CONTRADICTIONS OF MEDICAL PSYCHIATRY IN THEORY AND PRACTICE

CONTRADICCIONES DE LA PSIQUIATRÍA MÉDICA EN LA TEORÍA Y EN LA PRÁCTICA

Julio Company Ortega
Psiquiatra de la Seguridad Social, CSMA Maresme sud, Barcelona. España
ORCID: https://orcid.org/0000-0002-7729-7039

This article was published in Spanish. This is the English version.
Link to the Spanish version: (https://doi.org/10.33898/rdp.v31i115.329).

How to reference this article:

Company Ortega, J. (2020). Contradicciones de la Psiquiatría Médica. En la teoría y en la práctica. [Contradictions of Medical Psychiatry. In Theory and Practice]. *Revista de Psicoterapia, 31*(115), 167-183. https://doi.org/10.33898/rdp.v31i115.329

Abstract

This text is not about a new psychiatry or a manifesto breaking with the current approach to mental disorders. Rather, it tries to highlight the systematic distancing of the genuine from the individual, by a coarse, imprecise, but at the same time implacable procedure, characteristic of the prevailing medical psychiatry. I wonder if this approach to existential suffering does not contribute, on the contrary, to the chronification of this suffering when the subject is forced to identify himself, without option, to a passive position that situates him as mentally ill. From a psychiatrist's point of view, evident contradictions are highlighted, both in theory and in practice, and the nucleus of the stubborn clinging to them is investigated.

Keywords: *Mental Disorders, Genuine, Prevailing Medical Psychiatry, Chronification, Passive Position, Mental Illness, Contradictions.*

Resumen

Este texto no trata sobre una nueva psiquiatría o un manifiesto de ruptura con el abordaje actual de los trastornos mentales. Más bien trata de poner de relieve el alejamiento sistemático de lo genuino del individuo, por un proceder basto, impreciso, pero a la vez implacable, característico de la psiquiatría médica imperante. Me cuestiono si esta aproximación al padecimiento existencial no contribuye, por el contrario, a la cronificación de dicho sufrimiento al verse forzado el sujeto a identificarse, sin opción, a una posición pasiva que lo sitúa como enfermo mental. Desde la mirada de un psiquiatra al uso se resaltan contradicciones evidentes, tanto en la teoría como en la práctica, y se indaga sobre el núcleo del aferramiento, terco, a las mismas.

Palabras clave: *Trastornos Mentales, Genuino, Psiquiatría Médica Imperante, Cronificación, Posición Pasiva, Enfermo Mental, Contradicciones.*

ISSN: 1130-5142 (Print) –2339-7950 (Online)

Received v1: 3-11-2019. Received v2: 6-12-2019. Accepted: 25-1-2020.

Correspondence:
E-mail: disonante.grupo@gmail.com

Decompensation Is Always Due to Lack of Medication

One of the most common precepts in daily practice in psychiatry, which is given in conversation with peers or in coordination with other devices, is that the decompensation of a mental disorder is always explained by lack of medication. I will give an example here of a particular case that made me think, utilizing the most naïve questions, that I still have not been able to answer yet. It was a coordination with a specific service with whom we worked and they told us about a case of a woman who presented with a manic phase. They explained that she was a patient diagnosed with type I bipolar disorder, and that, in the last four years, she hadn't taken her eutimizing medication. The conclusion was that the decompensation was due to abandoning the medication.

The inescapable question was: What kept her stable for so many years? If we apply the organicist formula, i.e. [brain lesion + stabilising medication], the only explanation is that the psychopharmaceutical took four years to metabolise. Would this case be the case if we compared it to a patient with diabetes or hypertension? What would we think if for four years a medication was abandoned and there were no symptoms? At this point other contradictions are presented, such as, for example, asymptomatic people with theoretically infratherapeutic doses; people who improve when they establish new links or when they break with them (whether they are relatives, partners or even with the staff at the institution); others who do so when their social situation (to find a job, to be included in a social group, to improve their economic condition, etc.) preserving, however, the same medication pattern with which, until now, their evolution had been lethargic. On the other hand, it's worth mentioning people who, in spite of an invariable pattern of medication, decompensate.

The question is, if our discussion focuses on describing chronic mental illnesses equating them with the rest of somatic illnesses, that is, requiring continuous medication and for life, how do the previous situations fit into this equation? Why, instead of ignoring these facts, do we think about what factors allow the person to be stable, beyond taking psychopharmaceuticals? In other words, what other variables make a person remain compensated? They are questions that fall from their own weight, because they are not isolated cases, but why don't we stop and think about it? I will cite some factors that could contribute to this:

- The burden of care: a psychiatrist used on an outpatient basis may have between three and six hundred patients on his or her agenda. This is an enormous burden of care, as it includes not only the clinical aspect (scheduled visits, therapy groups, visits or emergency calls), but also the bureaucratic aspect (referrals, care reports of various kinds), the social-juridical (expertise in trials), coordination with the team itself or other devices of the mental health network, meetings of various kinds and teaching agreements. In my opinion, this burden of care totally affects the case being dealt with, providing crude, generalised responses and moving

away from the uniqueness of each situation.

