Crises and Crossroads of a Psychiatry in Search of a Future

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ABSTRACT

On the understanding we accept where psychiatry would today be located in the metaphor of the crossroads, as proposed by Santiago Levín, the purpose of this article is to explore certain aspects of a paradigmatic crisis in mental medicine that has raised some concerns as to its future. Certain deep epistemological questions are addressed, such as the schema of "truth", where experts should supposedly manage themselves, and the dilemmas raised from the two key elements of a clinical session: diagnosis and treatment. Finally, the study emphasises the importance of the ethical, social, and political aspects of rethinking knowledge and practices.

Key words: psychiatry, postpsychiatry, paradigms.

INTRODUCTION

We have been pointing out for several years now that psychiatry is going through a period of paradigmatic crisis. The influence of Lantéri-Laura's work[1] in describing the three paradigms in modern psychiatry (mental alienation, mental illness, psychopathological structures) was and still is very significant in this type of epistemological reflection. From the 1980s and 1990s onwards, a fourth paradigm, based on a scientific-naturalistic or biomedical model, emerged with force, as it was pointed out at the time by Juan Carlos Stagnaro*,[2] and later analyzed in depth by Santiago Levín[3] in "La psiquiatría en la encrucijada" (Psychiatry at the crossroads). A biomedical paradigm backed by flourishing neurosciences caused concern about the scientific and social legitimization of psychiatry. Jean Garrabé wondered: "Is psychiatry going to disappear, getting confused with neurosciences or splitting into several branches to be taken care of by psychologists, psychoanalysts, psycho-behaviorists, pharmacologists, etc., or is psychiatry going to learn how to integrate inputs from these sciences outside its field but which can enrich its practice as medical therapists of the mentally ill"[4] (p. 41).

Recently, Levín and Matusevich[5] have convincingly argued -which could be construed as a response to Garrabé's concern- that "psychiatry has a future." Following Conti[6], these authors argued for a "re-philosophization" of psychiatry and for integrating knowledge and a necessary and inalienable ethical dimension. And Stagnaro[7] himself, in one of his latest editorials in Vertex, appealed, in similar terms, for the journal's pages to reflect the debates surrounding the current problematic statute of psychiatry.

These are times of crisis and uncertainty which, necessarily and taking up Levín's proposal[3], place psychiatry at a series of crossroads on which it is still worthwhile to continue reflecting. If a crossroads is a junction of paths going in different directions or, in other words, the metaphor we use to describe a difficult or compromising situation in which there are several possible courses of action and we do not know which one to choose, there is no doubt that psychiatry finds itself in a web of dilemmas of a complex solution. In recent decades, many psychiatric specialists have made efforts to raise constructive criticisms and propose alternatives to this reductionist, fragmentary, and subjectless biomedical mode[l3,8,11]. The following pages aim to try to add some

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more elements to this debate, identifying possible routes to follow in an attempt to contribute to unraveling the ideological and technical entanglement in which psychiatric practice finds itself immersed.

Unresolved problems and endless discussions

As is well known, in 1980, the DSM-III was published, which marked a very important trend change[12]. The focus shifted from unconscious conflicts, childhood trauma, and psychotherapy to broken brains, neurochemical imbalances, and psychopharmacological treatments. Then came the decade of the brain as a vast research program focused on 1) neuroimaging techniques, 2) dementias and brain aging, 3) genetics and its possible therapeutic applications, and 4) psychopharmacology[13]. Undoubtedly, this meant a significant change in the understanding of mental problems, but it posed epistemological and clinically complex problems to solve. We should recall, for example, the debate that arose at the end of the 1990s on the essentialist and non-essentialist views of mental disorder, which generated an impressive and wide-ranging bibliography[14,15]. From essentialist positions, "...mental disorder would be understood as a natural entity, as a concrete and fragmented reality established in the individual and correlated with permanent somatic variables"[16]. On the contrary, "from non-essentialist positions, mental disorder would be considered beyond a concrete reality (which may or may not have a biological origin), as a cultural entity that is integrated into the totality of the individual, taking into account not only the phenomenon itself but its variable contextual condition, which refers us to symbols and myths, values and relationships, individual and collective mentalities, experiences and subjectivities"[17].

