

# Agreements And Disagreements In Psychiatry ( \* )

## Convergências e Divergências em Psiquiatria

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### SUMMARY

This article focuses on several aspects about which experts on Mental Health usually agree and disagree among them. In the theoretical field, agreements and disagreements refer to the polemic aspects of mental disease: etiopathogeny, physiopathology, semiology, nosology, therapeutics and prevention. In practice, discussion deals with three fundamental aspects of the psychiatrist's activity: undergraduate and post-graduate teaching, scientific research and patient's attendance.

**Key words** – Psychiatry, Anti-Psychiatry, Nosology, Epistemology.

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### RESUMO

Este artigo focaliza diversos aspectos acerca dos quais especialistas em Medicina Mental concordam e discordam entre si. Quanto ao "logos", as convergências e divergências dizem respeito a aspectos polêmicos da doença mental: etiopatogenia, fisiopatogenia, semiologia, nosologia, terapêutica e prevenção. Quanto à " praxis", os consensos e dissensos referem-se a três aspectos fundamentais da atividade do psiquiatra: ensinos de graduação e pós-graduação, pesquisa científica e assistência psiquiátrica.

**Palavras chaves** – Psiquiatria, Anti-Psiquiatria, Nosologia, Epistemologia.

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### 1) INTRODUCTION

This article focuses on several aspects about which experts on mental health usually agree and disagree among them. If it is true that mental health experts disagree among themselves as to discourse and practice more than other experts do, the originality and particularity of the psychiatric or psychopathologic object are to blame. The psychiatric object is situated at the interface of the

human sciences and nature sciences; between the soma (brain activity) – which is its infrastructure – the psyche (mind) – its inner world ("Eigenwelt") and the sociocultural space, its environment. Psychiatry has always presented distortions and reductions either of etiological/ pathogenic or therapeutic nature in these three directions. Thus, one should not be surprised at the great amount of disagreements between psychiatric thinkers and practitioners.

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In the theoretical field, agreements and disagreements refer to the polemic aspects of mental disease etiopathogeny, physiopathology, semiology, nosology, therapeutics and prevention. In practice, discussion deals with three fundamental aspects of the psychiatrist's activity: undergraduate and post-graduate teaching, scientific research and patients' attendance.

Lets us take a look at how different theoretical-doctrinaire positions and practice are in reality. As to etiopathogeny, for example, somatists, psychogeneticists and sociogeneticists, followers of political psychiatry, the antipsychiatrists, cognitivists and neobehaviorists confront doctrinally among them.

In praxis, the ones who are for neuro-chemistry and psychopharmacology come up with their therapeutic devices, worrying about psychopharmacological interactions and side effects; The organicists who make use of static and dynamic neuro images and do brain-mapping experiments as Kleist and many others have done in the past and the neuro geneticists, who in search of genes, polygenes or of the particular " locci" (site) of a certain pathology, try to explain the physiopathogeny of mental disorders. The psychoanalyst who approaches the patients trying to find unconscious determinisms and symbolic aspects of mental phenomena, analyses the transference and counter transference into the therapeutic relation, and interprets the content of symptoms; the phenomenologists who by means of empathy try to get into touch with the client in order to understand the essence of the symptoms; the existential psychoanalytic followers who value the various modes of pathologic existence and of being in the world; the cognitive-behaviorists whose techniques aim at eliminating symptoms regardless of causes.

After all, like witchcraft apprentices they once were, each and every one of these professionals try to mobilize their practical and doctrinal resources to mitigate human suffering.

## 2) ANTINOMIES IN PSYCHIATRY

Focus will be placed on the multiple and traditional antinomies in Psychiatry.

2.1) Psyche (mind) vs. Soma (body). It refers to the classical Cartesian dualism - separation of mind and body – and shapes the famous "Psychiatric Dilemma" about which Henry Ey ( 1952,1960) had so much to say. Organicism X Psychogeneticism. Today one talks about "an embodied mind" , according to J. Burns (2006)

2.2) Brain vs. Mind. Here again, a dualism consecrated by the so-called "Decade of the Brain", namely, the nineties of the twentieth century, which obscured the importance of the mind in psychic life (psyche as resulting from brain activity) and the brain as the infrastructure of psychic life.

2.3) Nature vs. Nurture. In other words, this refers to the importance of the issue innate and/or acquired in psychic life; the ancient dialectic play between nature and nurture (Paris, 1999 ) and the role of genetic and inherited risk, that is to say, "Odds Ratio" in epistemological terms. Biological heritage does not mean fate or predestination but an evolutionary possibility, which depends on modulating environmental factors. Nowadays one Says. "Nature via Nurture".