- The official psychiatric instruction: the traditional formation, especially for the psychiatrist, and despite the fact that in theory, different perspectives are promulgated, such as the communitarian, rehabilitation or different models of psychotherapy, in practice, and, above all, in the treatment of the so-called *serious mental disorder*, there is an evident hierarchy of the biological. Very exceptionally, it is heard that a psychotherapy gains ground over a medication; or that a personalized approach to the needs of a person from the community point of view (for example, finding a specific space where an activity can be developed that acts as a substitute, generate new social ties or act as a companion as a anti-anxiety agent, etc.) replaces psychoeducation programs or allows the progressive remission of the medication pattern. Psychological spaces or more personalized accompaniments can be proposed, but (almost) always as something complementary and keeping the chronic medication pattern unquestionable. It is also proven in daily practice that the most available personnel at street level, such as the individualized follow-up program or PSI, act, once again, as a reiterator of the medical discourse or to instruct or supervise that the user adheres to this prevailing knowledge, rather than taking advantage of the opportunity to link up and get to know that genuine subject with more time and space, regardless of the symptomatology he or she suffers. Fortunately, I must say, there are exceptions to the rule.

Although, above all, in the formative period, different approaches are promoted, in daily practice as an supplement, in a more or less allusive way, every approach is directed towards the biologicist paradigm, remaining, whatever the psycho-social means, relegated to a secondary level.

Comfort or the avoidance of more stress: it is much easier to associate decompensation with lack of medication, as it only takes a few minutes to instruct a person, than to find out which external or subjective factor has precipitated the decompensation, which, on the other hand, can lead to several visits, that is, months, and that in the event that there is a disposition on the part of the interviewer. To instruct a person to use neurotransmitters and a couple of medications, with the precept that it is for life, takes very little time. To explore the personal dimension, on the other hand, that is, their position before life, their relationships, their fantasies, their root anguish, their defenses, their substitutions, the signifiers that designate it, the situations of destabilization, etc., that is to say, to investigate the specifics of the person is something very complex for what would be required, on the other hand, years.

In this same vein, in daily practice, if there is recovery or improvement it will always be due to medication, whether the change occurs immediately or months later. For example, during the rotation in the acute hospital unit in my time as a resident, I sometimes observed that clinical stabilization occurred suddenly and I

naively asked what factors contributed to a person recovering within a few days of being admitted, while another one took up to four weeks to do so. The answer was always by the introduction of this or that pharmacological guideline. The forcefulness of the answer that I perceived was such that I did not dare to question it. I remained silent, but in my inner self I thought how two opposing aspects could have the same solution, without introducing any other variable.

With regard to psychopathological stability in general, is it not possible to exclude distancing with certain triggering factors that position a person in this way or another, the narrative of what happened that the same person elaborates over time, the acquisition or recovery of substitutions or new relationships that allow for a different subjective positioning. All these variables, perhaps less palpable and difficult to evaluate, and yet determinant, are not contemplated, or what is more serious, there is hardly any notion of them.

Sometimes, it also happens that, after years of medication, the person who abandons it becomes destabilized, with which, it is inferred, again, that it is due to the lack of medication. Is it not also possible that the person, after years of constant psychoeducation, and subjugated to ideas such as *medication is forever*, *do not stop taking the medication or will you worsen*, or indirectly with continuous allusions to it, is represented by a series of signifiers, outside of which he or she is totally devoid of identity?

I would like to quote, now, some examples of first decompensations extracted both from psychiatric literature and from daily practice and which, in this sense, make me think about what is at stake beyond a supposed irreversible imbalance of neurotransmitters.

- A patient's sister marries; and they begin to live with together; the sister's husband goes to the military; in this period of the husband's absence, the sister takes a lover; the patient, although against the relationship, facilitates the relationship; at a given moment, she begins to feel that the sister's new lover is attracted to her (the patient); she comes out with this when she sees the older sister and the lover kissing.
- Paul Schreber (2018), a classic case of psychosis, presents a psychotic episode when he is appointed member of the Dresden Court of Appeal.
- A mother, who had always dreamed of being one, goes into psychotic decompensation when the doctor gives her the baby after delivery.
- A woman, who had been sodomized since she was a child, has faecal incontinence in her teens. Begins a serious hallucinatory episode the moment her anal sphincter is reconstructed.
- A researcher who has been working on research for decades. Presents a psychotic episode at the time he publishes it.

