CHAPTER 1

Historical Roots of the Concept of Mental Illness

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1.1 INTRODUCTION

Of all medical specialities, psychiatry and psychotherapy are probably the ones that are most intensively connected with political, historical and social developments taking place in society [1]. However, the relationship between psychiatry and society is typically an ambivalent one. On the one hand, society puts psychiatry in charge of mentally ill people, especially in order to develop efficient therapeutical tools and carry out research. On the other hand, there are often sceptical or even suspicious under currents when psychiatric issues are debated publicly. The complex reasons for this cannot be discussed here, but a historical perspective, especially the history of psychiatric ideas, might help to bring more clarity and scientific argument to the debate. Of course, any such overview shortens and, by this, simplifies the field. One of the main intentions of this chapter is to exemplify the practical significance of the historical perspective for present-day psychiatry.

1.2 ANCIENT GREECE TO THE ENLIGHTENMENT

The exponent of ancient Greek medicine, Hippokrates von Kos (460–377 BC), postulated – in a very modern way – that empirical data and not (only) theoretical speculation should guide our practical behaviour towards health and illness, explicitly including mental health and illness. He favoured a 'somatic' etiology of mental illness, but did not regard the brain as the central factor. His suggestion was that different types of illnesses ('humoral pathology') were caused when the equilibrium of body fluencies was disturbed. Therapeutic ideas included not only diatetic or somatic methods but also differentiated suggestions for how to

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deal with disturbed people, which we might well call precursors of modern psycho- and sociotherapeutic techniques.

The Middle Ages and Renaissance saw more setbacks than positive developments in terms of the understanding of 'madness'. Although hospitals were beginning to accept mentally ill people as patients (e.g. 1409 in Valencia, Spain), at the same time there was discrimination against psychotic individuals, who were described as 'possessed' or 'witches', and even killed. Nevertheless, there were already critical voices. For example, in the writings of Paracelsus (1491–1541)[1] and Johann Weyer (1515–1588), we find a remarkable combination of highly speculative *and* empirical, 'pre-modern' arguments. Before and even during the Enlightenment, however, rationalistic and person-oriented behaviour towards mentally ill people was far from widespread. In their early days, the large mental asylums of Paris, such as Bicêtre and Salpêtrière, were a peculiar mixture of homes for orphans, poor and homeless people; prisons; and, finally, mental hospitals.

1.3 THE EMERGENCE OF PSYCHIATRY

It was not until the 18th century – in the context of enlightenment – that psychiatry began to emerge and define itself as a medical discipline, rooted in scientific research and debate, and dedicated to the treatment of the individual mentally ill person. The number of psychiatric hospitals increased and, all over Europe, there were initiatives to free especially severely psychotic persons from the many and often cruel mechanical and other restraints that had previously regularly been imposed upon them. Prominent figures in this context are Philippe Pinel in Paris, William Tuke in York and Johann Gottfried Langermann in Bayreuth. John Conolly (1794–1866) later became known as the leader of the 'non-restraint' movement.

From this time on, psychiatrists also began to be regarded as experts by the courts in civil law and issues regarding penal code. This development, in turn, partly influenced clinical psychiatry and especially the nosological debate. By creating the new diagnostic entity of 'moral insanity', the English psychiatrist James Cowles Prichard (1785–1848) initiated a controversy that has continued to the present day. He used the term to describe people who ignored the commonly accepted values, behaved egoistically and would not recognize their own behaviour as unjustified or even a problem at all. The controversy arises from that very question, of whether such individuals simply do not *want* to respect other people's rights (although they could) or they really *cannot* do so (due do their 'moral insanity'). Nowadays, precisely this issue is discussed with regard to the forensic relevance of personality disorders, especially antisocial personality disorder or 'psychopathy'.

1.4 THE NINETEENTH CENTURY

1.4.1 Romanticism

The first decades of the 19th century saw an influential group of psychiatric authors, mainly in German speaking countries, who were part of the romanticism movement. Philosophically, romanticism was strongly oriented to Schelling's philosophy of nature, and its emphasis was on affectivity, irrationality and vagueness, in contrast to the

Enlightenment's strong focus on rationality and measurement. Nowadays, this period is known mainly for the 'romantic' style of its art and literature, but there was also a strong interest in and influence on psychiatric issues. What is central, for our present context, is the interest that was taken by 'romantic psychiatry' in the subjective perspective of the individual person and his or her 'idiographic' development before becoming mentally disturbed. This, in a way, was opposed to the more or less 'nomothetic' approach of the Enlightenment some decades earlier. 'Romantic psychiatry' explicitly recognized the relevance of affects and emotions (*Leidenschaften*, to use the strong German expression) for normal and disturbed mental phenomena [2, 3, 4]. Prominent authors of this time were, for example, J.C.A. Heinroth (1773–1843) and K. Ideler (1795–1860) [5].

