Rev Psiquiatr Salud Ment (Barc.). 2014;7(4):186–194

Revista de Psiquiatría y Salud Mental

www.elsevier.es/saludmental

SPECIAL ARTICLE

Is it time to awaken Sleeping Beauty? European psychiatry has been sleeping since 1980☆

Jose de Leon[a,b]

[a] *University of Kentucky Mental Health Research Center, Eastern State Hospital, Lexington, KY, United States*
[b] *Psychiatry and Neurosciences Research Group (CTS-549), Institute of Neurosciences, University of Granada, Granada, Spain*

Received 8 November 2013; accepted 23 December 2013
Available online 26 November 2014

KEYWORDS
Europe;
Diagnostic and Statistical Manual of Mental Disorders;
History 19th century;
History 20th century;
United States

Abstract The *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, published in 1980, has led to a dead end, the *DSM-V*. Following the allegory of *Sleeping Beauty*, the *DSM-III* put European psychiatry to sleep; it now must wake up to create a 21st century psychiatric language for descriptive psychopathology and psychiatric nosology.

Four topics are reviewed. First, the review of descriptive psychopathology focuses on: (a) Chaslin's and Jaspers' books, and (b) Schneider's transmittal of Jaspers' ideas and involvement with Kraepelin in incorporating neuroscience into psychiatric nosology.

Second, US psychiatry's historic steps include: (a) the pseudoscience of psychoanalysis, (b) the low level of pre-*DSM-III* diagnostic expertise, (c) the neo-Kraepelinian revolution which led to *DSM-III*, (d) the failure to improve diagnostic skills, and (e) the reprise of Kraepelin's marketing (''neuroscience will save psychiatry'').

Third, the *DSM-III* devastated European psychiatry by destroying: (a) the national textbooks which increased consistency but eliminated creative European thinking; and (b) the *Arbeitsgemenschaft fur Methodic und Dokumentation in der Psychiatrie*, the most reasonable attempt to reach diagnostic agreement: start with symptoms/signs (first level) rather than disorders (second level).

Fourth, Berrios elaborated upon Jaspers, who described psychiatry as a hybrid science and heterogeneous. Berrios affirmed that psychiatric symptoms/signs are hybrid. Some symptoms are in the ''semantic space'' and cannot be ''explained'' by neuroscience.

☆ Please cite this article as: de Leon J. ¿Es hora de despertar a la Bella Durmiente? En 1980, la psiquiatría europea cayó en un profundo sueño. Rev Psiquiatr Salud Ment (Barc.). 2014;7:186–194.

E-mail address: jdeleon@uky.edu

2173-5050/$ – see front matter

PALABRAS CLAVE
Europa;
Diagnostic and Statistical Manual of Mental Disorders;
Historia del siglo XIX;
Historia del siglo XX;
Estados Unidos

¿Es hora de despertar a la Bella Durmiente? En 1980, la psiquiatría europea cayó en un profundo sueño

Resumen En 1980, la publicación del *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) dio lugar a un callejón sin salida, el DSM-V. Siguiendo la alegoría del cuento de *La Bella Durmiente*, el DSM-III hechizó la psiquiatría europea, que cayó en un profundo sueño. En la actualidad, es hora de que despierte y cree un nuevo lenguaje psiquiátrico para la psicopatología descriptiva y la nosología psiquiátrica de acuerdo con los conocimientos del siglo XXI.

Se revisan 4 temas. En primer lugar, la psicopatología descriptiva, incluidas a) la obra de Chaslin y la de Jaspers, y b) la transmisión de las ideas de Jaspers por parte de Schneider, que participó en las tentativas de Kraepelin de incorporar la neurociencia a la nosología psiquiátrica.

En segundo lugar, los progresos de la psiquiatría estadounidense: a) la seudociencia del psicoanálisis, b) el bajo grado de experiencia diagnóstica antes de la publicación del DSM-III, c) la revolución neo-kraepeliniana, que dio lugar al DSM-III, d) el fracaso en mejorar las habilidades diagnósticas y e) la repetición del «mensaje» de Kraepelin («la neurociencia salvará la psiquiatría»).

En tercer lugar, el DSM-III devastó la psiquiatría europea al echar por tierra: a) los libros de texto nacionales, lo que aumentó la coherencia pero arrinconó el pensamiento creativo en Europa, y b) la escala del sistema *Arbeitsgemenschaft fur Methodic und Dokumentation in der Psychiatrie*, la tentativa más razonable de llegar a acuerdos diagnósticos empezando por los síntomas (primer nivel), en lugar de por los trastornos (segundo nivel).

En cuarto lugar, Berrios ha desarrollado el concepto de Jaspers de que la psiquiatría es una ciencia híbrida y que los trastornos psiquiátricos son heterogéneos. Berrios explica que los signos y síntomas psiquiátricos son híbridos. Algunos síntomas corresponden al «espacio semántico» y la neurociencia no puede explicarlos.

Introduction

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) was published in May 2013.[1] Its publication has been linked to a growing controversy about some specific diagnoses, but it does not represent a ''paradigm change''.[2] However, among the main psychiatrists in the USA, it is hoped that future editions of the DSM will incorporate the advances of neuroscience in the field of psychiatric diagnosis.

