Research Article ISSN 2641-4317

International Journal of Psychiatry Research

Psychiatry, Psychotherapy and Psychology – Links and Boundaries

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Received: 11 Aug 2025; **Accepted:** 23 Sep 2025; **Published:** 03 Oct 2025

Citation: Mikhail M Reshetnikov. Psychiatry, Psychotherapy and Psychology – Links and Boundaries. Int J Psychiatr Res. 2025; 8(5); 1-5.

ABSTRACT

The article critically examines the history of the formation and development of theoretical concepts in psychiatry. The author analyzes their influence on modern approaches to the treatment of mental disorders, and summarizes the relationships and interdependencies in the formation of modern theoretical concepts in psychiatry, psychotherapy, and psychology.

Keywords
Methodology of psychiatry and psychology, Psychotherapy, The theoretical foundations of modern psychopharmacology.

In recent years, psychology has begun to actively share responsibility with psychiatry in the field of mental disorders. This represents another step, not so much toward expansion as toward the humanisation of care for preclinical mental disorders. The era of humanisation has a long history, but it is usually dated back to 1797, when in France shackles were first removed from psychiatric patients. Before that, these patients were kept in cages and special visits of such "menageries" were arranged for the general public; they were locked in the holds of ships later sent to the will of the gods and the waves, branded with hot irons, and burned at the stake. Madness was believed to be either a form of demonic possession or a punishment for sin [1]. The merit of abolishing shackles is usually attributed to the humanist physician Philippe Pinel (1745–1826), who was already a recognised authority at the time. However, it was actually J.-B. Pussin who first introduced this practice, and whom Pinel later invited to join his clinic.

F. Pinel became particularly well known for his classification of mental disorders, published in 1798, which was among the first and most widely recognised at the time. In this classification, Pinel adopted a psychological approach to psychopathology and reduced its clinical manifestations to four main forms: melancholia, mania, dementia, and idiocy. Notably, he characterised mania (used synonymously with insanity) not as a loss of reason, but as a development of internal contradictions within it. He also suggested that these contradictions could be resolved by appealing to the rational part of the psyche—just as a physician relies on the body's inherent vitality in treatment. However, Pinel's gifted student, Jean-Étienne Dominique Esquirol (1772–1840), gradually moved away from these views. He began to favour the idea that the root of all psychopathology lay in brain disease and that it should be treated with medicinal interventions. This marked the beginning of the medicalization (2) of psychiatry.

The next revolutionary step in the development of the modern model of psychiatry was the creation of the mental disorders classification (close enough to the modern one) by Emil Kraepelin (1856-1926) and the appearance in 1901 of his book 'Introduction to Psychiatric Clinic' [2]. E. Kraepelin's classification was subsequently refined and modified many times, but its essence did not change in any significant way.

As a student of one of the founders of modern psychology Wilhelm Wundt (1832-1920), Emil Kraepelin first became interested in experimental psychology and in a surprisingly talented and, better to say, artistic manner described psychological portraits of his patients, as well as mental and behavioural phenomena observed in certain mental disorders, thus laying the foundation of *descriptive psychiatry*.

It is important to recognise that Kraepelin's classification was purely psychological. As Karl Jaspers noted, it contained an element of artistry—much like the descriptions of literary characters [3].

But just at this time the causative agents of cholera (1854), malaria (1880) and tuberculosis (1882) were discovered. Under the

influence of these discoveries in microbiology E. Kraepelin makes a sharp 'u-turn'. He moves away from the psychological approach to psychopathology and transfers the so-called 'linear principle' of somatic medicine to psychopathology.

Based on these new ideas, E. Kraepelin (following Esquirol - without any proof!) postulates that all mental disorders are certain, like all other diseases, be caused by viruses, bacteria and toxins, though they cannot yet be found because of the imperfection of technology [1]. Due to the authority of E. Kraepelin, this (initially false) idea is easily accepted by almost the entire psychiatric community.

Thus, an unjustified and, I would say, tragic 'turn' for psychiatry takes place. *The psychological approach to psychopathology is suddenly transformed into a medical one, and psychological classification is somehow inconceivably elevated to the rank of biological classification*. And since this is not psychology, but viruses and bacteria, consequently, the brain allegedly affected by these viruses must be treated. From then on, the psyche and brain tissue are fully identified.

Let us reiterate: the etiological concept of psychopathology without any real (scientific and experimental) justification became biological, while the classification remained psychological. But now, those who fell under the criteria of this (originally psychological) classification, be subjected to any physical and biological methods of treatment, including electroshock, insulin shock, and the testing of various chemical substances to study their effects on brain tissue.

