

CONCEPTUAL DISCORD IN PSYCHIATRY: ORIGIN, IMPLICATIONS AND FAILED ATTEMPTS TO RESOLVE IT

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SUMMARY

Unlike other medical disciplines, psychiatry abounds in conceptual models. All of them are legitimate as there is no conclusive evidence that either is more proper than others in terms of its capacity to explicate the very nature of mental disorders and make possible more efficacious treatment of those with mental illness. There are two major sources of the existence of numerous models in psychiatry: difficulties in discerning the role played by the biological and the psychological in the genesis and treatment of individual mental disorders, and want of a widely accepted theory of the mind-body relationship. The conceptual divide in psychiatry has numerous negative effects: scarce communication or no communication between the advocates of different approaches; overrating of the benefits of the concept one clings to; lack of interest in other approaches; confusion of clients when confronted with different explanation of the origin of their troubles and most appropriate treatment; tarnished image of psychiatry. There have been several attempts to correct conceptual cacophony in psychiatry. None of them proved successful.

Key words: psychiatry – concepts - discord

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INTRODUCTION

Psychiatry abounds in models. Models are “conceptual frameworks, or sets of ideas, by which, in any given area, people structure and make sense of the world around them” (Fulford and Colombo 2005). In psychiatry, the models have also been dubbed “prominent emphases within psychiatry” (Sabshin 1990), “predominant theoretical representations of psychiatry” (Beigel 1995), “approaches to the mind” (Havens 1973, 2005), and “systems of explanation” (Moncrieff and Crawford 2001).

Although various authors (i.e., Siegler and Osmond 1974, McHugh and Slavney 1983, Weckowicz 1984, Tyrer and Steinberg 1987) classify psychiatric models in more than three groups, virtually all of the models can be reduced to three models: the medical, the psychological, and the social model. Other models are but derivatives of these three types of basic orientations within psychiatry.

Given the multiplicity of models in psychiatry, a number of questions arise. This text deals with four of them. First, why are there many models in psychiatry? Second, how do psychiatrists choose their preferred model. Third, is psychiatry a multi-paradigmatic or pre-paradigmatic discipline? Fourth, should the existence of many general orientations within psychiatry be considered as psychiatry’s advantage or disadvantage? There have been several endeavours to overcome the divide in psychiatry caused by the simultaneous existence of numerous legitimate conceptual models. They will be analysed as well.

WHY ARE THERE MANY MODELS IN PSYCHIATRY?

There are several reasons for the existence of many models in psychiatry. First, there is no a widely accepted theory of mind-body relationship in the mentally sound and mentally disordered. It is missing in psychiatry because it is missing in philosophy. Okasha, in the “Foreword” to Oxford Textbook of Philosophy and Psychiatry by Fulford, Thornton and Graham, asserts that, as a discipline, “psychiatry should be deeply interested in the mind-body problem, the answer to which, if there is one, cannot be sought without help from philosophy” (2006: XXIX). The existence of different philosophical conceptions of the mind-body relationship – for example, Cartesian dualism, parallelism, epiphenomenalism, theory of double aspect – provides a fertile ground for the articulation of different psychiatric models. Neither psychiatrists nor clinical psychologists will be able to reach a consensus in regard to the fundamental issue of the relation between the physical and the mental until a general accord is attained in philosophy or at least until one view of the cited relation prevails in philosophy.

It is easy to identify the philosophical background of some psychiatric models; for example, epiphenomenalism underlies the medical model. The leading figures of some other models refer to the philosophers in the writings of which they find inspiration and foundation for their concept and practical activities. Thus, the advocates of the phenomenological-existential model (Ludwig Binswanger, Eugène Minkowski, V. E. Freiherr von Gebattel, Ronald D. Laing) quite often make reference to the writings of Martin Heidegger, Edmund Husserl, Jean-Paul Sartre).

Second, biological, psychological and social-cultural factors co-determine the genesis and shape of mental disorders. As there is no unifying perception of these factors, of how they are intermingled in each individual, be they a mentally sound or mentally unhealthy individual, each psychiatric model addresses only one of the cited factors. “We must apply different sets of concepts to these factors, and we must employ logics in our reasoning about them” (Schwartz & Wiggins 1988).

By addressing only one side of mental disorders, each psychiatric concept or model ignores all other sides. By focusing on only one aspect of mental disorder it affirms its specificity and overrates its relevance. As the advocates of each individual model do not take into account other possible perspectives on the same phenomena, they do not see, or more accurately, they cannot see the deficiency of their own vantage point. Thus, they make conceptual chasm between individual models ever wider.

Third, the truth is that the same psychopathological occurrence can be explained and interpreted as the result both of causation and intention. For example, depression and associated suicidal ideation may be explained as the consequence of distorted neurochemical processes, or interpreted as a person’s intent to punish someone who will feel hurt by that person’s death. And what is most important, there is no way to confirm or dismiss either view. In reply to possible remark that the efficacy of antidepressant drugs in alleviating or eliminating depression does testify to its biological origin, I would refer to Parker’s assertion that “evidence of any ‘treatment specificity effects’ is hard to find despite enormous database” (Parker 2009). Moreover, “studies have shown that cognitive therapy is as efficacious as antidepressant medication at treating depression,” and it seems “to reduce the risk of relapse even after its discontinuation” (DeRubeis et al. 2008).

Thus, there is no convincing evidence that any approach (model, perspective) is superior to other(s), that is, that any model should be discarded altogether. Secondary to such a state of affairs, however strong is the dominance of a particular model at a particular time, other models do not disappear without a trace. They keep on existing as shadow models.

Fourth, the dominance of one, and rarely two, conceptual models is more often than not conditioned by social, financial and ideological reasons (Kendler 2005). As these reasons change so do the dominant models; thus, if not dominant at the moment, a particular model is a model in waiting. Its time will come.

Fifth, there is an epistemological seductiveness in one single perspective. Schwartz and Wiggins (1988) draw attention to this phenomenon originally described by Karl Jaspers in his work *Psychology of Weltanschauungen*. However paradoxical it may sound, each single perspective is universal in spite of not being able to be universal. It is not able to say everything about all aspects of reality, but it can say something about

everything. For example, the medical model can say something regarding any psychopathological phenomenon. It provides an explanation for such different occurrences as lack of concentration, depression, high mood, delusions, hallucinations and aggressiveness. “Because one can assert something about everything, one can mistakenly suppose that one can assert everything ‘worth saying’ about everything.” This epistemological seductiveness may be one of the subjective reasons for the sustainability of different psychiatric models.