The author of this article suggests that the DSM-V is stuck in a blind alley of the historical process, initiated in 1980 with the publication of the DSM-III,[3] which constitutes an important step in the history of psychiatric vocabulary. This terminology has 2 interrelated levels (the level of symptoms and that of diagnosis). The description of psychiatric signs and symptoms is generally called descriptive psychopathology[4] or simply psychopathology.[5,6] Nosology is the scientific discipline of the classification of illnesses. Using Walt Disney's version of *Sleeping Beauty* as an allegory, this article presents the suggestion that the DSM-III was the spindle on the distaff through which European psychiatry (Sleeping Beauty) fell into a deep sleep. At present, she has to wake up and establish a 21st-century psychiatric (descriptive psychopathology and psychiatric nosology) to advance in scientific development and practical usefulness.

To defend the idea that, in 1980, European psychiatry fell into a profound slumber from which is has yet to awaken, the author of this article briefly explains: (1) the concept of descriptive psychopathology and the attempts of Kraepelin to incorporate neuroscience into psychiatric nosology; (2) the context and establishment of the DSM-III in the US; (3) the devastating consequences that the DSM-III had on European psychiatry; (4) the possible solution, the psychiatrist German Berrios as Prince Charming, who will be able to wake European psychiatry up from its sleep; and (5) the conclusion.

Descriptive psychopathology

The foundation of descriptive psychopathology, which made it possible to create psychiatry as a medical discipline, was initially developed in France and, later on, it spread to Germany during the 19th century.[4] Its historical culmination is considered in the studies of Chaslin (France) and Jaspers (Germany). Immediately afterwards, Kurt Schneider is reviewed as the key figure in its transition. He participated in the first well planned attempt (obviously, unsuccessful) to integrate neuroscience in psychiatric nosology at the German Institute for Psychiatric Research (founded by Kraepelin) and translated the ideas of Jaspers about descriptive psychopathology for German physicians in a simplified language that they could understand and, later on, transmit to psychiatrists who spoke English.

French descriptive psychopathology and Chaslin

In 1912, after 25 years of research, Chaslin published a 956-page work on psychiatric symptoms, which included 350 clinical cases.[7] He also published a wonderful article in 1914, which highlighted the weak points and lack

of precision in psychiatric terminology, but also included an unrealistic commentary indicating that his textbook would turn psychiatry into a ''well-studied science'' with ''well-made language''.[7] The fact is that Chaslin's book remained untranslated until 2010, when it was translated into Spanish,[8] which emphasises 2 factors ignored by the current leaders of psychiatry in the USA: (A) the decisive importance of ''the historical contingencies'' in understanding the weak points of nosological systems in psychiatry,[9,10] and (B) the difficulties in satisfying the fantasy that psychiatry could become a science.[11,12]

German descriptive psychopathology and Jaspers

In 1913, the first edition of a book called *General Psychopathology* was published by a 30-year-old psychiatrist who worked at the University of Heidelberg.[13] In 1963, the first translation into English was published, a 900-page book that reflected the 7th German edition.[14] Jaspers worked on this during his training in psychiatry, but he soon stopped seeing patients and became a philosopher known the world over. Kurt Schneider updated the 5th and later editions.[15] Jaspers wrote this textbook because he felt that the discipline of psychiatry needed a systematic clarification of then-current thinking,[16] something that the author of this article believes is even more real in the 21st century.

General Psychopathology is hardly an easy work to read, but it contains 2 essential interrelated ideas on the language of psychiatry[12]: (1) psychiatric disorders are heterogeneous (some are medical illnesses, some are variations from normality and others are medical terms, such as schizophrenia and the serious mood disorders). Consequently, (2) psychiatry is a hybrid scientific discipline that has to combine methods of the sciences, both natural and social. These provide, respectively, an explanation of the illness that follows the medical model and an understanding of the psychiatric anomalies that are variations of human life.

General Psychopathology has influenced British psychiatry considerably, but had a very limited direct influence in the USA. Paul McHugh was Director of Psychiatry at Johns Hopkins University for some 25 years, a job that he initiated in 1975 and where he trained a high number of the main residents in US psychiatry. The excellent textbook by McHugh and Slavney, *Perspectives in Psychiatry*,[17] was an influence in this country during the eighties and the nineties, and summarises the principal ideas of Jaspers. The concept that psychiatric disorders are heterogeneous entities, defended by Jaspers and McHugh, lacked practically any impact on the DSM-III or the DSM-V.[18]

Kurt Schneider at the crossroads

Kurt Schneider played a key historical role as a bridge for transition in the history of psychiatry.[19,20] He was a member of the German Institute for Psychiatric Research, created by Kraepelin to integrate neuroscience into psychiatric nosology.[21] Schneider was crucial in transmitting the ideas of Jaspers to English psychiatry.[19] In contrast to Jaspers, he began to study philosophy but ended up becoming a practicing psychiatrist and an excellent physician.[20,22]

Kurt Schneider and Kraepelin's German Institute for Psychiatric Research

In the USA Kraepelin is considered the founder of psychiatric nosology. In 1917, he inaugurated the German Institute for Psychiatric Research (presently called the Max Planck Institute of Psychiatry).[21,23,24] The neuroscientists and psychiatrists that worked at the Institute were a unique team of brilliant minds in the history of psychiatry. Alzheimer, a well-known neuropathologist and collaborator of Kraepelin, died before the Institute opened its doors. Nissl, Brodmann and Rudin worked there. Nissl was an outstanding histopathologist that developed the most important method for staining neurons. Brodmann established the topographical classification system for the areas of the cerebral cortex. Rudin introduced genetic studies in psychiatry. Later on, in 1931, Schneider was made director of the Clinical Department. The Institute was multidisciplinary and initially included laboratories for experimental psychology, neuropathology and chemistry, while those for serology and genealogical demography were added afterwards.[23,24] The successive deaths of Alzheimer in 1915, Brodmann in 1918 and Nissl in 1919 constituted an irreparable loss for Kraepelin, who, in turn, died in 1926.

