The role of psychopathology in the new psychiatric era

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Summary

The recent increase in mental health problems probably reflects the fragmentation of social cohesion of modern society, with changes in family composition, work and living habits, peer communication and virtual-based reality. Fragmentation can also be due to the rapid expansion of urban agglomerations, too often chaotic and unregulated, the increase of market illicit substances, the reduction of social networks and the increase of social distance among people. As society changes, psychiatry has to adapt its role and target, moving from the treatment of mental disorders to the management of mental health problems. This adaptation will require a re-examination of the paradigms of psychiatry on which mental healthcare professionals have based their practice over the last century. Re-examination should include the paradigm of mental disorders as nosological entities with the development of a new psychiatric nosology, the concept of single disease entity, and a patient-centered psychopathology, since actual descriptions are not able to catch the inner world and reality of patients with mental health problems. Some of these changes will be highlighted and discussed in this paper.

Key words

Psychopathology • Biopsychosocial model • Nosology and classification of mental disorders • DSM-5

Introduction

Since the institution of asylums, which had been functioning for several centuries, introduction of antipsychotic drugs brought about a revolution. In many parts of the world by the middle of the 20th century, asylums had started to close and patients were being treated in the community. Towards the latter part of the same century, the focus shifted towards basing treatments at home and functional teams in many parts of the world. These changes reflect progress of psychiatry [1].

The role and target of psychiatrists in the last century changed from the custody of the insane to the treatment of mental disorders and to the management of "mental health problems", which are not proper mental illnesses, but rather the consequences of psychological stressors [2]. The question of defining mental illness remains an important one. In many settings, terms such as mental health issues, mental health problems and even mental health concerns have been used, which all under-estimate the seriousness of mental illness and its burden on society. There is no doubt that many of these "problems" may be due to the many social changes, economic upheavals including ongoing economic downturn, revolutionary advances of knowledge and to other developments. All this now requires a serious re-examination of the paradigms on which psychiatry and mental health care have been based in the last century [3-6].

The fragmentation of social cohesion, which has determined changes in family composition, working and living habits, problems in peer communication and the constitution of virtual-based realities, has brought many of these problems to the attention of mental health professionals. Other factors, which may have contributed to the rise of modern mental health problems, include the rapid expansion of urban agglomerations, too often chaotic and unregulated, the increase of online marketing of illicit substances among the youth [7], the reduction of social network and the increase of social distance among people [8].

Addressing these changes should be a priority for psychiatrists and psychiatry as a profession. The question is how these roles are redefined in this changing context [9]. The debate over the role of the psychiatrist has been going on for decades. This is the case for the "bio-psycho-social model", that from its identification in early '70s has been progressively transformed into a "biomedical model" with the consequences at times that the psychological and social factors involved in the aetiopatogenesis, management and treatment have been disregarded [10]. Another issue is the case of psychopathology, whose original definition as the "the study of the abnormal phenomena of mental health" [11], has been reduced to its descriptive nature and is no longer considered as the psychiatric science used to ac-

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cess to the patient's inner world [12 13]. In this paper, we explore the relationship between changing psychopathology and social systems.

The biopsychosocial model

Recently, Frances [14] published a provocative editorial on "Resuscitating biopsychosocial model". The title is evocative of someone or something that is disappearing and should return to live. The author questioned the current debate on the future of psychiatry and its current conceptual crisis. Is it the rediscovering of a previous model or a way to enter in a new fruitful period of the discipline? The limitations of current diagnostic criteria and the failure of neurobiological research are among the possible factors behind this "crisis" [15-17]. In this framework, psychiatry needs to adapt to a different social context; as society changes, psychiatrists have to adapt their target [18].

At the beginning of the 1970s, several major challenges threatened psychiatry's credibility: the unreliability of psychiatric diagnoses, the presence of mental health hospitals where patients were admitted without appropriate treatments and the heterogeneity of models and theories to explain the psychopathology of mental disorders. At that time, psychiatry was facing a crisis and the public image of psychiatry was temporarily restored with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), the beginning of the deinstitutionalisation process and the identification of the biopsychosocial model of mental illness [14]. Several authors have argued that the bio-psycho-social approach to mental illness has been progressively reduced to a mere biological model [14 19], with the discovery of the importance of neurotransmitters and of receptor systems in the aetiopatogenesis of mental disorders. However, despite encouraging progresses made in this field in the last years, this approach failed to identify the pathophysiological bases of mental disorders [20], as a neurobiological phenotypic markers (or genes) useful for diagnosis in psychiatry are still missing [21 22]. The most evident consequence of this failure is that progresses of neuroscience have not had an impact on psychiatric practice. The enthusiasm brought about by a period of exceptional progress of research in neuroscience has been followed by some disillusionment [23]. Another element which favoured the adoption of the biological model was the commercialisation of the first drugs for treatment of psychiatric disorders in the late 1950s. Since then, pharmaceutical companies strongly encouraged both research in the field of neuropsychopharmacology and in psychiatric practice. In fact, the "pill and appointment" became the dominant psychiatric treatment, and evidence on the effectiveness of antidepressants, mood-stabilisers and antipsychotics helped to the shift from the biopsychosocial model to "the bio-bio-bio model" [10].

