reform Health System," *Psychiatric News* 40/12 (2005), 4.

³⁶ William A. Anthony, "A Recovery-Oriented Service System: Setting Some System Level Standards," *Psychiatric Rehabilitation Journal* 24/2 (2000), 159-168.

³⁷ <http://govinfo.library.unt.edu/mentalhealthcommission>

³⁸ Gerald L. Klerman, "Historical Perspectives on Contemporary Schools of Psychopathology," in *Contemporary Directions in Psychopathology: Toward the DSM-IV*, eds. Theodore Millon and Gerald L. Klerman, New York: Guilford Press 1986, pp. 3-28.

³⁹ Edward Shorter, *A History of Psychiatry*, New York: Wiley & Sons 1997.

By being agnostic, however, the DSM-III approach created a conceptual void. Psychoanalytic orthodoxy was rejected, as was Meyerian theory. Biological reductionism did not take its place. And thus, there was uncertainty regarding what was to be taken as the basic model of psychiatry. The BPS filled this void, since it was consistent with all approaches. The main *raison d'être* for the BPS was to keep peace between the biological and psychoanalytic dogmatisms, while giving each space to survive. It provided mental health professionals a rationale for preserving the clinical use of psychotherapies, in the face of increasingly relentless pressure from psychopharmacology, a compromise which could only hold so long.

What Next?

A critique should stand on its own merits. One has no intellectual obligation to provide a solution. Identifying problems clearly is a hard enough task by itself. But psychiatrists and philosophers are first human beings, not doctors or scientists. And human beings always want beliefs. They have a hard time living with doubts. My colleagues frequently tell me that my critiques of the BPS model are not helpful when there is nothing better to replace it. So, despite feeling that I am not obligated to provide such a new metaphysics, I will do so, since I have already proposed a new approach to psychiatry, based on the work of Karl Jaspers.

I will note in passing that some colleagues also focus on criticisms of my proposed alternative theory, as opposed to adequately defending the BPS model against my criticisms. This is a danger of mixing a negative critique with a positive proposal. I would emphasize that even my alternative approach were totally wrong, this would not affect at all any of my critiques of the BPS model.

A basic idea behind Jaspers' view of psychiatry has not been properly understood, I believe, especially by those who claim to be followers of Jaspers' tradition in the schools of phenomenology and psychopathology. Jaspers' approach involves the following—eclecticism is rejected: there are right and wrong methods to use; dogmatism is also rejected: the same method is not used for all conditions. This non-eclectic pluralism gives us answers, avoiding the eclectic limitations of the BPS model, while at the same time moving us beyond dogmatism.

What methods do I mean? Using the BPS lingo, one can talk of three methods: biological, psychological, or social. Jaspers himself used the terms *Erklären* or

causal explanation, which would correspond to biological approaches, and *Verstehen* or meaningful understanding, which could be seen as psychosocial. The Jaspersian method does not reject reductionism, i.e., using one method only, such as pure biological reductionism, or even pure social reductionism. It does not insist on combining methods, as in holistic assumptions.

This is why Jaspers has been misinterpreted as a mere existentialist, a hermeneutic thinker like Heidegger or his followers. Jaspers was a biological reductionist too, and also sometimes an existential reductionist. This is what I mean when I say he is not eclectic, and this is the alternative to BPS eclecticism that has not been understood by many psychiatrists and philosophers.

Let me explain this matter further, using an analogy I have given previously. Suppose billiards were played differently: let's say that each ball is supposed to go into a specific hole, and no other. Kraepelin hits only the black ball and claims it should be allowed into every hole; player Freud hits only the white, claiming the same. Adolph Meyer, seeking to please everyone, argues all balls should be allowed in all holes. George Engel divides the balls into three groups, and says one of each group should go into each and every hole. Jaspers, knowing the rules better than the rest due to his careful study of the history of billiards, takes a different approach: He hits one ball into one hole, another into a second, a third into a third, and so on. Each ball goes in its own hole, and no other.

The audience, watching the scene, clearly understands that Freud and Kraepelin are opposites; Meyer and Jaspers, in contrast, seem to randomly hit the balls into any hole. It takes many games for careful observers to note that Meyer is indeed random, but Jaspers consistently hits the same balls into the same holes. Jaspers might say: "This is billiards. Each ball belongs in its own hole." But some philosophers want to hear a philosophy that explains why this is the case. Why does one ball belong in a certain hole, and not another. What is the nature of ballness; or holeness? And why are we playing billiards anyway?