Kraepelin was too optimistic, given that he considered that identifying the cause of general paresis (late-stage syphilis with neurological involvement) would lead to the discovery of the causes of other psychiatric disorders, such as schizophrenia and manic-depressive psychosis. In the Institute, his own words for his objective as regards mental illness were ''the discovery of means to prevent them, cure them or make them easier to bear''.[21]

The failure, in the German Institute for Psychiatric Research, of the first well-planned attempt to incorporate neuroscience in psychiatric nosology could seem irrelevant for those who plan to include it in future editions of the DSM, given that now, a century later, the development of funding for research, technology and methodology can make Kraepelin's attempt seem laughable. From 1966 to 2005, contemporary scientists witnessed an annual increase of 4% in the number of articles on neuroscience and psychiatry.[25] However, if one faces the complex undertaking of using neuroscience to understand psychiatric disorders, optimistic wishes and marketing do not guarantee success even if your name is Kraepelin (or you live in the 21st century). The arrogance and lack of historical knowledge of contemporary neuroscientists and psychiatrists,[9] who want to incorporate neuroscience into psychiatry, bring to this author's mind the famous aphorism from Santayana (a philosopher born in Spain who taught at Harvard): ''Those who cannot remember the past are condemned to repeat it''.[26]

Kurt Schneider as a spreader of the ideas of Jaspers

The title of Schneider's brief textbook, which is easier to read than Jaspers' work, is *Clinical Psychopathology*.[27] In the United Kingdom, it was Mayer-Gross, a psychiatrist who trained at the University of Heidelberg (where Kraepelin, Jaspers and Schneider worked at different times), who spread the ideas of the latter 2 men.[22] When Mayer-Gross

fled from Nazi Germany, he settled in the United Kingdom, where he wrote an influential textbook that succeeded in having 3 editions, becoming the main textbook in British psychiatry[28] until the appearance of the DSM-III.

Schneider was very well known in Continental Europe, South America and Japan, areas of the world from which psychiatrists were sent to work rotations with Schneider after the Second World War.[19,20] Nevertheless, this author was ignored in English-speaking countries[19] until the 1960s, when British psychiatrists became interested in his work after the successive publications of Mayer-Gross' textbook in 1954,[28] the translation of Schneider's textbook in 1959[27] and an article in one of the leading scientific journals, in which Schneider's criteria for diagnosing schizophrenia were described.[29] Influenced by Jaspers and Schneider, Wing and his collaborators at the London Institute of Psychiatry attempted to standardise the psychiatric interview (the ''examination of the current state''), following Schneider's criteria for the diagnosis of schizophrenia.[30] The contrast between this shortened way of diagnosing schizophrenia, compared with the more [extended] method (influenced by Bleuler and psychoanalysis) that included more patients, was one of the major catalysts for change in psychiatry in the United States.

Development of the *Diagnostic and Statistical Manual of Mental Disorders-III* and its later editions in the United States

In this article, it is impossible present an in-depth review of the complex historical influences[31] that led to the DSM-III. The author will briefly address the following in this section: (1) the scientific method problems with psychoanalysis; (2) the dominance of psychoanalytical thought in the USA, which generated limited clinical diagnosis experience among the US psychiatrists before the appearance of the DSM-III; (3) the neo-Kraepelinian revolution, which fought the psychoanalytical dominance and gave rise to the DSM-III; and (4) the lamentable consequences of the DSM-III and its later versions, which did not really lead to improvement in diagnostic abilities or greater knowledge of descriptive psychopathology among the North American psychiatrists.

Psychoanalysis, science and explanation against comprehension

It is evident that Freud's original intention was to become a scientist. In 1895, he wrote his *Project for a Scientific Psychology*.[32] However, in spite of its excellent marketing and his skills for teaching, Freud never received the Nobel Prize for Medicine. Instead, in 1930, he received the foremost award in German literature, the Goethe Prize, an unsurprising event, given that he wrote like a novelist.[33]

Popper, who played a crucial role in transferring the philosophy of German science to English-speaking countries, used the psychoanalysis of Freud as an example of pseudoscience, instead of true science.[34] Jaspers considered interpretation to be important in psychiatry even though such interpretation followed social science methodology.[14] Freud erroneously believed that interpreting is the same thing as explaining, but his hypotheses cannot be falsified by means of the scientific method used in natural sciences; that is the reason why Popper classified psychoanalysis as pseudoscience.[34]

Dominance of psychoanalytical thought and lack of interest in descriptive psychopathology

At the same time that German and Central European psychiatrists emigrated, fleeing from the Nazis, descriptive psychopathology spread to the United Kingdom[35] and psychoanalysis arrived in the USA. In the middle of the 1950s, nearly all the North American chiefs of psychiatric services stood up for psychoanalysis.[36,37] Consequently, the training that psychiatrists received in the USA was in the hands of clinicians who made psychoanalytical diagnoses interpreting patient symptoms using psychoanalytical theory. Psychiatrists in the USA therefore lacked training in descriptive psychopathology and were uninterested in psychiatric diagnosis based on clinical symptoms.[38]