This is undoubtedly one of the crossroads at which psychiatry continues to find itself. But it is not new; it is an ongoing debate; they are loop discussions, which are repeated with different nuances naturally depending on the moment and the context we consider. I believe that what we can call psychiatric paradigms, namely, the body of knowledge and methods accepted by the community of specialists, have coexisted with more or less success throughout history. In other words, it is impossible to constitute a science of the mind as astrophysics does. In Kuhn's model[18], after a paradigm shift, the scientific community ends up accepting, internalizing, that things "can no longer be thought of in any other way" (Ptolemy's geocentric theory is incompatible with Copernicus' heliocentric theory; Newton's classical mechanics cannot answer the questions that gave rise to Einstein's theory of relativity).

But in psychiatry, things do get to be thought of differently: the theoretical, epistemic, methodological tension between the somatiker and the psychiker has been, I repeat, a historical constant: Body vs. Soul, Brain vs. Mind, Matter vs. Thought, Neurotransmitter vs. Significant. In other words, a coexistence of paradigms among which there is a struggle for the story that will give rise to a dominant narrative, which will be regarded as the prevailing paradigm, but which will continue to confront other minority ways of thinking, though not for that reason lacking in fundamentals, outdated or outmoded. In fact, in psychiatry, reactions to the "prevailing paradigm" often arise not from nostalgia for previous theories and practices but from critical analysis and the proposal of alternatives to this prevailing model which, yes, enters into crisis because it is unable to answer questions of scope regarding new problems that arise in the field of mental health, but also because it loses support both from the scientific community and from other economic, political, social and cultural bodies.

The criticisms of the DSM-5 from psychiatric corporations themselves are well known, and even the US National Institute of Mental Health (NIMH) has withdrawn its support for the DSM-5. Pharmaceutical companies are, to some extent, moving away from psychiatric research and the development of psychotropic drugs. Psychiatric research, diagnoses, and treatments have come under fire from activists, journalists, and academics from various perspectives. All these circumstances create a great deal of uncertainty and, as Bradley Lewis[20] points out, make psychiatry veer towards an "arduous desert" because it cannot find its way. And so we return, put another way, to the metaphor of the crossroads. Against this backdrop, I would like to raise some issues between history, epistemology, and critical thinking that can perhaps contribute to the debate.

The problematic statute of "Truth"

In 2017, Ortiz Lobo claimed that "probably the greatest constraining factor in the clinical practice of modern psychiatry is the 'truth' value of its discourse," a discourse rooted in the reason and the certainty of science, which defines mental illness as a natural, substantive reality delimited by a supposedly univocal, transparent, and universal language and which constitutes the knowledge of expert professionals, whether they are biological psychiatrists, psychoanalysts or of any other psi family. In this ontological and epistemological discussion about mental illness and its realistic conceptualization, any modern psychiatric narrative holds a power based on its status of the 'truth' that determines the clinical encounter in content and form"[21]. From this idea of "truth," which is a truth tailored to every theory, every approach, and every model, serious conflicts arise. Two examples: 1) the uncritical identification with a theory or approach may result in the professional applying it systematically, disregarding other possibilities that he/she overlooks or is unaware of; 2) the specialization in a specific mental disorder may lead to overdiagnosis and an evident confirmation bias. However, our commitment cannot be to the theory, the technique, or the protocol but to the patient, the person who suffers and demands our professional help. A psychiatrist or clinical psychologist often simplifies clinical situations to make them fit in with theoretical knowledge. Very often, their expert status can be in the form of what we could call "powerless omnipotence." That is, their "truth," in essence, may

not be the truth because of insufficient substantiation: there are no identified biological causes; there is no unequivocal biological marker for any mental disorder; there is no conclusive evidence for psychic conditions caused by a chemical imbalance or that drugs might work in correcting such imbalances, nor can everything be explained through the symbolic.

In any case, is it necessary to have an answer for everything? After all, our object of knowledge is uncertain (the human being); our methods are debatable (observation, listening, experience); our metrics are subject to bias (one human mind evaluating, judging, and intervening on another human mind). Therefore ambiguity, contradiction, and uncertainty (from the patient and the professional) are unavoidable factors in the clinical encounter.

