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Categorizing Priorities in Mental Illness Treatments

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Abstract

The inappropriate naming and meaning of psychiatric diagnoses and treatments, as well as the lack of valid diagnostic criteria for mental illnesses, has led to significant ambiguity regarding the priorities of proposed treatment. Each patient is faced with a multitude of therapeutic options, while each mental health professional applies the treatment he knows as the best therapeutic option. The therapeutic options in the field of mental health come from a huge variety of known and unknown theoretical fields and are applied by a huge or even unknown number of so-called or self-proclaimed mental health specialists. The psychiatrist, having lost the privilege or obligation to follow the patient's progress, has been reduced to a degraded role, often far from the obligations and capabilities of medicine. We support the need to prioritize treatments for mental illnesses, in accordance with the valid discoveries of neuroscience. Aiming at integrated medico-social care, psychiatry must return to its home, that is, to the field of medicine, while leaving non-medical interventions to non-medical professionals. We believe that the handling of psychiatric cases based on this path will lead patients to clear, effective and safe treatment, protecting them from unnecessary and sometimes harmful trials.

Keywords

Mental Illness, Treatments, Psychiatrist, Therapy, Neuroscience.

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Psychiatry in the real world – Need for radical changes

Depressives are not the only ones with 'depression', nor are psychotics the only ones with 'psychosis'. Also, antidepressants are not prescribed only for depression and antipsychotics are not prescribed only for psychosis. It seems, however, that a correct diagnosis is not necessary for patients to receive the best possible treatment. The biological basis of mental disorders is poorly understood, diagnostic criteria tend to change, and diagnostic entities appear or disappear with relative ease in diagnostic manuals. To date, both accurate diagnosis and effective treatment of mental disorders remain unfulfilled goals. As a result of diagnostic and therapeutic confusion, psychiatrists work as balancers between patient needs, treatment guidelines, evidence-based research, meta-analyses, and everyday clinical demands.

While the reliability of psychiatric diagnoses has improved significantly with the use of explicit diagnostic criteria, their validity remains uncertain. Over time, the isolation of psychiatry from other medical specialties has diminished the value of diagnosis and treatment, reducing psychiatry to a specialty that provides non-specialized psychological support. According to Nancy Andreasen (2007), "The validity of psychiatric diagnosis has been sacrificed to achieve reliability. The DSM diagnoses have given researchers a common nomenclature, but rather the wrong one. Although the creation of standardized diagnoses that would facilitate research was an important goal, the DSM diagnoses are not useful for research because of their lack of validity." It is now clear that we must change our understanding of the names and concepts related to mental illnesses. The processes of renaming, redefining and reconceptualization in this 'Tower of Babel' of mental health are long and challenging, although there is no serious difficulty, apart from our own internal resistance to change (Giotakos, 2023, 2024).

How did the story develop to this point? The term 'neurology' comes from the English physician Thomas Willis, after his study of the anatomy of the brain in the 1660s. Then, in 1808, Johann Christian Reil, a German physician and philosopher, gave the term 'psychiatry'. However, the two disciplines had common origins. The seminal work Mental Pathology and Therapeutics by Wilhelm Griesinger in 1845, still has a place in the 21st century. For Griesinger, mental illness was essentially a disease of the brain, a fact reflected in the title of the journal Archives of Psychiatry and Neurology that he founded in 1867. Over the years, researchers have emphasized other etiological factors, such as genetic and environmental, resulting in the separation of psychiatry from medicine, proposed by Silas Weir Mitchell as early as 1894. Thus, the 'handling of madness' passed from the medical profession to the professional group of psychiatrists of that time. The split became even more pronounced in the United States between 1930 and 1980, when psychoanalysis and psychotherapy largely took over psychiatry. The advent of diagnostic imaging and neuroscience has brought a high degree of clarity to the field. Kandel even points out that if neuroimaging had been available in 1895, when Freud wrote the Project for a Scientific Psychology, it would likely have steered psychoanalysis in a very different direction.

