Emil Kraepelin: Icon and Reality

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In the last third of the 20th century, the German psychiatrist Emil Kraepelin (1856–1926) became an icon of postpsychoanalytic medical-model psychiatry in the United States. His name became synonymous with a proto-biological, antipsychological, brain-based, and hard-nosed nosologic approach to psychiatry. This article argues that this contemporary image of Kraepelin fails to appreciate the historical contexts in which he worked and misrepresents his own understanding of his clinical practice and research. A careful rereading and contextualization of his inaugural lecture on becoming chair of psychiatry at the University of Tartu (known at the time as the University of Dorpat) in 1886 and of the numerous editions of his famous textbook reveals that Kraepelin was, compared with our current view of him, 1) far more psychologically inclined and stimulated by the exciting early developments of scientific psychology, 2) considerably less brain-centric, and 3) nosologically more skeptical and less doctrinaire. Instead of a quest for a single "true" diagnostic system, his nosological agenda was expressly pragmatic and tentative: he sought to sharpen boundaries for didactic reasons and to develop diagnoses that served critical clinical needs, such as the prediction of illness course. The historical Kraepelin, who struggled with how to interrelate brain and mind-based approaches to psychiatric illness, and who appreciated the strengths and limitations of his clinically based nosology, still has quite a bit to teach modern psychiatry and can be a more generative forefather than the icon created by the neo-Kraepelinians.

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For postpsychoanalytic 20th- and 21st-century American psychiatry, Emil Kraepelin (1856–1926) has been an icon who helped guide us to the now dominant view of psychiatry that is medical in orientation, diagnostic in focus, and based predominantly on the brain. Indeed, this paradigm shift in psychiatry has been termed the neo-Kraepelinian "revival" (1) or neo-Kraepelinian "revolution" (2). A credo for the neo-Kraepelinians, first articulated by Klerman (3) and later commented upon by Compton and Guze (2) included the following major tenets: 1) psychiatry is and should remain in its essence a branch of medicine; 2) diagnosis should be a major focus of psychiatry, with careful attention to symptoms, signs, and course of illness; 3) psychiatric disorders are discrete, real illnesses that can and should be defined using research-supported criteria; and 4) the focus of psychiatry should be on the biological aspects of mental illness generally and relevant brain mechanisms more specifically and not on attempts to explain psychiatric disorders in terms of psychological or sociocultural factors.

While some of these tenets are apt characterizations of Kraepelin's fundamental assumptions about mental illness, others are less so. In this essay, we—a psychiatric historian and Kraepelin scholar (E.J.E.) and a psychiatric researcher and nosologist (K.S.K.)—seek to correct some of the misperceptions and oversimplifications of the image of Kraepelin promulgated by the neo-Kraepelinians. Indeed, for over four decades, many in our field have projected onto the figure of Kraepelin what they might have wanted from a predecessor—a tough-minded, brain-focused, hard-nosed nosologist. It is time to set the historical record straight because, as we will show, Kraepelin does not always fit well into these iconic categories.

KRAEPELIN'S INAUGURAL LECTURE IN DORPAT/TARTU (1886)

We begin with a key document for any Kraepelin intellectual biography: his inaugural lecture for his first chair in psychiatry at the university in Dorpat/Tartu in Russian Estonia in 1886 (4). In order to interpret the significance of the lecture, two brief background points are in order. First, the dominant figure in mid-19th-century German psychiatry had been Wilhelm Griesinger (1817–1868) (5, pp. 51–87). Although Griesinger himself developed a subtle and sophisticated nosology of psychiatric illnesses (6), his influential students took a much harder, reductionist line in advancing his pathbreaking claim that "mental illness is brain disease." Over the ensuing decades, with advances in both gross and microscopic neuropathology, an entire generation of researchers set out to verify Griesinger's claim. As a group, these researchers tended to reduce psychiatry to neuropathology and to reinterpret it as a natural science rather than a clinical one. However, this wave of brain research never lived up to its promises, and, increasingly, as the expected breakthroughs from neuropathological research failed to materialize, critics began searching for alternative approaches. Kraepelin was one such critic.

