Toward an Osteopathic Psychiatry: The Biocognitive Model of Mind

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Osteopathic medicine represents a valid tradition in Western medicine, but there are concerns about whether it is a viable tradition: will it end up a “poorer cousin” of the allopathic tradition or will it eventually simply be absorbed by the dominant model? This is particularly the case in psychiatry, where osteopathic medicine has never established a firm presence. Currently, the dominant ethos in psychiatry is reductive biology, which tries to eliminate the notion of mind as a causative factor in behavior. The author’s case is that this has failed to give rise to a human-centered psychiatry. His own model of mental disorder, the biocognitive model, is based on a molecular resolution of the mind-body problem (ie, the ancient question of how the immaterial mind and the material body interact). It is manifestly dualist (ie, it accords causative primacy to mind). This is firmly in the osteopathic medical tradition and is offered as a means of developing a distinctive model of psychiatry and hence a holistic general medicine.

In a thoughtful commentary, Delengocky1 offered three reasons why osteopathic medicine should remain parallel to but distinct from allopathic medicine. First, there is the widespread and growing interest in complementary and alternative medicine (CAM) in the United States. For a number of reasons, osteopathic medicine is an alternative to the reductionist biological tradition of allopathic medicine. Osteopathic medicine places great emphasis on the fact that the body is a self-regulating unit in which structure and function are reciprocally interrelated, providing a basis for a rational, holistic therapy.

Second, he argued that because of the prevalence, the morbidity, and the huge cost of musculoskeletal disorders, there is a place for a form of medicine that sees a need to manage these debilitating conditions as more than “simply pains.”

Third, he saw a political advantage in medicine having two “separate but equal” traditions to counter the aggressive push by nonmedical professions for equal rights (eg, laboratory investigation, prescribing, procedures) with physicians within their narrowly defined areas. Medicine must see the patient as a whole, must advance by rational scientific research and must be distinct from the paramedical professions, which seek to advance themselves by legislative advantage. Medicine is strengthened, not weakened, by having the two traditions of allopathic reductionist biology and osteopathic holism.

However, other authors express concerns about the ability of osteopathic medicine to define itself as distinct in what is all too often an unequal struggle against the dominant biomedical tradition.2 This is despite the faults of reductionist biology, which are widely acknowledged even by its practitioners. Over the years, there have been many calls for the major medical model to take a more holistic and human-centered approach, such as the late George Engel’s call for a “biopsychosocial model.”3 This, he hoped, would allow physicians to integrate the various aspects of the fully functional human—the biological, the psychological and the sociological—achieving a broad understanding of the nature and causation of disease states. Unfortunately, despite its intrinsic appeal to the more sensitive members of the profession, Engel’s model was never written.4 Nonetheless, the biomedical juggernaut powers ahead, showering the public with the near-miracles they have come to believe are their birthright. Given the astounding success of reductionist biology, is there any place for a milder, more humane medical tradition? In other words, if treating patients as biological preparations is so successful, who needs to be polite to them? If drugs can cure all, what place is there for a healthy lifestyle? Why go without that cream cake if the medical insurance will pay for a coronary bypass next year? This is nowhere more the case than in psychiatry, which doesn’t have a strong presence in the osteopathic medical tradition.

In the present article, I examine what becomes of a psychiatry pushed into the Procrustean bed of reductionist science. My case is that reductionism has failed to give a human account of mental disorder, leaving a huge intellectual and moral gap that a holistic medicine is best suited to fill. The risk

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is that if physicians don’t fill this gap, then other professions will use our failure to try to take over.