The weak nosological points of the North American psychiatrists became evident in the 70s. The studies by Kendell et al.[38] demonstrated that the psychiatrists in New York used a much wider definition of schizophrenia than did those at the London Institute of Psychiatry. Later on, it became clear that this was the tip of the iceberg and that, in the USA, before the publication of the DSM-III diagnosing schizophrenia was almost equivalent to diagnosing a psychosis.[39]

The neo-Kraepelinian revolution that led to the *Diagnostic and Statistical Manual of Mental Disorders-III*

Eli Robins, who had fled from psychoanalysis to the University of Washington in St. Louis with the help of his student Samuel Guze, began writing articles using a scientific approach to psychiatry. This neo-Kraepelinian revolution consisted of forgetting Freud's teaching and returning to Kraepelin's nosology, which followed the medical model of interpretation of psychiatric disorders.[36,37] The neo-Kraepelinians were successful, ''converting'' Spitzer and Endicott at the New York Psychiatric Institute. Spitzer became the leader of editing the DSM-III and selected many US psychiatrists contaminated by the neo-Kraepelinian virus to develop DSM-III criteria,[3] after tactically overcoming the higher psychoanalytical echelons.[36]

The *Diagnostic and Statistical Manual of Mental Disorders-III* has led to a blind alley

Something went wrong with the neo-Kraepelinian revolution.[40] In 1972, with the criteria of Feighner, there were 14 ''valid'' psychiatric disorders; in 1975, there were 25 according to the Diagnostic Criteria for Research; and, in 1980, with the DSM-III, there were 256.[40] Consequently, although Robins and Guze were initially worried about validity, Spitzer's DSM-III seem to centre mostly on ''diagnostic democracy'' (agreement among ''experts'') and inter-examiner reliability.[40]

During the 80s and the 90s, Andreasen was one of the most influential North American psychiatrists. He studied at the University of Iowa, where Winokur (one of the neo-Kraepelinians) emigrated, eventually becoming a full professor of psychiatry. The schizophrenia scales developed by Andreasen represent by far the best attempt in the USA to combine the scientific methodology of North American psychiatry with the German descriptive psychopathology. In his magnificent 2007 article,[41] this psychiatrist indicated that the ''unintended consequence'' of the DSM-III was the extinction of North American interest in descriptive psychopathology, recently resurfaced.

In our opinion, there are 2 realities in the practice of psychiatry in the USA (1–the absence of appropriate psychiatry teachers well-trained in descriptive psychopathology, and 2–the lack of access to patient psychiatric histories due to the existence of multiple psychiatric hospitals, in comparison with the European system, where hospitals gather together all the admissions in the catchment area), as well as 2 factors in North American society (1–pragmatism and 2–the high cost of the physician's time) that are essential for understanding why the DSM-III eliminated the opportunity of providing North American medical residents with proper clinical training and interest in descriptive psychopathology.

The unsatisfactory state of clinical diagnosis in the United States has made it almost impossible for studies to be published, in this country, with clinical diagnoses established by physicians with limited diagnostic training. To be able to publish, North American psychiatry in the USA (which is fundamentally pragmatic) uses transversal diagnostic research interviews, carried out by staff lacking clinical experience, who face the impossible task of trying to compensate for the absence of psychiatric case histories and the unavailability of patients' relatives. It is of concern that transversal descriptions from the patients themselves are considered reliable for diagnosing illnesses such as psychosis and drug abuse, conditions that–by definition–alter the capacity for introspection. Furthermore, trusting in patient memory seems even more worrying, bearing in mind the findings in the neurosciences indicating that human memory has numerous elements in common with imagination and that the very act of remembering modifies our memories.[42]

Consequently, just like Andreasen,[41] the author of this article considers that the USA's interest in descriptive psychopathology has disappeared. Instead, the leaders in North American psychiatry have decided to enter a blind alley: the fantasy that neuroscientific advances are the answer for 21st-century psychiatry. The US National Institute of Mental Health (NIMH) is probably the equivalent of the Kraepelin Institute towards the end of the 20th century and beginnings of the 21st century. Just like Kraepelin a century earlier, Insel (the current NIMH director) is responsible for marketing to capture funding and, once again just like Kraepelin, promises to prevent and cure mental illnesses.[43] Insel has strengthened the progressive abandonment of descriptive psychopathology by indicating that the NIMH will pay attention to the physiopathological mechanisms shared among psychiatric disorders to contribute to the development of new treatments, and will select patient subgroups for treatment.[44] In contrast to the NIMH, pharmaceutical laboratories have to present their short-term results to shareholders and are perfectly aware that the discovery of the first antidepressants, antipsychotics and anxiolytics was pure luck.[45] Given that ''in the preceding 3 or 4 decades it had been impossible to generate new, effective psychotropic agents from a mechanistic approach'', pharmaceutical laboratories have decided to abandon this area, indicating the need to ''consider basic reconceptualizations of psychiatry itself''.[45]

The devastating consequences of the *Diagnostic and Statistical Manual of Mental Disorders-III* for European psychiatry

The DSM-III has had disastrous consequences for European psychiatry. This can be illustrated using 2 fairy tales as allegories. In *Sleeping Beauty*, a distaff spindle made Sleeping Beauty fall into a deep slumber; the DSM-III caused European psychiatry to fall into a deep sleep and put an end to the production of original textbooks in each country. Secondly, we should consider a combination of Walt Disney's version of *Snow White* with that of his *Sleeping Beauty*. Imagine that Snow White was pregnant and that the poisoned apple she ate not only made her fall into a deep slumber, it also made her lose the baby that she was carrying.