Surprisingly, this approach remained the main one until the 1980s. Viruses and bacteria were sought along with pharmaceutical agents to eliminate them. Viruses and bacteria were never found, but in 1957 chlorpromazine was discovered, which supposedly controlled (suppressed) psychopathological symptomatology by affecting brain tissue [4]. This marked a new era in the therapy of psychiatric disorders and, in fact, was supposedly a confirmation that the medical approach is the only correct one: there are brain diseases that produce psychopathological symptoms and there are medical drugs to treat them.

However, a few decades later, one of the developers of chlorpromazine, Henri Lobarit (1914-1995), analysing this new era, admitted that they had invented merely a 'chemical straitjacket' [1]. *Chlorpromazine and its subsequent modifications did not eliminate psychopathology, they only suppressed the patients' psyche*.

We must admit that here we are faced with a kind of systematic error: scientists and physicians, from Hippocrates and up to the present day, for two millennia have been writing and talking about the study and therapy of the psyche, while actually studying and treating the brain, creating pseudo-psychological and pseudo-physiological terminology.

Now let me remind of another fatal mistake. The next turning point in the history of psychiatry was the discovery of serotonin in 1935. It was first found in the intestine, where it is involved in the regulation of smooth muscle tone. Then it was found in the blood, and later in brain tissue and in the synaptic cleft. Mistakenly it was first called a hormone, and then (nobody knows who started it) labelled as a 'happy hormone'. But serotonin is not a hormone. It is just one of the neurotransmitters, like norepinephrine or dopamine, which is involved in the transmission of nerve impulses in any state of the body: in happiness and in grief.

But the name 'happy hormone', which stuck to it, played a surprising (if not sacramental!) role in the history of psychiatry. Our outstanding compatriot Prof. I.P. Lapin, basing on this metaphorical definition (which appealed to happiness), in 1969 very cautiously formulated the idea that, perhaps ('as a possible determination'!), serotonin is a 'thymoleptic' - that is, a substance that improves mood, and thus it can cause an antidepressant effect [5].

This idea was immediately taken up by our Western colleagues; the hypothesis was theoretically and experimentally substantiated in the shortest possible time, and mass production of a new class of drugs with an intriguing name - 'selective serotonin reuptake inhibitors in the synaptic cleft' (SSRIs) - started. On this occasion, the same Professor I.P. Lapin, who was very sceptical about the theoretical and practical implementation of the hypothesis he himself had proclaimed, once said to me with a high degree of sarcasm: 'For a long time they have been searching for the soul and finally found it in the synaptic cleft'!

This psychopharmacological boom continues to the present day. Hundreds of drugs in this class have been synthesised, despite substantial studies that cast reasonable doubt on the serotonin hypothesis of depression and offer serious criticism of it [6-8].

Patients with mental disorders are treated with pills, or rather, their brains are treated with a focus on serotonin reuptake in the synaptic cleft, which is supposedly lacking there. There is a certain element of sacrilege here. A person has lost a beloved child, wife or husband, brother or friend, job or social status and is experiencing depression. He or she is naturally prescribed antidepressants (SSRIs), usually for several months, sometimes even years or for life. So, the main thing is not the patient's grief and experiences. It is all about serotonin deficiency.

When a person has an iron or vitamin D deficiency in their tests, they are prescribed the appropriate medication. I have had to ask very simple questions many times. Can you name me one psychiatric clinic that does serotonin testing? None does. And SSRIs are advertised at all conferences and prescribed everywhere and for any reason, including general practitioners' unqualified approaches (without knowledge of the basics of psychiatry and psychology).

Let us mention one more factor which is also quite important:

despite the appearance of the most modern neuroleptics (antipsychotics) and large tranquillisers, the recovery of patients from their use has not yet aroused much enthusiasm. Except that the new drugs allegedly have fewer side effects - mainly in the form of emotional flatulence and intellectual decline, effects on the liver, kidneys, sexual function and fertility.

It should be noted that not all psychiatrists accepted—or continue to accept—E. Kraepelin's still prevailing hypothesis. In his 1926 book *Introduction to Pathological Reflexology* [9], Prof. V.M. Bekhterev argued that, since psychiatry is a science of the spirit, its subordination to natural-scientific medicine is highly questionable. He went so far as to describe the very notion of mental illness as absurd (3).

Z. Freud was more nuanced in his conclusions. After an unsuccessful attempt to write a *Physiological Psychology*, he arrived at the view that the psyche should be studied as such—as if only the psychical were before us [10,11]. In essence, this marked an effort to return psychiatry to a psychological approach, one that focused on the experiences and suffering of the individual, rather than on a hypothetical lesion of brain tissue.