1.4.2 Griesinger

One of the most remarkable figures in the history of modern psychiatry, Wilhelm Griesinger (1817–1868), marked the turning point from romanticism in psychiatry to what may be called the rise of modern empirical, and especially neurobiological, research into mental illness. Griesinger postulated that psychiatry should deal with the mind-body relationship empirically (i.e. by clinical and psychophysiological research) and not metaphysically. But – and this is often underestimated – he also criticized any simple materialistic attitude towards mental phenomena, voting for a *methodological*, not a *metaphysical* materialism. This is important in order not to misinterpret his often quoted thesis, that 'mental illness is an illness of the brain' (in 19th century German: '*Geisteskrankheiten sind Gehirnkrankheiten*').

Griesinger's work also strongly influenced two other areas of psychiatric practice and research. Nosologically, he postulated the existence of only one psychotic illness, which can appear clinically in different stages ('unitary psychosis', or '*Einheitspsychose*') from affective syndromes to paranoid-hallucinatory and catatonic syndromes and, finally, to chronic states with severe cognitive deficits, nowadays called dementia (1845; 2nd ed. 1861 [6]).

Griesinger also gave strong impulses to develop community-based care models for mentally ill people ('*Stadtasyl*') and is therefore one of the forerunners of modern social psychiatry [7, 8]. So, Wilhelm Griesinger, although often regarded as *the* symbolic figure of neurobiologically oriented psychiatry, is in fact a very good example for the basic idea of person-centredness with all its perspectives.

1.4.3 Neuroanatomical and Biological Research

In the second half of the 19th century, neuroanatomical and biological research brought many new insights about the structure and the function of the brain. Many authors regarded mental illness predominantly as a biological disorder of the brain, e.g. the influential Viennese psychiatrist Theodor Meynert (1833–1892), who chose 'illnesses of the forebrain' ('*Erkrankungen des Vorderhirns*') as the subtitle of his psychiatric textbook from 1884. This very strong position was later criticized as 'brain psychiatry', 'brain mythology' or 'psychiatry without the mental', e.g. by Karl Jaspers. Given our present day debate about the epistemological status of neuroscientific evidence for psychiatry, this, again, is convincing proof of the relevance of the historical perspective.

1.5 DEGENERATION THEORY

In the late 19th and early 20th century, degeneration theory was a highly influential psychiatric concept; this was an even more general way of thinking in the context of the zeitgeist. Degeneration theory had its roots in French psychopathology, especially in the writings of B.A. Morel (1809–1873) and V. Magnan (1835–1916). The central idea of this concept was that in 'degenerative' illness there is a steady decline in mental functioning and social adaptation from one generation to the next. For example, there might be an intergenerational development from a nervous character to major depressive disorder, then to overt psychotic illness and, finally, to severe and chronic cognitive impairment, i.e. dementia. It should be noted, however, that this theory has always been a vague and highly speculative concept, which was put forward decades before the rediscovery of Mendelian genetics and their application to medicine in general and psychiatry in particular [9, 10, 11, 12, 13].

Most of the influential psychiatric authors of that time used arguments derived from degeneration theory broadly. This, for example, is the case in Emil Kraepelin's (1856–1927) writings. He made special reference to degeneration theory with regard to manic-depressive illness, paranoia and personality disorders. His attitude towards degeneration theory was not unambiguously positive, however, but in some ways ambivalent. On the one hand, Kraepelin can be seen as an early forerunner of evolutionary biology, which was strongly reactivated in Konrad Lorenz's writings in the 20th century. The concept of disease – especially chronic mental disease – fitted very well into this framework, insofar as these phenomena were regarded as signs of an evolution in the wrong direction, as 'degeneration': a 'degenerative' process in this sense leaves the usual path of nature. So far, Kraepelin was clearly advocating degeneration theory.