How are all these examples explained from a biological point of view? Is it perhaps an acute stress that leads to the disorganization of neurotransmitters? Could you prove this so that you can state it so categorically? For example, in terms of

the first assumption, surely the person has endured throughout their life situations of greater emotional burden, so why has it been in that specific context where the psychosis has come out? Why, on the one hand, do we neglect to look for the finger that triggers madness, but on the other, we give a clear biological explanation?

Don't we function, perhaps, on the basis of parameters that determine the perception of both the world around us and our identity, with the possibility of situations that make them waver?

Contrast of Psychiatry with Respect to Other Medical Specialities

One of the things that is required of any medical specialty, and even more so today, is the anatomical-clinical correlation. That is to say, the relationship between the clinic and the causal lesion and its sequelae, not in one, but in different areas: anatomical (macroscopic), pathological/histopathological (microscopic) and currently, even genetic and epigenetic. This is perhaps one of the most evident contradictions, since a psychiatrist will never be seen to ask for a single diagnostic test, but on the contrary will say that he is asking for one in order to rule out organicity, but hadn't we already agreed that psychiatry is biological, then later organic? So, do we assume that psychiatry is sustained in medicine without being able to explain any of its illnesses from an anatomical, physiopathological or genetic point of view, that is, without a causal agent?

Throughout the seventeenth century a philosophical movement emerged in Europe and America that would be known as *the age of reason or enlightenment*. Its participants wanted to illuminate human intellect and culture after the dark Middle Ages. The interest shifted towards man and concretely in the attainment of plenitude through reason, which gradually extended to the social, economic, political and scientific spheres. Within this framework, physicians imposed the hierarchy method over general theories and insisted on finding the ultimate causal agent of bodily diseases. On this axis, they sought to identify the natural diseases of man (which had to be numerable and irreducible) with a determined process and prognosis and consequent to a concrete causal agent. For example, pneumonia had to be differentiated from appendicitis and appendicitis from gout, since the three would have specific signs in different orders: clinical, anatomical and anatomopathological. At the same time, if the causal agent of a pathology was found, a specific treatment would be defined for it. As a result, on the one hand, general theories were discarded and, as a corollary, panaceas were also rejected, that is to say, those treatments that served, in theory, for any type of ailment.

Psychiatry could aspire to approach the rest of medicine if a concrete causal agent were found for each supposed illness, that is, to corroborate that a person had, let's suppose, schizophrenia, we would find in the blood a unique and common substance in all the people we had diagnosed with it. We could call this substance, by way of example, schizophrine, and, if we observed that certain values above started the clinic that we associate with this psychosis, and other values below it remitted,

we would be able to affirm that its origin is biological. The same for melancholy/mania and for paranoia. Said so plainly, it seems absurd, reductionist, almost like a stereotype from science -fiction, however, it is what medical psychiatry longs for, that is to say, a biological marker that delimits one disease from another. If we are far from reaching this point, we are even further from assigning a mental illness to a certain gene, which, revealing an impossible feat has been chosen to be justified from the multicausality, the multifactorial or the biopsychosocial, that is, to return, in my opinion, to general constructs and vague theories that do not point to anything in particular, isn't that just another contradiction?

This aspect is even more blurred in the realm of neurosis, which is masked by terms as common and nonspecific as *depression*, *dysthymia* or *personality disorder*. Under these ambiguous constructs one can find, in various instances; from exhausted people and in very diverse external conditions, people in mourning for losses of different natures, internal conflicts reactive to diverse stress factors, to even, initial symptoms of a later psychotic trigger. Given that today, the value of psychic causality has been lost and rapid diagnosis has been promoted by equating the superficial symptom with the structure, an enormous number of superficial diagnoses of little prognostic value have appeared, much less that indicate precise treatment.

On the other hand, treatment in psychiatry is the closest thing to a panacea, that is, a little specific remedy that is useful for many things, which is due to the fact that there is no natural substance on which to act. For example, we could use the same treatment, say an antipsychotic, for a case of excessive impulsivity, for a situation of generalized anxiety sufficiently disabling, for an obsessive ideation, for psychotic symptomatology or for persistent insomnia. As well as for someone whose extravagance worries us. Faced with this we are impassive, but what would we think if, for hypertension, we were given an antidiabetic or thyroid hormone? Wouldn't we doubt its diagnostic and therapeutic precision?

There is also a difference in the ultimate goal pursued by medical specialties with respect to psychiatry. The purpose of the former, is to avoid the death of the subject, derived from a natural morbid process and direct consequence of an organic dysfunction or to alleviate somatic pain. Psychiatry, however, tries to control unreason or existential suffering. Rather, they seem to be different realities, given that death is something universal, while the sense of conduct or existential suffering is associated with a particular culture and a particular historical time.