Logical Status of Reductionist Bioligism in Psychiatry

Some 30 years ago, there was a revolution in psychiatry as the psychoanalytic model passed quickly from the scene to be replaced by a rigid biological reductionism. In a few years, the Freudian theories, which had so dominated academic and private psychiatry for half a century or more, disappeared from curricula all over the country. The many institutes of psychoanalysis lost their students and their prestige. Equally quickly, psychoanalytically oriented psychiatry lost its funding as insurers and governments swung behind the confidently expressed diagnostic and therapeutic power of the burgeoning biological movement. With the publication of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (3rd ed) (DSM-III) in 1980, the revolution was complete. For better or for worse, psychiatrists were transformed from “trick-cyclists” into white-coated physicians ordering brain scans and powerful drugs to treat patients with chemical imbalances of the brain. Huge sums of money poured into basic biological research in the mental disorders and transformed academic psychiatry from a somewhat contemplative and even mystical backwater to a mainstream biomedical institution.

However, the biological revolution was not a scientific revolution in the sense expounded by the philosopher Thomas Kuhn. Granted, one model of mental disorder was discarded and another totally different model took its place, but psychoanalysis was dropped not because it lacked explanatory power (to its practitioners, it certainly had that) but because it lacked scientific status. However, the new model that replaced it—the concept that mental disorders could be reduced directly to brain disorders and allowed definitive management of precisely delineated illnesses—was never defined. In simple terms, people grasped at the model of biological reductionism in desperation: the psychodynamic models had failed, therefore biology had to succeed or there was nothing. Thus, every time an influential psychiatrist proclaimed the power and scope of a biological psychiatry, the audience applauded and congratulated each other on attaining what psychiatrists had always wanted: coequal status with the “real doctors.”

One of the most influential psychiatrists of the late 20th century, Samuel Guze, gained excited reviews when he announced: “There cannot be a psychiatry which is too biological.” The harsh jargon of DSM-III soon entered the common parlance. No longer suffering the ravages of an overactive id, a patient now proclaimed he was “bipolar” or had “ADD” [attention-deficit disorder] and he needed “his” drugs or he could not be held responsible for what he might do. In short order, hugely influential voices joined the apparently unstoppable drive to medicalize the human condition. For example, the Nobel Prize–winning neurophysiologist Eric Kandel expanded upon his belief that basic biological sciences would transform psychiatry by explaining and providing rational treatment programs where “talking therapies” had failed. It was only a matter of time, the chorus echoed, before such endeavors as the human genome project finally delivered the secrets of that ancient scourge madness.

Problems With Biological Reductionism

Gradually, however, voices were heard doubting not just the efficacy of biological psychiatry but also its fundamental precepts. In a minutely detailed analysis, Horwitz and Wakefield examined the process by which the normal human emotion of sadness was transformed into a biological illness—for which, of course, the correct treatment is not just kindly support and the passage of time but drugs. This meant very powerful drugs, often for life, and, if and when these drugs failed, admission to a hospital for electroconvulsive therapy (ECT).

Joseph9,10 teased out the statistical claims for the biological basis of mental disorder, showing that many of the major claims lacked validity. Over many years, I published a series of papers arguing that the entire logical status of the biological claims in psychiatry were misconstrued and that mental disorder is not a matter to which the reductionist model can be applied.11,12 These are in addition to the arguments of Breggin13 and other authors who amassed clinical evidence to show that an unthinking chemical response to mental problems may produce more difficulties than it solves—quite apart from the human and ethical dimension. Recent incidents in which senior biological researchers appear to have traded their ethics have done nothing to reassure an increasingly skeptical public. However, it is not the public that needs convincing; it is the profession. At the beginning of the 21st century, psychiatry is in a very difficult position: if biological reductionism fails to “deliver the goodies,” we have nothing left. Will it fail? Will it go the same way as psychoanalysis and behaviorism? In my view, it has already failed.