In the end, the Germans and the French (who had ignored each other for decades) decided to forget their disputes and join forces to write a manual that would make it possible for all the European psychiatrists to use the same definitions for psychiatric signs and symptoms. The DSM-III replaced this attempt. In *Sleeping Beauty*, the wicked witch's spell makes her victims forget that Beauty's kingdom exists. Consequently, a side-effect of this 2nd is that nobody even remembers the existence of this European attempt, thwarted, to reach an agreement on descriptive psychopathology, the system called the Association for Methodology and Documentation in Psychiatry (*Arbeitsgemenschaft fur Methodic und Dokumentation in der Psychiatrie*), or AMDP.[46]

The elimination of national European textbooks

When the DSM-III was published, residents in psychiatry in the United Kingdom probably studied with Mayer-Gross's work.[28] It is likely that French residents used the main French textbook.[47] The Germans almost certainly used Schneider's textbook[27] or another German textbook. In other European countries, residents in psychiatry may have studied with any of these textbooks, depending on cultural influences and the availability of translations or of a national textbook written in their own language.

Later, in 1980, the DSM-III was published.[3] The initial European reaction was to ignore it, just as in Sleeping Beauty's kingdom where everyone tried to hide all distaff spindles as dangerous weapons. However, after some years, the same psychiatrists who had opposed the work ''accepted it without any problems'', as they did its successive editions. Not long after that, European textbooks and national traditions became the spinning wheels that had to be hidden and they ended up completely forgotten in following the successive editions of the DSM and North American textbooks. Pichot, a French psychiatrist with a cosmopolitan and

very deep psychiatric culture,[48] is one of the latest examples of the best European psychiatrists. Pichot described an initial European ambivalence, followed by the ''speedy adoption in all the countries, even in those where its opposition was strongest''.[48] He later indicated that the DSM was on the wrong track due to the great number of diagnoses and comorbidities, and he made comments about the imbalance between US and European psychiatry.[49]

The loss of interest in the Association for Methodology and Documentation in Psychiatry system

The AMDP system was established in Continental Europe to standardise the documentation of psychiatric case histories and to take changes in symptoms into account during clinical trials. It was inaugurated in 1960 when 5 German universities attempted to standardise data gathering for patients treated with antipsychotics. By 1966, the AMDP system included the German and Swiss universities and the 1st French translation had appeared. The definitive version was translated to 12 languages, including English, in 1982.[50] The AMDP system consists of 3 forms for gathering previous psychiatric history and 2 scales for overall rating of psychiatric symptoms (100 items + related items) and somatic symptoms (40 items + related items). The symptoms are rated on a 5-point scale (absent, slight, moderate, severe and very severe). Three subscales were designed to assess anxiety, maniac-depressive symptoms and schizophrenia more specifically. The time spent on an exam using the AMDP system is no greater than that required for a clinical interview (30–45 min); calculating the score given to the form takes another 10–15 min.[46] The review articles, published in English and included in the PubMed database, are relatively limited; these include 2 from 1986 published in a British journal[51] and a German one,[50] as well as a journal number difficult to obtain, devoted entirely to the AMDP system.[52] As has been mentioned, interest in the AMDP system disappeared completely in the 1980s. A rare case is a recent article (from 2012) describing a study in which non-psychometric multidimensional scales were used to examine symptom structures in a sample that dated back to 1980 and included nearly 1500 patients and a 2002/2003 sample with more than 2000 patients.[53]

Will European psychiatry wake up from its dream thanks to Berrios?

German E. Berrios is the Director Emeritus of Epistemology and Psychiatry in the Department of Psychiatry at the University of Cambridge. He may not look like the handsome Prince Charming from Walt Disney's film, but he has ''a marvellous mind.'' (I am referring to the title of the film called ''A Beautiful Mind'' in English and translated as ''*Una mente maravillosa*'' in Spanish.) To demonstrate this, the author's opinions about the following 3 subjects are presented: (1) his training as a requisite for carrying out the role of Prince Charming in this narrative, (2) his assistance in understanding the history of psychiatry, and (3) his contributions to its future.

Training Prince Charming

Looking back, Berrios' training seems perfect for carrying out this role. (1) He studied philosophy in his native Peru and at the University of Oxford and while he carried out the tasks of his first academic post at the University of Leeds, statistics with Max Hamilton (who introduced scales in psychiatry). (2) He trained with the ''appropriate'' mentors in descriptive psychopathology—at first with Hamilton and then at Cambridge with Martin Roth (Mayer-Gross' principal disciple). (3) He collaborated with the Departments of History and Philosophy at the University of Cambridge and with the Department of Psychiatry at the University of Heidelberg (the heirs of Kraepelin, Jaspers and Schneider). (4) He dedicated his life to reading psychiatric texts from the 19th and early 20th centuries, written in their original languages. (5) He worked as a physician in the interaction between neurology and psychiatry.[54]

Berrios' contributions to the comprehension of the history of psychiatry

The main original contribution given by Berrios to the history of psychiatry is his insistence that, in the texts by many French and German physicians before Kraepelin, there were important ideas about descriptive psychopathology[4] and psychiatric nosology,[55] as well as attempts to convert psychiatry to a discipline of the illnesses of the brain (neuropsychiatry or biological psychiatry).[8] Understanding the imperfections and strong points of such sophisticated pre-Kraepelinian ideas is crucial to avoid their errors.