At the beginning of the 20th century, there was already considerable interest in psychoanalysis. More than 70% of all publications in Russia's leading scientific journals were devoted to this theory and its clinical practice. A second wave of interest emerged in the 1990s, immediately following the lifting of the ban on all things related to psychoanalysis. How can this phenomenon be explained? In this presentation, we will set aside the anthropological and cultural dimensions of Z. Freud's theory—which have their own intrinsic value—and focus solely on the factors directly related to psychiatry and psychotherapy. Why did this happen?

First and foremost, this can be attributed to the dissatisfaction within parts of the psychiatric community with E. Kraepelin's descriptive psychiatry and medical model. This model essentially adopted the principles of somatic medicine, in which a specific set of symptoms points to a particular organ and diagnosis. In psychiatry, the brain was identified as the corresponding organ. However, the psyche is by no means an organ—it is an ideal, immaterial entity [12,13].

Therefore, with the exception of gross organic pathology, i.e. with damage to brain tissue as a result of inflammation, trauma, tumours or haemorrhage, there is no common aetiology and no common pathogenesis in psychiatric patients. And more than 70% of all psychopathology develops as a result of purely psychological factors: mental traumas and internal experiences. This is always a deeply individual psychogenesis, which depends on the patient's nationality, language and culture in which he or she was formed, individual sensitivity and personality structure (down to favourite childhood fairy tales).

One important point must be emphasised: unlike in somatic pathology, in psychiatry and psychotherapy a symptom does not indicate the cause of a mental disorder. The same symptoms may result from entirely different forms of psychological trauma, just as identical traumas and experiences may give rise to very different symptoms. For this reason, the ICD-10, while including numerous sections devoted to diseases of specific organs, does not list any "mental illnesses"—only *mental disorders*. And yet (surprisingly) even prominent psychiatrists continue to speak of "mental illnesses," which is just illiterate. This, in brief, is the point that should have been introduced as 'firstly.'

Secondly, even despite the undeniable successes of psychopharmacology, truly effective therapy both according to rigidly standardised protocols and the method of selection of medication —without noticeable impairments to patients' personalities—has not been consistently achieved. Why? Because in psychiatry we address our therapy not to the patient's body and brain, but to their personality. And personalities differ immensely. Let us repeat once more: even when symptoms appear identical, their psychogenesis is always deeply individual[4]. When some of our colleagues realised this fact, they turned to Freud's *explanatory therapy and explanatory psychiatry*.

There have been more than enough critics of the traditional psychiatric approach in recent decades: the most active part of such critics has been called 'anti-psychiatry', whose aggressive position is not close to me. I am sure that the Kraepelin's approach will continue to prevail for a long time to come: the older generation of our colleagues was taught this way. And it is too late to retrain.

Let us turn to the present. We must admit that we are living in the era of triumph of psychopharmacology. Even though it would take half a page to list all the side effects of even light drugs, neuroleptics have even more. But it is tranquillisers and neuroleptics that remain the mainstay of treatment. I have no negativism towards psychopharmacology, but I am against its unjustified prescription, not time-limited and isolated use, i.e. without combining it with serious and systematic psychotherapy.

We have already overcome the period when many psychiatrists categorically rejected psychoanalysis. It is true that at some stage, in order to distance itself from psychoanalysis, the name of the method was modified and replaced with a more neutral one, labelled 'psychodynamic psychiatry and psychotherapy'. But the heart of all these new methods - CBT developed by psychoanalyst Aaron Beck, Gestalt therapy developed by psychoanalyst Fritz Perls, and many others - is made by classical psychoanalysis. And all psychotherapists speak the language created by Z. Freud. But, as it turns out, not everyone understands what psychodynamics is?

Let me remind you that the concept of "*psychodynamics"* was first introduced in 1874 by one of Z. Freud's teachers, Ernst von Brücke. Drawing on the physical principles of thermodynamics, he proposed that all living organisms are energy systems governed by the law of energy conservation. By analogy, Freud formulated the idea of "*a law of conservation of psychic contents".* Importantly, no modern psychotropic drug is capable of altering these internal

contents—because they reside not in the brain, but in the psyche. Psychotropic medication may influence brain function and can, of course, "*dampen"* or even "*suppress"* these contents entirely (in the latter case together with previously mentioned side effects).

Let me repeat that, as a result of the developments by talented students and followers of Z. Freud, the so-called 'classical' psychiatry of E. Kraepelin was replaced by several modifications of psychoanalysis, united by the name 'psychodynamic psychiatry and psychotherapy'. In fact, we now have two different psychiatries and psychotherapies - the old one, based on Kraepelin's erroneous hypothesis, and the new one, based on Freud's psychodynamic approach.