If we claim that mental disorder is just a special case of brain disorder, in which the symptoms affect only the mental life, what sort of conditions must be satisfied for that claim to be true? Let us look at the standard explanation for mental disorder given to distressed patients and their worried relatives: “It’s a chemical imbalance of the brain. That’s what mental illness is.” This is in fact an ideological claim, not an empirical statement. The psychiatrist hopes that before long the neurosciences will show it to be true, but for the time being he accepts it on faith. But this claim rests on certain assumptions, and if they are shown to be false, then science can never justify the claim. This is what happened to psychoanalysis and behaviorism: logical analysis showed that they could never achieve what their supporters hoped. Biological psychiatry is no different. It rests upon a series of
assumptions that must be tested independently of any empirical evidence.

The primary claim of reductionist science is that the properties or behavior of any higher order entity can be fully explained in terms of the properties or behavior of its lower order constituents. Thus, the properties of water are just the properties of H₂O molecules; the properties of a large rock are the combined properties of the molecules that comprise the rock; the properties of a car are the composite properties of the components of that car; and the properties or behavior of an animal’s body just are the properties or behavior of the organs that comprise the body. Reductionism has been the most powerful explanatory tool in human history; however, it may have met its match in the human mind. The reductionist view cannot be assumed to be true because that would beg the question (i.e., to assume the truth of that which required proof). Thus, when Kandel claims that by looking down a microscope (or some such laboratory instrument) we will learn all we need to know about the causes of human behavior, he is making an unjustified claim. If his case is true, then, for example, his religion would be a matter of his brain’s physiology, not his moral choice. I do not believe he would go to that extreme, but it is a logical consequence of his oft-repeated claim that there can be a “biology of human mental processes” that can be understood mechanistically.⁷

In general, anyone claiming that the human mind can be reduced to a matter of properties of molecules (or individual ions or subatomic particles—they are never sure) must show that the properties of mind (seeing green, feeling happy, translating Urdu) are fully explained by the properties of the brain’s chemical constituents. This, of course, is impossible because the brain uses symbols, and symbols, by definition, are never the same as the objects or processes they represent. Language, for example, can never be reduced to brain properties because language is a function of a different order from brain chemistry. So the whole goal of the reductionist program in biological psychiatry—to show that the human mind can be fully explained in terms of the human brain—is doomed from the outset.

Proponents of reductionism will argue that science has a habit of confounding people who try to set limits on it, such as those who said there would never be heavier-than-air flight or that DNA could never be decoded. This is true. Science definitely progresses, and it progresses by questioning the standard view, but only when those views are of an empirical nature. That is, science questions empirical (observational) facts, but it does not question logical truths. It is a logical truth that the experiences of tasting beer, struggling with a math problem, and feeling grief are not properties of molecules but are properties of a highly ordered system. That is not to say that chemicals cannot influence the mind but only that a full explanation of mind needs more than chemicals.

Alternative Theories
The claim “mental disorder is brain disorder” is only true in the very restricted case where mental events are, in fact, brain events. This is called mind-brain identity theory, and it was popular in the 1950s and 1960s. However, it rests on a logical claim, not an empirical fact. Again, the claim breaks down at the point of language and other symbolic human functions. If we try to maintain that a word in a sentence is identical with a brain element—say, a neuron—then we run into all sorts of problems. There is not enough genetic material in the human genome to provide for even a very simple language. And if there is a one-to-one relationship between a word and a part of the brain or even a molecule, how can the brain generate the infinite range of language with a finite supply of molecules? There are dozens, if not hundreds, of similar objections to mind-brain identity theory. A clever philosopher could dream up objections faster than a biologist could possibly answer them. So mind-brain identity theory has fallen out of favor with philosophers and cognitive scientists.

There is another group of theories that can potentially save the biological model in psychiatry: a disparate group known as the monist theories of mind. These theories are defined partly by their opposition to mind-body dualism, which is the ancient notion that the mind is of an entirely different nature than the body. Dualists accept that the mind is a real thing and that it is causally effective in human behavior; their problem lies in saying just what sort of thing the mind is and how it interacts with the body. The classic formulation of mind-body dualism is attributed to Rene Descartes, the French polymath who died in 1650. By a process of elimination based on radical self-doubt, Descartes argued that, in a world of uncertainty, the mind or soul is the only thing we can be sure of. The human body is essentially no different from the bodies of all other animals, just a collection of clever machines stuck together. But Descartes maintained that we humans have a soul to guide our activities. While the soul is not a material thing, it is able to interact with the material body to the extent that humans can do things no other animals can do. He suggested that the soul and the body touch at the pineal gland, allowing information to move back and forth between the body and the soul.

