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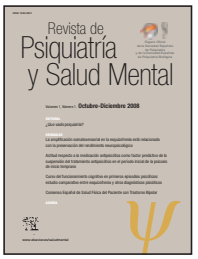

EDITORIAL

Quo Vadis, Psychiatry?

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Psychiatry begins victoriously the 21st century, in which the misfortunes of the past are forgotten in favour of a deserved prosperity. Is this euphoric climate justified? Relatively, it is. It must not be forgotten that psychiatry has passed through various distinct phases[1] since the beginning of its history. The promising beginnings of the Greek Hippocratic age and part of the Roman era up until Galen gave way to the Obscurantism, which lasted until the French Revolution. In this dying period, the culture was relegated to the monasteries and many mentally ill patients were executed at the hands of the inquisition.

With the French Revolution, Pinel begins a new age of splendour that extended over the entire 19th century, thanks to French and German psychiatry. Organicist approaches and the study of psychiatric symptoms were established under the tutelage of descriptive psychopathology, culminating with Kraepelin's categorical classification towards the end of the century.[2]

Over the first half of the 20th century up until World War II, it passed through a placid and not very productive journey, guided by the beginning of psychoanalysis, existential analysis, phenomenology and the failure of the organicist approaches. After World War II, several phenomena occurred that brought about various and sometimes conflicting paths of expansion.[3] Group dynamics and concern by social factors generated a trend of interest in the role of the family and its importance in the genesis of mental illness, which culminated in the 1970s with the overwhelming emergence of anti-psychiatry. Two decades were enough to cause the devastation of large mental hospitals due to the vital, young influence of this psychiatric trend that, although it contained the positive ingredients of criticism of an outdated system, the social scope was radically reduced and it lacked a theoretical basis for becoming established as a solid alternative.[4] It gave rise to community psychiatry, which was very important because, for the first time in history, the goal was to have the patient live and be treated right in the community, and not in mental hospitals.[5] However, at the same time, in the 1950s, psychoactive drugs that truly acted on psychiatric illnesses and disorders were made available. Lithium, anxiolytics, antipsychotics, and antidepressants meant a true revolution that totally changed the perspective. Mental hospitals suffered a reduction in stays for the first time, and all of this facilitated the emergence of the aforementioned community psychiatry. However, although this was very significant on its own, the success of these psychoactive drugs favoured research into new and productive etiopathogenic hypotheses.[6] More specifically, the effectiveness of antidepressants stimulated the catecholamine and indoleamine hypotheses for depression, and the effectiveness of neuroleptic drugs encouraged the dopaminergic hypothesis for schizophrenia.

These research directions crystallised in reliable studies on neurochemistry and neuroendocrinology. At the same time, genetics and the study of brain imaging were being developed thanks to the advance of techniques in these fields.[7]

With all of the foregoing, we now come to modern times, in which community psychiatry continues to expand, psychoactive drugs are being refined without new revolutionary molecules appearing, and the so-called biological psychiatry is inexorably advancing, led by neurochemistry, genetics, and neuroimaging.[7] The new era again represents movement of psychiatry towards more and more radical biologist positions, because they support the biological basis with regard to disorders such as anxiety, phobias, posttraumatic stress, hysteria, or personality disorders, which have up to this point been considered to be psychosocially based.[8]

The big question is where psychiatry is headed. Not many years ago Eysenck[9] decreed that psychiatry would be divided

into 2 approaches: one biological, led by neurologists; and the other would encompass the field of prior neuroses, which would be in the hands of clinical psychologists. Fuller[10] also predicted the death of psychiatry and some ingenious minds today still surprise us with similar opinions. Are such statements well-founded? In principle they are not, but psychiatry must safeguard itself against the dark dangers that surround it and lie in wait for it. We shall mention a few of these.

In our opinion, the most serious danger to psychiatry, according to the 3rd revision of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III), is that for 30 years, the interest in symptomatology and careful clinical examination has disappeared in favour of quick diagnoses based on criteria that are highly reliable but that have limited validity.[8] Descriptive psychopathology has hardly become enriched and new symptoms are limited.[11] A consequence of this is that the classifications have universal consensus, but they are not consistent. In this approach, psychiatry must return to refined clinic, or it may become a branch of medicine with limited reliability.

All of the above has a bearing on 2 significant problems.

The first refers to the limited correlation of clinical psychology to biological data. In this respect, a dangerous contradiction has appeared between the results of biological data, which are becoming more and more refined, and clinical data, which are becoming more and more diffuse and imprecise. Furthermore, clinical inconsistency negatively impacts therapeutic data. Indeed, studies with very meticulous methodologies result in imprecise and sometimes seriously flawed data when therapeutic results are analysed in a sample lacking a precise clinical profile (eg, major depressive disorder), in which the results obtained with limited clinical reliability cannot be trusted. Only clinical precision (eg, major depressive disorder with or without melancholy) can offer trustworthy results.

Another danger that modern psychiatry must avoid is the refinement and improvement of biological techniques, particularly those referring to precise symptoms. We must move away from boundless and unjustified optimism; otherwise, we may fall into vain arrogance with no real basis. Some of this is happening in new psychiatry and it must be avoided. Indeed, the boundless expectations of the last few years with regard to neurochemistry, brain imaging and genetics have not brought about the expected results. Only vague conclusions about illnesses, such as serotonin involvement in depressions, brain involvement in schizophrenia, or genetic involvement of obsessive disorders, have been reached, without obtaining substantial advances or conclusive results.

Let us be humble in our progress, which is real, but that does not allow us to gloat fatuously over the subject. If we do not improve clinically and phenomenally on the symptoms, the Eysenck's prediction may come about, showing that neurologists are capable of assuming major disorders and clinical psychologists are capable of assuming minor disorders, with the resulting blurring of the role of the psychiatrist.

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