Recent developments in mental health science have clearly demonstrated that causes or risk factors of mental disorders can operate at many levels, including genetic, neural, individual, family and social [24]. The recognition of the multifactorial aetiopatogenesis of mental disorders clearly shows that a reconsideration of the biopsychosocial model is needed. Depending on the specific situation, the biological level can be more or less relevant with respect to the social or to the individual psychological level [25]. This new approach has obvious diagnostic, clinical and therapeutical implications, which will be discussed in the next paragraphs.

The "operational revolution" and the rediscovery of psychopathology

The publication of the DSM-III signed the so-called "operational revolution", a radical remark in which the body of clinical knowledge and descriptions of mental disorders were shortened and simplified into labels and well defined psychiatric syndromes, available for the general public and deprived of their theoretical background [26]. Differently from DSM-III, the two previous editions of the manual did not adopt a categorical approach to mental disorders. In fact, the DSM-I, published in 1952, relied mainly on psychodynamic concepts of diagnosing psychopathology, dividing mental disorders into the standard psychoanalytic categories of neurotic, psychotic, and character disorders [27]. Moreover, in the first edition of the DSM the term "reaction" was extensively used throughout the manual, underlying that mental disorders derive from a "reaction" in response to emotional states brought on the circumstances of life [28]. The second edition of the DSM, published in 1968, continued to conceptualise psychopathology from a psychodynamic perspective, keeping the overall approach adopted by the first edition of the DSM. Despite this, several changes in terminology were made, in order to make it comparable with ICD-8 [29]. Only with the publication of DSM-III the operational criteria were formulated. The introduction of explicit diagnostic criteria, initially only for research purposes and subsequently also for use in regular clinical practice, had the main aim to overcome the subjectivity in the diagnostic process and was also a response to the foothold that psychoanalysis had on practice of psychiatry in the USA. Interestingly, the authors of DSM-III clearly stated that the use of operational criteria did not exclude clinical judgment, and that the use of fixed labels in psychiatric diagnoses requires a "considerable amount of clinical experience" and knowledge about the underly-

ing mechanisms of abnormal phenomena. Although operational criteria should have been used only as "suggested criteria" in order to standardise psychiatric diagnoses [30], structured diagnostic interviews and checklists progressively became the most frequently used instruments to make psychiatric diagnoses [26]. As a consequence, psychopathology has been neglected in recent generations of psychiatrists, in-depth descriptions of mental abnormal phenomena and syndromes [31] have simply been removed from psychiatric educational programmes, and the term "psychopathology" has been used in a trivial way, referring to the subject matter of psychiatry, instead of the discipline that studies the phenomena of mental disorders [32-33]. In fact, following the operationalisation revolution, psychopathology was emptied of its original meaning and became synonymous of symptomatology (the study of isolated symptoms) or nosology (the study of psychiatric diseases intended as a combination of symptoms) [34]. The dehumanisation of psychiatric clinical encounters and of the psychiatric profession as a whole has been one of the most evident consequences of this "operational revolution".

However, operational criteria also did something good for psychiatry, since they provided psychiatric diagnoses with good scientific evidence and helped to fight irrational and unscientific attitudes toward psychiatry [35]. In fact, before the publication of the DSM-III, psychiatric diagnoses were criticised for their lack of objectivity and the scarce reliability – the diagnostic agreement among two psychiatrists on the same evaluation was little more than random chance [30]. Since the DSM-III, loss of subjectivity and agreement among researchers or clinicians has led to better diagnoses. However, the role of insurance companies in pushing for inclusion of many diagnostic categories, which have not found an adequate counterpart in the clinical practice, needs to be acknowledged.

The need to rediscover psychopathology as the basic science of psychiatry has been claimed by several experts worldwide, and represents one of the educational priorities for early career psychiatrists [9]. A recent survey carried out in 32 European countries found that training in psychopathology during residency is not fully satisfying, and that the number of hours dedicated to training in psychopathology is limited and far from adequate [10]. These data show that, if psychiatry wants to enter a new era it needs to rediscover its basic sciences, such as psychopathology, in order to better understand the inner experience of its patients and provide patients with appropriate and integrated treatments.

