more problems at follow-up, as well as more legal difficulties, and more often developed dependence. The question is whether requiring two abuse items justifies the loss of the ability to diagnose individuals with one item when the latter also predicted adverse outcomes. Similarly, Drs. de Bruijn and van den Brink contend that our results suggested that all abuse criteria performed equally well, but our tables note differences in the proportion endorsing specific items, their demography, and some differences in outcome (e.g., 1.7 future problems for those with hazardous use versus 3.05 for those with baseline social problems). However, with the possible exception of legal problems, there were enough similarities across criteria to consider continuation of the use of those items. Contrary to what Drs. de Bruijn and van den Brink state, a wide range of cross-sectional validators and outcome measures were incorporated into our study. These include drug use, alcohol problems, and demography, as well as quantities and frequencies of intake. This range of items appears to adequately measure aspects of abuse criteria. Finally, Drs. de Bruijn and van den Brink question the validity of our results. Apparently, rather than validity, they are referring to reservations about the generalizability of the sample used by the Collaborative Study on the Genetics of Alcoholism. As we highlighted in paragraphs five, nine, and 10 of the Discussion section, of course our study group had liabilities as well as assets. We agree that the interpretation of any results must consider both the methods and the populations used. The final answer regarding the reliability and predictive validity of the abuse criteria requires careful evaluation of a range of studies using different methods in different subjects. Giving careful consideration to the different results across studies without rejecting the findings from careful investigations that disagree with one's own data is how science steps forward.

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Explanatory Pluralism and Patchy Reductionism

TO THE EDITOR: A major hurdle for clinicians regularly engaging in the critical reductionist approach advocated by Kenneth S. Kendler, M.D. (1), is our own method of diagnosing psychiatric problems, embodied in the DSM-IV-TR. This approach consists of grouping symptoms and applying a label. Purely phenomenalistic, it makes no mention of the underlying causes of those symptoms—whether they are biological, psychological, or social. We must remember that in psychiatry, unlike most other fields of medicine, a diagnosis represents the beginning of the assessment of a patient, not the end. Successful treatment is based on an explanation of the biopsychosocial factors that make up a diagnosis, not only on the diagnosis itself.

Reference

1. Kendler KS: Toward a philosophical structure for psychiatry. Am J Psychiatry 2005; 162:433–440

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TO THE EDITOR: The concept of mental first-person experiences is not as irrevocably grounded as Dr. Kendler suggested. He maintained the solipsism of the individual, ignoring Wittgenstein's concept of language as a tool that individuals use to interact with the environment (1). Wittgenstein noted that language and action produced by thought are a means of producing an empathic relationship between the first and second person. Psychiatrically, this empathic interaction results in a phenomenological psychopathology, a process that is vital to the practice of psychiatry.

Dr. Kendler avoided the basic problem psychiatry faces, which is, what is a mental state? In so doing, he leaves any potential framework hanging in limbo, maintaining the gulf between the mind and the brain. Dr. Kendler did not mention intentionality, which Brentano noted in 1874 (2) as characterizing "the mental." The concept of intentional causality associated with meaning and belief and the nonintentional associated with chemical and physical law-like relationships can provide an acceptable explanation of mental function. The mind can then be explained in a framework of dynamic intentional and nonintentional causal processes in which top-down and bottom-up causality can explain all mental functions and dysfunctions, from molecular interactions to the higher-level intentional processes that produce consciousness.

References

1. Wittgenstein L: Philosophical Investigations. London, Prentice-Hall International, 1958
2. Brentano F: Psychology From an Empirical Standpoint (1874). Edited and translated by Kraus O. New York, Routledge, 1973

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Dr. Kendler Replies

TO THE EDITOR: I appreciate the interest expressed in my recent article by the authors of these letters. I agree with the critical point made by Dr. Ivany that our current approach to psychiatric disorders is descriptively and not etiologically based. This poses important problems that I could not explore in this article. Peter Zachar and I (1) have tried to bring a bit of light to this important question in a review to be published in the *Journal*.

My ability to respond to the letter of Drs. Campbell and Pearce is limited by my lack of understanding of Wittgenstein's writings as well as parts of their letter. I am less certain than they are that his work, combined with an emphasis on the long-central concept of intentionality, can solve the mind-body problem. I agree with Fodor's critique of the problems of applying the work of Wittgenstein to questions in psychology (and psychiatry) (2). However, I see an ideal theory as so far beyond our current reach that I am happy to settle for explanatory pluralism and patchy reductionism.

References

1. Zachar P, Kendler KS: Psychiatric disorders: a conceptual taxonomy. Am J Psychiatry (in press)
2. Fodor JA: Language of Thought. Cambridge, Mass, Harvard University Press, 1980

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