Particularities of our Diagnoses

It is inferred from the above that if there is no causal agent our diagnosis will not point to a specific organic lesion either, as it is, for example, a myocardial infarction with ST-segment elevation, which will lead to an intervention determined in accordance with the lesion described. According to this particularity, both treatment and prognosis in psychiatry become imprecise. As we will see later on, psychopharmaceuticals inhibit or attenuate behavior by a depressing effect on the

nervous system, but not because they are correcting a lesion. So sometimes, the same diagnostic label is given to completely different individuals with clinical and behavioral manifestations so disparate that they have nothing to do with the diagnosis to which they are perpetually associated. What would a person with an acute delirious idea (that later remitted) and then continues with their normal life in appearance have to do, with another who decided to silence himself forever; or with another whose behavioral disorganization is such that he can only live in a closed center; or with another who perhaps listens to voices from time to time and, far from scaring him, they keep him company; with another whom they constantly frighten and vociferously to get rid of them? How is it possible for a single diagnostic label to unite all that discontinuity?

Another peculiarity of our diagnoses occurs, sometimes, when we notice structures that we can consider as psychotic because of the symptoms, because of the way of relating, because of the type of anxiety, because of the general functioning, because of the weight of certainty of their ideas, etc.., but in spite of this, we decide to diagnose disorders classified as *mild* because we agree that the person had handled the situation *normally enough* not to be diagnosed with such a strong label, that could risk stigmatizing the person leaving a big impact on their life, which sometimes comes from being diagnosed with a mental illness, and question whether this stigmatizing effect common to other medical specialties?

Psychiatry must be one of the few medical specialties whose official diagnostic manual radically changes its criteria from time to time without there being a natural or biological cause to justify it. It would be as if suddenly we found that in the diagnostic manuals of cardiology that the heart is placed to the right without finding an explanation for it. As if nature changed according to the consensus between a handful of experts!

Many things can be said about this manual. Firstly, these texts speak of mental disorders and not of mental illnesses, which seems to be a sign that there is no consensus on the concretion of a brain lesion that allows the second term to be carved in stone. In this same way, we are not talking about the brain, but about the 'mental', in so much as all things related to the 'mind' and not the 'brain'. The first refers to an organic, material and palpable aetiology; while the second, on the other hand, is an abstract, intangible and more common term in the field of psychology, anthropology, literature or other humanistic sciences. Recognized even by the official manuals (MSD, EID), this fact is striking, and at the same time contradictory, the habitual way that mental illness is spoken about in daily practice, equates it with the rest of somatic diseases, and consequently orienting its handling in a generalised and systematized way, not taking it on a case-by-case basis.

The MSD defines the disorder in terms of behaviour, which results in the dissemination of the pathology. For example, instead of considering shyness and nervousness as symptoms of an undiscovered underlying clinical category, these become a category in themselves, social phobia. The idea of complex psychic

causality or inner life disappears, to be defined as acausal and atheoric. And isn't it a contradiction to remain in the medical field and declare yourself without any biological cause to justify a diagnosis? The difference between the symptom and the structure crumbles. Anyone can have a tic, a phobia, an eating disorder, an obsession, but we should study what place that occupies in the life of the individual. An obsessive behavior makes you an obsessive neurotic; a hysterical behavior makes you hysterical. In short, the difference between the superficial and the profound is erased, with which more and more clinical categories are generated, making it easier for every aspect of the human condition to become a disorder. It seems that, the lighter the diagnostic criteria, the greater the sector of the population will cover and the easier it will be to diagnose and treat a behaviour.

Another outstanding feature is that sometimes diagnoses are forced for different purposes, such as to seek social resources, to introduce the person in protocols that ensure greater follow-up and adherence or to comply with specific programs, because if a minimum of certain diagnostic labels is not reached, it is not financed or penalized. For example, in a given GAAMHS (general ambulatory adult mental health services) they must reach 33% of SMI (severe mental illness) diagnoses at the end of each year, or else the administration sanctions with an economic fine. The user must adapt to the device and not the other way around.

We operate as if we were dealing with natural laws and yet in our clinical practice we never request a single biological diagnostic test. Isn't that questionable? This position is continually revolving, thus justifying chronic psychopharmacological treatment and even clinging to it, and yet we cannot present a single piece of evidence to support it. It will never be based on anything real that I can show that person, but on the contrary, a speech will be made about something imaginary that both of us will have to accept. In fact, in the rest of the medical specialties, if, under an assumption, a diagnostic test is done and it is not finally confirmed, the cause is still sought or the disease is finally defined as idiopathic, but something indemonstrable is not affirmed or generalized continuously.