Berrios' contributions to the future of psychiatry

His main contribution to the future of psychiatry is the attention that he pays to the hybrid nature of psychiatric symptoms[56,57] at a moment in which psychiatry in the USA is intoxicated with neuroscience and European psychiatry imitates that intoxication. Early in the 20th century, Jaspers warned us about the precarious methodological position that psychiatry held among the social and natural sciences.[13] For 100 years, almost nobody paid any attention to this bad methodological news until Berrios reminded us that psychiatry addresses hybrid objectives[58] with varying degrees of difficulty of study using the traditional scientific methods employed in medicine.[59]

The doctrine related with the foundations and the methods of knowledge is called epistemology. It can be defined as the science that studies the origins and validity of knowledge.[57] Berrios suggests that the studies on epistemology and the history of psychiatry are closely related, because they use the same methods and require collaboration with other experts, such as historians and physicians.[60] Being educated in all these fields, Berrios has progressively concentrated on the history and the epistemology of psychiatric symptoms[56] and, in addition, on psychiatry in general.[57] He has suggested that not only psychiatric disorders are heterogeneous, as Jasper proposed, but that psychiatric symptoms are as well.[59] When psychiatric symptoms are directly linked to cerebral signs, such as those observed in patients with ''neurological disorders'', it is

reasonable to follow a neuroscientific strategy and use methods such as brain imaging techniques, given that such symptoms can be explained by a cerebral illness. In contrast, when psychiatric symptoms have a relationship with ''semantics'' (communication between human beings), both a neuroscientific approach and the use of methods like brain imaging techniques are unreasonable, because we can only understand these symptoms–in the meaning of ''understand'' as used by Jaspers–[14,17] and they cannot be explained by illnesses of the brain. These relatively simple concepts represent bad news for psychiatric researchers. Despite the fantasy that the DSM-III is ''atheoretical'', Berrios indicates that ''psychiatric objectives cannot be studied independently of the systems of description, explanation and management used to express them in the first place''.[60] Berrios also describes the difficulties involved in formulating new elements (such as new symptoms) in psychiatric language, because experienced physicians reinterpret them using known psychiatric symptoms defined in agreement with the language of the 19th century.[59]

Conclusion

The DSM-III constituted an important step in limiting Freudian influence on psychiatry in the USA, but it has given rise to 2 negative aspects. Firstly, it extinguished North American interest in descriptive psychopathology. Secondly, the current leaders in US psychiatry want to ''sell us'' the idea that neuroscience ''will cure and prevent mental illness''.[43] Within 100 years, these words will seem as laughable as those of Kraepelin seem to us today.

The DSM-III brought about 2 devastating consequences in European psychiatry. The disappearance of national textbooks made greater international agreement possible but destroyed original thinking in European psychiatry. The termination of the AMDP system eliminated the first reasonable attempt to reach an agreement in psychiatry at the first level of symptoms. The DSM-III increased interrater reliability at the second level of psychiatric diagnoses. To achieve true agreement in psychiatric language, we have to first agree on the definitions of the signs and symptoms and this has to be followed later by an agreement on psychiatric disorders defined using previously accepted mental symptoms.

Psychiatry still utilises the psychiatric language of the 19th century. Berrios studied the strong and weak points of descriptive psychopathology, nosology and the neuropsychiatric approach in the 19th century. Jaspers was not taken into consideration when he pointed out that psychiatric disorders are heterogeneous and that some of them should be studied with social science methodology. It is likewise possible for Berrios to be ignored when he emphasises that psychiatric signs/symptoms are heterogeneous and that some correspond to ''semantic space'' (a concept that is gradually becoming part of the cognitive sciences[61]) and, in Jaspers' opinion, cannot be explained using neuroscience. Berrios proposes that the 21st-century European psychiatrists should formulate a language for descriptive psychopathology that lives up to this century, with the objective of establishing a new nosology. This article, written as a fairy tale, presents a simplified image of Berrios as the only European Prince Charming, although there are others. Articles by Parnas, Sass and their colleagues have expressed a lasting interest in descriptive psychopathology. More recently, they dealt with psychiatric epistemology[5] and the fundamental role of the psychiatric interview,[62] while Stanghellini and his colleagues have published interesting articles on patient attitudes to illness[63] and hallucinations.[64] Van Os, one of the most original European researchers in the field of psychosis, recently published a commentary[65] on the need to ''create links between research strategy in social sciences and that of natural sciences'' in which he mentioned that ''...according to what is defined in the DSM and the International Classification of Diseases, psychological and psychiatric research indicates that most mental disorders represent a quantitative deviation from health''.

Ethical responsibilities

Protection of people and animals. The author declares that no experiments have been carried out on human beings or animals for this research.

Data confidentiality. The author declares that no patient data appear in this article.

Right to privacy and informed consent. The author declares that no patient data appear in this article.