According to Thibaut (2018), "This isolation has harmed psychiatry and caused significant problems in raising funding. It has diminished the value of careful diagnosis, thereby reducing psychiatry to a non-specialized psychological support, which contributes to an increase in stigma." Today, psychiatry is limited to human subjectivity and existence, interpreting labyrinthine meanings and creating a "narrative about narratives." Neurology, on the other hand, is based on fundamental neuroanatomical and neurophysiological relationships. Reinforced by the Cartesian mindset, the separation of neurology and psychiatry has led to a separation of 'brain' from 'mind', 'physical' from 'mental', which are useful elements for both disciplines. However, overlap is also evident in the relevant medical journals of the disciplines. A study of papers published in Neurology and the American Journal of Psychiatry found that less than 5% of the papers in the American Journal of Psychiatry dealt with meningitis, epilepsy and headaches, and less than 5% of the papers in Neurology dealt with schizophrenia, panic and mania. However, there is significant overlap in other categories. The proportions for ADHD were 23% and 77%, for autism 30% and 70%, and for mental retardation 70% and 30%, in Neurology and the American Journal of Psychiatry, respectively (Fitzgerald, 2015). Note that some neurological disease is associated with 15% of acute and 70% of chronic psychiatric patients.

What is the current situation? Modern psychiatry has reduced the value of diagnosis, which has reduced the status of psychiatry to the provision of 'non-specific psychological support'. The limitation of neurology to the study of the nervous system and psychiatry to the social brain has caused significant side effects in the diagnosis and treatment of mental disorders. In the real world today, the diagnostic and therapeutic space of mental illnesses is teeming with invalid diagnoses and overwhelmed by innumerable and uncontrolled 'treatments', carried out by also innumerable and diverse 'therapists'. All of this constitutes a major scientific paradox: Psychiatry, the science that for many decades has served significantly in understanding the functioning of the brain and mind, has lost its intended object. It is unable to 'read' the diagnostic and therapeutic needs of the 'other', using exclusively a mechanism of an ego-centric perspective. At the same time, not using allocentric mechanisms, it is unable to 'read itself' and observe it as part of the medical community (Giotakos, 2023, 2024).

Being outside the medico-social framework of operation, psychiatry now presents significant difficulty in 'reading' the basic properties and needs of its own scientific field. Aiming at integrated medico-social care, psychiatry must return to its 'home', that is, to the field of medicine, while leaving non-medical interventions to non-medical professionals.

Treatments for mental illness – Need for prioritization

In recent years, there has been a growing recognition of the importance of holistic care in mental health treatment. Integrative approaches that combine psychotherapy, medication, lifestyle changes, and alternative therapies have gained popularity.

We consider that *Primary treatments* (or first-line therapies) are causal treatments. For example, treatments for immunologically mediated diseases target the source of the disease and pathology. It is useful to keep such a category of treatments open, regardless of whether there is currently no clear etiological definition of mental illnesses, and therefore, corresponding primary therapeutic approaches. With the absence of such an open category, research will show a decreasing interest in the generative cause of things.

Secondary treatments (or second-line therapies) are those that dominate today and aim at neuroregulation of the brain. They are treatments targeting the symptoms of mental illnesses. For example, the appropriate regulation of neurotransmitters has proven effective in a series of mental illnesses. They have been the dominant group of treatments since the 1960s when antipsychotics and antidepressants were gradually discovered,

Tertiary treatments (or third-line therapies) are treatments for treating the consequences caused by the symptoms, that is, the behaviors or thoughts that come from the depressive mood, hallucinations, etc. The main representative is the various psychotherapies that have been applied over time, driven by various theoretical directions.

The table below describes the categorization of mental illness treatments**.** First-line treatments are close to the primary cause of the disorder, containing the 'white box', that we expect to continually fill with the discoveries of neuroscience.