Sixth, there is no convincing evidence that any single model outweighs others in terms of its capacity to better explain the nature of mental disorder(s) and make psychiatric treatment more efficacious. The lack of such evidence is the major source of the legitimate existence of numerous models. Tyrer and Steinberg formulate the same view in the following way. “Knowledge in psychiatry”, they write, “is far outstripped by theories and opinions and these are allowed to flourish because the evidence needed to contradict them is not available” (1987: 2).

HOW DO PSYCHIATRISTS CHOOSE THEIR PREFERRED MODEL?

In writing about models in psychiatry, due attention has not been accorded to the important question of the choice of the preferred model. If one bears in mind that it is a rather significant decision in the professional life of a psychiatrist, it is even more astonishing that this question has not been fully addressed to date. Such a decision tailors how psychiatrists look at their patients. Such a decision determines the kind of services they will provide to patients who approach them for help; further on, it has an influence on how many working hours they will spend in emergency psychiatric departments, state hospitals, public or private facilities; which conferences they will be attending; which colleagues they will preferably associate with; where a significant portion of their income will come from.

I will list some of the most common reasons for psychiatrists’ decision to pick one particular model rather than another one.

The conceptual orientation of the leading figures in the institution wherein one starts a professional career

During residency, would-be psychiatrists work at different departments, at different facilities whose staff prefer this or that conceptual model. Thus, residents have the opportunity to get acquainted with different models. A number of them express their preferences for a specific model under the influence of one or more leading figures in a certain institution wherein they do residency. At times, the choice of a particular model as superior to others is made, consciously or unconsciously, through identification with one’s superiors; at

other times, it is a matter of opportunism, the manifestation of one's compliance with the dominant orientation of the given institution or department.

Biological or psychological mindedness

Some psychiatrists are more biologically than psychologically minded even before they start studying medicine. The inclination towards biological sciences somewhat predisposes them to adopt the medical model once they become psychiatrists. Yet those who are more psychologically minded are likely to prefer the psychological model. Those who are mostly interested in social and cultural issues will probably give priority to the social-cultural model.

The perception of psychiatry

There are people who nurture the image of psychiatry as a psychological, even spiritual, discipline. And that is what makes psychiatry attractive in their eyes. They complete medical studies because there is no psychiatry without medicine, but all the time, that is, from the first year of medical studies they keep an eye on psychiatry. Needless to say that these people are more likely to endorse the psychological or may be the social-cultural rather than the medical model.

The dominance of a particular model in an era

The psychiatric model that prevails at a particular time has high recruiting potential. It is hard and usually not much rewarding to swim against the tide. On the other hand, there are a good number of advantages if you are in tune with the model governing most psychiatrists' practice. Those who are part of mainstream psychiatry get employment comparatively easily; they are more sought after than those who are not; there are more conferences dealing with various aspects of the dominant model; information related to this model is more frequently presented in the mass media and general psychiatric journals. Thus, the popularity of a particular model motivates a number of psychiatrists to espouse it.

It is truism to say that the dominant culture cannot help but to favour a particular psychiatric model. In other words, there are fashionable models in psychiatry as there are clothes that are in fashion. And the same as not all people follow the dictate of the prevailing dressing style there are always psychiatrists who pay lip service to the dominant way of reasoning in psychiatry. Thus, relying on what he has seen during his long professional life, McHugh writes: "During the thirty years of my professional experience, I have witnessed the power of cultural fashion to leave psychiatric thought and practice off in false, even disastrous directions." Then he adds: "I have become familiar with how these fashions and their consequences cause psychiatry to loose its moorings" (2006: 3).

The financial interests

Of course, no one talks about them when discussing the reasons for holding on to one specific model and when discussing the benefits of preferring a particular model to others(s). However the financial rewards may play a role in prioritizing a particular model. This does not mean that the expectations of better financial remuneration when practicing one particular model always turn out to be well-founded. What is important is that some psychiatrists do believe that they will be better off if they provide services according to the principles of the medical model, or of the psychological model. Tacitly, the social-cultural model is believed to be much less rewarding than either the medical or the psychological model.

What matters is a psychiatrist's conviction that a particular model he or she has chosen suits the reality of mental disorders better than other models. Such a belief certainly has a motivating force. The question is, however, whether this belief precedes the decision to endorse a particular model, or is the result of rationalizations, i.e., post hoc justifications, or it is the practice of a model that generates the certainty that there is no other model worth considering than the chosen one.

PSYCHIATRY: MULTI-PARADIGMATIC OR PRE-PARADIGMATIC

Are conceptual models in psychiatry the same as paradigms? Do they fit with the meaning that Thomas Kuhn gave to the notion of paradigm in his classical work *The Structure of Scientific Revolutions* (1962).

Psychiatric conceptual models and paradigms in Kuhn's terms could not be considered as the same. Kuhn called paradigm shift a radical change in key epistemological assumptions, not only within science, but also in relation to the dominant world-view. According to this author, a new paradigm, i.e., a new world-concept, excludes the fundamentals of the old one. In other words, two different paradigms never co-exist. One always replaces the other. That is not the case in psychiatry. As stated above in the text, different models co-exist in psychiatry. The dominance of one model does not make all other models totally obsolete.

Yet, Kuhn's paradigm and psychiatric paradigm – if for the moment we call psychiatric models paradigms – appear to have two common characteristics. According to Kuhn, the new paradigm is acknowledged as dominant not so much due to its capacity to explain reality in a more accurate way as "because it is better able to justify social practices of the relevant discipline" (Horwitz 2002: 57). The same holds for psychiatry. A particular psychiatric model does not become prevailing because it more accurately explains mental illness and is more useful when its principles are implemented in clinical practice, but because it is in tune with the current social circumstances.

Moreover, according to Kuhn, paradigms are matchless. Paradigms are so different that one paradigm cannot be translated into another. It is the same with psychiatric models. Although a few attempts have been made to identify common features of two models – for example, Coleman (1971) did it when he contended that the psychoanalytic approach to symptoms formation can be understood as a social process, and Kandel did it (1998, 2005) when he strived to explain that psychological (psychodynamic) and biological models have some common points – individual psychiatric models are incommensurable, to use Kuhn's phrase.