At the same time, the number of psychiatrists adhering to the traditional Kraepelinian approach is still much larger, while those who are beginning to gravitate towards the psychodynamic approach are often accused of apostasy from classical psychiatry and its vulgar psychologisation. Although it is the later Kraepelin approach that is vulgar.

Freud's system is often referred to as *explanatory*, but to this definition we should also add the term *understanding*. When we rely solely on psychopharmacology and merely wait for its effects, we reduce psychiatry and psychotherapy to something not understanding and impersonal—what might, in more blunt terms, be called *veterinary psychiatry*.

Let us now turn to psychology, which over the last century was developing in the fairway of physiology and psychiatry, gradually losing its own face. The beginning of this was laid back in the pre-revolutionary period by our undoubtedly outstanding compatriot Prof. I.M. Sechenov, who introduced the concept of 'brain reflexes' in his essay with a similar title [5]. Then, inspired by the enthusiastic acceptance of this work, I.M. Sechenov went on to write another work under the pretentious title 'Who Should Develop Psychology and how?' and he himself answers this question: of course, physiologists. This idea inspired another of our distinguished compatriots Prof. I.P. Pavlov to conduct his experiments to develop the conditioned reflexes theory, and then to formulate the doctrine of higher nervous activity.

It should be noted that the term 'doctrine' does not have any scientific status. In this doctrine, the results obtained in experiments on gastric secretion in dogs were quite freely extended to all higher mental functions. Moreover, at the World Congress of Physiologists in Rome, I.P. Pavlov proposed to fully abandon the use of the term 'mental' and replace it with the term 'higher nervous activity' [14]. To the honour of this outstanding scientist, at the end of his life I.P. Pavlov refused this thesis and wrote: "I would like to prevent misunderstanding in relation to me. I do not deny psychology as cognition of the man's inner world" [14].

One final point. It is entirely understandable that future medical doctors begin their training with anatomy, physiology, and neurophysiology, followed by general and specialised pathology. This progression is essential for developing medical thinking, the essence of which is as follows: identify symptoms, confirm them through diagnostic tests, establish a diagnosis, consult clinical guidelines or reference materials if necessary, prescribe etiologically and pathogenetically grounded drug treatment, and monitor the patient's response. This is an entirely appropriate and effective approach—but only within the domain of somatic medicine and the treatment of bodily diseases. Toward the end of their training, students are introduced to the notion that a person possesses one additional, so-called "organ"—the psyche. However, by this point, a fixed way of thinking and acting has already been instilled. Yet the psyche is not an organ. As noted earlier, it is an *ideal* entity, a position I developed in the *Non-material Theory of the Psyche*, which has been published multiple times in Russia and abroad, recognised as a discovery, and served as the basis for nomination by the Nobel Committee for the Prize in Physiology or Medicine [12,13,15-17]. It is extremely difficult to persuade physicians that the mechanisms of mental activity are qualitatively distinct from the regulation of somatic functions. They have been trained otherwise, and most psychiatrists continue to operate within the framework of the medical model: they prescribe a drug and wait.

Strangely enough, the training of psychologists often follows a similar sequence. They are first required to study anatomy and physiology, followed by courses in neurology and central nervous system physiology. One might reasonably ask: why, and for what purpose? I would try to explain: the purpose is to form a medicalised approach to the psyche—one that continues to dominate over academic psychology—and to convince the immature minds of future psychologists of the validity of the reflex-based (and extremely reductive) theory of the psyche, originally derived from studies on gastric secretion in dogs. We should seriously reconsider of qualitative revision of the curricula used to train both psychiatrists and psychologists.

I cannot refrain from criticising many of my fellow psychoanalysts who narcissistically consider psychoanalysis to be some special branch of science and practice. Psychoanalysis is certainly a part of psychological science, and it is gradually returning to the curricula of psychology departments in all universities, although so far in a rather neutered, sometimes optional or even extra-curricular form. But this stage will be overcome in the coming decades. There is a powerful intellectual demand from the side of the young generation of colleagues for qualitatively different psychological training, and it will be satisfied, no matter how much they try to oppose it.

Notes

1. Pinel F. Philosophical Nosography, or Method of Analysis applied to Medicine. 1798. In French.
2. Medicalisation refers to the extension (often unjustified) of the boundaries of medicine's competence. That is, when ordinary human situations not related to any organ pathology are considered as medical problems and become the object of treatment and prevention.
3. V.M. Bekhterev is certainly right, since in order to claim the

status of a disease, it is required to identify and investigate a specific structural and functional damage in the organism, to establish precisely its aetiology, pathogenesis, clinical manifestations, pathological anatomy and histology. None of this exists with regard to mental disorders. There are only certain psychological and behavioural (external) phenomena. The tissues and structure of the brain in a psychiatric patient are no different from the brain of a healthy individual.

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