Conflict of interests

No commercial organisation played any role at all in the writing of this article for its publication. The author has no economic relationships of commercial interest to declare for the past 36 months.

Acknowledgements

The author wishes to thank Lorraine Maw, M.A., for her editorial help. Under the title, *A post-DSM-III wake-up call to European psychiatry*, a short version of this article was published without the summary and literary component. Acta Psychiatr Scand. 2014;129:76–77, http://dx.doi.org/10.1111/acps.12196.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5). 5th ed. Washington, DC: American Psychiatric Publishing; 2013.
2. Kendler KS, First MB. Alternative futures for the DSM revision process: iteration vs. paradigm shift. Br J Psychiatry. 2010;197:263–5.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM–III). 3rd ed. Washington, DC: American Psychiatric Association; 1980.
4. Berrios GE. The history of mental symptoms. Cambridge, UK: Cambridge University Press; 1996.
5. Parnas J, Sass LA, Zahavi D. Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object. Schizophr Bull. 2013;39:270–7.
6. Stanghellini G. The meanings of psychopathology. Curr Opin Psychiatry. 2009;22:559–64.

7. Berrios GE, Fuentenebro F, Chaslin P. Philippe Chaslin and descriptive psychopathology. Is ''psychiatry'' a well made language? Hist Psychiatry. 1995;6:395–405.
8. Chaslin P. Elementos de semiología y clínica mentales. Tomos I y II. Buenos Aires: Polemos; 2010.
9. Berrios GE, Markova IS. Conceptual issues. In: D'haenen H, den Boer JA, Willner P, editors. Biological psychiatry. Chichester, UK: John Wiley & Sons, Ltd.; 2002. p. 1–24.
10. Kendler KS. An historical framework for psychiatric nosology. Psychol Med. 2009;39:1935–41.
11. Berrios GE, Marková IS. Symptoms – historical perspective and effect on diagnosis. In: Blumenfield M, Strain JJ, editors. Psychosomatic medicine. Philadelphia: Lippincott Williams & Wilkins; 2006. p. 27-38.
12. de Leon J. Is psychiatry scientific? A letter to a 21st century psychiatry resident. Psychiatry Invest. 2013;10:205–17.
13. Jaspers K. Allgemeine psychopathologie. Ein leitfaden fur studierende, arzte und psychologen. Berlín: Springer; 1913.
14. Jaspers K. General psychopathology (traducido del alemán por Hoening J y Hamilton MW). 7th ed. Manchester, UK: Manchester University Press; 1963.
15. Berrios G. Psicopatología: pasado, presente y futuro (en español). Informaciones Psiquiátricas. 2007;189:2–10.
16. Kirkbright S. Karl Jaspers: a biography. Navigations in truth. New Haven: Yale University Press; 2004.
17. McHugh P, Slavney PR. The perspectives of psychiatry. 2nd ed. Baltimore, MD: Johns Hopkins University Press; 1998.
18. McHugh PR. Striving for coherence: psychiatry's efforts over classification. JAMA. 2005;293:2526–8.
19. Hoenig J. Kurt Schneider and Anglophone psychiatry. Compr Psychiatry. 1982;23:391–400.
20. Huber G. Kurt Schneider: the man and his scientific work. Zbl Neurol Psychiat. 1987;246:177–91.
21. Kraepelin E. The German institute of psychiatric research. J Nerv Ment Dis. 1920;51:505–13.
22. Janzarik W. Jaspers, Kurt Schneider and the Heidelberg school of psychiatry. Hist Psychiatry. 1998;9:241–52.
23. Hippius H, Müller N. The work of Emil Kraepelin and his research group in München. Eur Arch Psychiatry Clin Neurosci. 2008;258 Suppl. 2:3–11.
24. Weber MM. Psychiatric research and science policy in Germany: the history of the Deutsche Forschungsanstalt fur Psychiatrie (German Institute for Psychiatric Research in Munich from 1917 to 1945). Hist Psychiatry. 2000;11:235–58.
25. Weber MM, Berrios GE, Engstrom EJ. Psychiatry and neuroscience — history. Handb Clin Neurol. 2012;106:1–7.
26. Santayana G. The life of reason [accessed 01.11.13]. Available in www.gutenberg.org/etext/15000
27. Schneider K. Clinical psychopathology. London, UK: Grune & Stratten; 1959.
28. Mayer-Gross W, Slater E, Roth M. Clinical psychiatry. London, UK: Cassell and Co.; 1954.
29. Bourdillon RE, Clarke CA, Ridges AP, Sheppard PM, Harper P, Leslie SA. ''Pink spot'' in the urine of schizophrenics. Nature. 1965;208:453–5.
30. Wing JK. Use and misuse of the PSE. Br J Psychiatry. 1983;143:111.
31. Wilson M. DSM-III and the transformation of American psychiatry: a history. Am J Psychiatry. 1993;150:399–410.
32. Freud S. Project for a scientific psychology. In: Stratchey J, Freud A, editors. The standard edition of the complete psychological works of Sigmund Freud, vol. 1. London, UK: Hogarth Press; 1955-1974. p. 283–397.
33. Wortis J. Freud the novelist. Biol Psychiatry. 1992;32:1063–4.