Kraepelin continued to be sceptical about oversimplistic versions of this concept, however; although he commented approvingly on the basic ideas of Cesare Lombroso's 'criminal anthropology', he did not accept the idea of overt '*stigmata degenerationis*', by which individual persons could be identified as being 'degenerated' simply by their physical appearance [14, 15].

There is an important reason that degeneration theory is a very sensitive issue in psychiatric history and should be dealt with as thoroughly and scientifically as possible. From its beginnings until the end of World War II, National Socialism used the central ideas of degeneration theory, social Darwinism and eugenics to pseudo-justify their barbaric world view and – as an ultimate consequence – the killing of people whose lives were defined as 'unworthy'. It is of utmost importance that historians of psychiatry follow the line that runs from the early concepts of degeneration theory to the unprecedented cruelties of National Socialism. But it must not be forgotten that the concept of degeneration was always vague and heterogeneous. Morel, for example, argued from a position of moral philosophy, whereas Magnan tried to link the idea of degeneration with empirical science. In the following decades, authors also addressed quite different issues when using the term 'degeneration'. So, there is definitely a line that runs from degeneration theory to National Socialism, but – as is so often the case in the history of ideas – it is by no means a simple and direct one. From a political point of view, there have been right wing and left wing supporters of the ideas of degeneration, social Darwinism and eugenics in many countries; but the National Socialists in Germany were the only group with the political power not only to *think* those ideas but also

to *put them into action* on a large scale, up to the final, cruel consequences. This topic will be addressed again later.

1.6 EARLY TWENTIETH CENTURY

1.6.1 Seminal Clinicians

Around the turn of the 20th century, a number of seminal clinicians shaped major psychiatric concepts in a way that is still relevant nowadays. Some of them are covered here.

Kahlbaum and Kraepelin

Karl Ludwig Kahlbaum (1828–1899) and, a generation later, Emil Kraepelin (1856–1926) emphasized the importance of describing and evaluating the course of illness in a clinical and pragmatic way. Both were sceptical about orientating psychiatric nosology mainly at the actual clinical picture with its constant fluctuations. With 'progressive paralysis of the insane' as an example, Kahlbaum explained the way from the 'syndrome-course unit' ('*Syndrom-Verlaufs-Einheit*') to the – postulated – etiologically-based 'disease entity' ('*Krankheitseinheit*').

Kraepelin followed Kahlbaum in taking this central idea of psychiatric 'disease entities', and expanded his position further. He postulated that the essential features of all psychotic disorders will eventually be classified in a 'natural' (i.e. primarily biological) system, no matter what scientific method is applied; anatomy, etiology and symptomatology, if developed sufficiently, will necessarily converge in the same 'natural disease entities'. The most influential result of this basic idea was Kraepelin's nosological dichotomy, dividing the area of major psychotic illnesses into the two areas of 'dementia praecox' (markedly bad prognosis) versus 'manic-depressive insanity' (markedly better prognosis).

Kraepelin's nosology showed a remarkable stability over time. From the second to ninth editions of his textbook (i.e. from 1887 to 1927), Kraepelin did not change the central postulate. This strong hypothesis is limited to a certain extent, however, in three of his theoretical papers, written between 1918 and 1920: 'Ends and means of psychiatric research'(*Ziele und Wege der psychiatrischen Forschung*) [16]; 'Research on the manifestations of mental illness' (*Die Erforschung psychischer Krankheitsformen*) [17]; and 'Clinical manifestations of mental illness' (*Die Erscheinungsformen des Irreseins*) [18]. Here, Kraepelin took into account contemporary arguments by Karl Birnbaum (the differentiation between pathogenetic and pathoplastic factors in mental illness) and Robert Gaupp (the possibility of psychogenic delusions). He now acknowledged the value of defining certain *syndromes* as a medium level between nosologically unspecific symptoms and specific diseases. But – and this is the essential point – at no time did he abandon his postulate of underlying distinct and natural disease entities [19, 20].

Kretschmer

Ernst Kretschmer (1888–1964) developed the concept of a multidimensional approach to psychiatry, taking psychopathological, biographical and somatic findings into consideration,

especially concerning the relationship between body habitus and personality traits or even distinct types of mental illness.

Wernicke

Carl Wernicke (1848–1905) suggested a psychiatric nosology that in some respects resembled the classification of neurological disorders. He, and the later authors of his school, such as Karl Kleist (1879–1960) and Karl Leonhard (1904–1988), regarded Kraepelin's dichotomy of the major psychoses as too narrow. Taking forward the line of thought of association psychology from earlier in the 19th century, they subdivided mental life into different functions that may be disturbed separately or in various combinations. This led, for example, to the sophisticated, albeit psychopathologically stimulating, nosological model proposed by Karl Leonhard, which has just the opposite basic intention (i.e. a multitude of clearly distinct psychotic illnesses) to Griesinger's unitary psychosis.

