American Journal of Psychotherapy, Vol. XLIII, No. 1, January, 1989, pp. 54-67

The Dilemma of Contemporary Psychiatry

Sanford L. Drob, PhD/ Fielding Graduate University

This article was originally published in the *American Journal of Psychotherapy*, Vol. XLIII, No. 1, January, 1989, pp. 54-67.

Several years ago a patient with an unusual treatment history, was referred to me for psychological testing. The woman, who suffered from bouts of depression, anxiety, and "panic attacks" had seen four psychiatrists, two psychologists, and a social worked over a three-year period in an effort to find relief from her symptoms. In the course of her various treatments she had been prescribed thorazine, three anti-depressants, at least three anxiolitics, and had been treated by a behaviorist, a cognitive therapist, a family-systems therapist, and an existential-humanist, all, she reported, without any lasting benefit. She had now finally decided to "buckle under" and seek "a thoroughgoing psychoanalysis". The analyst she had found had sent her to me with the query: "is the patient a candidate for intensive dynamic psychotherapy?"

Upon questioning, the patient noted that her three-year odyssey from therapist to therapist had left her disheartened and very confused. She stated that she had never been able to understand why it was that psychiatry did not have one standard, recognized treatment for her disorder. Putting aside my suspicion that her own character pathology had contributed to her whirlwind tour of the psychiatric world, I had to recognize her question as an important one, perhaps the most important one facing the mental health professions. A dilemma exists both for patients and practitioners because a number of different schools, adopting widely divergent concepts and techniques, each purport to have solutions for the problems that patients bring them. It has become almost commonplace to remark that psychiatry, unlike general medicine and even more unlike the "hard" sciences of biology, chemistry, and physics, is "pre-paradigmatic" or "multi-paradigmatic[1]". There are indeed no standard treatments, because there are no universally agreed-upon ways to conceptualize the problems to be treated. Lazare[2] once remarked that there are four possible paradigms in psychiatry; the biologic, the behavioral, the psychoanalytic, and the social. My own view, as will soon be evident, is that there are (at least) six, but regardless of the number, the dilemma created by the division is not simply an academic one: the philosophical dilemmas confronting contemporary psychiatry are, if we look closely, often reflected in the conflicts that patients experience in regard to their own psychological suffering. Patients, for example, who reflect upon the question of whether their depression is or is not a disease caused by forces beyond their control, or who wonder whether their current anxiety is or is not a symptom of long-standing and deep-seated conflicts, are asking questions about which the field of psychiatry is itself deeply divided and confused. It is the goal of this paper to analyze the basic divisions within contemporary psychiatry and to map out the various possibilities for its resolution.

Six Schools of Contemporary Psychiatry

There is, of course, something arbitrary in making sharp divisions between "schools" of psychiatry, for in actual practice the work of any psychiatrists or mental health professional is almost always a function of a variety of greater and lesser influences. The behaviorist, for example, is often influences by concepts arising out of cognitive psychology (hence the term "cognitive behaviorism"); the family-systems therapist may be influenced by psychodynamic thinking, etc. Nevertheless, for expository purposes it is useful to divide the contemporary psychiatric scene into six, relatively discrete, schools of thought. Table I (reproduced in the Appendix) and the discussion that follows summarizes these schools of thought by (1) noting their views of the presumed underlying nature or "deep structure" of psychopathological phenomena, (2) describing their theoretical conceptions of a common psychiatric disturbance (depression), (3) listing prescribed treatments for depression, (4) indicating each of their value orientations or treatment goals, (5) tracing some of their historical antecedents and (6) linking them to a philosophical perspective that serves as their conceptual foundation. I will now consider each of theses schools, the biological, the behavioral, cognitive, family systems, psychodynamic\psychoanalytic, and existential-interpersonal, in turn.