Second, Kraepelin had spent a year and a half during his academic training working in the laboratory of the prominent

early experimental psychologist Wilhelm Wundt (1832–1920). Wundt's scientific reputation was based on his efforts to redefine psychology as a natural science grounded in physiology. But instead of relying on brain dissection and animal experimentation, Wundt deployed experimental techniques to study, in humans, sensory perception and various cognitive faculties, such as memory, decision making, attention span, and so on. The time Kraepelin spent in Wundt's laboratory proved to be a formative intellectual experience for him, not least because he soon proceeded to put key Wundtian concepts (such as "apperception" and "psycho-physical parallelism") and methodologies (such as reaction time experiments) to use in the study of mental illness. Throughout his life, Kraepelin conducted laboratory research in experimental psychology and maintained a keen interest in the then new natural science of psychology and its possible relevance for psychiatry (4, 7, 8). The attraction of Wundt's science to the young Kraepelin is well captured by this remark in his memoirs: "I decided to become a psychiatrist, as it seemed that this was the only possibility to combine psychological work with an earning profession" (9, p. 3).

In the 1886 inaugural lecture celebrating his acceptance of his first professorship, the 30-year-old Kraepelin outlined his view of the future of psychiatric research and clinical care. We focus here on three major points about the young Kraepelin. First, while lauding Griesinger for having anchored psychiatry in medicine ("it is to the eternal merit of Griesinger … that he admirably advanced the cause of psychiatry's profound and deep union with general medicine" [4, p. 351]), Kraepelin was also critical of Griesinger's brain-based vision for psychiatry:

> Griesinger … insisted that hopes for an expansion of psychiatric knowledge rested on the study of neurological diseases. Nevertheless, to date it cannot be said that our understanding of mental disorders has been significantly advanced by the results of patho-anatomic studies of the brain (p. 352).

While some early consistent findings were emerging from the "brains of paralytics" (that is, CNS syphilis), Kraepelin argued that decades of effort had produced "no definitive achievements" and "results of postmortem examinations continue to leave us entirely in the lurch" for most of the "fundamental forms of madness" (p. 352).

Second, Kraepelin was deeply critical of the dominant brain-based approach to psychiatry led by the famous psychiatrist, neuro-anatomist, and chair of psychiatry in Vienna, Theodor Meynert (1833–1892). Kraepelin argued, in often pointed language, that the etiologic speculations of this school far outstripped the available findings:

> Accordingly, it is at this point that fantasy, unfettered by the uncomfortable shackles of fact, begins to overtake the slow pace of empirical research (pp. 352–353).

Kraepelin went on to criticize specific features of Meynert's neuropathological research program, which he pointed out were highly speculative. He then broadened his concern to much of German academic psychiatry, where many of the leading figures were doing research in cerebral anatomy that had no meaningful connection to the current problems of psychiatric illness. Kraepelin concluded this section by criticizing the pseudo-neurologic language that pervaded much of the writing of psychiatry across Europe during that period, giving a few choice examples: "system of moral fibers," "logic of a brain process," and "seat of enervative feelings."

Third, in part as a consequence of the lack of definitive findings, Kraepelin shifted his attention from neuroanatomy and neuropathology to psychology. He began by noting the poor, unscientific state of the speculative and spiritualist psychological doctrines associated with Johann Christian August Heinroth (1773–1843) and other advocates of the "psychical" school of psychiatry in Germany in the first third of the 19th century. By the 1870s, however, hard-line somaticists—by then the dominant school of German neuropsychiatry—had thrown the baby of psychology out with the bathwater of the psychical school. Their "loathing of the non-scientific probably explains the often astonishing ignorance of alienists concerning psychological things" (p. 356).

