Eclecticism and Adolf Meyer's Functional Understanding of Mental Illness

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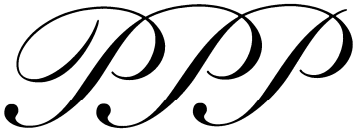

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I am grateful to Nassir Ghaemi and Edwin Wallace for their commentaries. Both are very knowledgeable about Adolf Meyer and the biopsychosocial model in general.

Ghaemi's Commentary and Meyer's 'Eclecticism'

I am not against humanism. How could anyone be against the humanistic wisdom rooted in the worthy writings of Socrates, Hippocrates, Shakespeare, Cervantes, Osler, and the others listed by Nassir Ghaemi? Psychiatry should recognize the dignity and value of all people. The problem is that it may not always do so, coming from a reductionist paradigm as it so often does.

Ghaemi appreciates that Meyer's compromising attitude meant that he was "unable to inoculate psychiatry from biological dogmatism." My emphasis is on the challenge of Meyer's psychobiology to biomedicine. In the same way, Engel's biopsychosocial model acknowledged the need to neutralize the power of an impersonal and mechanical medicine. Doctors tend to overemphasize physical abnormalities at the expense of dealing with difficult personal issues.

At the risk of oversimplification, I am juxtaposing biopsychosocial and biomedical models in psychiatry. Or in other terms, for our modern understanding, I am asserting a neo-Meyerian approach in contrast to neo-Kraepelinianism. Merely restating the Meyerian perspective will not do, because of Meyer's 'give and take,' and his consequent failure to follow through the implication of his position. At least the ethical ramifications of his conceptual framework need to be acknowledged.

Neo-Meyerianism also needs to be realized in the context of the reaction to anti-psychiatry. After anti-psychiatry's attack, our modern understanding of mental illness has tended to be been subsumed into the binary opposition of 'pro-psychiatry' and 'anti-psychiatry.' But neo-Meyerianism is as much pro-psychiatric as biomedical psychiatry. It is in this sense that biopsychological approaches have been undermined by the biomedical reaction to anti-psychiatry.

I also agree with Ghaemi that there is a way in which the failures of the biopsychosocial model allowed the development of anti-psychiatry. For example, even though Laing quoted favorably from psychologically minded psychiatrists such as Manfred Bleuler, as far as I know he never made any reference to Meyer. There was never a systematic Meyerian theory to which Laing could refer. In fact, Laing wished to move beyond an interpretative understanding to abandon the metaphor of pathology (Double 2006). Perhaps if the biopsychosocial model had been more clearly defined, Laing would not have felt he needed to take this step. Or, at least in doing so, he would have been clearer about where he stood on this issue. When labeling Laing's views as 'anti-psychiatry,' biomedical psychiatry would have had to state more precisely how Laing's position was anti- rather than pro-psychiatric.

My main disagreement with Ghaemi is his view of Meyer as eclectic. Meyer's willingness to allow 'anything goes' in psychiatry meant that he did not oppose or challenge too much the views of those with whom he disagreed. Nonetheless, he did not combine together different sources to create an unintegrated philosophical and conceptual understanding. His theoretical position is internally consistent.

Modern American psychiatry studied by participant observation is "of two minds," in that there is a divided consciousness created between the practices of drug therapy and psychotherapy (Luhrmann 2000). In this sense, it is eclectic because there is no consistent theory that combines the two practice modes. True, psychiatry often claims that the foundation for this mixture is the biopsychosocial model. It asserts that everyday psychiatry is not as purely biomedical as is often maintained because it takes into account psychosocial factors that may precipitate mental disorders. It, therefore, says that it bring together the biological and psychosocial. This compromise avoids the adoption of any one model and was proposed to neutralize the dogmatism engendered by the anti-psychiatry debate (Clare 1980). I agree with Ghaemi that such eclecticism has outlived its usefulness.

Where I think Ghaemi is mistaken is that he sees Meyer and Engel as the originators of this eclecticism. I regard the Meyerian approach as more genuinely pragmatic than Ghaemi suggests. Meyer's dynamic psychology sought an integration of mind and brain as a way of dealing with the philosophical dilemma of the mind–body problem. According to William James, this is the hallmark of pragmatism, which is "primarily a method of settling metaphysical disputes that otherwise might be interminable" (1907).