I. *Biological Psychiatry* can be understood as those forces within psychiatry that are committed to the view that the most fundamental explanations for psychological phenomena derive from the discoveries of human biology, particularly the biology of the nervous systems and the brain. Biological psychiatry therefore searches for an organic deep structure to psychopathological phenomena and is inclined to view psychiatric disorders as akin to organic disease. For example, a commonly held biological theory of depression states that depression is caused by a functional deficit of one of more brain neurotransmitter amines (serotonin, norepineophrine) at a specific central synapses[3]. The treatments, which follow from the biological point of view, are somatic in nature and generally pharmacological. Thus, for depression, medications (antidepressants) that inhibit the reuptake of brain amines into the presynaptic neurons are prescribed. While the specific details of the "catecholamine hypothesis" many prove incorrect, and the specific mechanisms by which antidepressant medications are effective may for a time remain unknown, biological psychiatry is committed to the idea that the best way to both understand and treat depression is to view it as a neurophysiological disorder. The ultimate somatic treatment for depression and other psychiatric disorders will not simply alleviate symptoms, but will correct the underlying biological causes of a disease. Biological psychiatry aims to cure mental illness in the same way that general medicine aims to cure cancer.

While the biological perspective has a long history dating back at least as far as Hippocrates, today's biological psychiatry has its philosophical foundations in a doctrine known as scientific materialism. This doctrine, which has been advocated in various guises since the pre-Socratic philosophers Democritus and Leucippus, holds in its modern form, that the world consists of material things (the ultimate particles\entities of physics), their states and their relations.[4] [5] All material phenomena, including conscious states, are understood as a casual function of material events. While the findings of biological

psychiatry do not stand or fall upon the defense of a particular philosophical doctrine, the main impetus for the view that biological explanations in psychiatry are *fundamental* is an *a priori* commitment to scientific or reductive materialism.

II. *Behavioral Psychiatry,* like biological psychiatry understands psychological phenomena as a function of material events, but the material events with which it concerns itself are macroscopic as opposed to microscopic in nature. Behavioral psychiatrists are committed to the view that psychological (and therefore psychopathological) concepts are best understood as referring to behavioral dispositions, generally thought to result from an organism's interaction with the environment.[6] Behavioral psychiatry rejects the notion that psychiatric symptoms have a "deep structure" within either the "mind" or nervous system of the individual who suffers from them. It instead seeks to discover the environmental conditions that maintain these symptoms though various contingencies of reinforcement; postulating, for example, that depression is the result of a lack of reinforcement, or the result of environmental events that make an individual incapable of achieving or controlling outcomes (learned helplessness).[7]

Behavioral psychiatry can trace its historical roots to influences as diverse as age-old common sense, the biblical book of *Job,* Aristotle, Descartes, Darwin and the various objectivist or positivist tendencies in modern philosophy. It has its current philosophical foundation in a broad doctrine known as philosophical behaviorism.[8] [9] For this point of view, consciousness and introspective states are either seen as an illusion, or as methodologically irrelevant for psychology and consequently for psychiatric practice. While philosophical behaviorists recognize the role of the brain and nervous system in human behavior, they argue that because the meaning of psychological language is grounded in observations of molar units of behavior, it is this level which provides the key to the proper understanding of our mental life.

III. *Cognitive Theories:* Broadly speaking, psychiatrists with a cognitive orientation are committed to the view that psychopathological phenomena are best understood as a function of beliefs, judgments, and\or a variety of other cognitive states and processes. While often recognizing that cognitive states are themselves dependent upon biological processes, cognitive therapists argue that the most useful way to conceptualize psychological and psychiatric phenomena is in terms of functional relations between abstract cognitions rather than through descriptions of concrete events on the neurophysiological level. They argue, using a cybernetic analogy, that the mind is better understood though an explanation of its "software" (the concepts and information that characterizes it) than through a detailed consideration of the hardware (or neuroanatomical circuitry) which permits the information to be processed. It is this reasoning that permits cognitive psychologists to produce computer-generated "mind models" that serve as analogs of human thinking, feeling, etc.

Cognitive theorists in psychiatry see psychopathology as a disorder or distortion of normal cognitive process. For example, depression is understood as resulting from a series of irrational judgments, generalizations, and negative beliefs about self, the future,

and the environment.[10] The prescribed treatment is a form of verbal therapy in which the patient is encouraged, conditioned, and "educated" to produce more optimistic, rational, and less depressogenic cognitions. The aim of cognitive therapy is the cure of psychiatric symptoms by altering the disordered cognitions that lie at their base. The ultimate goal of this treatment is the promotion and production of rational living.