For most people, this seems to gel with everyday experience, and the Cartesian solution reigned for several hundred years until, with the growth of materialist science in the 19th century, thinkers began asking the obvious question: “How can an immaterial soul (or mind) act upon the material body without breaking the fundamental laws of the material universe?” Of course, it cannot. Hence, modern philosophy has been struggling to rid itself of all traces of the Cartesian model on the basis that it inevitably leads to the idea of a dualism of a supernatural soul or spirit in a material world. This, of course, is unacceptable in modern physics. There have been several attempts at an antidualist model, the most
important of which are Daniel Dennett’s functionalism and John Searle’s biological naturalism.

Dennett, one of the most influential living philosophers of mind, has developed a monist, or nondualist, model of mind. This accepts the reality of mental states (and thus allows them to control behavior), but he argues that they are functional states of the brain. Essentially, this means that mental states are, in some critical sense, biological states. However, he then has the difficult task of showing that his “biological” states of mind do not fall into the trap of mind-brain identity. Although he is satisfied with his account of the essential features of mind, he has many critics. The Dutch philosopher of science Anthony Derrksen believes that Dennett is not so much a scientist as a sophisticated pseudoscientist who makes his points only by some very clever sleight of hand. I have to agree: I believe that Dennett’s breezy style skips across some dubious suppositions. However, my main case against Dennett is that he has absolutely failed in his attempt to write a monist theory of mind because he uses dualist concepts to do all the work. Thus, he talks about the human brain “spinning” a biological self via language, a process he equates with spiders spinning their webs. The self is a “virtual machine” that by complex programming is able to generate further virtual machines that support the processes of mentality. This is nonsense: a virtual machine is just a dualist notion. He hasn’t written a monist, biological theory of mind at all, so his program fails. A much more detailed outline of this case is available elsewhere.

Anybody reading some of the exchanges between Dennett and Searle would think their work is separated by a vast conceptual gulf, but this is not quite the case. The differences would seem to be personal as much as ideological. Searle’s biological naturalism is a similar attempt at writing the fallacy of dualism out of our concept of mind. He opposes Dennett’s functionalism on the basis that it does not give any account of human experience and is therefore dehumanizing. Searle insists that any adequate account of mind will take as its starting point the experience of being a sentient human. Searle appears to tackle the problems of mentality head on, without attempting to hide them under a flood of puns and biology. However, Searle also falls into the trap of using concealed dualist elements to complete his chain of explanation. Initially, he claims that brain processes and their various products are all of a biological nature: “[M]ental phenomena are ordinary biological phenomena in the same sense as photosynthesis or digestion.” However, he admits that the mind could be duplicated in a computer, even though computers only function with information, and information is not the same as its physical substrate. That is, he separates the world of information, which operates according to the laws of semantics and syntax, from the material world, which operates according to the laws of thermodynamics. So the second major attempt to write a nondualist theory of mind founders. This means that biological psychiatry, which is based on a biological explanation of the mind, lacks a formal explanatory model in which to base its science.

Taken together, the failure of these theories of mind leads to the conclusion that there cannot be a materialist explanation of mind. It follows, then, that purely psychological disorders of mind are a logical possibility. That is, the entire biological program in psychiatry (i.e., to give a physical explanation for every possible mental disorder, including personality disorder) can never be achieved. We need a formal theory of mind-body duality to account for the entirety of mental disorder. Is there any room for two substances?

Readers who wish to explore the historical material in this section are encouraged to refer to previously published material.