The question is, are diagnoses useful to us if they do not serve to specify, from a strictly biological point of view, a diagnostic test, a specific lesion, a prognosis or to specify a specific treatment? What difference is there, from the positivist periscope, between a paranoia, a brief psychotic reaction, a cyclic psychosis, a confusional state or a toxic psychosis? How does the theory of mono-aminergic explain this difference? What difference is there from this point of view, between an obsessive idea, a deliroid idea, a transitory delirious idea, a superficial belief, a deep conviction, a rumination or a concern? Does this biological imprecision not point to a forced attempt to delimit what is subjective?

In relation to this section, there is a phenomenon that is very difficult to circumvent that results from diagnosing a mental illness. From that moment on, any manifestation of discomfort is suspected of being a principle of decompensation and, as the physician's usual reaction, will readjust the pharmacological pattern.

It is as if a unambiguous and unquestionable sense were established, which starts from an immovable idea and which will surely be enlivened by various conditioning factors, such as, for example:

Scarce time. Sometimes, in order to deal with a situation effeciently, that would perhaps require days to clarify itself and to allow the necessary margin for the person to put their discomfort into words, the doctor, on the contrary, is impelled to give an answer in fifteen or thirty minutes every 'so' many months.

- Space. This situation is the same as in as any other medical specialty, that is to say, that the person is positioned as a sick or passive person in the face of his or her illness; needs to have the context taken into account. Is the monitoring of an anaemia similar to that of a mental state with all its conditioning factors? Doesn't this willingness oblige us to assess the problem in absolute terms, and, therefore, to give a generalised response, and not in a relative way?
- Pressure. This is facilitated by not being able to supervise the situation with more continuity, which is conditioned, at the same time, by the bureaucratic and clinical load of the hundreds of patients scheduled. The worst part of this, is not the burden of care itself, but much of it moves away from what we are supposed to take on, that is to say, pathological mental states, and ends up welcoming all forms of social unrest, for example, unemployed people, immigrants without papers who on the one hand are sheltered but who at the age of eighteen are thrown into the street without many explanations, or people without the possibility of social resources who take on mental illness as their last resort, and so on. It is not so much the fact that we do not want to give way to this whole mess of unrest, which cannot be and which ends up congesting our consultations making them inoperative, but rather that it gives the impression that the insufficient social and political response to mental illness is masked. For example, it is not that there are no resources to help a person who, for instance, must act as the main caretaker of her sick/insane parents, who also supports her family with her only salary, given that her husband has been thrown out of his company at fifty-one years of age and cannot find work at his age, and is logically exhausted, but has a mixed adaptive disorder. That is to say, by flipping the coin, she is the person who, supposedly, because of her biological or genetic weaknesses, does not have a sufficient response to a situation that is already impossible, and is not capable of adapting. Will we not be accomplices, with our actions, of an unbalanced society? Does this diagnosis help that person, or the psychiatrist who has to codify it?
- The pressure exerted by the environment. People around the one who has been diagnosed with a mental disorder, have been, usually, psycho-educated with the univocal vision of the mental illness, they are alerted by

> an imminent decompensation when they detect certain signs. Occasionally it is agreed that minimal symptons can be tolerated by both the patient and the doctor, however when patient lives with other people, such as family members, they may find it more difficult to tolerate even minimal symptons and put pressure on the patient to take a medication even though both the patient and the doctor might agree that this isn't always the best cause of action, or at least not as a long-term solution.

It may be the case that, before the same clinic, in one case it is possible to cope and in another case it is necessary to proceed to an admission due to the tension that is generated. It happens that this aggravating factor, in the majority of cases, goes unnoticed, and yet, in my opinion, it contributes to fixing the symptom and thus favouring chronicity.

These are just some of the conditioning factors to which the psychiatric professional is subjected, and, consequently, pushed, rather than giving a meditated and particular response, to decompress at all costs that tension generated by factors that even have nothing to do with this situation of supposed decompensation. In any case, the intervention will go through medicating or deriving. Do these types of actions, over time, do not silence the subject who suffers from these symptoms? Doesn't the doctor inexorably drag him into the position of sick? Doesn't the doctor also chronicle himself? Doesn't he abandon, over time, other ways of thinking about the situation and, therefore, of offering another type of response?

It seems that there is no notion that certain ailments have a certain rhythm, and require, perhaps, an accompaniment only, but in no case refer to a disease or supposed decompensation of it. Since there is only one meaning to discomfort, there can only be one answer or solution to it, and both the patient and the physician are then trapped by the same principle.

I wonder whether the current approach of medical psychiatry does nothing more than reinforce the illness time and time again, giving a pathological meaning to processes which, perhaps with a relationship of trust and sufficient accompaniment, can be tempered. I also wonder whether this procedure from the beginning and for years does not restrict other possible solutions to this suffering and over time an *ego* is impoverished with other possibilities of identification. Is there not a part of the subject that is drowning and another, on the contrary, is forced to cling to the unique float of the disease? Is it not possible that this procedure, in sufficient time, weakens an individual who must resign himself to unique and implacable responses?