Cognitive psychiatry has its historical roots in the Stoic doctrine that all of life's virtues are based upon knowledge, and in the various rationalist trends in Western thought. It has its philosophical moorings in contemporary rationalism that has seen a revival in recent years, both as a result of the revolution of cybernetics, and because of important developments in psycholinguistics.[11] Cognitive theorists in psychiatry however have this far paid minimal heed to either developments in contemporary philosophy or current theories in the field of cognitive psychology. It is to be expected, for example, that information-processing theories and cybernetic models will have a greater influence upon psychiatric theory in years to come.

IV. *Family-Systems Approaches:* Grouped under this heading are clinicians and theorists who can best be characterized by their rejection of an assumption that is implicit in nearly all psychiatric thinking: the assumption that psychopathological symptoms and behaviors are to be understood as resulting from processes within the bodies or minds of *individuals*. Instead, the family-systems theorist sees individual psychology as a function of the patterns of interaction and equilibrium that occur in a network of individuals. The source of what appears to be individual psychopathology (such as depression or schizophrenia) is a disordered interaction between individuals.[12] Since the family forms such a system, it is often taken by systems theorists to be the basis for both psychological explanation and psychiatric treatment.

From the family-systems point of view depressive symptoms exhibited by an individual are an expression of a dysfunction of, or disequilibrium within a system of two or more persons. For example, depression can result when an individual is forced into a family role that conflicts with the role he or she is expected to take in a wider social system, or when an individual is *scapegoated* for difficulties in a relationship between two or more other persons.

Family-systems theory is radical in its rejection of the individualism (both methodological and substantive) that has been the hallmark of Western philosophy and psychology. Nevertheless, one can find its historical antecedents in the various collectivist ideologies in Western thought. Plato's views in the *Republic,* Marx's collectivism, the sociological viewpoint, exemplified in Durkheim, are all important antecedents. Still, family-systems psychiatry has yet to find its theoretical underpinnings and philosophical foundations. Some theorists attempt to integrate their clinical findings through concepts derived from general systems theory,[13] a conceptual system originally formulated to account for the interaction of biological processes on microscopic and macroscopic levels.

V. *Psychodynamic Approaches:* Psychodynamic concepts inundate and, until recently, have completely dominated psychiatry. It is nonetheless difficult to define precisely what psychodynamic psychiatry is. This is in part due to the fact that a huge variety of important contributions to psychiatry have been broadly classified as "psychodynamic" and "psychoanalytic" and in part due to a tension that many believe exists within psychodynamic thought itself: a tension between a scientific, naturalistic, deterministic view of man and a humanistic, libertarian approach. This tension has a variety of sources. One of them is the dichotomous nature of Freud's own professional development; his background in medicine and particularly neurology, on the one hand, and his interests in the humanities and literature, on the other. The ultimate expression of this tension within psychoanalysis is in the distinction between Freud's metapsychology (his abstract theoretical formulations) and his clinical observations and practice. [14] [15]

Freud operated as an interpreter in all of his clinical work, but when it came to formulating theories to account for his findings he adopted a mechanistic or structuralist rubric, which reflected the influences of late 19th-century neurology. Thus Freudian metapsychology came to reflect a philosophical commitment to *structuralism*: the view that concrete psychological phenomena are to be understood as a mechanical function of abstract mental structures (e.g., id, ego, superego). In contrast, Freud's clinical theory reflects a commitment to *hermeneutics*: the view that concrete psychological and behavioral phenomena are to be understood in terms of the meanings they have for the individual who exhibits them. The tension between structuralism and hermeneutics, and in a wider sense between natural science and the humanities is at the core of psychodynamic psychiatry, and accounts both for some of its theoretical difficulties and perhaps much of its popular appeal.

The distinction between structuralism and hermeneutics is reflected in the specific theories and techniques of psychoanalytical psychotherapy. In general the structuralist viewpoint emphasizes psychic equilibrium as the goal of treatment, whereas the hermeneutic point of view is far more humanistic and libertarian in spirit (Table 1).