A 21st Century Dualism

The computer revolution of the second half of the last century changed the way we think. These days, every child understands that machines can do all sorts of clever things that once were reserved for humans. Machines can add and multiply, they can choose things and devise things, they can play games and solve problems, they remember, and they even make mistakes. That is, we now accept a fundamental duality in our view of the world—a duality of material things and of immaterial information. Descartes, as has often been said, was before his time. If we propose that the mind is just a matter of information, we can satisfy his requirements that it be indispensable yet be causally effective in the material world. However, that still leaves the problem of experience: what does it mean to say that the experience of seeing yellow or of feeling blue is “a matter of information”? The philosopher David Chalmers has proposed that the mind is both a real thing and a product of the natural world; therefore, it can interact with the physical world without breaching the laws of thermodynamics. However, he went further, proposing that the mind itself consists of a duality—one part being experience and the other the thinking, calculating, or knowledge-based mind. Experience, he said, is too difficult; we will have to leave that for the time being. The thinking or decision-making mind, on the other hand, represents nothing conceptually new that a desktop calculator does not already embody.

This approach gets us through some very difficult patches. The knowing part of the mind is essentially unconscious. Knowledge-based functions are not open to introspection but take place, silently and at very high speed, in an informational space generated by the brain. We cannot inspect our knowing mind in action—we are only appraised of the outcomes of its functions. So I do not know how I recognize the color red; the brain does that for me. If we accept this formulation, we solve a large part of the problem Descartes bequeathed us: the nature of interaction between
the mind and body. Information from the peripheral receptors enters the brain as impulses coded into the afferent neurons. It is manipulated by the neuronal subsystems, interacting with the memory and other sensory modalities to generate a response that is appropriate for the person at that time. All this is done silently and very fast, in the order of hundreds of milliseconds from input to output: the individual cannot say why he chose something, only that it seemed correct at the time. Information enters the brain, is manipulated, and exits the brain without leaving the informational realm, so the problem of mind-body interaction falls away. Simultaneously, the informational input is further manipulated by some means we cannot even begin to understand to generate an experience of “feeling like something.” That is, the same sensory input is split to generate two outcomes: one being the instructions to action and the other being the experience of being a sentient human.

In extending and developing Chalmers’ model for the “wetware” of the brain, I have emphasized certain points that the philosophical approach can overlook. First, we put the mind as a decision-maker at the center of the model, in contrast with the Freudian model, which saw emotion as primary. The human becomes a high-speed, multimodal information processor, taking input from the environment, comparing it with memory, then activating the appropriate output state. Second, we relegate emotion to the level of an output state. That is, a decision activates certain brain centers, which are then experienced in the same way as the sensory experiences—that is, as a further input. This means there is a feedback loop between the cognitive part of the mind and the experiential, which has major theoretical significance for psychiatry. Last, by breaking decisions into their constituent parts, and distributing them through the brain substance, we reach a point where the individual mental functions are assembled from their subroutines, in accordance with the modular model of neuropsychiatry developed by the Soviet neuropsychologist Aleksandr Luria. For want of a better term, I called this model the biocognitive model of mind to emphasize that the cognitive functions and the body interact constantly—and not always predictably. As it happens, that name was already in use, but there is actually no conflict. Of course, this model would also apply to the higher animals at least, negating Descartes’ belief that animals have no mind.

**A Modern Dualism**

From the medical point of view, the biocognitive model of mind has great predictive value. It says, for example, that the mind will be able to influence the body’s function without the individual actually knowing how he does it. Information from the body influences the mind silently and at high speed, and the mind does the same in reverse. That is, it provides a basis for a model of psychosomatic medicine, a field that allopathic medicine has never been able to grasp. The reason for this particular failure of the reductionist model is that it recognizes only one-way action, from body to mind. The new dualist model says that there is two-way interaction between mind and body. This has the immediate consequence of suggesting that, under certain conditions, mind and body can set up feedback loops with unpredictable effects. In medicine, of course, we are interested in negative feedback loops, such as the maladaptive states that represent psychosomatic illness.