About our Treatments

Normally, in medicine you first do extensive research, for example, you look for a biomarker, a protein, an enzyme, a molecule and then you make a custom drug. In other words, a key is made to open a certain door. In psychiatry, on the other hand, a specific key was validated and the door was made to measure.

In the case of antipsychotic drugs, it seems that they were accidental dis-

coveries and were not related to any physiopathological alteration. For example, chlorpromazine was used as a tranquilizer in anesthesia; reserpine to treat hypertension; iproniazid to treat tuberculosis; lithium urate to sedate guinea pigs before experimenting with them. What happened is that the narcotic qualities of these drugs were promoted and equated with the rhetoric of cure and treatment. They went from being chemical restraints, equivalent to mechanical restraints, to precision cures, by marketing campaigns of certain corporations.

The effects seen after the taking of these substances served as a bridge to strengthen the medical armor. One of the most common effects is indifference to the environment. They acted as a chemical straitjacket, in fact, we must not forget that the original term designating these medications was neuroleptic, which literally means substance that binds or stops the nervous system. It is therefore, deduced that this substance reduced brain activity in all its facets, which allowed it to go from being a tranquilizer or suppressor of the nervous system to an antipsychotic, that is to say to act in the chemical process, supposedly, of psychosis and reverse it.

Does this mean that whoever responds to this substance by reducing, for example, impulsivity, anxiety, or insomnia, is psychotic? Is it then an antipsychotic, or is it more logical to define it as neuroleptic? It serves as an anecdote obtained from daily practice, which is not considered valid the result of an intelligence test of a person who chronically takes psychotropic drugs since it is considered that such substances hinder general psychic performance Does not this example draw more to a neuroleptic than to a precision antipsychotic? Attributing the role of human behaviour to neurotransmitters would be like attributing the existence of literature to the ink of the pen or saying that we speak thanks to the mouth, without contemplating the links that precede the final consequence. A material or biological support is necessarily required, but the manifest conduct is not inferred from it. If it is a matter of illnesses of biological cause, and, therefore, by the rigorous alteration of a natural substance, why is it not present in the rest of the animal species, and yes on the other hand, the rest of somatic illnesses? Will it not have to do rather with language, desire, and ultimately with the symbolic field? Will not the latter be particularly developed in the human species and therefore be governed by *sui generis* rules?

Likewise, the attempts to approach according to specific psychological models can be equally alienating. Starting from the fact that the diagnosis in mental health is a theoretical construct of partial and not absolute value, that is to say, that it varies according to the historical moment or the medical context in which the subject finds himself, homosexuality is an example, and not the finding of a universal substance, a certain suffering will be treated with general ideas according to such construction, moving away, consequently, from the genuineness of the person who suffers it. These interventions would be in the same way that we previously commented, which would be none other than to create a powerful matrix where the patient would be impelled to identify himself.

The Inheritance of Mental Illness

Another chapter where medical psychiatry becomes blurry in its attempt to approach medicine on the subject of the genetic inheritance of mental illness. To paraphrase M. Foucault, heredity [seems] to be a way of giving body to disease at the very moment when it cannot be placed on the plane of the individual body.

One constantly hears that there is a clear hereditary component, but there is not enough genetic evidence to confirm it, but there are also inaugural cases of disease. Isn't the latter something contradictory, or at least should motivate us to pay attention to these last cases and not the first ones? How can one explain the same fact from two opposite starting points and call it evidence? Slogans in the field of psychiatry usually draw the path of a shooting star: with great intensity at first, but fading quickly. An article begins by talking about irrefutable evidence and two lines later it is rectified. Is psychiatry comparable to the evidence of a pure science such as physics or mathematics? Can human subjectivity be transferred, with anthropometric tests, since we do not have analytics or image tests, to science? Don't we risk falling into an extreme and alienating reductionism? One aspect that strikes me in this chapter is that we always talk about genes, which are activated and deactivated, like a Mendelian pattern, always without any participation of the individual, but it is obvious that psychic and cerebral growth is built through their environment, in the early stages of life. Even if we focus exclusively on the biological point of view, it seems that there are certain conditions that facilitate the release of neurotrophic factors, as well as the quantity and quality of neuronal connections in the early stages of life and, on the other hand, other situations that hinder it. In comparison with what happens with human beings, the behaviour of other animals, in their natural habitat, does not require any prior learning and is phylogenetically attached to the members of a species, i.e. it is set in motion by instinct. For example, they are born and no one teaches them to walk, communicate, eat, identify their predators, etc., but something that unfolds automatically in each member of the species, without exception. That is to say, these behaviors have their cause in nature itself, they are innate.