The historical antecedents of "structural psychoanalysis" include the pre-Socratic philosophies of conflict and strife, Plato's tripartite division of the human soul, and the psychological and neurological theories of the late 1800s. The antecedents of hermeneutics or "interpretive" psychoanalysis are to be found in the exegetical traditions of Judaism and Christianity, and the incorporation of exegesis into the social sciences in the late 19th century.[16]

Because of the dichotomous nature and origins of psychoanalytic thought, and because psychoanalysis attempts to bridge the gulf between the "two cultures" of the sciences and the humanities, there can be no simple explanation of its philosophical foundations. While philosophers such as Ricouer,[17] Yankelovitch and Barrett,[18] and Grunbaum[19] have addressed the natural science\hermeneutics issue with some success, the issue has not been adequately addressed by psychoanalysts themselves, who tend with a few notable exceptions[15] [20] to either defend analysis as totally scientific or retreat into the position of calling it mainly art. How natural scientific and humanistic approaches to man's inner

experience and behavior can be integrated into a single psychology is seen by many to be the challenge not only for psychoanalysis but for psychiatry and all of the social sciences as well.

VI. *Existential-Interpersonal Psychiatry:* Under this heading are grouped those psychotherapeutic approaches that Abraham Maslow once referred to as the "third force" in psychology. Maslow contrasted the libertarianism and humanism of the third force with the determinism and mechanism implicit within behaviorism and the more traditional forms of psychoanalysis.[21] Often referred to simply as existentialists or humanists, psychotherapists broadly sharing Maslow's point of view hold that psychological symptoms reflect basic choices that individuals make in their modes of relating to themselves and others in the here and now, and are not relics of the forgotten past. While there is a great deal of diversity within the existential-interpersonal school, the emphasis on current relationships and experiences, as well as upon the potential for individual choice and freedom are unifying conceptions. The aim of existential-interpersonal psychiatry is to bring about the fulfillment, freedom and self actualization of individuals involved in treatment.

For existentialist, humanist, and interpersonal psychiatry, depression and other so-called psychopathological states are not diseases or disorders which simply "happen" to an individual. Rather they are frequently understood as ways of calling ourselves, our values, our relationships and the paths of our lives into question, and their aftermath is typically a burst of productivity and creativity.[22]

The existential interpersonal school has its contemporary philosophical foundations in phenomenology[23] and existentialism. The former can be understood as the "descriptive" and the latter as the "normative" science of "lived experience." Phenomenologist such as Husserl and Merleau-Ponty and existentialists such as Heidegger and Sartre have exercised enormous direct and indirect influence upon contemporary existential and interpersonal psychiatry.

Six Potential Solutions

Contemporary psychiatry is faced with a crucial dilemma, a dilemma that in some ways parallels on a huge scale the problems of the patient who is faced with a bewildering array of theories and potential treatments for his\her psychological difficulties. Psychiatry is confronted by the questions of how it is to deal with its current factionalization. Does either fact or logic dictate that a single paradigm and a unified science will ultimately emerge? If such a unified paradigm does not emerge, will it include the theories and findings of only one of the current schools of will it result in an integration of several or all of them? Or perhaps the subject matter of psychiatry is such that a multiplicity of perspectives and continued factionalization of schools is theoretically and practically inevitable.

There are, of course, considerations other than logical and scientific ones that determine the present factionlized state of psychiatry and which will contribute to its future. Nevertheless, it will be worthwhile to exclude factors such as economics and politics from consideration, and focus on the purely conceptual issues involved in the future unity or diversity of psychiatry.

A philosophically minded psychiatrist has at least six options in his\her attempt to come to grips with the multiplicity of psychiatric schools. He/she can (1) opt for some form of *reductionism*, (2) hold that psychiatric theories are in open scientific competition or *commensurable,* (3) hold that they are relative to one's point of view or *incommensurable,* (4) opt for some form of *eclecticism,* (5) hold that some theories in psychiatry are *referentially distinct,* or (6) hope for an *ultimate synthesis* that will encompass the findings and theories of each of the contemporary schools. Each of these options will be examined in turn.