Kuhn asserts that paradigms are incommensurable for three reasons. First, the dominant paradigm determines the perception of reality, which means that the perception of reality differs from one paradigm to another. Second, the meaning of individual topics within a paradigm also differs from the meaning of individual topics within another paradigm. Third, each single paradigm gives different importance to individual phenomena.

Could the same reasons for incommensurability be identified as far as the incommensurability of psychiatric models is concerned? Let us consider two psychiatric models: the medical and the psychological (the psychodynamic variant of the psychological model). Biologically oriented psychiatrists are primarily interested in the symptoms an individual presents; on the other hand, psychodynamically oriented psychiatrists focus on how the client experiences the therapist, how they relate to the therapist. Those who favour the medical model believe that brain pathology causes the appearances of the symptoms, whereas those who stick to the psychodynamic model search for the meaning of symptoms in the personal history of the client, in their emotional past and in how they relate to the therapist. The biologically oriented psychiatrists have no doubt whatsoever that brain structural and biochemical abnormalities have caused the patient's symptoms. On the other hand, the psychodynamically oriented psychiatrist focuses on how the client has gone through the phases of psychosexual development. There is the clue to the client's current mental suffering.

For several years, Luhrmann, anthropologist, observed how American psychiatrists in various psychiatric facilities diagnose and treat patients. She came to the conclusion that American psychiatry is deeply divided. That is why she called her widely cited book *Of Two Minds*. Luhrmann writes: "Psychiatrists are taught to listen to people in particular ways: they listen for signals most of us cannot hear. Their two primary tasks, however – diagnosis and psychopharmacology, on the one hand, and psychodynamic therapy, on the other – teach them *to listen and look in different ways*" (2002: 22, my emphasis). The same holds for psychiatrists in other countries.

THE EXISTENCE OF NUMEROUS PSYCHIATRIC MODELS: BLESSING OR CURSE

One could argue that the existence of more than one model in psychiatry is at the same time plausible and the reason for concern.

A general favourable remark about having many models is that it indicates how vital and dynamic psychiatry is. It would appear that it is good to have several perspectives in psychiatry because reality is heterogeneous. So every aspect of reality is to be approached in a different way, and that is why multiple concepts are welcome.

There are arguments that different approaches are needed because to claim that "the meaning of any psychiatric fact depends upon the particular perspective employed is to say that apart from all perspectives, facts make no sense" (Schwartz & Wiggins 1988). The idea, originated by Karl Jaspers, is that "perspectives arrange the mass of data in an intelligible order. They tell us what regarding the patient is relevant to his or her disorder and what is irrelevant."

Two critical remarks can be levelled at this idea which somewhat defends the existence of many models in psychiatry. First, a unified theory about different aspect of reality could perform the same function of organizing reality, of making it intelligible. Such a concept or theory might be of greater help in understanding reality because it would not provide different perspectives on different aspects of reality. Second, by introducing order into chaos, different approaches or concepts parcel reality and thereby create different sections of reality. Briefly said, they make sense of reality but at the price of fragmenting it; thereby they sow seeds of new misunderstandings and conflicting opinions about one and the same reality. With a bit of exaggeration one might say that the formation of many concepts about reality has replaced a big chaos by not so big chaos.

The downsides of having many models in psychiatry by and large outweigh the possible advantages. Indeed, the existence of many models in psychiatry nurtures "a continuing view that psychiatry is a discipline without a clear sense of identity or focus" (Beigel 1995). Yet, this is not the most negative fall-out of the legitimacy of more than one psychiatric model. There are more serious effects such as alternative explanations of the same psychopathological phenomenon; confusion in patient caused by different messages coming from the advocates of different models; dilemmas about the "right" treatment; latent or open antagonism among psychiatrists favouring different perspectives, and so on.

The epistemological premises of various general concepts about the basic nature, causes and treatment of mental disorders tend to be more than simply differences in perspective. "Each is an encompassing

view resting on certain assumptions legitimacy and importance; and each develops in part in opposition to the other” (McHugh and Slavney 1983).

A great many psychiatrists are mostly unaware of how much the particular model they endorse influences their way of thinking about mental illness and their clinical practice. They usually take their chosen model for granted. They do not question its assumptions, and they do not discuss its weak points. Also, they are usually not much interested in other models, in what is going on beyond the model they consider as the best among all the possible models. They are so engrossed in their model that they never think about making it explicit except when they oppose it to other models.

To date, critically assessing one model from the vantage point of another has not born fruit. In most cases it was followed by a stronger embrace of one’s own model. Partisan psychiatrists are so little amenable to criticism coming from the other side of the fence that they either ignore it or consider it as a justification to firmly cling to the model the validity of which they never question.

It is of note that “no other branch of medicine has developed such different orientations nor as much animosity between the defenders of different theoretical and practical orientations. Like Gods in anger, the sects in psychiatry seem to be ready to reject all the knowledge or insight that sects other their own held: the good and the bad in others have equally viciously attacked” (Sartorius 2002: 194)

Psychiatrists are not the only members of psychiatric team who are infected by sectarianism. Other mental health workers are not immune to it, either. Thus, as noted by Fulford and Colombo (2004), “doctors approach mental disorders on the model of physical diseases (in terms of symptoms, syndromes, and test results); social workers find medical diagnostics ‘labels’ unhelpful, focusing rather on the social context of mental distress; psychologists are interested in behaviour (bodily and cognitive) and their contingencies; psychotherapists understand mental distress and disorder in terms of partially hidden affect and conation; and family therapists work by reference to family systems.”

The proponents of one model rarely change sides. If they do, they do it most often so as to benefit from the popularity of one particular model in a certain epoch. When one model takes centre stage, not only in psychiatry, but also in the broader community’s perception of what is a proper model (and these two processes usually coincide), it is much easier for the advocates of that particular model to get research funds and public approval; they are held in higher esteem and are accordingly more praised than those psychiatrists who stay committed to one of the “shadow models.”

The influence of the dominant psychiatric model can be traced in various aspects of psychiatric work. For example, it is mirrored in the content of psychiatric journals (Kecmanovic and Hadzi-Pavlovic 2010). Also,

“with each dialectical shift in the prevailing theoretical paradigm, the vintage point for the retrospective construction of the discipline has changed” (Micale 1996). Micale dubs this phenomenon “the paradigmatic structuring of psychiatric historiographies.”