There are very tangible aspects of psychiatric practice at this crossroads. Without ruling out others, I will refer to two crucial elements of the clinical encounter: diagnosis and treatment.

The Problem of Diagnosis and descriptive psychopathology

Some authors have called for the recovery of the so-called classical descriptive psychopathology (after mandatory historical and clinical recalibration) as a way to overcome the templates of symptom lists (DSM; ICD)[22], but it becomes necessary to take into account that the semiological virtuosity of psychiatrists and alienists of 150 years ago originates in a very specific space of observation, which is the asylum.

Descriptive psychopathology (like any other semiology) seeks to identify and describe the symptom (or sign), in order to define it, order it and classify it, but not to interpret or understand it. The diagnostic process of modern psychiatry consists of transforming the experiences of the patient or person with psychic suffering, gathered from his or her own verbal or nonverbal communication, into psychopathological terminology that allows them to be standardized into categories. This requires a clearly structured psychopathological language with which to construct a specialized discourse of great utility in certain fields. In this sense, of course, you have to know psychopathology and of course, you have to know how to deal with diagnostic categories, but it never hurts to be aware of how problematic a psychiatric diagnosis can be, how it can commodify and stigmatize an individual[23,24]. It is evident that to understand each other among professionals or to explain oneself before a judge, for example, categorical diagnosis is necessary and sometimes unavoidable. It may also be indispensable in the face of administrative, institutional, or legal requirements, but in these cases, the need arises to count on the patient to clarify the meaning and purpose of its use. However, in the usual clinical practice, especially in the so-called critical psychiatry or postpsychiatry[8,25], it is recommended to "overcome categorical diagnosis and try to understand the complexity of the human being, not through a standardized and reductionist label, but through a narrative formulation"[8,25], and not only for the reasons mentioned above but also because - if the subject's experiences are translated mechanically into symptoms or pathologies - there is a tendency to separate the clinical manifestation from the social, cultural and biographical context in which they have appeared, thus discouraging the search for meanings that may be related to them[21].

The treatment problem

A lot has been written about the spectacular increase in the use of psychotropic drugs and the interests of the pharmaceutical industry, about new drugs appearing for new illnesses (alprazolam for anxiety attacks or panic attacks), or new indications for the same drugs and the pushing of disease boundaries (methylphenidate for ADHD; paroxetine for social phobia). In any case, these are old issues I will not dwell on. Many critics of psychiatry argue that what crystallized the current consensus around the biological/pharmacological model of psychiatry[26-28] was the power of pharmaceutical promotion. There is currently a whole movement that advocates the judicious use of psychotropic drugs, taking careful account of the indications and doses, maintaining them for a limited time, trying to avoid side effects and iatrogenic effects (with a clear desire for quaternary prevention), and also advocating deprescription, i.e., a management that allows the withdrawal of excess medication. Joana Moncrieff[29,30], for example, is one of the most cited authors in this regard.

However, it is worth noting that, in recent years, the pharmaceutical industry has drastically reduced its efforts in developing new drugs due to the lack of promising molecular targets capable of impacting mental disorders and the consistent failure of new compounds to demonstrate superiority over placebo[31]. It seems that the current bet of the biological model is not psychopharmacology but genetics. Based on the success of the Genome Project, in 2013, the US administration announced the launch of the BRAIN Project (Brain Research through Advancing Innovative Neurotechnologies), which aims to map brain activity[32]. It may be that their results may lure the pharmaceutical industry back into psychiatry, but mapping the brain is a long-term project, and such results will be fragmentary and disconnected, at least for a while.

The paradigm or biological model will, naturally, persist hand in hand with neuroscience and neurotechnology, but it will probably have to coexist with other models that originate elsewhere. It is undeniable that coinciding with the period of the great boom in biological and neuroscientific psychiatry, the humanities (history, philosophy) and social sciences (sociology, anthropology, cultural studies) have developed a very vast activity within the framework of the so-called "narrative research," that is, the study of experiences as a story capable of generating meanings. Narrative-based psychiatry offers the possibility of considering fields beyond neuroscience and more in-depth reflections on how psychiatry creates

meanings and constructs its models. Ultimately, there are many ways to present a mental health problem, but you cannot say that only one is right and all the others are wrong.