Method-Based Psychiatry

I have come to use the term "method-based psychiatry" to reflect what I think Jaspers was trying to say, and how it differs from eclecticism and dogmatism. Sometimes people use the word "pluralism," and I used to do so, but I have stopped using it since in practice

most people seem to mean eclecticism, the way I understand it, when they use the word pluralism. Let me clarify what this analogy means.

For eclecticism, any theory is potentially correct but no theory definitely so; method-based psychiatry maintains that only one theory is correct, but it is not the same one for all parts of psychiatry. Eclecticism claims that all methods should be used together: more is better. Method-based psychiatry uses methods purely and, if needed, they are to be combined sequentially, rather than simultaneously: less is more. Eclecticism contends that the choice of method is based on the (often subjective) preference of doctor or patient (proponents of a version of pragmatism see this as a good thing).⁴⁰ Method-based psychiatry asserts that choice of method is based on empirical data (as available) and on conceptual soundness (otherwise): One must justify, not merely prefer.

In political analogy, tyranny, of whatever kind, is like the diagnosis of a terminal illness: it is simple, clear, and deadly. Psychoanalytic orthodoxy is the twin of biological reductionism, much as fascism is the reverse of communism. To those who have known nothing but tyranny, a government of laws—where no single person sets the law—is complex to the point of producing delirium. For them, democracy (method-based psychiatry) can seem little different from anarchy (eclecticism).

One reason for Jaspers' weak influence in Anglo-American psychiatry, I think, has to do with just this: Kraepelin and Freud were expressive and convincing writers, whose translations flow smoothly. Jaspers was ponderous in German, and worse in translation. Einstein once said that reading Jaspers, in German, gave him a headache; this anecdote is more poignant when one realizes that it came in the context of Einstein declining to help Jaspers escape Nazi Germany. Much as I admire Jaspers' thought, I do not recommend that American students of psychiatry read the *General Psychopathology*⁴¹ without much prior preparation. I would much rather they take in some of his shorter

philosophical works (like *Way to Wisdom*,⁴² which is based on lectures he gave to the BBC), or his transcribed lectures on the history of philosophy. The *GP* should only be opened, in my view, after one has read and appreciated Jaspers as a profound thinker based on his other works; and after one has appreciated the limitations of any other perspective in psychiatry (preferably through experiencing the vagaries of clinical practice and, through study, noting the blind spots of the schools of Kraepelin and Freud and Meyer). Then, hungry for some kind of orientation, the student will find that the *GP*, despite its purple prose, is like a rose garden in the centre of Los Angeles, all covered up with smog. The closer one gets to it, the more the smog recedes, and the more the colors of the roses impress.

Jaspers' basic idea in the *GP* is best understood as the concept of method-based psychiatry (even though Jaspers did not clearly state it thus) and that this idea is not a metaphysical commitment but rather it is what Jaspers meant by science itself. I make this emphasis partly because Jaspers has become so famous as a philosopher and as a phenomenologist that his specific views on the nature of psychiatry (not specific psychiatric concepts, such as his theory of delusions, but rather his meta-theory of what psychiatry is all about) have been underappreciated. My choice of emphasis does not mean that Jaspers was not a viable philosopher of interest, or that he has little philosophically to say to current psychiatry. I think this is not the case; it is just that *GP* is not the best place to look (his later works are more apt).⁴³

Jaspers' impact on psychiatry has been like a thunderstorm—a gale that falls all at once, hard and torrential, on the high and the low, replenishing some dry plots of land, while washing away needed soil in other regions, and even at times leading to blackouts so that we are briefly left in the dark. But in the end, we need these rains—the only alternative is a desert of dogmas, or the vast, bland plain of eclecticism that represents psychiatry today.

⁴⁰ David H. Brendel, *Healing Psychiatry*, Cambridge, MA: MIT Press 2006.

⁴¹ Karl Jaspers, *General Psychopathology*, transl. Julius Hoenig and Marian W. Hamilton, Chicago: The University of Chicago Press 1964. [Henceforth cited as *GP*]

⁴² Karl Jaspers, *Way to Wisdom*, New Haven: Yale University Press 1951.

⁴³ Edith Ehrlich, Leonard H. Ehrlich, and George Pepper, eds., *Karl Jaspers: Basic Philosophical Writings*, Atlantic Highlands, NJ: Humanities Press 1994.