Given so many arguments for the assertion that the existence of more than one model in psychiatry is, mildly said, not beneficial to psychiatry, Bloch rightly concludes that “psychiatry’s continuing failure to address both biomedical and psychological dimensions of professional knowledge in an integrated fashion has been a major hindrance to its progress.” Competing explanations, “not uncommonly contradictory,” are dividing psychiatry from within. Bloch is very realistic when he contends that “an integrating paradigm to counter fragmenting forces seems elusive.” Hence, his conclusion: “the unfortunate outcome is a profession working without a sense of unity seemingly oblivious of the peril it faces” (1997).

Katschnig (2010) shares the same view. After pointing out that our discipline is threatened by the existence of de facto ideological subgroups, he states that “if psychiatry is to persist as a profession, it needs to have a conceptual centre.” And he adds: “What this might be in the future is not clear.” It is not clear, indeed.

ATTEMPTS TO OVERCOME THE CONCEPTUAL CACOPHONY IN PSYCHIATRY

To date, a number of attempts have been made to correct conceptual cacophony in psychiatry. Some of them just foreshadow how it would be possible to harmonize the multiplicity of voices within psychiatry, how to make them sound more or less euphonic. Others constitute articulated concepts about the best way to conceptually homogenize psychiatry.

I’ll first just mention two undertakings aimed at bridging conceptual divide in psychiatry. In recent times there has been talk that the empirical approach will resolve the sectarianism in psychiatry. The mantra of this move is that only empirical evidence can disperse the clouds of the theoretical confusion caused by different perspectives. Schwartz and Wiggins (1988) elaborated upon this issue, and I will rely on them in depicting the true character of this determination to put things in order with regard to psychiatrists’ confronting views of the same phenomena.

Speaking in more concrete terms, the aim of those who are determined to give priority to the facts is to “link specific kinds of therapies and techniques with specific kinds of disorders.” The idea is that once “diligent and systematic empirical investigations have finally established the most effective approaches to the different kinds of disorders,” there will no longer be room for claims coming from the practitioners of different models that their approach is the most

successful one. The relocation of psychiatry back into medicine is supposed to be a collateral and worthy effect of such a new state of affairs.

Schwartz and Wiggins grasped the danger of this tendency “to install positivistic methods of inquiry as the only acceptable ones.” And promoting the positivist approach as the only right approach is nothing less than reaffirming the medical model as the only valid model. “If one wished to discuss forms of treatment, for example, one could do so only by offering statistical analyses of clinical trials of groups of patients. These clinical trials would see highly specified techniques and procedures, careful definitions, standardization, treatment manuals, and the like. For the new psychiatry, evaluations and procedures should be as mathematical as possible” (1988).

This is a new form of sectarianism under the guise of the medical model, as Schwartz and Wiggins rightly noted. Mathematical and statistical methods are welcome and useful in psychiatry. However, psychiatrists must be aware of the limitations of the application of these methods to understanding psychiatric phenomena. Regardless of the claims of the advocates of these methods, they cannot be accepted as universally valid in psychiatry.

Such claims enunciated in the eighties seem to have heralded today's assertions that there is no psychiatry unless it is evidence-based psychiatry. And the same criticisms that have been levelled at evidence-based psychiatry apply to this kind of new sectarianism.

There have been still other attempts to resolve the conceptual conundrum (conceptual “trichotomy”) in psychiatry. As the mind-body dualism underpins the majority of conceptual hard-to-resolve questions in psychiatry, Dewhurst and Burges Watson (1996) have resorted to the notion of a person, which supposedly should be able to bridge the divide caused by the mind-body dualism. The cited authors are of the opinion that the concept of a person could provide psychiatrists with a powerful instrument in overcoming the various dualistic and materialistic perspectives. Why? Because “a person is a psychobiological being whose psychical and physical aspects are integrated, with psychological and physical qualities being ascribed to the very same subject.” In addition, as a member of the community “a person is involved in various interpersonal and social relationships.” Thus the notion of a person would connect all three aspects or sides (biological, psychological, and social-cultural) dealt with by individual psychiatric models.

The notion of a person does not seem to be much heuristic in resolving the psychiatric conceptual puzzle.

So far I have made a brief reference to the two not fully developed ideas about how to overcome conceptual cacophony in psychiatry. Now I will focus on three elaborated and authorized endeavours to achieve this goal: the biopsychosocial model, methodic pluralism and pragmatic psychiatry. I will sketch each one of them and show that none of them has been successful.

The Biopsychosocial Model

Advocates of the biopsychosocial model claim that it is a corrective of other models, the biological model above all, insofar as it integrates the specificities of all traditional models.

George Engel is the author of the biopsychosocial model. He is an internist (gastroenterologist) who trained in psychoanalysis with Franz Alexander. Engel inaugurated the model in two papers: “The need for a new medical model: a challenge for biomedicine” (1977) and “The clinical application of the biopsychosocial model” (1980). Although the latter was published in *The American Journal of Psychiatry*, it elaborates the implications of the psychological-social model for the study and care of a patient with acute myocardial infarction.

Conceived of as holistic, this model pays equal attention to various explanatory concepts in natural sciences, individual psychology, sociology, economics, politics, and anthropology.

According to the biopsychosocial model, all dimensions of the mentally ill are interrelated, that is, they influence one another.

The model has attracted the attention of and is heeded by those who are interested in how to resolve the conceptual cacophony in psychiatry because it is comprehensive and gives equal weight to all aspects of the mentally ill.

Has this model achieved the goal of being an alternative to the reductionism of the biological, psychological and social-cultural models? Many critics of Engel's concept (for example, Paul Fink, Michael A. Schwartz and Osborne Wiggins, Laurence Foss, Kenneth Rothenberg) hold that the biopsychosocial model does not address the practical aspects of clinical work.

The major problem with the model is that however good it is as a concept, it does not provide a recipe for how to implement it. It recommends a diversity-of-sciences approach but provides no guidelines for selecting the science that applies to a particular patient at a particular time (Schwartz & Wiggins 1985). “Moreover, the biopsychosocial model provides no formal model of anticipating the idiosyncratic problems that every individual patient presents; only the interdependence of the various system levels is emphasized” (Sadler & Hulgus 1992).