1. *Reductionism* is a philosophical theory, which broadly speaking, states that the propositions of one or several theories in an area of inquiry can be translated or "reduced" to propositions in another, more fundamental, theory without any loss of meaning. Freud for example, was reductionistic in his proclaimed hope that someday the psychological concepts of his metapsychology (e.g., id, ego, superego) would be understood as referring to neuroanatomic structures and\or physiological processes.[24]

Most reductionists in psychiatry, however, are biologically oriented. The appeal of biological reductionism is that, if successful, its program would unify psychiatry with the rest of medicine and ultimately with the foundations of medical science in biophysics and biochemistry. There have also been noteworthy behavioral reductionists, who attempted, e.g., to translate psychodynamic concepts into the language of reinforcement theory or who argued that the effectiveness of all forms of psychiatric treatment, including psychopharmacology, can be explained using the principles of learning theory and behavior modification.[25] [26]

The problem with any reductionist program is that it encounters the seemingly insurmountable task of translating and ultimately reducing propositions about thoughts, behavior, will, feelings, and neurophysiology into a language that acknowledges only one of these human dimensions as real.

2. *Commensurability* theorists hold that the propositions in one of more of the various theories in psychiatry are not reducible to propositions in one of more of the other theories, but that one theory may prove to be "better" or more valid with respect to some valid criterion of truth. Thus, those who hold that psychiatric theories are commensurable usually advocate the idea that an experiment or series of experiments could decide between them. The problem with commensurability theory is that it is exceedingly difficult to arrive at criteria for validity which are acceptable to the advocates of each of the competing psychiatric schools, and which do not simple reflect the value orientation of one. One criterion which have been offered in a variety of forms is the oft-cited principle of verification (or falsification), which states that only those theories are

meaningful that are formulated to make predictions concerning operationally definable observables.[27] Those theories that are meaningful by this criterion could presumably be tested and compete with one another on the basis of the predictions they make concerning human behavior, the effectiveness of certain treatments, etc. All other theories would be eliminated on the grounds that they were devoid of scientific content or meaning.

The principle of verification/falsification suffers from several drawbacks, one of which is the fact that the principle is itself meaningless by virtue of its own criterion of meaning. In addition, several psychiatric theories (e.g., those that have their foundations in existentialism and hermeneutics) hold that human behavior is understandable but essentially non-predictable. These factors have led to the introduction of other criteria for the evaluation of psychiatric theories, such as the phenomenologists' notion that the value of a psychiatric theory is a function of its coherence with "lived experience."[28] The criteria that are used in evaluating theoretical predictions and treatment outcomes in psychiatry are more often than not colored by the theoretical stance of the evaluator, and the results of attempts to place psychiatric theories in direct competition have generally not proven persuasive to the advocates of each theory.

3. *Relativism or Incommensurability Theory* is the view that no criteria for making effective decisions regarding the validity of various theories in psychiatry will or should ever be acceptable to the advocates of all theories.[29] This is because each theory is dependent upon initial assumptions about the nature of man, assumptions which are not open to empirical test. The relativist would argue, for example, that one cannot test the philosophical assumptions of materialism or universal determinism underlying biological psychiatry; these assumptions are accepted as a matter of conviction or faith. The fundamental assumptions of psychiatry are, according to relativists, essentially contestable and the various psychiatric theories are, therefore, incomparable or incommensurable. The emergence of a single dominant paradigm for psychiatry, if it occurs at all, will be determined by historical, economic, sociological, and other nonscientific factors. More likely, the various psychiatric schools will continue to coexist like a plurality of different religions or cultures.