	Primary treatments	Secondary treatments	Tertiary treatments
Importance	First-line, First level	Second-line, Second level	Third-line, Third level
Causality	Direct relationship to the cause	Indirect relationship to the cause	Distant relationship to the cause
Timing	Close to the time of initial illness	Far from the time of initial illness	Far from the time of initial illness
Efficacy	High	High to Moderate	Moderate to Low
Type of treatment	(the 'white box')	Pharmacotherapy (antipsychotics, antidepressants, etc), ECT, rTMS,	Psychotherapies (CBT, IPT, Art therapy, Dance therapy, Yoga, etc), Nutraceuticals, Physical exercise.
Place of action	The whole body / organism	Mainly at the Brain	Mainly at the Mind
Way of action	Elimination of cause	Neurotransmission modification, Plasticity	Thought / behavior modification
Disease Progression	Significant improvement or complete recovery	Modification of the course of the disease	Harm reduction / functionality improvement
Results	Recovery, Total healing	Improvement, Treatment of individual symptoms	Improvement, Rehabilitation
Professional setting	Medical setting	Medical setting	Any mental health setting
Patient monitoring	Medical settings	Mainly monitoring in medical settings	Monitoring in both medical and non-medical/rehabilitation settings

Primary treatments

Psychosis as an autoimmune disorder

Is psychosis a systemic disease? Can we see its abnormalities outside the brain? Are inflammation and abnormal immune activity a risk factor, as in the case of diabetes?

The disruption of myelination and delays in information processing caused by dysmyelination can produce phenocopies of psychosis like schizophrenia. Reviewing the clinical and pathophysiological similarities between demyelinating or dysmyelinating diseases (such as Multiple Sclerosis) and psychosis, we can consider that the disconnection syndrome of psychosis represents the phenomenological and behavioral outcome of a multifaceted dysmyelinating disorder, based on a lifelong process of immunogenetic dysregulation. Recent research suggests that adaptive myelination can normalize neuronal electrical excitability, which in turn modifies myelin plasticity, resulting in altered neuronal activity and therefore behavior. It can therefore be hypothesized that interventions that maintain white matter integrity or repair localized, or periodic disruptions of white matter may improve information processing and therefore function in psychosis (Giotakos, 2019).

For Najjar et al (2018), the proposal for the diagnosis of "seronegative but probable autoimmune psychosis" (SPAP) leaves an open window of research and possible response to corresponding therapeutic treatments. This distinction is therapeutically important as autoimmune-related psychot-

ic symptomatology can frequently respond well to timely treatment with proper immune modulatory therapies. The authors suggested that seronegativity is likely attributed to autoantibodies that either have not yet been discovered or present exclusively in the CSF that is often not analyzed in this subgroup of individuals. SPAP might masquerade as antipsychotic drug-resistant primary psychotic disorder.

Psychiatric illnesses contain a significant autoimmune component. Several lines of evidence suggest a predisposition to a pro-inflammatory state in the brain in schizophrenia, and anti-inflammatory drugs could potentially counteract this predisposition. The study by Çakici et al (2019) sought the efficacy of agents with anti-inflammatory activity on schizophrenia symptoms, tested in randomized controlled trials (RCTs). They meta-analyzed 56 studies that provided information on the efficacy of the following components on symptom severity: aspirin, bexarotene, celecoxib, davunetide, dextromethorphan, estrogens, fatty acids, melatonin, minocycline, N-acetylcysteine (NAC), pioglitazone, piracetam, pregnenolone, statins, varenicline, and withania somnifera extract. Aspirin, estrogen, minocycline, and N-acetylcysteine (NAC) have been found to be effective. The authors observed greater beneficial effects on symptom severity during the first episode of psychosis or during the early phase of schizophrenia.

Systemic inflammation in the pathophysiology of mental disorders – Recent evidence

Liu et al (2025) investigated the association of systemic immune-inflammation index (SII) with depressive symptoms in individuals with and without cardiovascular disease (CVD), using cross-sectional data from NHANES (2005–2016). They found that the SII is independently associated with an increased risk of depressive symptoms, particularly in individuals without CVD. The authors suggested that the SII may serve as a valuable predictor of depressive symptoms in the general population, with potential implications for early screening and intervention strategies. Zhang et al (2025), using data from the National Health and Nutrition Examination Survey (NHANES) from 2007 to 2016, including 5,676 participants, found that an increase in the systemic immune-inflammation index was significantly associated with obesity in adolescents. Xiao et al (2023) explored the associations of the systemic immune-inflammation index (SII) with total cerebral small vessel disease (CSVD) burden and cognitive impairment. They found that elevated SII is associated with severe CSVD burden and cognitive impairment. The mediating role of severe CSVD burden suggests that higher SII may contribute to cognitive impairment through aggravating CSVD burden. Liu et al (2025) explored the potential relationship between the systemic immune-inflammation index - SII and Parkinson's disease - PD. The SII showed a positive correlation with the incidence of PD, particularly in females.