Furthermore, however comprehensive it may be, the biopsychosocial model is not specific. “With any particular patient... only a limited number of factors will play a role in treatment, but the biopsychosocial model offers no help in delimiting and circumscribing them. For one patient the spiritual support afforded by his religion may prove relevant. For another patient the financial support he lacks may be crucial. For even another patient, the political support he receives from his constituents may be quite important. The biopsychosocial model provided no guidance in locating and specifying the relevant variables” (Schwartz & Wiggins 1985).

Apart from its comparatively small usefulness, the biopsychosocial model has not provided even at the conceptual level what could be expected of it, given its name and claims. The biopsychosocial model has not managed to synthesize the achievements of the traditional individual models in a new concept that would assist psychiatrist in getting a comprehensive view of the complexity of mental illness. "Engel's model lists the ingredients but does not provide a recipe" (Slavney & McHugh 1987: 122).

None of traditional conceptual models has lost its identity in the biopsychosocial model. On the other hand, it is difficult to perceive the identity of the biopsychosocial model itself.

There is no better way to present Engel's way of thinking, to give the reader an idea of how much the biopsychosocial model is lacking in practical guidelines which are precondition for its clinical implementation than to cite Engel himself. After having mentioned diabetes mellitus and schizophrenic disorder as paradigms of physical diseases and mental disorders, Engel says that the biomedical model is not of much help in the proper interpretation, explanation and treatment of these maladies. Then he adds: "To provide a basis for understanding the determinants of disease and arriving at rational treatment and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician's role and the health care system. This requires a biopsychosocial model. Its scope is determined by the historic function of the physician to establish whether the person soliciting help is 'sick' or 'well'; and if sick, why sick and in which ways sick; and then to develop a rational program to treat the illness and restore and maintain health."

The knowledge provided by individual psychiatric models cannot be ignored. If we did that we would ignore psychiatric knowledge. The point is that there is no psychiatric knowledge outside the knowledge afforded by individual psychiatric models. At this moment, there is no useful knowledge for psychiatric practice other than the knowledge acquired within individual psychiatric models. The biopsychosocial model which upholds a conceptually, in fact, neutral position does not offer new psychiatric knowledge that could either supplement or replace existing knowledge. It is one thing to say that psychiatric practice and theory should integrate the contributions, no matter how partial, of individual psychiatric models, and another thing to create new knowledge.

In conclusion, while opposing "one-sided knowledge" (Eisenberg 1977) of the traditional models, the biopsychosocial model did not provide "multisided knowledge." Hence, it is not surprising that the biopsychosocial model has been accepted as a catch phrase but has not been translated into a new form of clinical practice.

Methodic Pluralism

Due to the fact that Karl Jaspers was the first one to assert that psychiatrist should make use of both causal explanation and meaningful understanding, this psychiatrist-turned-philosopher should be considered the forefather of methodic pluralism. S. Nassir Ghaemi holds that, apart from Karl Jaspers and himself, Leston L. Havens, Paul R. McHugh and Phillip R. Slavney are advocates of methodic pluralism. Ghaemi presented his ideas in his seminal work *The Concepts of Psychiatry. A Pluralistic Approach to the Mind and Mental Illness* (2003). More recently he has written on methodic pluralism in the paper titled "Pluralism in psychiatry: Karl Jaspers on science" (2007).

In order to delineate the specificity of methodic pluralism as clearly as possible Ghaemi points out the difference between eclecticism and the biopsychosocial approach. These two approaches might be conceived as a defense against dogmatism, that is, against commitment to only one model. Ghaemi criticizes eclecticism and the biopsychosocial model alike. According to him, the former is "an obstacle to further progress" (2003: VII). As for the latter, he writes that "the problem exists, perhaps, in the failure of the model itself, not failure to implement it" (2009).

Ghaemi's basic assumption is that keeping to only one method is not sufficient in psychiatrists' approach to the mentally ill because every method is partial, and thus suitable for only one aspect of those with mental illness. "Multiple independent methods are necessary in the understanding and treatment of mental illness" (2003: 15).

Eclectics say that since physical-biological and mental factors concurrently determine mental disorders, all methods are welcome in diagnosing and treating people with mental illness. And they should be used simultaneously. On the other hand, according to pluralism, to which Ghaemi signs up, individual methods and techniques should be used separately and purely. Psychiatrists should know the strengths and weaknesses of each individual method and technique. On the basis of such knowledge they should know when it is recommended to use one particular method (somatic, medical or psychotherapeutic), and when some other method or technique (medical, somatic or psychotherapeutic) is preferable.

Eclectics, Ghaemi adds, do not assess the perfections and imperfections of individual methods and techniques. "Little work is done on specifying when and why medications work or do not work, when and why psychotherapy is effective or not, and when they might (or might not) work best together" (2003: 82).

Thus the key difference between eclecticism and the biopsychosocial approach, on the one hand, and methodic pluralism, on the other, is that the practitioner of methodic pluralism is cognizant of what might be achieved by using a particular method, and therefore selectively applies this or that method. They use one or

more particular methods only in those cases where research results have shown that this is likely to give the best results.

In line with his pluralistic approach, Ghaemi is a fervent advocate of the two-person model. He devotes the concluding pages of his book to this model.

The two-person model, as its name indicates, comprises two therapists: a psychiatrist who prescribes drugs, and a psychologist and/or social worker who provides psychotherapeutic services. This model is gaining popularity particularly in the U.S.

What are the advantages and downsides of the two-person model? There are two putative advantages of this model. The first one pertains to cost-effectiveness. As psychiatric services are more expensive than the services provided by psychologists and social workers, the economic rationale says that a psychiatrist sees a patient for medication management a few times yearly, and that non-medical therapists see them on a weekly or fort-nightly basis. (There is, however, no convincing evidence that the two-person model has a fundamental advantage.) The other putative advantage of this model is that it is vehicle of the pluralistic approach, its organizing basis.

And what are the downsides of this model? They have been elaborated in the paper “The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist” (2001) by Gabbard and Kay. I will mention only a few of them. First, two therapists, one in charge of the brain, the other in charge of the mind, suggests tacit acknowledgement of the appropriateness of Cartesian dualism. On the other hand, the one-person treatment model implicitly endorses an integration of mind and brain in both the psychiatrist's and the patient's perspective. Second, the therapeutic alliance between one patient and two therapists is less beneficial than the alliance between one patient and one therapist. Third, if the psychiatrist's role is reduced to the role of psychiatrist-prescriber, the patient is likely to experience medication treatment as something that has nothing to do with their mind and mental suffering, with an ensuing negative attitude towards medications in general and low adherence to prescribed medications in particular. Fourth, since health insurance companies are not ready to compensate therapists for the time they spend discussing about the patient, they quite often do not exchange opinions about the patients they treat, about how the treatment is going, what should be done to improve its efficacy. It is not uncommon for therapists dealing with the same patient to never meet and not know each other. Such a lack of communication between therapists cannot help but to have a negative impact on the treatment of a patient, and in some cases might even be harmful.