Turning then to more recent developments, Kraepelin insisted that a new kind of psychology had displaced its speculative precursor:

> Over the course of the last decade, psychology has become a natural science like any other and therefore it has a legitimate right to expect that its achievements receive the same respect and recognition as other auxiliary disciplines that we use to construct our scientific house (p. 356).

Given the key focus of psychiatry on the world of the mental (which Kraepelin believed had been abandoned by many academic researchers in favor of neuroanatomy), and given the increasing maturity of rigorous Wundtian psychology, he argued that alienists

> should not be allowed to duck the responsibility of describing mental processes and conditions in a manner that is consistent and compatible with the science of psychology (p. 345).

Kraepelin went into some detail about what specific psychological functions might best be studied in psychiatric patients. But this broader summary best captures his views:

> Ever since psychology, thanks to its impartial investigation of the facts, has risen to the status of a natural scientific discipline, it has succeeded in creating strictly empirical research methods that might, upon further development, be applied to the difficult study of morbid mental states (p. 356).

In summary, this inaugural lecture illustrates how, as a young man beginning his distinguished psychiatric career, Kraepelin turned away from what he perceived as the unsuccessful efforts in the preceding decades to use the emerging discipline of neuropathology to document Griesinger's strong claim that all psychiatric illness was brain disease. Kraepelin was deeply critical of what he later called the "brain mythology" that dominated much of the

neuroanatomical/neuropathological approaches to psychiatry. Research in this area might lead to academic prominence but would not, he suggested, soon lead to learning much about psychiatric illness. Instead, Kraepelin turned with enthusiasm to the young discipline of scientific psychology, believing that its quantitative and rigorously scientific techniques had produced important and reliable empirical results. This new psychology of the 1880s, with its grounding in physiology and its emphasis on objective, reproducible results, bore little resemblance to many later clinical, psychodynamic, and humanistic approaches to psychology. But Kraepelin believed that it held a key to the problem of understanding the nature and, potentially, the origins of the symptoms of mental illness.

CLINICAL PSYCHOPATHOLOGY

Turning to his later writings, we now review the degree to which Kraepelin followed through on the promises of his inaugural lecture of 1886. Did he in fact distance himself from the brain-based vision and antipsychological bent of his contemporaries?

Certainly his views on Griesinger did not change much over time. In particular, unlike the vast majority of his colleagues, Kraepelin rejected Griesinger's institutional efforts to weld together the emerging disciplines of psychiatry and neurology. Griesinger had insisted that because psychiatric disorders were essentially only a subgroup of neurological disorders, the two fields should not be separated from each other. Kraepelin disagreed, arguing that neurology and psychiatry were completely separate spheres of medicine. Speaking at the inauguration of the university psychiatric hospital in Munich in 1904, where he had been appointed Professor of Psychiatry a year earlier, Kraepelin decried the fact that Griesinger's paradigmatic attempt to unite neurology and psychiatry had led to an "alienation between university hospitals and mental asylums" and that neurology had very little to offer alienists in the way of practical, hands-on therapeutic advice (10, pp. 34–35; 11, pp. 132–133).

Reviewing the successive editions of his famous psychiatric textbook published between 1887 and 1915 adds nuance to our understanding of the trajectories and contexts in which Kraepelin saw his own clinical work evolving. In the early editions (12–14, pp. 1–3) he framed his work against the backdrop of two historical extremes: "lopsidedly psychological and even moralistic views" on the one hand and "extreme somatic explanations of madness" on the other. Eventually, however, these extremes had been overcome in the mid-19th century by a physiological understanding of mental functions: psychiatry had become a "special branch of neurophysiology." For Kraepelin, however, this contemporary state of psychiatry was inadequate. He insisted vehemently that the notion of psychiatry as nothing more than a special branch of neuropathology or neurophysiology, although scientifically fertile, would never be able to deliver on its promise of a comprehensive understanding of mental disorders. No understanding of "brain mechanisms" could entirely incorporate mental processes. Psychiatric research therefore had to pursue not just the somatic foundations of mental illness but also—using the tools and methods of the clinical sciences—the phenomena of mental life. Only if cerebral pathology could be "intimately linked" with psychopathology would it be possible to explore the "laws governing the interrelationship between somatic and mental disorders."