Disturbances of the immune system and immune responses after activation are a common finding in neuropsychiatric disorders. Psychotic and affective disorders such as major depressive disorder (MDD), schizophrenia (SCZ) and bipolar disorder (BD) also share high rates of comorbidity with inflammatory and metabolic disorders (Hughes and Ashwood, 2020). Chen et al (2024) investigated whether the combination of abnormal systemic immune-inflammation index (SII) levels and hyperglycemia increased the risk of cognitive function decline and reduced survival rate in the United States. The findings suggest that the impact of diabetes on cognitive function/survival rate is correlated with SII levels, indicating that their combination enhances predictive power. Evidence of elevated circulating inflammatory cytokines, of altered numbers and function of immune cells, and evidence of neuroinflammation including activation of microglia in the brain, have been found in patients with SCZ, BD and MDD. Often these findings correlate to psychological state at the time of measurement (Hughes and Ashwood, 2020).

Ninla-aesong et al (2024) compared the power of the novel inflammatory markers systemic immune inflammation index (SII) and the system inflammation response index (SIRI) versus the classical hematological indices neutrophil-to-lymphocyte ratio (NLR), monocyte-to-lymphocyte ratio (MLR), platelet-tolymphocyte ratio (PLR), and platelet counts in distinguishing between major depressive disorder (MDD) with and without suicide attempts and distinguishing the non-response to selective serotonin reuptake inhibitor (SSRI) treatment. The findings highlight the potential benefit of combining novel and classical hematological indices in predicting depression, suicide attempts and treatment response. Cui et al (2023) evaluated the clinical value of systemic immune-inflammation index (SII) based on peripheral blood neutrophil, lymphocyte, and platelet count in evaluating the subtype and severity of depression in patients with depressive disorder. They found SII may be a useful, repeatable, convenient, and affordable index to identify moderate/major depression in depressive disorder. The systemic immune-inflammation index (SII) serves as an indicator of inflammation and immune response. Pan-immune inflammation value (PIV) and SII have been investigated as new inflammatory markers. Ayhan et al (2025) investigated and compared the PIV and SII in different mood episodes in bipolar disorder (BD) and healthy controls (HC). Their findings highlight the role of the low-grade systemic inflammation in the pathophysiology of BD, particularly during the manic episode, and suggest that PIV could serve as an inflammation marker to distinguish the manic episode of BD from other phases.

The right intervention, at the right time

The issues of timing and neuroplasticity also suggest a series of considerations for therapeutic interventions. The most important principle that emerges from this developmental theme is: "The right intervention, at the right time". This means, however, that the intervention should ideally be done at an unsuspected time, that is, at the onset of autoimmune processes affecting neurons. Any immunological or anti-inflammatory agent should therefore be administered at a time when psychopathology is not yet evident or has perhaps given few signs. Finding or developing appropriate immunological biomarkers

would perhaps be the most appropriate attempt at early intervention in mental illnesses. Clinicians can consider the use of anti-inflammatory and antioxidant agents, to long-term gene expression modification therapies. Also, early intervention in known autoimmune diseases that are closely involved in the development of mental illnesses, such as thyroid diseases, is expected to yield the expected results.

As the famous champion Carl Lewis stated, "Life is about timing". "Timing is everything" also emphasizes the Swedish endocrinologist Ake Lernmark (2021) in his recent article on the diagnosis of type 1 diabetes, specifically stating: "Neither the precursor stage of autoimmune islet disease nor the clinical onset of type 1 diabetes tells us much about the etiology. On the contrary, the islet autoantibody that appears first and persists signals the diagnosis of autoimmune islet disease (AID). Multiple islet autoantibodies without (stage 1) or with impaired glucose tolerance (stage 2) or with symptoms (stage 3) determine the pathogenesis of clinical type 1 diabetes. The etiology concerns the timing of events that occur before the first islet autoantibody appears.