As stated, Ghaemi is a strong advocate of the two-person treatment model. His view of this model is rather radical. Ghaemi writes: “There is absolutely no general reason why one treater would be better than two, three, or four. There is absolutely no general reason why a

psychiatrist would provide better psychotherapy treatment than a psychologist or social worker. For that matter, there is no reason to assume that a psychiatrist would provide better psychopharmacology treatment than a highly skilled and experienced nurse practitioner. It all comes down to knowledge, experience, and conceptual clarity” (2003: 306).

I agree with Ghaemi's first assertion. Psychologists and/or psychiatric social workers who are well trained and skilful in providing psychotherapy might be therapeutically more successful than a psychiatrist who does not have additional psychotherapeutic training and/or experience. However, it is highly doubtful that a nurse, no matter how skilled and experienced, could know more about psychopharmacological treatment than a psychiatrist. The knowledge about neurochemistry, physiology, pathophysiology, neuroanatomy and pharmacology that a psychiatrist acquires during medical studies makes them much more knowledgeable about psychopharmacotherapy than a nurse.

Ghaemi points out that “the best treatment is provided by the most expert treater” (2003: 306) and adds that no single clinician can be extremely expert at more than one approach or method in psychiatry. For example, a psychopharmacologist is not equally competent at the psychopharmacological treatment of all kinds of mental disorders. There is no such a thing as a universally competent psychopharmacologist. A psychopharmacologist who is expert in the treatment of bipolar disorder can provide the best psychopharmacological treatment for people suffering from this kind of disorder. The same holds for psychotherapists. A psychotherapist who is highly qualified for the treatment of general anxiety disorder, for example, can provide the best psychotherapeutic services to those with this disorder. “The best outcome will arise from multiple treaters, each of whom is expert in what she or he does” (2003: 307)

In addition, empirical evidence about the kind of psychopharmacological or psychotherapeutic treatment that is the most effective should determine the choice of both the treatment and therapist. In other words, prior to the application of any kind of therapy, a decision is to be made regarding the kind of treatment and therapist. First, a decision is made on the basis of empirical evidence of which kind of treatment has proved the most successful in the management of that particular disorder. Second, a decision is made after searching through a list of therapists (both psychopharmacologists and psychotherapists) where they are classified according to their expertise in the management of particular disorders. If such a list exists at all!

Several questions arise in regard to the cited way of deciding which kind of therapy to administer and which therapist(s) to recruit.

First, there are several hundred types of psychotherapy today. In order to know which one gives the best results in the management of a particular disorder, one has to know how many kinds of psychotherapy

have been tested in regard to their efficacy in the treatment of that particular disorder. In addition, bearing in mind that measuring the outcome of psychotherapy is not the best side of the studies dealing with the efficacy of psychotherapy, it is questionable whether a valid conclusion can be reached regarding which kind of psychotherapy is best suited to this or that kind of disorder.

Second, there are several hundred forms of mental disorder in DSMs. We are far from having experts, either psychopharmacologists or psychotherapists, able to manage hundreds of forms of mental disorder. So what should be done in those cases where there are no experts at treating them? Is the two-person model justified in these cases, or is its usefulness confined to people with mental disorder where experts have been confirmed and sanctioned in its management?

Third, if subspecialists in a specific type of treatment of a single mental disorder will be more in demand in years to come, and consequently the ambition of more and more psychiatrists will be to be experts at the management of only one disorder by only one therapeutic measure, we can expect in no so distant future that there will be psychopharmacologists dealing only with Depression type I, or only Depression type II, or those who are the best in the management of Delusional Disorder, and those who are the most competent in the management of Schizophrenic Disorder? Or, along the same lines of reasoning, will there be psychotherapists who excel in the treatment of Generalized Anxiety Disorder, but are not as good in the management of Panic Disorder. (Given the rather frequent change of the names of psychiatric syndromes or entities, it will not be easy to make out which disorder a psychopharmacologist or psychotherapist excels in managing!)

Fourth, as comorbidity is ever more frequently diagnosed, does this mean that experts in the management of each single disorder should provide services to a patient who suffers simultaneously from more than one disorder? If the answer is in the affirmative, does this mean that the two-person model should, in those cases, be superseded by the four-person or the six-person model? (Two therapists for each disorder.)

Fifth, in how many regions around the world would it be possible to organize the provision of mental health care according to the principle of the two-person model? In how many countries are there experts in the management of particular disorders, and how many of them are available to those suffering from this or that kind of mental disorder? In other words, demanding that the best treatment should be provided by the most expert treater, however sensible it might sound, seems elitist in its assumption and fall-outs.

In addition, by advocating the two-person model, Ghaemi acknowledges that a psychiatrist is not able to skillfully master different methods originating from different psychiatric models. By the same token he affirms a division within psychiatry, regardless of

whether one calls the existence of different models in psychiatry psychiatric conceptual cacophony or euphony.

Finally, although he presents himself as an advocate of pluralism, Ghaemi, judging by the last pages of his book, turns out to be more the supporter of the new perspectivism in the sense that Schwartz and Wiggins (1988) gave to this term, than a pluralist. When he says that empirical evidence will tell us which kind of treatment is the most efficient for a particular disorder, he actually installs “positivist method of inquiry as the only acceptable one.” As Ghaemi knows, empirical evidence cannot be obtained without the use of statistical analyses of clinical trials of groups of patients, without “highly specified techniques and procedures, careful definitions, standardization, treatment manuals, and the like.” And these procedures and techniques are an integral part of the hypothetic-deductive approach, and more broadly of the medical model.

Pragmatic Approach

David H. Brendel is the author of the pragmatic approach in psychiatry. He has presented his ideas in several papers published in journals such as “Harvard Review of Psychiatry,” “Journal of Clinical Ethics,” “Journal of Medicine and Philosophy” and “Philosophy, Psychiatry and Psychology.” The book *Healing Psychiatry. Bridging the Science/Humanism Divide* (2006) is his major work.