Meyer was consistent in his understanding of mental disorder. He was more thoroughgoing in pursuing the implication of psychogenesis than an eclectic approach allows. He did not see the biological foundation of psychoses as dissimilar from other mental disorders, such as the neuroses and personality disorders. Eclecticism acknowledges that stress may precipitate mental disorders on the basis of a biological vulnerability. It emphasizes the biological causes of psychotic disorders, which may be difficult to understand in personal terms. The role of psychogenesis in neurotic and personality disorders is more easily accepted, whereas psychosis is presumed to have biological origins.

Meyer, by contrast, sought an integrated biopsychological understanding. Of course, mental disorders have their biological foundation. As he was fond of saying, it is mere "neurologizing tautology" to state otherwise. By this, he also meant that it was pure speculation to suggest that biological abnormalities will be found that will explain the cause of functional mental illness. The wish for absolute understanding should not hide the uncertain nature of psychiatric practice. Meyer had a psychogenic understanding of dementia praecox, and believed that such psychological understanding should apply to dementia praecox as much as to any other psychiatric disorder (Meyer 1906). The reasons why people become psychotic are not understood by suggesting that such a process occurs because of a condition behind the symptoms called dementia praecox.

Recognizing the pluralism of psychiatry is not the same as being eclectic. It is desirable that people from different perspectives work together in psychiatry. The psychiatric field is inevitably diverse. The problem is that psychiatry too readily becomes dogmatic in promoting a biomedical orthodoxy.

Wallace's Commentary and Functionalism

I agree with Wallace that the roots of medicine are functionalist. In a sense, the importance of the psychosocial context for medicine had to be relearned because of the spectacular triumphs of the anatomoclinical method in the last decades of the nineteenth century.

People have had all sorts of ideas about the nature of illness, including mental illness, which no longer seem viable. For example, in the eighteenth century, disturbances of blood and its circulation were frequently cited as the cause of mania and melancholia. Friedrich Hoffman, for instance, attributed both these diseases to insufficient perfusion of the brain, the extent of which determined whether it was mania or melancholia that occurred.

As another example, our context is different from the somaticist–mentalist conflict of the early nineteenth century. When J.C. Heinroth outlined the mentalist case that psychiatric disorder was due to the soul becoming ill through sin, he was writing before our modern secular understanding meant that the soul could no longer be seen as relevant to the notion of mental illness. The somaticists also believed in the soul. For instance, Johannes Baptista Friedreich regarded the soul as immutable and immortal. From his point of view, therefore, it could not become ill, as Heinroth proposed. Instead, the root cause of psychic disease must be in a bodily organ, which was not necessarily the brain, although its effect was generally seen as being mediated via the brain (Kirkby 1992).

Griesinger differed from Friedreich in always seeing the brain as the origin of mental disease (Beer 1996). This is essentially the same principle as our modern biomedical understanding. It is not always appreciated that Griesinger did not see psychopathology as necessarily involving structural changes, which only occurred secondarily, before possibly leading on to a third phase of deterioration and incurability (Marx 1972).

As the nineteenth century progressed, evidence of histological abnormalities in organic psychoses, such as general paresis, encouraged the biomedical perspective. Even though many late-nineteenth-century psychiatrists used the term *functional psychosis* to denote conditions that had no gross anatomical changes, they still often thought there must be 'sub-anatomical,' molecular disturbances. The assumption developed that there is an undiscovered organic etiology for endogenous psychoses.

There were trends focusing on the person, such as Meyer's psychobiology, that counterbalanced the biomedical perspective. Nonetheless, the biomedical approach remains dominant in modern psychiatry. I am aware of the selective and schematic nature of the history I have outlined. Despite this, a genealogical understanding can help to make theories about the concept of mental illness intelligible. At the risk of oversimplifying, I think there is merit in stating a neo-Meyerian perspective as an explicit challenge to biomedicine.

Contemporary psychiatry needs to be clear that the concept of mental illness can be applied to psychological dysfunction (Farrell 1979). The focus needs to be on understanding the patient as a person. To quote from Wallace's favorite paper by Engel:

> [T]he biomedical model represents a limiting case the utility of which is in no way diminished as long as its use is restricted to that which it was designed. . . . To become more fully scientific, medicine requires a paradigm capable of encompassing the human domain. (Engel 1988, 131)

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