Let it be clear that both Evidence-Based Medicine meta-analyses and the narratives are tools and not paradigms, as has come to be argued.

The Division of Clinical Psychology of the British College of Psychologists proposes that "the Power Threat Meaning framework can be used as a tool to help people create narratives or accounts of their lives and difficulties, which they may have encountered or still have, rather than viewing themselves as guilty, weak, defective or mentally ill"[33,34]. In developing these ideas, the participants included psychologists, psychiatrists, social workers, and technicians in health, education, labor, justice, and others. In other words, this cannot be understood as a choice of psychologists versus psychiatrists, as has sometimes been wrongly argued, but as a consensus document that crosses disciplines and which, I believe, is worth knowing and considering.

The Importance of Social

Finally, this brings me to the last point I want to make: the social and political dimensions. The main historical crossroads of psychiatry has been its status as a "special service", its dual status as a medical specialty (for therapeutic purposes), and as a guarantor of social defense. Stripping psychiatry of its status as a discipline of power to turn it into an emancipatory practice is probably one of the unavoidable priorities. It is more relevant to de-alienate than to cure. Therapeutic accompaniment, continuity of care, the search for forms of care that are closer and in normalized environments, and the firm desire not to pathologize/psychiatrize complaints or adaptive reactions (although they do provide support) imply changes in care models that, ultimately, are the result of political decisions. To talk about mental health in our current society is not only to expose the consequences of privatization and neoliberal cutbacks to healthcare resources; it is also to warn of the "cultural" fallacies of the system, and it is, of course, to insist time and again on the proven consequences of the economic crisis, poverty, and precariousness on mental health[35]. The only option is to rethink or, at least, to be very aware that, when faced with a demand for care with evident socio-cultural and political conditioning, the clinical response is usually individualized[36].

The recovery of people with psychic suffering requires access to employment and housing and scrupulous respect for human rights. That will not require the work of neuroscientists in their laboratories but of psychiatrists, psychologists, social workers, and others.

A final aspect to consider in these dynamics is the growing importance of paying attention and listening to the associations and groups of patients, users, and ex-users of psychiatric devices (not only those of family members). Mutual support groups, experts through experience or activism firsthand have progressive implantation and influence in the Anglo-Saxon world[37], probably less so in our environment, but I think this is something to count on in the future, even at the risk of relativizing our knowledge[38-40]. We should be wary, or be on guard, of what Ota de Leonardis[41] called some time ago the "myth of specialized competence," explaining that the work of specialists gives concrete form to the rationalist/positivist problem-solution paradigm so that "to a rational, scientific, codified definition of the problem corresponds a rational technical solution". The institutional solution determines, in many cases, how the problem is analyzed and even formulated, to the point of disregarding or ignoring those that do not fall within the limits of the knowledge and strategies that this institutional framework is capable of developing. That happens in psychiatry and many other disciplines; we should remember that experts do not necessarily have all the answers and that some other knowledge considered profane or inferior gained through experience can play an equally important role in the framework of a therapeutic relationship.

Clinical and therapeutic, epistemological, ethical, and political crossroads.

It is likely that psychiatry has the opportunity at this time of profound instability to identify contradictions in order to consciously and critically position itself in the face of its dilemmas and attempt to reconstruct its professional identity. I think that a possible and hopeful path may be to do it from a critical and person-centered psychiatry, which avoids coercion, excessive technological interventionism, and iatrogenesis, which transits from the patient with his symptoms to the person in his context (giving greater prominence to the social aspect); that overcomes the authoritarianism/paternalism of the professional in favor of a horizontality respectful of the patient's will, that facilitates the joint construction of meanings or fields of meanings, not necessarily definitive, that seek to give meaning to the patient's narrative.

All this without demonizing biological or dynamic psychiatry, neurosciences, or the couch, but being aware of the complexity of such a hybrid specialty and so exposed to reductionism as psychiatry.

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