In subsequent editions of his textbook, Kraepelin never substantially deviated from these fundamental convictions. When in the mid-1890s he rewrote the introduction, his views remained essentially unchanged. The important but consistently meager results of patho-anatomical research made it paramount that scientific research be conducted

> not just on the somatic conditions of the cerebral cortex, but also the mental manifestations of those conditions. In this way we obtain two closely intertwined, but fundamentally incomparable strands of evidence of somatic and mental phenomena. The clinical picture is a product of the causal relationship of these strands to one another (15, pp. 6–7).

Kraepelin's sensitivity to the role of psychological factors in the etiology of psychiatric illness is likewise well illustrated by this quotation from his 6th edition, in the section discussing "mental causes":

> Nowhere does the specific individuality, the sensitivity of the patient in question, play a greater role than in the causation of insanity due to mental factors. We know, however, that the physical resistance of different individuals varies widely, but experiences show that these differences are likely to be even more considerable in the mental domain (16, p. 49).

Over time, however, Kraepelin further softened his deterministic language. Somewhat more tentatively in the introduction to the 8th edition in 1909, he wrote that although an "explanation" sensu stricto of the relationship between psyche and soma was not possible, the two might nevertheless at least be correlated with one another:

> Given the fundamental difference between the two strands of [somatic and mental] phenomena, it may not be possible to provide an "explanation" of one strand based upon the respective other. But it nevertheless does seem possible to draw conclusions about specific somatic changes based on observable mental disorders and vice versa, and furthermore to predict the mental symptoms that will arise in the wake of a certain kind of damage to the cerebral cortex (17, vol. I, p. 9).

It is also worth emphasizing that contemporary reviews of Kraepelin's textbook agreed that he had adopted a decidedly psychological standpoint that appeared to challenge psychiatry's hard-won anatomical and histopathological foundations. Early skeptics lamented the central importance of psychological terminology in his writings, arguing that it was "neither useful nor agreeable" (18). Later, when the 5th edition of the textbook was published in 1896, colleagues roundly criticized it as being "psychiatry without the brain" (19, p. 449). Others, however, extolled the virtues of Kraepelin's psychological approach. In an 1896 review of the same edition, Adolf Meyer (1866–1950), who later became the leading

psychiatrist of his generation in the United States (20), praised Kraepelin as "the foremost psychological worker among the alienists of today" (21). Similar praise for the textbook's grounding in psychology appeared in a review of the 7th edition, published in 1903: "Throughout [the book, Kraepelin] proceeds from purely psychological premises and incorporates observations on the normal psyche" (22).

Finally, one recent study has further underscored the limitations of an overly brain-centric perspective on Kraepelin's writings. In his book *American Madness*, Richard Noll argues convincingly that Kraepelin's somatic orientation was far from entirely brain focused (23, pp. 111–113, 123). Rather, Kraepelin adopted a larger, systemic, whole-body approach that took account of metabolic, serological, endocrinological, and other potentially "auto-toxic" etiologic factors. While it has been our aim simply to counter the one-sided appropriation of Kraepelin as a hard-nosed brain-focused psychiatrist, Noll is correct in reminding us that Kraepelin's general perspective on mental illness relied heavily on internal medicine, not least because at the time, psychiatry was still in the process of demarcating itself as a medical specialty in its own right.