2.4) Psychiatry vs. Antipsychiatry. Antipsychiatry, spuriously born from counterculture, Social Psychiatry and Political Psychiatry, took advantage of the insufficient etiopathogenic and physiopathogenic knowledge of mental disorders. It is curious that among the many existing medical specialties, psychiatry alone has been the one to foster its own antagonist. It's almost impossible to talk about "anti- cardiology, anti-reumatology, anti-oncology, etc.

2.5) Diagnosis vs. Antidiagnosis. It concerns the denial of the psychiatric medical model, which

had its origin in the clinical activity of some psychoanalytic and psychotherapy schools (Rogerian, Gestalt), and which got stronger with the advent of Antipsychiatry.

2.5.1) Synthetic vs. Analytical Diagnosis. The synthetic diagnosis is unidimensional and the analytical, pluridimensional.. As José Leme Lopes ( 1954 ) puts it, the latter contemplates the syndrome and the etiology together with exogenic, endogenic, and psychogenic factors, in addition to the premorbid personality. The DSM III R ( 1977 ), the DSM IV ( 1994 ) and the ICD 10 ( 1990 ) accept five axis:

- 1) Mental disorder or syndrome;
- 2) Personality disorder;
- 3) Somatic features;
- 4) Psychosocial stressing factors;
- 5) Level of adjustment or social adaptation in the last two years.

2.5.2) Psychiatric Diagnosis vs. Psychological Diagnosis. Here, a relationship is established between how people get sick and 'ways of being in the world'. The psychological diagnosis is also characterological, while psychiatric diagnosis belongs to nosographic classifications.

2.6) Mental Disorder vs. Myth. This sprang from antipsychiatry development, particularly from Thomas Szasz's writings "*The Myth of Mental Disease*" (1961/1979) and "*Manufacture of Madness*" (1970/1979). It is evident that psychiatry seldom adopts the traditional medical model of internal medicine (the anatomo-clinical and etiologic model). Hence, the adoption of the expression "disorders" in modern nosographies. The word "disorder" presupposes the existence of definite clinical symptoms with a determined evolution, biochemical, epidemiological, genetic data, neuroimage features and similar therapeutic answers. The last five criteria are not always present.

2.6.1) Evolutive Course of a Disease vs. State Traits (symptoms)

This refers to the ancient argument between the "Dementia Praecox" (based on the evolutive course and on the outcome of the disease, E. Kraepelin (1996) and the Schizophrenia Group: primary and secondary symptoms (E. Bleuler, 1971)) or Kurt Schneider's first, second and third rank symptoms (1947,1948).

2.6.2) Illness vs. Disorder. Illness or Sickness vs. Disturbance, Disorder.

2.6.3) Positive Symptoms vs. Negative Symptoms (H. Ey. (1960), T. Crow (1985), etc) Crow's type I and type II schizophrenia (T. Crow 1980), on according to symptoms, neuroimage findings and therapeutic answer.

2.7.) Explaining vs. Understanding. Explaining mental disorders and finding their somatic origin is the task of Biological Psychiatry. There are two kinds of comprehension; the emphatic or phenomenological comprehension and the psychodynamic comprehension. The latter allows the interpretation of the symbolic contents and the pathoplastic elements of the neurotic and psychotic symptoms in mental manifestations. Symptoms, dreams and fantasies, Freudian slips, etc., they all get interpretations (1976).

2.7.1) Understanding vs. Interpreting. See the previous item.

2.8) Psychiatric Humanistic Model vs. Technological Model.

Biological Psychiatry promoted the creation of a less literary, humanistic and philosophical psychiatric model by fundamentally resorting to Neuroscience, Biostatistics, Computer Science and Epidemiology. As I am used to say: "psychiatrists today are not what they used to be".

2.9) Outpatient vs. Inpatient Psychiatric Hospitals. The inactivation of psychiatric hospitals instead of that of asylums, defined as little more than repositories for the mentally ill, has been proclaimed as if mental illness could be extinguished by a decree. Not even the University Mental Health Services, linked to undergraduate and post-graduate psychiatry courses, as well as to scientific research on mental disorders, had a better luck.