If we take a very simple example, skin rashes always seem to be worse when people are anxious. The dualist model says that the rash worries the patient and the worry makes him sweat; when the sweat enters tiny breaks in the inflamed skin, it causes itching, which the person then scratches and thus makes the rash worse. Similarly, a person who fears heart disease will worry over every tiny blip in his pulse rate; but anxiety causes many blips in the pulse, which convinces the patient that there is something seriously wrong with his heart. The clearest example, of course, is psychogenic impotence in men. A man worries about his sexual performance, but anxiety inhibits male sexual performance and so his problem gets worse, which convinces him there is something seriously wrong and makes him worry more.

Management of anxiety in this model relies on rectifying the patient’s destructive belief system. That is, we would use one or other form of psychotherapy to assist the patient in abandoning the old, damaging belief system and replacing it with a set of beliefs consistent with the facts of the real world. Simple forms of this psychotherapy would be essentially educational, such as, “You needn’t worry about catching an infection. Your body has plenty of defenses.” The more far-reaching forms of therapy would involve taking the patient back to the times he acquired his maladaptive beliefs and reorienting his entire mental set on the world and on himself.

Within the field of psychiatry, the biocognitive model explains anxiety states remarkably well without invoking primary “chemical imbalances of the brain.” The “cognitive” part says that an anxious person is just a person who responds to neutral events in the environment as though they were threats. That is, the patient misclassifies events as dangerous when, objectively, they are not. The patient then experiences the appropriate emotion (anxiety) too often and too intensely. Note, however, that the model predicts the patient’s brain is normal: he is simply mistaken in his beliefs. If there are any “chemical imbalances” in the patient’s brain, they are secondary to the beliefs and therefore are not primary pathology. Similarly, a panic state is just a self-reinforcing state of high agitation, where the person worries about the physical effects of anxiety (eg, shortness of breath, palpitations, gastric upset). However, worrying about the somatic effects of anxiety breeds more anxiety, so the process quickly becomes self-sustaining. When it settles, the patient is more afraid than ever.
of the first stirrings of anxiety, and a new panic becomes more likely because he has already had one. It is no coincidence that panic states often start when the individual is recovering from a viral or other debilitating illness.

When we turn to depression, the modular approach in the biocognitive model has immediate explanatory value. We can take the grief response as the archetype of the depressive reaction. The model says that the person realizes that he has experienced a substantial loss. Signals are then sent to those emotional centers, which subserve the sense of enjoyment and pleasure, effectively paralyzing them. We assume that this involves activation of the genome to produce chemicals that block neural transmission or even stimulate the outgrowth of inhibitory synapses. They no longer respond to normal input with activity that the individual experiences as “fun” and that is accompanied by stereotyped behavior such as laughing and clapping the hands. Life appears flat and colorless, and this persists for months until, slowly, the period of emotional paralysis wears off. Note that the neuronal inhibition induces a psychic paralysis. This conceptualization of depression, as a normal response to an abnormal event, even indicates where drugs and ECT have their effect. We would assume that antidepressants and ECT function at the synaptic level to overcome the temporary biological blockade before it would normally wear off. This would also explain why people relapse if the antidepressant is stopped too early. With drugs or ECT, the original neuronal blockade has not been reversed—only overcome functionally.

The fraught relationship between depression and anxiety, so often dismissed as “comorbidity,” assumes a different light when seen from the point of view of a model of dualist interaction. Most surveys show a very high coincidence of anxiety and depression, far higher than chance alone would predict. Cases of depression as a reaction to a pure loss show very little anxiety but these types of depression cases are a minority. Using the model of negative feedback, we propose only that chronic anxiety seriously affects the quality of life, to the extent of making the patient feel hopeless about his prospects. He experiences a major loss of hope—the state we call depression. That is, chronic anxiety causes recurrent depression, as my series show. For the treating psychiatrist, the significance is that unless the anxiety state is treated in its own right, it will flare up as soon as the (sedating) antidepressants are stopped, meaning the patient is at risk of a further bout of depression. It is for this reason that antidepressants are now prescribed long-term and often in conjunction with other sedating drugs called mood stabilizers. They function to stabilize the mood because they stabilize the anxiety which destabilizes the mood in the first place.