Brendel first states that it is opportune to criticize both the view of those who endorse a scientific approach and the view of those who favor a humanistic approach in psychiatry. When talking about the former he means the medical approach, and when discussing the latter he has in mind the psychological, mostly psychoanalytical approach. Brendel claims that in *Of Two Minds: Growing Disorder in American Psychiatry* (2000) Tanya M. Luhrmann has provided an accurate account of the deep divide in American psychiatry between those who espouse the scientific-empirical approach and those who are the proponents of a humanistic stance.

Brendel believes that he has found a remedy that will help cure psychiatry. Pragmatism is the name of the remedy. “It is by way of clinical pragmatism that the conceptual wounds in psychiatry and the emotional wounds in the lives of individuals can begin to heal” (2006: 6).

According to pragmatism, to remind the reader, explanations are valid if they are useful, if they provide benefit. The practical usefulness of a concept is the only reliable indicator of its truthfulness. Brendel is of the opinion that philosophical pragmatism, which originated in the United States and has its proponents in William James, John Dewey, and Charles S. Peirce, provides principles and instruments which psychiatrists can use to bridge the divide between science and humanism, a divide that drags psychiatry backward.

Brendel is right when he writes that it is the attitude of psychiatrists towards the said divide and their ability to bridge it that will determine the quality of mental health care, research and education in the mental health field in the twenty-first century. It is not only a theoretical and practical matter but also an ethical issue because psychiatrists have a professional and ethical obligation to provide the best possible assistance to patients. And such assistance is presumed on bridging the divide between science and humanism. Hence those who ignore or pay lip service to the need to cross the divide behave unethically.

Brendel has recognized instruments in the four major principles of pragmatism that will lead psychiatry out of the crisis caused by the existence of legitimate different approaches within psychiatry. To be able to heal wounds psychiatrists have to nurture the following approaches: practical, pluralistic, participatory, and provisional. If they do that they reportedly will provide patients the best possible care.

I will analyze each of these principles (approaches) in turn. Their implementation, according to Brendel, shows how pragmatism can help psychiatry to address its threatened disintegration.

Practical approach

Brendel writes: “Clinical psychiatrists ought to regard their theories not as ends in themselves but rather as tools for dealing with the practical challenges they confront each day in the clinic” (2006: 38). No matter how good a concept or theory sounds, only practical consequences matter. “Psychiatric explanations are coherent and plausible,” Brendel adds, “insofar as they are effective in the course of clinical care and are subjected to continual questioning, testing, and reassessment” (2006: 38).

Pluralistic approach

There is considerable proof that biological, psychological and social-cultural factors co-determine the origin of mental disorders, their clinical presentation and outcome. Therefore, only an approach that is pluralistic, meaning an approach that comprises all the sides of mental disorders, is well-grounded. In other words, the principles of all three models (medical, psychological, social-cultural) should be applied. These models are complementary because each of them is focused on one dimension of the mentally disordered. The weak points of individual models should not be a reason to shun them. Each model should be acknowledged for the specific knowledge it provides, regardless of its downsides. And there is no psychiatric model that is not useful, i.e., helpful to some extent and in some regards.

“Clinical judgment, of course is very difficult to define, but its core elements would include evidence-based hypothesis formation, consideration of a wide range of diagnostic possibilities, careful observation of a broad spectrum of clinical phenomena, flexibility to revise a clinical formulation on the basis of new

evidence, and open-mindedness to consultation with other colleagues in situations that are characterized by complexity, confusion, and uncertainty” (2006: 40).

The pluralistic approach should enable psychiatrists to find a conceptual synthesis of differing positions of individual models. What is important is to strike the optimal balance between scientific and humanistic views.

Participatory approach

The patient and possibly those who are close to them should partake in designing the therapeutic plan. The psychiatrist's opinion alone about what the therapeutic plan should be like does not suffice. The patient's view, as well as the view of those they live with, has to be taken into consideration. If the patient participated in defining the therapeutic plan, they are more likely to accept it and implement it. The same holds for people living with the patient. If they have a say in the articulation of the plan, they will more easily understand it, in particular its usefulness. Also they will more readily support the patient in the implementation of the plan, and will be more willing to monitor how strictly the patient follows therapeutic guidelines. Briefly said, a deliberative and collaborative approach is a genuine possibility for psychiatry.

Provisional approach

Pragmatism says that there are no ever-enduring truths, that concepts that proved unhelpful in the past might prove helpful in the future. Correspondingly, psychiatrists should not be fully committed to a particular view and believe that there is no other and never will be any other more useful view that will profit patients. New discoveries might easily make flawed a concept which we believe to be so congruent to reality that we take it for granted. A critical view of reality makes us humble and cognizant of how tentative beliefs are. The conviction that a concept will withstand the test of time is by and large futile.

The reader of the preceding lines rightly wonders what pragmatism offers to psychiatry that is new, what is the point in applying the principles of pragmatism in psychiatry, how can pragmatism help psychiatry heal the wounds caused by the science/humanism divide (Kecmanovic 2011: 263). Before Brendel taught us this, we knew that good practice is the best theory. There was no need to tell us that no model can encompass the totality of mental illness. There is also nothing new in the assertion that a paternalistic attitude towards the mentally disordered is harmful and that the patients themselves and those living with them should be included in the therapeutic process and in particular in the so-called resocialization of the mentally ill. Finally, all those who have read the history of psychiatry or have been in psychiatry for several decades know quite well that nothing is durable in the world of psychiatric ideas about the origin and nature of mental disorders and the best possible treatment.

Brendel fell short of answering the key question, the importance of which he clearly pointed out: how would it be possible to resolve, or to use his phrase to heal the deep wounds that the confronting conceptual approaches have left on the face of psychiatry (Brendel 2004), conceptual wounds that have resulted from dividing the human individual into an object of scientific scrutiny and a subject of personal experience.