There are many who would accept the notion that the value of religious or cultural ideas and institutions is relative, but that relativism is unacceptable for science. Primitive cultural institutions, it is argued, may be incommensurable with our own, but their medical practices, for example, are commensurable and decidedly inferior. While the notion of a simple experimental test deciding the validity of two of more theories has been recognized as philosophically naïve, attempts have been make to formulate more sophisticated rational bases for attaining commensurability between scientific ideas. It has been argued, for example, that a theory that can fulfill the truth criteria of its competitor better that the competitor itself has a rational claim to being a better theory. This certainly does not resolve the problem of multiple and contested criteria, but it does point to how a solution to the problem of factionalization in psychiatry might ultimately be achieved. If, in formulating their theories psychiatrists and psychologists can at the very least *address* (if not satisfy) the values and truth-criteria of theories perceived as

competitors then grounds for commensurability of theories and genuine exchange between theoretical camps will be established.

4. *Pragmatic Eclecticism* is the view that while theoretical unity in psychiatry is unlikely or impossible, an approach where each point of view is utilized where appropriate will overcome the fragmentation of contemporary psychiatric practice. Many patients are treated eclectically today, either by a single eclectically minded therapist or by a therapeutic team comprising professionals who are advocates of, and have expertise in, different treatment modalities. It is common for inpatients in many public facilities, for example, to receive a complement of biological (psychopharmacological), behavioral (milieu), and cognitive or dynamic treatments. Objectors to eclecticism argue that unless a psychiatric treatment is applied in rather pure form its effectiveness is undermined. Foe example, certain anti-therapeutic consequences can result when an interpersonally oriented psychiatrist attempts both to get his patient to accept responsibility for his depression and treats his patient with antidepressant drugs. The drug therapy tends to undermine the psychotherapy, for the psychiatrist, by prescribing medication, contradicts his own verbal message that the patient can and should be responsible for his own emotional states. Eclectic practice is much more difficult than is generally supposed, for it requires a sensitivity to the effects that a variety of implicit messages can have on patients, and a skill in steering clear or "reframing" potentially confusing or aversive combinations.

5. The idea that various theories in psychiatry are *referentially distinct* follows from the notion that careful differential diagnosis will always determine the appropriate explanation and treatment for an individual's psychiatric problems. The notion that some depressions are "reactive" and are to be treated with verbal psychotherapy while others are "endogenous" and are to be treated pharmacologically is illustrative of this view. Theories in psychiatry, on this view, do not compete with one another, not because of their different philosophical assumptions, but simply because they describe different phenomena.

While it may be true that existential theories of depression are generated through a consideration of a different population from the one that gives rise to biological or behavioral theories, the case presented at the beginning of this paper and countless ones like it make is difficult to maintain the position that adequate diagnosis would bring universal agreement as to the treatment of choice for each psychiatric patient. Perhaps as important as careful psychiatric diagnosis in determining the appropriate treatment modality for a given patient, is a careful assessment of the patient's own philosophical presuppositions. Some patients, for example, resist behavior therapy because of its failure to deal with existential problems and "meaning," others are attracted to it because it is technological and accountable. Patient-therapist match is an important variable determining success in psychotherapy. Patient-modality match may be an important variable as well.

6. Psychiatrists who hope for an *ultimate theoretical synthesis* in their field believe that the various schools or points of view are each levels of analysis or perspectives upon

complex psychological phenomena. According to this view, the various psychiatric theories will ultimately be joined in a unified science of psychiatry that will incorporate the significant insights of the various schools without either reducing one point of view or another, or combining various points of view in a purely pragmatic-eclectic manner. At various times psychoanalysis, phenomenology, and general systems theory have been proposed as the foundation for such a synthesis. Psychoanalysis, as has been indicated, has the advantage of incorporating within its conceptual structure the major tensions in contemporary psychiatry: that between natural scientific and humanistic viewpoints. Phenomenology, as it was conceived by its founder Edmund Husserl, sought to establish the natural scientific perspectives on man upon a humanistic epistemological base. Most recently, general systems theory, via the biopsychological model of psychiatry and medicine has provided a framework for understanding the various levels of analysis in psychiatry as distinct and yet built upon and interacting with one another.[30] Whether the biopsychological model or any other theory will ultimately provide either a practical or theoretical synthesis of contemporary psychiatric theories is an important and open question.