Bonhoeffer

Karl Bonhoeffer (1868–1948) postulated the *nosological unspecifity* of psychopathological syndromes. He saw the reason for this in the limited number of reaction types the brain can display when confronted with any given irritation. Thus, it is not possible to draw direct conclusions from the clinical picture to its etiology.

Bleuler

The Swiss psychiatrist *Eugen Bleuler* (1857–1939) published his influential work *Dementia praecox oder Gruppe der Schizophrenien* in 1911 [21]. He agreed with Kraepelin in some important respects; e.g. the dichotomy between dementia praecox and manic-depressive illness, and the generally naturalistic attitude towards mental illness. But, in marked contrast to Kraepelin, Bleuler integrated the psychological (also in the sense of hermeneutical) perspective into clinical psychiatry. He was the only prominent academic psychiatrist at that time who not only read Sigmund Freud's (1856–1939) works, but accepted and implemented his ideas, although he later came up with remarkably critical arguments against certain parts of the psychoanalytic school. Bleuler was especially interested in the psychiatric applicability of Freud's concept of unconscious mental events that can be made recognizable by means of interpretation.

Bleuler regarded the course of schizophrenic illness to be highly heterogeneous, departing definitely from Kraepelin's highly pessimistic point of view. His main argument to switch from dementia praecox to schizophrenia was that the disease does not always become a *dementia*, and it does not always appear *praecociter*. Recently, Christian Scharfetter [22] has given Eugen Bleuler's scientific and personal thinking a thorough overview and interpretation.

1.6.2 Behaviourism

The school of *behaviourism*, founded by J. Watson in the early 20th century and later continued by E. L. Thorndike und B. F. Skinner, was in many respects the counterpart of the

Freudian approach. It was not the subjective interpretation of any mental phenomenon, but rather the objective description of behaviour, that was placed at the centre of psychological and psychopathological activities, in diagnosis and therapy as well as in research. Since many psychiatric entities (e.g. phobic disorders) were regarded as conditioned by disturbed learning processes, therapy was the task of reversing, 'deconditioning', them. It took a considerable amount of time for both the psychoanalytical and the behavioural school to gain some influence in practical clinical psychiatry, Eugen Bleuler in Zurich being an exemption.

1.6.3 Jaspers

Karl Jaspers' (1883–1969) book, *General Psychopathology* (*Allgemeine Psychopathologie*) [23] must still be called a cornerstone of psychiatric conceptualization. He regarded psychopathology as a central, practical and research tool for the psychiatrist, and tried to establish it as both an empirical and theoretical scientific field. For Jaspers, it is not possible to completely describe or even explain human mental life by objective and quantitative procedures alone. One of his central arguments is that our access to the mental events of other people is never direct but indirect, and necessarily involves intersubjectivity insofar as we depend on the person's expressions through their language, non-verbal communication, behaviour patterns, even their literary or other pieces of art. As for the concept of mental illness in general, Jaspers regarded the Kraepelinian idea of natural psychiatric disease entities as practically relevant, but – according to the theoretical arguments above – not in the realistic sense of entities existing completely independently from the patient and the psychiatrist.

1.6.4 Schneider

Like Jaspers', part of the Heidelberg psychopathological tradition, Kurt Schneider (1887–1967) explicitly acknowledged that neurobiological factors play a major role in the etiology and pathogenesis of mental disorders, but added that this does not rule out other factors, e.g. psychological and social ones. He insisted that psychiatric diagnoses are by no means objective, 'naturalistic' statements, but conceptual constructs based on empirical data [24]. In his attempt to differentiate and sharpen the diagnostic process, for example by his subtle description of 'first and second rank symptoms of schizophrenia', Kurt Schneider may well be regarded as a precursor of modern operationalized diagnostic manuals like ICD-10 or DSM-IV-TR.

1.6.5 The Impact of National Socialism

Before we turn to developments from the end of World War II to the present time, the unprecedented and barbaric *abuse of psychiatric power* by National Socialist Germany has to be mentioned briefly. This has not to do with any differentiated concept of mental illness, being the topic of this chapter, but – on the contrary – has to do with very rude and unscientific, albeit powerful, simplifications that dramatically illustrate the potential vulnerability and weakness of a clinical and scientific field.