Will not the first stages of life be crucial for the formation of the symbolic field, language, and as a result of this we will notice dissimilarities with respect to the other members of our species?

In clinical practice, although it is not something that can be generalized, it seems more logical to understand a person's state of mind by his or her biography or subjective explanation of his or her life events, which, attributing it to a capricious activation or deactivation of a series of genes, will ultimately be something imaginary and inaccessible, both to the practitioner and to the person in front of us. Is it equivalent to a harmonious encounter with our caregivers in the early stages of life, or as Winnicott (2013) would say, a good enough mother, to a situation of abandonment or neglect? What exactly do we understand by *genetic predisposition*? The latter is constantly preached as a mantra, but it is difficult to explain in a logical

way and by threshing the events from the gene to a certain behaviour. Are not the psychiatric manifestations a consequence of the particularities of the development of our symbolic field in interaction with the circumstances of the environment? Should we not put the emphasis on understanding, in addition to those people who suffer from mental illness and have a diagnosed family history, those who, on the contrary, do not have them? Why does it seem that since scientism there is a certain inclination to annul an active position of the subject in front of his suffering?

Chronic or Chronified?

When our devices talk about someone being chronic, there is a certain murmar of impoverishment or deterioration over time. From the current neo-kraepelian viewpoint, one could understand such a process by assuming that the (precocious) disease itself entails a (supposed) biological deterioration and, therefore, a diminution of all psychic faculties. However, it is unacceptable for me to overlook the aspects discussed so far.

The medical theory of mental illness is still based on an assumption, (and not something on which there is a unanimous consensus) therefore it would have been transferred to the domain of neurology, which, on the other hand, has been cuantified by looking at cases of with senile dementia or Alzheimer's disease. How is it possible for this conception to be transmitted with such determination without even harbouring any doubt? If diagnoses do not serve to indicate an injury, a treatment or a specific prognosis, is it permissible to psycho-educate the person by providing a unique meaning to his suffering? Is it useful to the person or to the doctor? Is it possible that it has a negative repercussion in the long term or that it is limiting possibilities for improvement? And is it also possible that the same medication in the long term favours cerebral deterioration?

Despite the explanatory weakness of mental illness from the medical point of view, the institutional devices are arranged according to these premises. Taking this perspective as valid, why we need to see the patient? After the diagnosis, a panoptic is automatically unfolded from which the patient, in continuous inspection, can no longer escape, it is marked and its subjectivity invalidated in favor of a psychoeducation generalizations. One is not aware of how much he does not know the person in front of him, until he has to do the numbers. If the average number of visits in an ordinary mental health centre is once every three months and each visit, being generous, is thirty minutes (in some devices it can even be half the time), we would be assisting him around two hours a year. I repeat, two hours a year.

The inevitable question is, [can I help someone] who has fallen through the psychosis hole [spending two hours a year]? Assuming that this center filters the most complex and serious cases as far as mental health is concerned, is the adequate time that I should dedicate? Can I with this time, minimally, know its internal and external reality? From any other point of view it is a ridiculous time, not to mention the conditioning that originates space or clothing similar to when we have to value

a few points, however, from the official (im)position is more than enough time. From this point of view, drugs will acquire an essential value, since the only way to act on that person is not through the construction of a particular transferential relationship, joint reflection, questioning or addressing specific needs, but through a disciplinary submission of the body and its emotions, with drugs and psychoeducation. As we have already explained before, it should also be borne in mind that the outpatient physician has a collapsed agenda, so that the possibility of escaping fatigue and tension is improbable, inevitably reducing the capacity for reflection, questioning or the possibility of particularising the case. Thus, the response from the institution, generalist, inflexible and defensive, is, with great probability, assured.

Another interesting point is the issue of the supposedly more *horizontal services*, such as social clubs or day centres. I have always been powerfully struck by the fact that spaces whose purpose responds to social insertion, rehabilitation or integration are given the same name as those, whom to others, we are destined when we are socially unproductive, insane or a hindrance. For example, 'day centres for the elderly'. Is it not inferred from the name its true purpose? Another contradiction that I find is that most of the time, the person starts in these centers after two and three decades of medical institution and not, curiously, from the beginning. Is what they really want a derivation to these devices to reorganize the persons life and a joint questioning of their particular situation, as well as a spirit of prosperity?