2.10) Literature Review vs. Systematic Reviews and Meta-Analyses. The classical method of doing a systematic review limits itself mostly to national or international impact publications in the last five years. Up to a certain extent, references to classical literature on Psychiatry and /or less recent material are avoided. The diagnostic guidelines of the existing nosographies and of the therapeutic methods – the pharmacological ones in particular – are almost always based on meta-analyses which require statistical calculations done with similar methodologies.

2.11) Quantitative vs. Qualitative Methods in Psychiatric Research. Biological Psychiatry imposed the quantitative method through quantitative psychopathology. It suffered the influence of biostatistics, epidemiology and health informatics. Transversal and longitudinal studies have become more and more frequent, the latter containing cohort and case-control researches. Psychoanalysis, as well as studies derived from other sciences of human behavior such as Sociology and Anthropology mostly prefer to employ qualitative methods.

2.12) Categorical vs. Dimensional model. In other words, this refers to qualitative vs. quantitative diagnostic criteria. Psychiatry needs homogeneous criteria in nosographies. As to the dimensional diagnosis, no matter it makes numerical notation possible, it is hard to precise when grey turns into black or rose turns into red, that is, when the excess

of quantity transforms itself into qualitative distinctiveness, according to the Engelian Dialectics.

2.12.1) Constitution and Personality Traits vs. Constitution and Personality Types. This antinomy unfolds from the previous item. The constitution and characterological types such as studied in Biotypology and Characterology (E. Kretschmer in "Constitution and Character" (apud Delay, Pichot, 1969); K. Schneider in "Psychopatic Personalities", 1947) are a categorical concept which admits to the existence of other personality and constitutional traits in its different categorial units, as for example, a leptosomic biotype with an athletic complexion or a hypertimic personality with histrionic features..

2.12.2) Personality Traits vs. State Traits. This refers to a new terminology recently introduced into the psychiatric jargon. The patients once labeled 'neurotics' were distinctly classified either as being definitely or temporarily neurotics (Actual Neurosis vs. Character Neurosis, Freud, 1976) or Neurotic Character (A. Adler, 1971). Nowadays, the terms 'trait and state anxiety' are used. State anxiety would be transitory whereas trait anxiety would be stable, permanent and generally associated to Generalized Anxiety Disorder.

2.13) Medical Model vs. Psychological Model in Psychiatry. Some schools of Psychology, and the psychoanalytic ones, proposed a psychological model.

2.14) Medical Model vs. Sociological Model. Social Psychiatry stood up for the sociological model.

2.15) Medical model vs. anthropological model. The ethnologists were for the anthropological model.

2.16) Medical Model vs. Pedagogical Model. Fuller Torrey proposed a pedagogical model in his book "The Death of Psychiatry" (1976).

2.17) Medical Model vs. Political Model. Antipsychiatry allowed a political model.

Every one of these antimicrobial models held a certain prestige for some time in determined spheres.

2.18) Clinical Experience vs. Psychiatry Based on Evidences. In other words, clinical cases either in isolation or in a series are depreciated by Psychiatry based on scientific verification (Gray, 2004). Recent nosographies bring guidelines for diagnosis and lists of inclusive or exclusive symptoms with their respective duration. Hence, algorithms for differential diagnosis and for mental disorder therapeutics were established. In Biological Psychiatry, this approach assumes a dogmatic and exemplary character ('Magister dixit') and preponderates over clinical experience, a kind of individual empirical statistics.

### 3) MAIN CONVERGENCES AND DIVERGENCES CONCERNING:

3.1) The theoretic body (*Logos*) and psychiatric practice (*Praxis*)

3.1.1) The human being must be considered as a somato-psycho-socioculturally integrated whole that is definitely bigger than the sum of its parts, according to the principles of Gestalt Psychology. Man is, thus, a unique whole ("the most unique persona of the Ego" as referred to by Augusto dos Anjos, 1930), in which each man is singular, according to Guimarães Rosa (1970).

3.2) Genuine psychiatrists will agree that one does not learn Psychiatry in the manuals of modern nosographies (DSMIV, CID 10) or in their synopses. These manuals are useful to aggregate psychiatric knowledge learned through compendiums,

magazines, textbooks and through life itself. Let us bear in mind Ulysses Pernambucano's advice to Luiz Cerqueira about the first book on Psychiatry one should read: "Read the classics, read Proust! ...", to which I would add: "Read both the literature and the clinical psychiatry classics."

3.3) Though Neuroscience has made much progress, yet no safe and trustworthy biological markers are available in psychiatric practice. The Semiology of clinical practice still prevails.