In order to show that pragmatic psychiatry does not offer anything new, least of all a fix for the conceptual cacophony in psychiatry, I will present Brendel's recommendations about what a pragmatic psychiatrist should do when someone in need approaches them. First, they focus on achieving the possible treatment outcome, and do not wonder whether or not they are doing their job according to the principles of a particular model. Second, their approach is pluralistic; it includes the consideration of both scientific data and the patient's specific existential (psychological, interpersonal) position. Third, they ask the patient and whenever possible those who live with them or are close to them, to partake in deciding what kind of approach is satisfactory and useful, and if this is the patient's request, they integrate two or more models. Fourth, they acknowledge that any decision they have made, any plan they have formulated is only provisional in view of the long-term treatment. "This pragmatic model may entail a creative combination of psychotherapy and psychopharmacology, which is increasingly recognized by both psychotherapists and psychopharmacologists as more efficacious in many situations than either modality alone" (Brendel 2004).

Brendel's effort to formulate pragmatic psychiatry is worthwhile. However, he does not explain how psychiatrists will deal with combining or harmonizing the principles and treatment techniques of different models in everyday practice. When I say "how psychiatrists will deal with" I mean how can psychiatrists be equally good at providing pharmacotherapeutic and psychotherapeutic services, how can they reconcile antagonistic positions of the medical and the psychological model, or in Brendel's terms, how can psychiatrists heal the wounds created by scientific/humanistic discord? The above-mentioned principles or approaches of pragmatic psychiatry do not teach psychiatrists how to achieve this noble goal.

There is no better way to show how hard it is to carry out the *devoirs* which, according to Brendel, a psychiatrist should perform in the process of diagnosing and treating patients, than to cite Brendel himself. "The pragmatic psychiatrist will make use of every applicable explanatory concept along the biopsychosocial continuum in order to collaborate with patients toward the goal of achieving integrative and beneficial treatment outcomes. This pursuit will heed and incorporate any scientific evidence that may apply to the clinical situation at hand, but will do so in a flexible, interactive way, and humanistic fashion. It can and ought to be done without falling into the trap of

postmodernism's lack of theoretical and practical clarity" (2006: 48). It sounds good as a goal, a norm, a declaration. But the question arises as to will psychiatrists be able to make use of every applicable concept that emerges in biomedical or somatic psychiatry, in psychological psychiatry and social psychiatry? First of all, will they be able to follow all the innovations in the cited fields; second, will they be able to learn how to apply them; third, will they be able to reconcile different concepts and practices of the different and antagonistic models that are covered by the notion of biopsychosocial continuum?

In the introductory part of his book Brendel admits that "at this time, unfortunately, there is no well-defined and widely accepted third option that navigates between both sides of the science/humanism divide" (2006: 23). And it is not "forces in contemporary sciences (and in society in general)" that are to be blamed for the lack of a well-defined and widely accepted third option, as Brendel claims, but rather the fact that a mentally disturbed person lives in two worlds and there is no all-encompassing concept of both the mentally ill and the mentally sound, of mental disorder and mental health. Only such a concept, or concepts, can pave the way towards a psychiatric supermodel which will harmonize and above all unite opposing psychiatric models.

By its basic assumptions and the design of its practice, provided by Brendel, pragmatic psychiatry certainly is not such a sought-after third option, or supermodel. Pragmatic psychiatry is but one of many failed attempts to resolve the psychiatric conceptual cacophony or appease it at the very least.

CONCLUSION

There are many models in psychiatry. They are largely opposed and even mutually exclusive in terms of epistemology, conceptualization of the genesis of mental disorders and prescribing the most efficient type of treatment.

The existence of a great many models is not common in other medical disciplines. This is one of the specificities of psychiatry. In no medical discipline other than psychiatry it is appropriate to ask about a particular doctor's theoretical-practical orientation. Yet, prior to seeking psychiatric help, it is recommendable to get information about the model that potential care provider espouses.

There is no scientific or any other evidence that any model is superior to others in regard to how its proponents interpret the origin of mental disorders and threat those who suffer from them. That is one of the key reasons why all models are legitimate. Indeed, in various periods no more than one or two models have been considered as the most plausible. Nevertheless, the dominance of one or two models at a particular time, caused mostly by social circumstances and financial interests, has not made other models totally obsolete.

The result is conceptual cacophony as a stumbling block, or one of the stumbling blocks, in psychiatry. It is such a powerful disintegrating force within psychiatry that the future of psychiatry greatly depends on whether psychiatric conceptual heterogeneity will be resolved or at least reduced.

Moreover, conceptual discord tarnishes the public image of psychiatry and psychiatrists. Thus, McLaren maintains that comparatively frequent changes of the dominant model in psychiatry prevent people from taking psychiatry seriously. “On the theoretical basis of psychiatry there is no agreement,” writes McLaren. “Granted, the dominant approach to mental disorder today that is termed biological psychiatry... tomorrow could see yet another of the vertiginous swings which have characterized psychiatry for the past one hundred years. These types of swings have led some perfectly sensible people to ask why they should take psychiatry seriously” (2007: X).

Conceptual cacophony has a negative impact on relations within the psychiatric community as well. Professional communication is in a fair number of cases confined to practitioners of one and the same model. Those who are committed to a cause of a particular model are quite often not keen on learning what their colleagues on the other side of the fence think about a particular patient, which kind of problems they face, how far they have gone in detecting pathways leading to mental illness. There is no doubt that such state of affairs within the psychiatric community hinders dialogue between the holders of different views. And it is dialogue rather than its absence that might assist psychiatrists to bridge the science/humanist divide.

Even though mental disorder does not include the impairment of all mental functions, one might say that a mentally disturbed person is disturbed in all aspects of their existence. Therefore, an approach that respects the complexity of human beings has the greatest chance of proving helpful. By focusing only on one aspect of the mentally ill people individual psychiatric models have missed that chance.

Attempts to define a new approach that would correct the deficiencies of the individual models (the biopsychosocial model, pluralistic approach, and pragmatic approach) have not provided a satisfactory response embraced by most psychiatrists to the psychiatric conceptual puzzle. Eclecticism is not a seemingly option, either.

As far as the creation of conceptual unity is concerned, psychiatry is at a dead-end at this stage. The most worrisome thing is that the majority of psychiatrists are not aware of the extent of the damage caused by conceptual cacophony. They simply ignore the conceptual cacophony and the damage it has done.

In “Introduction” to *Philosophical Issues in Psychiatry*. Explanations, Phenomenology, and Nosology Kendler writes: “How can we develop a frame of reference in which we can anchor our multiple

perspectives, lest our pluralism degenerates into a disorganized list of facts that could more confuse than enlighten?” (2008: 5).

My answer to this question would be that, at this stage, nothing suggests that psychiatrists are likely to develop such a frame of reference any time soon.

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