CLINICAL NOSOLOGY

And so it seems that Kraepelin did not entirely share the brain-based, antipsychological approach to psychiatry that we have come to associate with his name. But what about Kraepelin's reputation as a clinical nosologist? If nothing else, his classification of psychiatric disorders must surely be counted among the most influential nosologies of the 20th century. And certainly this is how his psychiatric heirs have often described it. In the early 1960s, long before the rise of neo-Kraepelinian psychiatry, Kraepelin's work was praised for having "incorporated the entire occidental tradition dating back to Hippocrates" (24). Similarly, on the centennial of his birth in 1956, one German psychiatrist insisted that "practically the entire civilized world was indebted to Kraepelin for its psychiatric nosology" (25, p. 192). Even many of Kraepelin's own contemporaries were full of praise for his clinical nosology. His successor at the University of Munich, Oswald Bumke (1877–1950), agreed with Kraepelin that Griesinger's maxim that "mental illness was brain disease" had been a modern-day "fallacy" and instead credited Kraepelin's clinical work as having established the very conditions of possibility for ongoing psychiatric research (26, pp. 32, 34–35). And the renowned neurologist Oskar Vogt (1870–1959) went so far as to describe Kraepelin as "psychiatry's Linnaeus [Carl Linnaeus (1707–1778)—the Swedish father of biological taxonomy]" (27, p. 200).

In spite of such praise, however, if we ask how Kraepelin himself viewed his nosological efforts and what importance he attributed to them, it appears that he was not as nosologically self-assured as subsequent commentators have assumed. Turning again to his textbook, we find that the inflated legacy of his nosology fits awkwardly alongside Kraepelin's own assessment of his work. For one thing, contrary to Vogt's claim, Kraepelin had regularly and explicitly insisted that it was necessary to "abandon for all time a systematic demarcation of mental disorders along the lines of Linnaeus" (13, p. 236; 14, p. 240).

More specifically, however, in the prefaces to the early textbook editions, Kraepelin was rather candid about the subjectivity of his own clinical approach (12, pp. vii–viii; 14, p. v). In his search for "natural truth," he had relied explicitly—and very traditionally—on his "own experiences." Indeed, he noted that he had consciously *avoided* reference to the work of other scholars. This clinical self-reliance and willful neglect of the prior psychiatric literature had imbued the textbook with a distinctly "personal quality." Kraepelin considered this to be a "weakness," but it was a weakness that he accepted in the interest of greater coherence. To have drawn extensively on other psychiatric literature would have "disrupted" the textbook's "uniformity." And so in crafting his textbook and the nosology contained within in, Kraepelin put specifically didactic aims ahead of any pretense of professional consensus or collaboration in the demarcation of psychiatric disorders.

Arguably, such candid and self-effacing remarks were strategic in the sense that they could help garner additional legitimacy and support from practicing alienists who valued clinical expertise. And indeed, perhaps surprisingly from today's perspective, with its goal of objectively validated diagnostic categories, Kraepelin's emphasis on his own personal observations was praised by contemporary reviewers. One reviewer of the 3rd edition (1889) lauded its grounding in the "analysis of clinical observation" that set it apart from "the rank vines of prolific speculation" contained in other textbooks—textbooks that, instead of parsing out "specific symptom complexes," still adhered to the dogma of unity psychosis (28). Another admiring reviewer noted Kraepelin's dedication to "careful clinical observations" and his "entirely uncoerced construction of natural disease groups" (29, p. 109).

But Kraepelin himself was skeptical about whether he had in fact delineated such natural disease groups. To be clear, throughout his career Kraepelin never doubted the existence of natural disease entities. Nor did he doubt that those entities were ultimately knowable to medical science. But in his most explicit remarks on nosology, located in the textbook's evolving section on special pathology, he expressed reservations early on about the shortcomings of his categories: he readily conceded that they were based on "anything but uniform principles," and because he believed that all contemporary nosologies were "necessarily provisional," he chose simply "to compile a number of purely empirically derived disease categories" rather than attempt a "true classification" (12, pp. 208, 211). He even insisted that his categories could make no claim to general validity and that, indeed, they were of "no further scientific value." Their relevance was explicitly practical and didactic:

> Experienced observers will not fail to notice that the validity of the definitions of specific groups presented here can in no

> way claim to be unanimously accepted. Consequently, they are of no further scientific value; but they might—due to their emphasis on certain practically important fundamentals—help give students an overview of the diversity of closely related clinical cases (12, p. 212).