34. Popper K. Conjectures and refutations. New York, NY: Harper Torchbooks; 1963.
35. Peters UH. The emigration of German psychiatrists to Britain. In: Freeman H, Berrios GE, editors. 150 years of British psychiatry, volume II. The aftermath. London, UK: Athlone; 1996. p. 565–80.
36. Decker HS. How Kraepelinian was Kraepelin? How Kraepelinian are the neo-Kraepelinians? – from Emil Kraepelin to DSM-III. Hist Psychiatry. 2007;18:337–60.
37. Kendler KS, Muñoz RA, Murphy G. The development of the Feighner criteria: a historical perspective. Am J Psychiatry. 2010;167:134–42.
38. Kendell RE, Cooper JE, Gourlay AJ, Copeland JR, Sharpe L, Gurland BJ. Diagnostic criteria of American and British psychiatrists. Arch Gen Psychiatry. 1971;25:123–30.
39. Harding CM, Brooks GW, Ashikaga T, Strauss JS, Breier A. The Vermont longitudinal study of persons with severe mental illness. II: long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. Am J Psychiatry. 1987;144:727–35.
40. Dean CE. The death of specificity in psychiatry: cheers or tears? Perspect Biol Med. 2012;55:443–60.
41. Andreasen NC. DSM and the death of phenomenology in America: an example of unintended consequences. Schizophr Bull. 2007;33:108–12.
42. Schacter DL, Addis DR, Hassabis D, Martin VC, Spreng RN, Szpunar KK. The future of memory: remembering, imagining, and the brain. Neuron. 2012;76:677–94.
43. Insel TR, Scolnick EM. Cure therapeutics and strategic prevention: raising the bar for mental health research. Mol Psychiatry. 2006;11:11–7.
44. Insel T, Cuthbert B, Garvey M, Heinssen R, Pine DS, Quinn K, et al. Research domain criteria (RDoC): toward a new classification framework for research on mental disorders. Am J Psychiatry. 2010;167:748–51.
45. Fibiger HC. Psychiatry, the pharmaceutical industry, and the road to better therapeutics. Schizophr Bull. 2012;38: 649–50.
46. Guy W, Ban TA. The AMDP-system. Heidelberg, Germany: Springer; 1982.
47. Ey H, Bernard P, Brisset C. Manuel de Psychiatrie. Paris, France: Masson; 1960.
48. Pichot PJ. DSM-III and its reception: a European view. Am J Psychiatry. 1997;154 Suppl. (6):47–54.
49. Healy D. Pierre Pichot. In: The psychopharmacologists: interviews by David Healy. London, UK: Altman; 1996. p. 1–27.
50. Bobon D, Ansseau M. The AMDP-system in clinical psychopharmacology. Pharmacopsychiatry. 1986;19:55–7.
51. Bobon D, Woggon B. The AMDP-system in clinical psychopharmacology. Br J Psychiatry. 1986;148:467–8.
52. Bobon D, Baumann U, Angst J, Helmchen H, Hippius H. AMDP-system in pharmacopsychiatry. Mod Probl Pharmacopsychiatry. 1983;20:1–234.
53. Läge D, Egli S, Riedel M, Möller HJ. Exploring the structure of psychopathological symptoms: a re-analysis of AMDP data by robust nonmetric multidimensional scaling. Eur Arch Psychiatry Clin Neurosci. 2012;262:227–38.
54. Fuentenebro de Diego F, Olmo F, Eckart WV, Berrios GE. Heidelberg and Cambridge: history of two university departments (in Spanish). Rev Asoc Esp Neuropsiq. 2000;20:319–30.
55. Berrios GE. Historical development of ideas about psychiatric aetiology. In: Gelder MG, Lopez-Ibor JJ, Andreasen NC, editors. New Oxford textbook of psychiatry, vol. 1. Oxford, UK: Oxford University Press; 2000. p. 147–53.
56. Marková IS, Berrios GE. Epistemology of mental symptoms. Psychopathology. 2009;42:343–9.
57. Marková IS, Berrios GE. Epistemology of psychiatry. Psychopathology. 2012;45:220–7.
58. Berríos GE. Psychiatry and its objects. Rev Psiquiatr Salud Ment. 2011;4:179–82.
59. Berrios GE, Markova IS. Symptoms – historical perspective and effect on diagnosis. In: Blumenfield M, Strain JJ, editors.

Psychosomatic medicine. Philadelphia, PA: Lippincott Williams & Wilkins; 2006. p. 27–38.
60. Berrios GE. Historiography of mental symptoms and diseases. Hist Psychiatry. 1994;5:175–90.
61. Gardenfors P. Conceptual spaces. The geometry of thought. Cambridge, MA: MIT Press; 2000.
62. Nordgaard J, Sass LA, Parnas J. The psychiatric interview: validity, structure, and subjectivity. Eur Arch Psychiatry Clin Neurosci. 2013;263:353–64.
63. Stanghellini G, Bolton D, Fulford WK. Person-centered psychopathology of schizophrenia: building on Karl Jaspers' understanding of patient's attitude toward his illness. Schizophr Bull. 2013;39:287–94.
64. Stanghellini G, Langer AI, Ambrosini A, Cangas AJ. Quality of hallucinatory experiences: differences between a clinical and a non-clinical sample. World Psychiatry. 2012;11:110–3.
65. Van Os J. Solutions for patients depend on whether we can bridge the divide between social and natural science research approaches in the area of mental health. Rev Psiquiatr Salud Ment. 2012;5:135–8.