Elsewhere, I have outlined a cognitive model for psychosis that predicts that the familiar split of the functional psychoses into affective and schizophrenic is artificial. In briefest terms, it says that psychosis is the manifestation of a failing mind—not of a failing brain—and minds can “fail” for a variety of reasons. These reasons include intense and protracted psychological distress, drugs and other intoxications, metabolic problems, slowly progressive brain disease, and the confusing effects that mild, diffuse brain damage may have on the individual’s contact with the world. It is for this reason that orthodox psychiatry keeps finding structural, biochemical, and now genetic faults in a proportion of people with psychotic disorders.

The history of psychiatry is thronged with people who have “discovered the cause of schizophrenia.” The biocognitive model says that as the technology advances, more and different lesions will be found, but not one of them will ever be causative of the condition. It also says that cognitive therapy of the psychotic states is not only feasible but also almost certainly essential in managing these conditions. Perhaps this is the explanation for the endlessly mystifying fact that schizophrenia in developing countries is not so malign as in the West.

**Toward an Osteopathic Psychiatry**

If we say that osteopathic medicine is based on musculoskeletal manipulation, which bone should we manipulate when the disorder is mental? That is actually a serious question. The concept of manipulation is that it should feed back to the body as a whole, rectifying whatever imbalances the physician had diagnosed. This is based on a particular understanding of the body and its function that the founder of osteopathic medicine, Andrew Taylor Still, discovered more or less by chance.

Traditional medicine, of course, saw a total split between the mind and body. The mind or soul was conceived as perfect and immutable because it came from the divinity; therefore, if anything went wrong, it had to be in the body. Accordingly, a form of medicine developed that aimed to rectify the physical ailment to the complete exclusion of any involvement of the mind. The patient was a passenger in a damaged vessel; in order to get better, he called a mechanic of the body, and the mechanic performed much the same miracles on him as a veterinary surgeon performed upon his patients, and with much the same emotional investment. All the patient-passenger had to do was lie still, swallow when told to, and pay the bill at the end. It was a small step from there to forms of “treatment” that involved mortification of the flesh—the bleeding, scalding, purging and intoxications that regularly carried off anybody who wasn’t strong enough for the treatment. The attitude persists today. In orthodox psychiatry, the obesity and metabolic syndrome caused by so many psychotropic drugs is seen as “just a bit of collateral damage,” even though it can cause havoc in the patient’s life.

Still’s insight, as I understand it, was to recognize the essential unity of the mind and body and how it can be dis-
turbed. The mind is not a helpless passenger (an epiphe-
omenon, in philosophical terms) but is an integral part of the
whole human. The two aspects of the individual—the phys-
ical and the mental—interact in all respects and at all times.
This interaction can be beneficial or destructive, depending
on how it is configured. In the osteopathic model, the
emphasis shifts from an expert doing something to the
patient’s body while the patient looks on in bewilderment to a
process in which the nature of the illness is explained by the
expert and the patient begins to take control of the processes
that have, as it were, spun out of control. There is nothing
mystical about this process. We are not talking about a mag-
cical interaction between an immaterial spirit and its tempo-
rary vehicle. Instead, we need to see the mind as a higher-
order function of the most complex organ in the known
universe: the human brain. That function is nothing more
nor less than an informational state, hugely complex in its own
right, which is both independent of and utterly dependent
upon the intact brain.