Along these same lines, in the preface to the 3rd edition (1889), Kraepelin emphasized that it was precisely the "lack of a generally accepted clinical system" that "forced textbook authors to use their own best judgment and to coerce, more so than desirable, divergent individual cases into self-made categories" (13, p. iii). In this vein, Kraepelin would have agreed with the assessment of Adolf Meyer, who maintained that Kraepelin's sometimes dogmatic assertions could be attributed to the "didactic character of the book" (21).

Over time, Kraepelin's critiques of his own nosology grew in scope and skepticism (13, pp. 235–239; 14, pp. 239–244). He maintained that his own push to reconcile somatic and mental symptoms would "most likely bring to light the impossibility of any comprehensive delineation of mental disorders." Experience had shown that what at first appeared to be sharp clinical boundaries had become ever more blurred and that a "thorough differentiation between normal and pathological conditions" was an impossibility. In many cases, a satisfactory demarcation was an "entirely unsolvable task" because of the "fundamental obstacle of squeezing life-processes into sharply defined categories." There was "naturally no point in imagining sharp boundaries between congenital and acquired, between inner and external causes of disease, because in both cases experience had demonstrated completely seamless transitions."

In later editions of the textbook (17 [1910], vol. II/1, pp. v, 2–3), Kraepelin remarked that it was becoming harder and harder to present the "burgeoning growth of clinical psychiatry" in "textbook form." Confronted with "doubt" and "uncertainty" at every turn, Kraepelin believed that no one sensed more urgently than he just how "highly unsatisfactory" his nosology was. In fact, he maintained that two fundamental nosological difficulties would "never" be overcome. For one thing, there was no sharp distinction to be made between mental health and illness, but rather a broad boundary zone in which it was "more or less arbitrary" whether a condition was deemed pathological or not. In his 6th edition, he wrote:

> There exists … a vast area of transition where we are merely dealing with the estimation of differences in degree, so that it often depends upon the discretion and viewpoint of the observer whether the range of mental disease is wide or narrow (16, p. 205).

More importantly, however, the sheer diversity of endogenous conditions meant that in many cases it would likely never be possible to arrive at clearly defined disease categories.

It is important to note, however, that such nosological skepticism never dampened Kraepelin's diagnostic ambitions. While it may have tempered his expectations, it never undermined his deep-seated convictions about the importance of careful, discerning clinical observation and differential diagnosis. Indeed, it seems that Kraepelin was ultimately more concerned about empiro-clinical and diagnostic accuracy than he was about taxonomic validity (17 [1910], vol. I, pp. 3–4, vol. II/1, pp. 11–12). From the outset, therefore, he underscored and expanded on his views about the fundamental importance of direct observation for the construction of "clinical disease forms." Exploiting every means of clinical observation at his disposal became a fundamental nosological "principle." In turn, the forms derived from clinical observation served primarily the "practical considerations" of diagnosing the course of specific clinical cases. And although drawing on those forms in the service of diagnosis could lead to mistakes, he understood the importance of misdiagnosis as an aid to clinical research: overinterpreting clinical signs could in retrospect help sharpen diagnostic techniques and ultimately lead to "practically useful disease concepts that could be assumed to correspond very closely to natural disease processes."

Kraepelin's careful phrasing here suggests that he considered his nosology to be more a useful diagnostic tool than the last word on natural disease entities. This interpretation is further underscored in an addendum Kraepelin made to his introductory remarks on special pathology in 1893 and retained in all subsequent editions of the textbook:

> In closing I must emphasize that several of the categories I delineate are mere preliminary attempts at depicting a certain part of the clinical evidence in textbook form. Clarity as to the true significance and interrelationship of those categories must await additional, in-depth monographic study. Furthermore, it is beyond dispute that today, in spite of our best efforts, we are entirely unable to classify many cases as one of the known forms of the "system." Indeed, in some areas the number of such cases has grown so much that scientific confidence has been replaced by uncertainty and doubt. This fact is certainly a bit unsettling for students; but for researchers it simply means a break with the traditional vagueness of our diagnoses in favor of more precise terminology and a deeper understanding of clinical experiences (14, p. 245).