Summary

The author argues that psychiatry is currently multi-paradigmatic; psychiatry has no standard treatments because there are no universally agreed-upon ways of conceptualizing the problems to be treated. The author shows how the factionalization of psychiatric thought and practice is a problem for the field and is actually reflected in the dilemmas that patients themselves experience. After briefly reviewing what he regards to be the six paradigms of contemporary psychiatry (the biological, behavioral, cognitive, systems, psychoanalytic, and existential-humanistic approaches), the author discusses six potential routes towards a solution or rapprochement. These routes are (1) philosophical *reductionism,* (2) the view that psychiatric theories are in open competition or *commensurable,* (3) the view that such theories are relative to one's point of view or *incommensurable,* (4) *pragmatic eclecticism,* (5) the notion that theories in psychiatry are *referentially distinct,* and (6) the attempt to attain *ultimate synthesis*.

References

[1] Kuhn, T.S. *The Structure of Scientific Revolutions*. University of Chicago Press, Chicago, IL, 1970, pp. 43-51.
[2] Lazare, A. Hidden Conceptual Models in Clinical Psychiatry. *New Engl*. J. Med., 288:345, 1973.
[3] Goodwin, F. On the Biology of Depression. In *The Psychology of Depression: Contemporary Theory and Research,* Friedman, R. J., and Katz M. M., Eds. V. H. Winton, Washington, 1974.
[4] Smart, J. J. C. *Philosophy and Scientific Realism*. Routledge & Kegan Paul, London 1963.
[5] Armstrong, D. M. *A Materialist Theory of the Mind*. Routedge & Kegan Paul, London, 1967.

---

[6] Wolpe, J. *The Practice of Behavior Therapy,* 2nd Edition. Pergamon Press, New York, 1973.
[7] Seligman, M. E. P. Depression and Learned Helplessness. In *the Psychology of Depression: Contemporary Theory and Research,* Friedman, R. J., and Katz M. M., Eds. V. H. Winton, Washington, 1974.
[8] Ryle, G. *The Concept of Mind*. Harper & Row, New York, 1949.
[9] Wann, T. W., Ed. *Behaviorism and Phenomenology: Contrasting Bored for Modern Psychology*. University of Chicago Press, Chicago IL, 1970.
[10] Beck, A. T., Rush, A. J. Shaw, B. F., and Emery, G. *Cognitive Therapy of Depression*. Guilford Press, New York, 1979.
[11] Sayre, K. *Cybernetics and the Philosophy of the Mind*. Routedge & Kegan Paul, London, 1976.
[12] Framo, J. L. Symptoms from a Family Transactional Viewpoint. In *Progress in Group and Family Therapy,* Sayre, C. J., and Kaplan, H. S., Eds. Brunner Mazel, New York, 1972.
[13] von Bertalanffy, L. *General Systems Theory.* Braziller, New York, 1968,
[14] Home, H. J. "The Concept of the Mind". *Int. J. Psychoanalysis,* 47:42-29, 1966.
[15] Klein, G. S. *Psychoanalytic Theory: An Exploration of Essentials.* International University Press, New York:1976.
[16] Dallmayr, F. R., and McCarthy, T.A. *Understanding and Social Inquiry.* Notre Dame Press, Notre Dame, 1977.
[17] Ricouer, P. *Freud and Philosophy: An Essay in Interpretation.* Tr. Savage, D. Yale University Press, New Haven, CT. 1976.
[18] Yankelovitch, D., and Barrett, W. *Ego and Instinct.* Random House, New York, 1970.
[19] Grunbaum, A. *The Foundations of Psychoanalysis: A Philosophical Critique.* University of California Press, Berkeley, 1984.