Secondary treatments

Psychopharmacological therapies

Treatment approaches to anxiety disorders include pharmacotherapy and psychotherapy. Pharmacological treatment focuses on benzodiazepines, buspirone, tricyclic antidepressants (TCAs), such as clomipramine, amitriptyline, selective serotonin reuptake inhibitors (SSRIs), such as paroxetine, sertraline, citalopram, escitalopram, fluvoxamine and fluoxetine, atypical antidepressants, such as mirtazapine and serotonin & norepinephrine reuptake inhibitors (SNRIs), such as venlafaxine and duloxetine. Treatment of Panic Disorder includes cognitive-behavioral therapy and pharmacotherapy. In simple treatment trials, the immediate response rate ranges from 50% to 60%. Therapies aimed at immediate response include TCAs, high-potency benzodiazepines such as alprazolam and clonazepam, and SSRIs.

Short-term psychotherapeutic interventions, such as cognitive and interpersonal therapy, appear to be as effective as pharmacological treatments for mild forms of depression. However, severe depression responds better to antidepressant pharmacotherapy. Although they are called "antidepressants," these substances show beneficial effects not only in cases of depression, but also in anxiety, panic attacks, phobias, obsessive-compulsive disorders, body image problems, and chronic pain.

Antidepressants are the cornerstone of effective treatment for major depression. At least 50% of patients respond to the first antidepressant they are prescribed, and 75% respond to one of three antidepressants of a different class that are selected. Inadequate dosage and limited duration of treatment are the most common causes of treatment failure. The required duration of complete antidepressant treatment is 6 to 8 weeks, but some patients need 10 to 12 weeks to achieve maximum effect. Every patient undergoing antidepressant treatment should be informed about the course of recovery. Once the patient has achieved complete remission, maintenance treatment is recommended for at least 6 months to reduce the likelihood of relapses. However, due to the nature of major depression to relapse, preventive (long-term) treatment is indicated, especially in patients with more than 2 previous depressive episodes. Also, full-dose maintenance treatment (i.e., the same dose required to overcome an acute episode) has been observed to be more effective in many cases against relapse than lower-dose treatments.

If the response is inadequate, switching to a different antidepressant (after a period of discontinuation, if possible) or augmenting the antidepressant with another agent such as a mood stabilizer, a thyroid hormone, or another antidepressant may be effective. Patients who do not respond should be re-evaluated for the original diagnosis or the presence of comorbidities that could complicate the outcome of treatment. Up to two-thirds of patients with major depression respond to a single drug therapy, at an adequate dose, for at least 6 weeks. Of the remainder, most will have at least a partial response.

The term "mood stabilizer" refers to a heterogeneous group of drugs that are effective in the treatment of bipolar disorder, a psychiatric illness characterized by recurrent episodes of mania and major depression. The list of stabilizers includes lithium, several antiepileptic drugs, and atypical antipsychotics. The main goals of treatment for bipolar disorder include clinical response, recovery of patient function, and remission and absence of relapses. Because polypharmacy is often used in patients with bipolar disorders, it is essential to individually optimize treatment combinations to achieve the most satisfactory overall outcome for each patient.

The guidelines for schizophrenia conclude that there is no clear evidence of superiority of SGAs over FGAs. For the 1st psychotic episode are recommended: quetiapine, olanzapine, risperidone, haloperidol, or clozapine. For the acute psychotic episodes or relapse are recommended: quetiapine, olanzapine, risperidone, haloperidol, clozapine, amisulpride, aripiprazole, ziprasidone, or paliperidone. For resistant schizophrenia is recommended clozapine. For maintenance therapy is recommended: SGA>FGA, olanzapine, risperidone, clozapine, or amisulpride. Overall, approximately two-thirds of patients who switch from one antipsychotic medication to another do so for reasons related to the effectiveness of the treatment. The remaining one-third of patients switch medications mainly due to intolerable side effects.