After highlighting these points, is it not possible for us to participate, in some way, in this degenerative process, if from the beginning we go back to the only image of the mentally ill, in which we push the person to cling? If we add, moreover, that for years the continuous taking of medication and, in some cases, increasing, with the implicit physical impact that it entails, will it not contribute to their progressive impoverishment and inhibition, that is to say, to chronification? Wouldn't a similar deleterious process be established in a person who resigns himself to circling without the possibility of other incentives, expectations or possibilities of identification? Wouldn't it be immanent in chronification, resignation and despair? If we consider psychosis as a dramatic collapse of the identifications that up to now sustained the individual, wouldn't it be more appropriate to make possible as many identifications and from the beginning, better, instead of dedicating it to protocols, tests and psychoeducation programs? Don't we discourage, with our way of approaching, the subject that exists behind the symptoms? The question, then, would be: are they chronic or chronified?

Advances in Psychiatry

What, well thought out, advances in medical psychiatry in the last two hundred years medical psychiatry have there been?

- As for biological findings, one comes to mind, Alzheimer's disease. Since there is a consensus of an objective brain injury, it has been treated immediately as a brain disease, not a mental illness and therefore to be

catalogued within the neurological diagnoses. With this in mind, if we keep scratching, we see that there are cases of post-mortem brain alterations, suggestive of Alzheimer's disease (beta-amyloid bodies), never showed in life in the clinic. Does this example not suggest to us that there is something that transcends palpable matter? Perhaps our symbolic dimension? I have always asked myself, which is also very visible in daily practice, why are there people of a certain age who, by chance, become insane when they break a constant life routine? For example, in retirement. In these cases, given that it is not contemplated that elderly people can debut with pure psychiatric episodes (pure means not biological? but are mental disorders not of biological cause?), an image test is usually done that is given as valid when the brain shows signs of atrophy. Without going into the details, this is a once again imprecise procedure, since most of the elderly population may show signs of atrophy in a neuroimage and yet have no correlation whatsoever with their behaviour. However, once again, these doubts are swept under the rug, ignoring other arguments. Accepting the premise of cerebral atrophy as the origin of dysfunctional behavior in the elderly, why would this occur causally after a vital trigger?

- As for pharmacological treatments, they do appear, in the short term, to be less harmful, although in the long term and high doses, which is what often happens in chronic conditions, the results don't seem to be so clear. Currently, the monthly deposit is distilled and injected, which is justified as a more comfortable treatment for the patient (and for the physician, above all, who should no longer be concerned about the patient's adherence to pharmacological treatment). In my opinion, however, it is detrimental to their autonomy and their responsibility in terms of taking medication and its possible consequences. In short, it makes them more passive. On the other hand, we continue to administer classic drugs, some of which are even more than fifty years old, since, with time, first-line drugs, or even monthly deposits, lose their effectiveness and a greater neuroleptic effect is necessary. Another aspect of the treatments that is striking to me is the intense promotion of a procedure as old and controversial as electro-convulsive therapy. What I ask myself is, if in the rest of medicine purges or bleeds are still being promoted? This apparent stagnation in the therapeutic domain, with respect to the rest of medical specialties, is it not an indication of stubbornness in a target that does not exist? Are we not confusing the causes with the consequences? Are we not trying to turn off the alarms instead of stopping the fire that activates them?
- Another apparent advance could be the fact that there are currently no institutions, at least in our territory. Nevertheless, people are still being sent, and at very early ages, both to residential centres and to long-stay centres. It is also worth mentioning the number of people who are chro-

nically watched over, without the situation being re-evaluated, thus losing most of their civil rights.

It seems clear that we are as far from a cure for mental illness, just as at the beginning, but have we improved, in helping to integrate the mentally ill person, into society? Should it not be our priority to de-alienate them rather than cure?

If there has been an improvement in the evolution of mental illnesses, it does not seem to me that it has been due to the development of new drugs, or the greater biological knowledge of mental illness, but rather, and in spite of the current approach, because in sum there is greater assistance, rehabilitation programmes, day centres, social clubs, home care, therapy groups, etc., which is possible to translate into greater opportunities for desire, greater possibility in the satisfaction of basic needs, new interpersonal positions or greater presence in times of solitude.

Taking this inference as valid and concluding, would it not be more appropriate to dedicate economic and human effort, not so much to the generation of new medications, or to act as a dispenser, but to create more horizontal devices, and from a good start, to personalise each situation as much as possible, to value the needs of each person, as well as to be able to deal as best as possible with the family and social circumstances that surround them? Shouldn't we assume our contradictions and weaknesses, in order to move in a direction closer to the reality of each individual? Doesn't psychiatry aim to be closer to humanist disciplines rather than to medical disciplines? Doesn't this current stubbornness reflect the fear of facing situations that disarm our everlasting arguments? Or, moreover, are we afraid to finally question a position of recognition or power? Perhaps out of comfort or ignorance?

How else would one understand clinging to such contradictory arguments to date?

References

Schreber, P. (2018). *Sucesos memorables de un enfermo de los* nervios. Madrid, España: AEN.
Winnicott, D. W. (2013). *Realidad y juego.* Barcelona, España: Gedisa.