Long before 1933, social Darwinist and eugenic concepts became influential, not just in psychiatry but in medicine and even social politics in general. Against the background of 'degeneration theory' (see above), a number of overtly racist positions arose. One such was Alfred Ploetz's concept of 'racial hygiene', which regarded it as a prominent duty of the state to ensure that 'healthy' people have offspring – and to prevent 'ill' people from doing so, in order to continuously improve the social and biological status of society. In this context, a strong, increasingly cruel anti-Semitism forced many Jewish psychiatrists and psychoanalysts to emigrate. These included F. J. Kallmann (1897–1965), a genetician and psychiatrist, who in 1936 emigrated to New York, where he founded a genetic research unit at the Institute of Psychiatry.

From 1934, the sterilization of mentally ill people intensified in Germany. In later years, for some of the psychiatrists who actively supported National Socialism, there seem to have been no ethical or humanitarian barriers whatsoever. Besides sterilization, uncontrolled and cruel 'scientific trials' were carried out with psychiatric patients, patients with epilepsy or severe neurological disorders, physically or mentally disabled people, homosexuals and a number of other groups. It is estimated that about 360 000 individuals were sterilized between 1934 and 1945. Finally, 'euthanasia' was the cynical term for the killing of mentally ill or handicapped individuals; this cost between 80 000 and 130 000 people their lives, mainly in the years 1940 and 1941 [25].

1.7 DEVELOPMENTS TO THE PRESENT DAY

1.7.1 Anthropological Psychiatry

Following the horrifying crimes of the Nazi period, with their crude, pseudoscientific background, it is not surprising that biological, especially genetic, research in psychiatry practically came to a standstill in Germany for quite a long time. Until the early 1960s, academic psychiatry adhered to a completely different perspective. This was the era of anthropological psychiatry, which was decisively oriented towards existential philosophy and focused strongly on the idiographic and biographical aspects in the pethogenesis and etiology of mental disorders.

In particular, the existential school of Daseinsanalyse, founded by Ludwig Binswanger (1881–1966), declined any elementaristic approach (as opposed to association psychology) and tried to get access to the complete mental act and its inner structure ('*Ganzheit*'). In this perspective, psychosis, for example, is not only the appearance of isolated symptoms like delusions and hallucinations, but a specifically human disorder of shaping one's life. On the one hand, this disorder may severely diminish degrees of freedom and personal autonomy, and lead to 'loss of natural awareness of the world' ('*Verlust der natuerlichen Selbstverstaendlichkeit*') and to 'an inability to change perspectives deliberately' ('*Unfaehigkeit zum Perspektivenwechsel*') [26, 27]. On the other hand, to view psychotic (and other psychiatric) states not only as mere deficits, but also – albeit pathological and creating significant suffering – as carrying meanings with regard to the person's life and self-understanding, may open up psychotherapeutic options.

1.7.2 Gestalt

Basic Gestalt psychology ideas reached psychiatry through the work of Klaus Conrad (1905–1961). His approach was oriented to a subtle psychopathological perspective and the course of illness, especially in schizophrenic psychoses. He tried to establish this concept as a 'third way' between classical description (which he believed to be too static and not sufficiently differentiated) and strictly hermeneutical methods (which he believed were not reliable enough and often too speculative) [28].

The Heidelberg psychopathologist Werner Janzarik followed these lines and differentiated them further, and markedly, in his concept of 'structural dynamics' ('*Strukturdynamik*'). The *dynamic* component of any mental event (normal or pathological) includes affectivity and drive, whereas the *structural* component addresses longstanding and characteristic psychological features of the individual person, e.g. value systems, interactional styles or, in general, personality traits [29]. This basic idea was then fruitfully applied to different nosological areas like psychotic and personality disorders. Although this model is a genuinely psychopathological one, and therefore does not directly contribute to diagnostic, nosological or therapeutical issues, it proved (and will continue) to be a rich source of arguments and critical questions that have to be debated *within* psychopathology if this field claims to be an indispensable scientific tool for psychiatry [30].