Non-pharmacological management

Despite the misguided criticism of recent decades, electroconvulsive therapy (ECT) remains an essential tool for the treatment of depression. Of the currently available physical treatments for depression, ECT is the most established and effective. It appears to have a similar, but faster and more marked effect than antidepressant drugs, as well as a convincing mechanism of action. ECT appears to progressively stimulate amine function, starting with dopamine, then norepinephrine, and finally

serotonin. These neurochemical changes and the subsequent alterations in second messengers and growth factors are likely to underlie the mechanism of action.

Light therapy consists of daily scheduled exposure to intense doses of white light, with the aim of regulating seasonal mood swings, improving sleep patterns and ensuring an overall sense of well-being.

Transcranial magnetic stimulation (rTMS) involves the stimulation of cortical neurons with magnetic induction, using a brief, high-intensity magnetic field. The electrical current is rapidly switched on and off to produce a magnetic field of varying duration, lasting 100 to 200 microseconds. During the treatment session, repetitive stimulation with frequencies ranging from 1 to 20 Hz is applied for approximately 30 minutes. The magnetic pulse passes through the skull almost painlessly, causing excitation and depolarization of neurons at a depth of approximately 2 cm below the surface of the brain. Its potential clinical uses are the treatment of drug-resistant patients, possibly instead of ECT. Due to the rapid onset of effect, it may also accelerate clinical response, in combination with antidepressants. Transcranial magnetic stimulation transmits a magnetic pulse through a hand-held coil that is applied to the head and causes neuronal depolarization by generating an electric current in desired areas of the cortex. This safe and noninvasive technique has been widely studied in patients with depression: Variables that influence study outcomes include location, frequency, duration, and number of sessions per day.

Vagus nerve stimulation (VNS) is indicated for the treatment of drug-resistant epilepsy and is being investigated in some countries for the treatment of drug-resistant depression. An electrical wire is surgically placed around the right vagus nerve in the neck and connected to a stimulator placed on the chest. In an open-label study, intermittent vagal stimulation produced a 40% response rate in treatment-resistant patients, but there are no controlled studies to confirm these preliminary results.

Tertiary treatments

Psychotherapeutic approaches

Tertiary treatments (or third-line therapies) are treatments for treating the consequences caused by the symptoms, that is, the behaviors or thoughts that come from the depressive mood, hallucinations, etc. In this area, psychotherapy is the oldest form of treatment in use, although it has been little validated for indications by clinical control studies. Almost all psychotherapeutic approaches, however, emphasize the real approach to 'here and now' problems and the high level of functioning of the individual. Although each of the psychotherapies, focusing mainly on anxiety or depression, emphasizes the importance of various aspects of the patient's phenomenology, e.g. cognitive, behavioral or interpersonal factors related to the onset or persistence of the disease state, there are many common or theoretical elements.

Psychotherapy for depression can be done by clinical psychologists, psychiatrists and experienced therapists from other specialties. The classic course of treatment, which consists of 12 to 20 sessions, over a period of 3 to 6 months. Many psychotherapists combine cognitive and behavioral therapy, and the result is referred to as cognitive behavioral therapy (CBT). It is noted that few therapists truly apply 'pure' psychotherapy models, and most prefer to use an eclectic and case-specific mix of interventions. Psychotherapies for depression have not been evaluated for the treatment of more severe depressive states, such as psychotic depression. Psychotherapy is not indicated for the treatment of bipolar depression, without the concomitant administration of appropriate pharmacotherapy. It should also be noted that some patients have categorically "non-pharmacological preferences" and feel more comfortable approaching their problems from a psychosocial perspective, while others have a strongly negative image of psychotherapy.

Cognitive therapists help patients recognize the connection between depressive feelings and habitual ways of thinking and begin to organize automatic negative thoughts into schemas, which can then guide the standardization of incidents related to schema awareness.

Interpersonal psychotherapy (IPT) uses more conventional 'talk therapy' strategies to identify the problems patients face in relation to the onset or persistence of depressive disorder.