Diagnoses 2.0: the DSM-5 era

The Diagnostic and Statistical Manual of Mental Disorders (DSM) provides the standard language by which clinicians, researchers and public health professionals communicate about mental disorders [36]. This has been used since its first publication in late 1950s, mainly in the United States, while other countries have adopted the *International Classifications of Disease* (ICD), developed by the WHO. The initial versions of both manuals had similar but separated criteria, and several efforts have been made to harmonise diagnostic labels and criteria between these two classification systems. The DSM-5 Task Force and the ICD-11 Development Advisory Committee have created a more valid basis for the organisation of a classification of mental disorders. At the current status, the groups of disorders ("blocks") proposed for the ICD-11 will be overlapping with those included in the DSM-5. The ICD-11 classification will remain based on descriptions of the prototypes of the various mental disorders rather than on operational diagnostic criteria as in the DSM-5 [37 38].

Many significant changes have been included in the DSM-5. Some disorders have been revised by combining criteria from multiple disorders into a single diagnosis [9], new disorders, such as the disruptive mood dysregulation disorder, the binge eating disorder and the dysphoric mood disorder, have been included, the number of specifiers and subtypes has been expanded or removed, and a section on "Conditions for further study", including the "Attenuated Psychosis Syndrome", the "Internet Gaming Disorder", the "Persistent Complex Bereavement Disorder", the "Suicidal Behavior Disorder" and many others, has been added [36]. However, even in the latest version of the DSM, psychiatric diagnoses continue to suffer from heterogeneity within disorders, blurred boundaries between disorders, frequent use of "not-specified" categories and high rates of comorbidity [39]. Despite many innovations, the publication of the DSM-5 raises several doubts and questions regarding the categorical approach [40]. The use of fixed labels and rigid inclusion criteria does not permit to consider the clinical heterogeneity of symptoms with the consequence that DSM-5 sensitivity in detecting a clinical condition is greatly diminished. Another major problem with the DSM-5 is that several diagnoses, such as those related to the use of new technologies and to the spread of new synthetic drugs, are still not present.

Therefore, modern classification systems are still not able to capture the inner world and reality of patients with mental health problems and are thus not entirely satisfactory. An integration of psychopathological descriptions, operational diagnostic criteria, social and environmental changes, individual factors and biological substrates is needed to have a clear picture of persons suffering from mental disorders. A single-view approach is probably misleading and will generate several diagnostic and ther-

apeutic difficulties in future generations of psychiatrists.
To overcome the limitations of current diagnostic classification systems, a new framework has been proposed by the National Institute of Mental Health, called Research Domain Criteria (RDoC) program, with the aim to "develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behaviour and neurobiological measures" [41]. The RDoC is proposed as an alternative to the ICD/DSM systems and includes the integration of neurosciences with behavioural sciences and a qualitative dimensional approach to psychopathology. The RDoC reflects a wider conceptual framework that considers mental disorders as the result of several individual ("e.g." the biological and psychological) and contextual ("e.g." social) factors. Of course, this programme has both advantages and limits. The RDoC represents a new framework for planning and carrying on research on psychopathology that can reflect advances in genetics and other areas of neurosciences and behavioural sciences [42]. One of the most important advantages is that this programme aims to incorporate a dimensional approach in psychiatric diagnoses. However, the RDoC programme has some potential disadvantages, since too little attention is given to the subjective experience and to patients' inner experiences [43], while attention is mainly on brain circuits. Moreover, the RDoC programme is used for research purposes, and is very far from being applicable in clinical practice [44] and therefore, there is still much work to do to make this programme useful for clinical practice [45].

Conclusions

There is no doubt that psychiatry is in a transition phase in which psychopathology, considered as a discourse (*logos*) about the sufferings (*pathos*) that affect the human mind (*psyche*), still plays a fundamental role. Of course, psychiatrists must be able to adapt their current practice to the new era, identifying protective and risk factors for mental illness, redefining their target, and founding their practice on integrating the biomedical approach with traditional psychopathological background.
In our opinion, to enter the new era, psychiatrists need to adopt an integrative approach to mental illnesses, taking into account that the clinical presentations of mental disorders are influenced by different and interplaying biological, psychological and social factors. In fact, on one hand there is no doubt that many psychiatric symptoms (such as delusions, hallucinations and anxiety symptoms) are the result of a dysfunction in brain circuits. On the other hand, evidence clearly shows the role of psychological (such as poor communication, temperamental and cognitive characteristics, poor self-esteem, low social competence and negative attributions) and social (such as social cohesion, social competencies, resourcing, housing, family context) factors in influencing onset, severity and outcome of mental disorders.
Nowadays, a modern psychiatrist cannot be anymore a neuroscientist, a physician, a psychotherapist or a social psychiatrist, but these different aspects of being a psychiatrist today should be integrated into one professional [46]. The different targets and approaches of psychiatry should be considered as a strength rather than a weakness of our discipline.

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