# Editorial

## The Predictive Capacity of Psychiatric Knowledge

I am grateful to Dr. Gómez-Restrepo for asking me to write on the predictive capacity of the history of psychiatry. To a large extent, an answer to this question depends on how we define psychiatry, history and predictive capacity. By psychiatry I shall mean the set of narratives which (mainly Western societies) have developed to configure, explain and manage behavioural phenomena which, on the basis of social rather than neurobiological criteria, are defined as 'deviant'. Currently, such narratives are predominantly medical but the alliance between medicine and madness is also historical in origin and hence subject to social and political avatar (that is, it may dissolved in the future). Such dissolution would not be determined by scientific but by social factors.

History refers to the set of narratives developed to capture and reconfigure coetaneous clusters of human ideas, emotions and actions as they occur within given spatial-temporal coordinates. In the case of the history of psychiatry such coordinates will be determined by what is defined (within a given period) as the relationship between society and madness.

Predictive capacity refers to the power to specify in the present behavioural formats and interactions which will occur in the future. Predictions are harder (but more meaningful) within linear than non-linear historiographical models. For example, within a Viconian (circular) view, the repetition of certain ways of looking at things can be predicted with facility but such action will mean little.

The history of psychiatry can be conceived as an autonomous or as a utilitarian discipline. According to the former, it has as its object the understanding and explanation of how and why the language, construction and management of 'mental disorder' has developed throughout the centuries. According to the latter, it is but a 'source of errors', a 'treasure trove', a 'cosmetic adornment', or a 'predictive instrument' (or all combined). Although these two purviews are often confused, they need to be distinguished as history has no utilitarian obligations and none should be expected from it.

The fact that (in the Braudelian sense) the history of psychiatry seems to exhibits long, medium and short duration processes, may on occasions induce in all of us an oracular illusion, that is, the deep feeling that we

can 'see' patterns and repetitions in the evolution of psychiatry, and that these may allow us to predict the future. For example, it is tempting to feel that periods of psychiatric biologism à outrance are followed by hermeneutic rebellions (as it was the case of late 19thC neuropsychiatry and early 20thC Freudianism). This would lead one to predict that the current trend to 'naturalize' all psychiatric phenomena will be followed by a period governed by a more balanced semantic approach to mental disorder.

The hidden assumptions inspiring this wishful thinking must be made explicit. The main one is that psychiatry is an autonomous branch of applied science that evolves according to its internal laws of logic and its own scientific research and evidence. This view is, of course, nonsense. Psychiatry is but a parasitical discipline whose meandering path is not determined by internal evolutionary laws but by the vagaries of the market, that is, by economic, social and political factors. Even its current alliance with medicine would rapidly cease if the market found that there are cheaper and more saleable ways of managing madness.

Of course, the economic nature of such decision will never be made explicit for soon enough court philosophers and historians will move in to concoct justificatory narratives which will make it appear as if the decision has been taken on the bases of high ideals and hard-earned evidence. A good example, is the ongoing threat to 'continuity of care' one of the sacred principles around which British psychiatry became organized since 1948 (i.e. the desirability that the same psychiatrist should look after the patient and his/her family). Because it is cheaper to have psychiatrists doing only outpatients or inpatients, some British Mental Health Trusts have now decided to do away with the continuity principle. This has been covered up by a justificatory narrative, to wit, that it is better for a patient to be seen by many psychiatrists as this reduces the probability of diagnostic error!

This is, of course, nonsense for psychiatry has a limited number of 'diseases', a limited number of 'treatments' and is a 'safe' discipline in the sense that diagnostic 'errors' are difficult to make and rarely threaten life (as they might do in other medical specialisms). Be that as it may, far more important than the theoretical danger of 'diagnostic error' is the deep knowledge that throughout life a psychiatrist will accumulate of his/her patient, disease, family and social context.

It is true that on occasions the history of psychiatry may uncover ideas, treatments or approaches that were neglected either because the technology

of a given period was not up to it, or because the social standing of the psychiatrist who postulate them was too low or because the mandarins of the discipline had invested their reputation and money elsewhere. These ideas, treatments or approaches can in principle be rescued and in this sense it is said that history can be a 'treasure trove'. But this is not a common state of affairs.

In summary, each historical period has its own dominant narratives. These achieve power for they generate financial gain to all concerned (except the poor patients). If there is one lesson to be learned from history is that this structural situation tends to repeat itself in the sense that in each historical period the Establishment will appoint a particular elite to configure and manage madness for it. Unfortunately, who these elites will be and what narratives will they concoct, cannot predicted. All that can be predicted is the general arrangement will repeat itself and that no elite will last for ever.

This transitoriness should be a source of hope to those who feel that current biological fundamentalisms are not doing any good to our patients and that such exaggerated view must be balanced by the creation of a semantic space where we can meet those who need help.

There are causes and reasons for mental affliction. Causes in the sense that brain disorders may overwhelm their psychology. Reasons in the sense that the life of people may become unliveable because they are confronted with extreme situations vis-à-vis which their emotional and semantic organization feels insufficient or impotent. The fact that in the latter case their suffering also has 'brain representation' is utterly irrelevant to their treatment. To be helped, these patients must be met in their own psychological space. This is something that perhaps we cannot learn from history but that it feels true enough to those of us who look after them.

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