[20] Schafer, R. *A New Language for Psychoanalysis. Yale University Press, New Haven, CT, 1976.*
[21] Maslow, A. H. *Toward A Psychology of Being.* Harper & Row, New York, 1970.
[22] Solomon, R. C. *The passions: The Myth and Nature of Human Emotion.* Anchor Press, Garden City, 1976.
[23] Spiegelberg, H. *The Phenomenological Movement* (2 Vols). Martinus Nijhoff, The Hague, 1971.
[24] Freud, S. On Narcissism (1914). *Collected Papers of Sigmund Freud,* Vol 4. Basic Books, New York, 1959.
[25] Dollard, J., and Miller, N. E. *Personality and Psychotherapy.* McGraw-Hill, New York, 1950.
[26] Wachtell, P. L. *Psychoanalysis and Behavior Therapy: Toward an Integration.* Basic Books, New York, 1977.
[27] Hempel, C. G. The empiricist criterion of meaning. In *Logical Positivism,* Ayer, A. J., Ed. Free Press, New York, 1959.
[28] Needleman, J. A Critical Introduction to Ludwig Binswager's Existential Psychoanalysis. In *Being-in-the-World: Selected Papers of Ludwig Binswanger,* Needleman, J., Ed. Harper & Row, New York, 1963.

[29] Feyerabend, P. *Against Method.* NLB, London, 1975.
[30] Engel, G. L. The Clinical Application of the Biopsychosocial Model. *Am. J. Psychiatry,* 137:535-44, 1980.

Sanford Drob, Ph.D. holds doctorate degrees in philosophy and clinical psychology. He is on the Clinical Psychology Faculty of Fielding Graduate University. He can be contacted at SDrob@fielding.edu or through his website www.newkabbalah.com.

Appendix: Table I: Contemporary Schools of Psychiatry: Depression

School of Psychiatry/ Psychology	Presumed Underlying Nature of Psychological Phenomena	Conception of Depression	Treatment for Depression	Value Orientation/ Goal of Treatment	Historical Antecedents	Philosophical Foundations
I. Biological Psychiatry	Events and processes in the brain and nervous system	Catecholamine Hypothesis	Antidepressant Medication	Cure of mental illness	Pre- and Post-Socratic Materialistic philosophy; Hippocrates and Humoral Theory	Scientific Materialism
II. Behavioral Psychology	Behavioral dispositions resulting from an organism's interaction with the environment	Lack-of-reinforcement theory. Learned-helplessness	Behavior Therapy	Behavioral change, removal of symptoms	Ag-old common sense; the *Book of Job*. Behavioral notions in Aristotle's *De Anima*, Cartesian "Mechanism", British Associationism, Modern Positivism, Darwin's Theory of Evolution	Philosophical Behaviorism
III. Cognitive Theories	Beliefs, judgments, and other cognitive processes	Cognitive Theories of Depression	Cognitive or Rational Therapy	Rational living	Greek Stoicism; European 17th c. rationalism;, e.g. Spinoza's *Ethics*, cognitive psychology, cybernetics	Rationalism
IV. Family Systems Approaches	Disturbed patterns of interaction and equilibration that transpire in a network of individuals	Systems theories of depression, e.g. scapegoating, conflict of roles	Family Therapy	Family equilibration	Plato's *Republic*; Marx and dialectical materialism; Sociological point of view, e.g. Durkheim	Collectivist philosophies
V. Psycho-dynamic Approaches a.Metapsycho-logy	Mechanisms of abstract mental structures: e.g. intrapsychic conflict	Overdevelopment of the superego, prohibiting release and expression of libidinal energy	Psychoanalytic after-education of the super-ego	Psychic equilibrium	Pre-Socratic philosophies of conflict and strife; Pythagorean ideal of the soul's harmony' Plato's tripartite division of the soul; Helmholtzian physiology; Darwinian genetics	Structuralism
b. Clinical Theory	Meanings and intentions	Pathological mourning response; anger turned inwards; radical disappointment in the self	Psychoanalytic interpretation leading to insight	Self-knowledge leading to self-liberation	Judeo-Christian hermeneutics, e.g. Talmudic interpretation of scripture; 19th-c. philosophy of the social sciences: Dilthey, Rickert, Weber on "interpretive understanding"	Hermeneutics
V. Existential Interpersonal Psychology	Basic choices that individuals make in their modes of relating to themselves and others	Depression as a "call" to the self and a communication to others	"Here and now" existential or interpersonal therapy	Fulfillment, freedom and self-actualization	Socrates dictum "know thyself"; St. Augustine, 19th century existential philosophy: Kierkegaard, Nietzsche	Phenomenology and Existentialism