Another illustration of Kraepelin's ambivalent views about his nosologic categories late in his career is seen in one of his most thought-provoking essays, "Patterns of Mental Disorder" (Die Erscheinungsformen des Irreseins) (30). In an often quoted section of this essay, Kraepelin turned to the problem of how the differential diagnosis of his two great categories, dementia praecox and manic-depressive illness, might be viewed in the context of a more foundational typology of levels of psychopathologic processes that he developed in this essay. He noted how difficult it could be to reach a differential diagnosis between the two syndromes. Part of this problem could be ameliorated by an improvement of clinical tools, but he admitted that "qua diseases," we cannot always satisfactorily distinguish between them. But, he wrote, "the suspicion remains that we are asking the wrong question." He then turned to consider this problem in light of his etiologic system:

> We cannot help maintain that the two disease processes themselves are distinct. On the one hand [in dementia praecox] we find those patients with irreversible dementia and … on the other [manic-depressive illness] are those patients whose personality remains intact (30, p. 528).

Thus, while recognizing the deep difficulties in the practical application of his diagnostic categories, he nonetheless argued for the value of his underlying assumptions—that the distinction between a deteriorating and a nondeteriorating course of illness remained valid.

CONCLUSIONS

Retrospective assessments have helped to construct a distorted historical image of Kraepelin as a reductionist, proto-biological psychiatrist and a hard-nosed nosologist. Our historical understanding of Kraepelin has to some degree fallen victim to the success of his nosologic legacy—a legacy that continues to cast a shadow backward in time and to distort Kraepelin's original views. A careful rereading and historical contextualization of his works reveals that, compared with his popular iconic image in North America, the real Kraepelin was: 1) much more psychological in orientation, 2) considerably less brain-centric, and 3) nosologically more skeptical and less doctrinaire. Rather than seeking a single "true" diagnostic system, his nosological agenda was in fact largely pragmatic, as he sought to sharpen boundaries for didactic reasons and develop diagnoses that served critical clinical needs, such as prediction of illness course. As Paul Hoff (31) pointed out many years ago, Kraepelin considered himself much more of a clinical researcher than a nosologist. Believing that his own nosology would eventually be overtaken by the march of science, he would therefore have agreed with those who later resisted the canonization of his work and who would substantially revise his nosology in the face of new scientific evidence.

Our current view of Kraepelin might tell us more about the wishes of one branch of U.S. psychiatry in the last third of the 20th century than about the actual historical figure himself. Neo-Kraepelinian psychiatry in the United States arose in reaction to the excesses of the psychoanalytic and social psychiatry schools. For different reasons, both of these schools were uninterested in diagnosis, eschewed the biomedical model, and paid minimal attention to the brain. The neo-Kraepelinians saw in the historical Kraepelin a like-minded prestigious historical figure who could serve as their standard bearer. But in fact, he fit that role poorly. Unlike the neo-Kraepelinians, who were struggling to reorient the psychiatry they inherited in the late 20th century, Kraepelin was dealing with an entirely different set of historical and cultural forces in German psychiatry and psychology in the middle to late 19th century. Central to his career was the need to respond both to the failure of brain-based psychiatry to deliver on the promises of neuropathology and to the exciting rise of scientific psychology. We suggest that the historical Kraepelin, who struggled with how to interrelate brain and mind-based approaches to psychiatric illness and who appreciated the strengths and limitations of a clinically based nosology, still has quite a bit to teach modern psychiatry. He can be a more generative forefather for our field than the icon created by the neo-Kraepelinians.

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