1.7.3 Anti-Psychiatry

Fundamental questions of psychiatry (e.g. the notion of mental illness itself or the mind-body relationship) are by no means 'only theoretical'. They bear profound practical and ethical implications. This was proven by anti-psychiatry, a heterogeneous group of authors who, from about 1960, formulated a fundamental critique of classical psychiatric concepts. The core issue here was (and, in a more differentiated way, still is) the assertion that psychiatry claims to be a scientific medical field, objectively dealing with (neurobiological) illnesses; but in reality is a powerful instrument of society (or of politics) to deal with people who may exhibit strange behaviour without, however, being ill or in need of any treatment [31]. Such a critique (and many other less dramatic problematic issues within psychiatric practice and research) will only be answered in a convincing manner if psychiatry does not exclude or underestimate 'philosophical' or 'theoretical' topics.

1.7.4 Neurobiological Findings

In recent years, the enormous progress in neurobiological findings on the structure and function of the brain has also gained significance for psychiatric diagnosis in two respects. First, the efficacy of a certain drug with its neuropharmacological properties was regarded as diagnostically relevant information ('*diagnosis ex juvantibus*'), e.g. positive response of neuroleptics suggests a psychotic disorder. Second, new imaging, neurophysiological or biochemical techniques (fMRI, endophenotypes, pharmacogenomics) tend to leave the area of research and enter the clinical, especially the diagnostic field. Whether this process will already affect the upcoming versions of our diagnostic manuals (ICD-11 and DSM-V) remains to be seen.

1.7.5 Operationalized Psychiatric Diagnosis

Finally, the concept of operationalized psychiatric diagnosis itself should be mentioned. Situated in the epistemological tradition of logical empiricism and analytical philosophy, ICD-10 and DSM-IV-TR lay the emphasis on descriptive psychopathological elements that are delineated by explicit criteria and (wherever possible) stay clear from etiological presuppositions. This critical, even puristic attitude towards psychiatric (and especially diagnostic) terms has its merits, given the many incompatible and often idiosyncratic diagnostic and nosological systems our field has seen in the last two centuries. But one has to acknowledge the limitations of this approach, too; if quantification and reliability on the level of operationally defined single symptoms become the only points of reference for the diagnostic process, complex (albeit therapeutically relevant) psychopathological and intersubjective phenomena might be overlooked, underestimated or even regarded as unscientific (e.g. patient-doctor relationship; complex delusional experiences; specific affective qualities in severe depression). This, again, would create an unjustified restriction and simplification of psychopathology.

1.8 CONCLUSION

In concluding this brief historical and conceptual overview of the highly heterogeneous concepts of mental disorders, it can be stated that, for a number of reasons, psychiatry's self-understanding is (and will probably stay) more fragile than that of other medical specialities. In order to prevent future psychiatry from dissolving in a number of methodically defined subunits, and to further strengthen person-centred diagnostic approaches [32], we strongly need the historical perspective. Each psychiatric concept – be it of naturalistic, descriptive, hermeneutical, anthropological or sociological orientation – is necessarily (albeit often implicitly) linked with theoretical presuppositions.

But this is also true of the notion of the *person* or *personhood* itself. Of course, this issue leads us into the centre of philosophical debate. Not a few psychiatrists, both historically and today, were and are decisively sceptical about the benefits of such philosophical arguments for their field. However, if we do not want to reduce the notion of the person just to a single (usually the prevailing) scientific perspective, we will have to enter the debate on what is or what we call a person, and whether personhood can be affected by mental illness. One of the radical positions on this issue was developed by transcendental philosophers like Immanuel Kant and Johann Gottlieb Fichte, for whom the concept of an irreducibly autonomous and responsible subject was not (only) a matter of empirical science, but the prerequisite of any scientific approach to the *conditio humana*. These complex philosophical theories – and many others from the 18th and 19th centuries – have been criticized in recent decades, especially following the linguistic turn in philosophy in the 20th century and its (usually underestimated) consequences for psychiatry. Nonetheless, the issue of personhood and its relationship to the diagnosis and treatment of mental illness is far from being settled. So, if person-centredness is to become *the* essential framework for psychiatry, the philosophical debate needs to be specifically reflected upon and integrated into psychiatry. This, no doubt, is a demanding task for the future.

Already today, it is obvious that the questions of how mental health and mental disorder should be conceptualized and how one can be differentiated reliably from the other, cannot not be answered sufficiently without taking the history of psychiatric concepts into account. And this is what makes history of psychiatry a practically relevant scientific field.

NOTE

1. Paracelsus' real name was Philippus Aureolus Theophrastus Bombastus von Hohenheim.

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