3.3.1) The mapping of human genomes and the technological advances of static and functional neuroimages will very soon allow great advances in establishing the etiology and physiopathology of mental disease (Andreasen, 2005).

3.4) One should not use the expression 'psychiatric illness' as it is used in internal medicine (the anatomo-clinical and etiologic model). Nowadays one should rather employ the expression "Psychiatric Disorders" in view of the etiopathogenic and physiopathogenic difficulties.

3.5) The great psychoses schizopathic and humour disorders, as well as Dementia, some mental retardations and certain clinical symptoms of the once called Neurosis (panic crisis, OCD, hysteria) must display a functional or impaired organic substratum even though it may be little known.

Despite the presence of an organic substratum, the expression of the symptoms will always be psychopathological, open to a phenomenological, psychodynamic and existential approach. One should refrain from basing psychiatric knowledge on neurological assessment alone, preventing the appropriation of psychiatric knowledge by Neurology.

3.6) Agreement regarding the pluridimensional character of the current nosographies (DSM IV, DSM IV R and CID 10).

Old nosographic classifications by the authors of psychiatric compendiums and textbooks as well as national systematics such as the Adolf Meyer's American psychiatric school, which listed various kinds of reaction, have simply disappeared.

3.7) In spite of the quantitative psychopathologic partisans who always employ rating scales, self-evaluation questionnaires and structured interviews, one should advocate the employment of such instruments in research, but not in ordinary clinical activity. In everyday clinical practice, diagnosis should not be made by the addition, subtraction or duration of symptoms. Neither should the computer replace the doctor-patient relationship in therapeutic or semiological tasks. In psychiatry, one arrives at the diagnosis through a Gestalt, through the form and/or structure of the clinical presentation of symptoms.

3.8) Convergence regarding the importance of self-knowledge for psychiatrists or any psycho-professionals. Whenever possible, undertaking psychoanalytic training is useful and valuable to psycho-professionals, since the severely mentally ill must not work in this area. Undergoing some psychic suffering will no doubt be of some benefit to psycho-professionals' activity.

3.9) Agreement concerning the employment of associated therapeutics (pharmacology + analytical or cognitive-behaviorist psychotherapy) for treating most mental disorders. The last association is better accepted by Evidence Based Psychiatry.

The procedure may be carried out either by the same or by different therapists, according to the specific clinical case focused. Such assistance should be given to most of the patients formerly referred to as neurotics or belonging to the schizophrenic, depressive or OCD spectrums. This would help to keep the doctors away from the temptation of heavily relying either on prescription drugs ("drug doctors") or on any particular analytical psychotherapy in isolation, as it was in the past.

3.9.1) To extend the reach of psychiatric assistance to the family (couple, parents or relatives).

3.9.2) To attach greater importance to associations for sufferers of Alzheimer's disease, OCD and Bipolar disorders.

3.9.3) To use alternative community support organizations such as AA, Samaritans, etc.

3.10) Concerning the teaching of Medical Psychology and Clinical Psychiatry, it is of interest to distinguish undergraduate programs from postgraduate programs (Master and PhD degrees).

#### Divergence regarding graduate courses

3.10.1) Teaching programs with one-year disciplines vs. teaching programs with one-semester disciplines.

3.10.2) Traditional teaching with one-year or one-semester disciplines vs. Teaching programs with knowledge modules.

Courses offered in knowledge modules such as the Medical Course of the State University of Pernambuco are structured around three axes: 1) Theoretical-Demonstrative; 2) Humanistic; 3) Practical and Constructivist. People who advocate knowledge modules criticize expository classes, classical disciplines, Basic Course and favor only the consolidation of the professional courses. As a matter of fact, a variety of new disciplines taught by specialists from different fields has been recorded.

3.10.3) Agreement regarding extending the internship period to the final two years of the undergraduate course;

3.10.4) A trend to transform Master's courses into Doctorates and have Theses and Dissertations published in influential national or international periodicals has been observed.

### 3.11) Institutional research vs. private research

There is general agreement on institutional research supported either by federal (CNPQ and CAPES) and state (FACEPE, FAPESP, etc.) institutions or by the pharmaceutical industry (an option which needs be considered with some caution).

Private and amateurish research initiatives have been dismissed altogether.

### 3.12) Disagreements in psychiatric research.

In item 2.12, reference was made to the controversy between qualitative and quantitative methods. In Neuroscience, quantitative methods predominate, whereas in sociocultural and psychoanalytical works, qualitative methods are preferred.