The use of self-help books can also enhance traditional therapy. The use of bibliotherapy in a relapse prevention program has shown significant reductions in panic frequency, panic cognitions, anticipatory anxiety, and agoraphobic avoidance.

Yoga and mindfulness help with self-awareness, acceptance, and tolerance of emotional experiences, which are useful skills for addressing some aspects of depression, such as anxious hypervigilance and negative thinking. However, there are no well-controlled RCTs for these approaches.

Art therapy holds a strong place in alternative psychotherapy. Painting, music, dance, theater, and writing have always been vehicles for human expression. In recent decades, experts in these fields have expanded knowledge, established training programs, established certification systems for therapists, and have used these methods to treat emotional and psychiatric illnesses. Therapists using creative arts "draw on the emotional rather than the cognitive process" and this can more directly and directly engage patients.

Dance can be an externalization of feelings that cannot always be expressed verbally or logically. People from various disciplines have created complementary and alternative movement therapies, such as oriental yoga-like movements. The proposed benefit of each therapy may be through improving functional status, improving comfort and awareness of movement (mental-physical focus), achieving a specific form (Pilates-based methods), or alleviating emotional blocks (choreotherapy).

Non-Psychotherapeutic Approaches

Also, studies comparing therapeutic intervention that focuses on lifestyle, such as diet, fluid intake, physical exercise, use of

caffeine, nicotine and alcohol, with the care received by a general practitioner in people suffering from panic attacks with or without agoraphobia, have shown that these intervention methods are similarly effective, showing a similar reduction in anxiety at the end of treatment.

Aerobic exercise has been studied and found to have an antidepressant effect of sufficient magnitude, such as to justify its use as a common complementary approach to classical treatments. Physical exercise as a treatment method is quite economical, unlike other psychotherapy methods. However, few experts in the field, psychologists and psychiatrists, recommend it as a treatment. Exercise is beneficial as a complement to virtually all forms of antidepressant treatment. Most studies show significant improvements in depression scores regardless of the type of exercise program used.

The term 'nutraceuticals' is a broad term used to describe any product derived from food sources with additional health benefits beyond the basic nutritional values already found in them. They are also called Food for Special Medical Purposes (FSMPs) by the FDA. They can be considered non-specific biological therapies used to promote general well-being, control symptoms, and prevent adverse effects. Nutraceuticals are products derived from food sources that are claimed to provide additional health benefits beyond the basic nutritional values already found in foods.

Alpha phospholipids are the main structural components of all inner and outer membranes of neurons and contain both unsaturated fatty acids from the Omega-3 and Omega-6 series, as well as inositol. There is evidence that these fatty acids may have positive therapeutic effects in atherosclerotic heart disease and depression.

Deficiencies in B12 and folate are known to be associated with secondary depression and there is some evidence that folate may serve as an adjunctive therapy for patients with primary depression.

Finally, S-adenosylmethionine (SAMe) is a naturally occurring amino acid found in all cells. It is involved in methylation and as a dietary supplement may increase the availability of neurotransmitters such as the monoamines 5HT, DA and NE. Although SAMe has attracted the interest of complementary medicine specialists for more than a decade, it has only recently become a popular treatment for depression in the United States.

Conclusion

As specialists, we should take a more responsible approach to the management of psychiatric cases, providing timely and valid treatment. Considering the high degree of comorbidity, the coherence of services and the continuity of treatment are important. The infinite number of provided therapies, by an indeterminate number of therapists, of diverse and often unknown origin, tends to constitute a public health problem.

The psychiatrist has the privilege and the obligation to follow the patient's progress. We support the need to prioritize treatments for mental illnesses, in accordance with the valid discoveries of neuroscience. We believe that the handling of psychiatric cases based on this path will lead patients to clear, effective and safe treatment, protecting them from unnecessary and sometimes harmful treatments.

In addition to the improvement of diagnostic conditions that must be made, the enormous therapeutic knowledge must be organized, with the aim of causally addressing mental illnesses. Otherwise, both patients and their loved ones will be swimming in a treatment ocean of unknown destinations and many risks of deception.

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