The move, then, to a form of psychiatry based upon the
notion of an interactive body and mind leads to a novel
approach to psychiatry (novel only in terms of Western
biomedicine, I should say). Using Still’s model, we can revise
our views of a range of psychiatric disorders, from “chem-
ically imbalanced biological specimen” to “functional im-
balances of the brain.” Just as an amplifier can pick up a signal and set up a
feedback loop, so too can the mind and body. Thus, an anx-
ious person becomes more frightened of his own palpi-
tations than of the frog that triggered them. A man’s anger at
somebody taking advantage of him pushes him toward
taking a hostile stance toward everybody, thus increasing
his isolation and distress. In his aroused and agitated state, he
misconstrues an innocent remark and lashes out. A grief-
stricken person lets the things that he previously valued slip
away, adding to his sense of loss and desolation. Armed
with the interactive approach, we can reformulate many, if
not most, psychiatric disorders as abnormal patterns of
behavior stemming from disorganized beliefs in a normal
brain. The “wetware” is fine, one could say, it’s just a pro-
gramming error.

It is not uncommon for people committed to biological
psychiatry to ask, “How could anything so devastating as
bipolar disorder or ADHD [attention-deficit/hyperactivity
disorder] have anything but a biological cause?” The answer
is the modern version of Archimedes’ then-shocking claim
that, with a suitable lever, he could move the earth: “Give me
a place to stand on, and I will move the Earth.” The biocog-
nitive principle is the same as a bridge that shakes itself to bits
or an aircraft that explodes as it crosses the sound barrier:
reciprocal amplification of a small signal by a reverberating
circuit. In psychiatric terms, fear feeds on itself. This is only
one of many novel conceptual tools by which we can grasp
the idea of a nonorganic psychiatry.

Orthodox psychiatry has difficulty embracing these
simple explanations for a number of reasons. For a start, there
is the huge weight of tradition forcing allopathic psychia-
trists to be “more like physicians.” As George Orwell
noted, “traditions are not killed by facts.” This is especially the
case when powerful reputations are invested in a particular
model that is manifestly struggling to “deliver the goods.”
Faced with a dearth of solutions to the problem of mental dis-
order, orthodox psychiatry’s response is “more of the same”—
more scanners, more studies of the genome, more statistical
surveys, more DSM. The one thing they never do is question
the model itself. In addition, there is the lack of conceptual
tools, such as reverberating circuits, because the allopathic
model sees causation as unidirectional.

Conclusion
In the present article, I can indicate only the very briefest
outline of a highly complex and entirely original approach to
psychiatry, one based in a model of dualist interaction. This
is exactly in the tradition of osteopathic medicine. I see osteo-
pathic psychiatry as a humanist alternative to the reduc-
tionist model now dominant in the psychiatric world. Just as
an osteopathic physician uses his hands to manipulate the
patient back to health, so an osteopathic psychiatrist uses
his own self to begin the restorative process. Certainly, there
is a place for drugs, as many patients are in such highly
aroused states that they are unable to comprehend the sub-
tleties of the novel concepts put before them. The essential first
step in this process is for the physician to know just where
the patient’s mind is, to reach out and make contact, not with a
“chemically-imbalanced biological specimen” but with a
human being whose worst fears make sense to somebody
who is prepared to take the time to understand them. The one
thing even the most terrified patient can understand is a
kinder, gentler human being reaching out to guide him or her
back to sanity.

It has always been said that psychiatry is the specialty
that always has a bright future. Perhaps by shifting from the
reductionist to the holistic model, that future can finally be
realized. I would like to recommend that the osteopathic
medical profession consider the model outlined in the present
article. I believe it is very firmly in the tradition of holistic
medicine, yet it relies on the most modern concepts available
to place that tradition wholly in the field of science.

References
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(continued)


**Editor’s Note:** This special communication article expresses the opinions of Dr McLaren and does not necessarily represent the views of the American Osteopathic Association or the American College of Osteopathic Neurologists and Psychiatrists.