### 3.13) Disagreements as to medical assistance.

Inpatient treatment vs. Community treatment of mental illness.

There is a growing tendency to concentrate financial resources on outpatient attendance such as that offered by "CAPS" (Psycho-social Assistance Centers), where multidisciplinary teams are available (2005).

CAPS I – offers assistance to municipalities with a population between 20,000 and 70,000 inhabitants.

CAPS II – offers assistance to municipalities with a population over 70,000 and less than 200,000 inhabitants.

CAPS III – offers assistance to municipalities with a population over 200,000 inhabitants. Assistance is provided 24 hours a day, 7 days a week. Five beds are available 10 nights per month.

CAPS ad – this center is designed for psychoactive substance-dependent patients.

CAPS i – this center is designed for children and teenagers.

All of the divergences commented on here are wholesome and testify to the strength and dynamism of the science of Psychiatry. If

convergences were all that existed, Psychiatry would be stagnant or even dead. After all, it is debate that begets light.

## REFERENCES

ADLER, A. *El Caracter Neurótico*. Buenos Aires: Editorial Piados; 1971.

ANDREASEN, N.C. *Admirável Cérebro Novo: Vencendo a Doença Mental na Era do Genoma*. Porto Alegre: Artmed; 2005.

ANJOS, A dos . *Eu e Outras Poesias*. São Paulo: Companhia Editora Nacional;1930.

BLEULER, E. *Tratado de Psiquiatria* .Tercera Edición Madrid: Espasa- Calpe SA ; 1971.

BURNS, J. The Social Brain Hypothesis of Schizophrenia. *World Psychiatry*. 5 ( 2 ):77-82, 2006.

CROW, T. The Two-Syndrome Concept: Origin and Current Status. *Schizophrenia Bulletin*. 11: 471-486, 1985.

DELAY, J., P. Pichot. *Manual de Psicologia*. Barcelona: Toray-Masson; 1969.

DSM IIIR. *Diagnostic and Statistical Manual of Mental Disorders*. 3<sup>rd</sup> Edition. Washington DC: American Psychiatric Association Press; 1977.

DSM IV . *Diagnostic and Statistical Manual of Mental Disorders*. 4<sup>th</sup> Edition . Washington DC: American Psychiatric Association Press; 1994.

EY, H. *Études Psychiatriques, Tome I, 2ème Édition* Paris: Desclée de Brouwer et Cie; 1952.

EY,H., Bernard, P., Brisset, Ch. *Manuel de Psychiatrie*. Paris: Masson et Cie,;1960.

FREUD, S. Edição Standard Brasileira das Obras Psicológicas Completas de Sigmund Freud. Rio de Janeiro: Imago; 1976.

GRAY,G.E.. Psiquiatria Baseada em Evidências. Porto Alegre:Artmed; 2004.

ICD 10. Draft of Chapter V. Mental and Behavioural Disorders. World Health Organization. Division of Mental Health. Genève; 1990.

KRAEPELIN, E. La Demencia Precoz. Buenos Aires: Editorial Polemos AS; 1996.

LEME LOPES,J. As Dimensões do Diagnóstico Psiquiátrico. Contribuição para sua Sistematização . Tese. Rio de Janeiro: Agir;1954.

PARIS, J. Nature and Nurture in Psychiatry. Washington,: American Psychiatric Press, Inc.; 1999.

RABELO, A.A.A .Q..M., D.M.Coutinho, N.N. Pereira. Um Manual para o CAPS. Centro de Atenção Psicossocial. Série Saúde Mental. Neuro-Psiquiatria UFBA. Bahia, Biograf; 2005.

ROSA,G. Ave Palavra. Rio de Janeiro: Livraria José Olympio Editora; 1970.

SCHNEIDER, K. Problemas de Patopsicologia y de Psiquiatria Clínica. Madrid: Ediciones Morata; 1947.

SCHNEIDER, K. Las Personalidades Psicopaticas y Problemas de Patopsicologia y de Psiquiatria Clínica. Madrid: Ediciones Morata; 1948.

SZASZ, T. O Mito da Doença Mental. Rio de Janeiro: Zahar Editora,1979.

SZASZ,T. A Fabricação da Loucura. Rio de Janeiro: Zahar Editora, 1979.

TORREY, E.F. A Morte da Psiquiatria. Rio de Janeiro: Paz e Terra, 1976.