Systemic Alternative in Psychiatry

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The alternative systemic approach to mental health issues and of a more humane mental health care system suggests focusing on understanding mental distress as stemming from problems in living, using medications as agents facilitating psychotherapy, or as a last resort and short-term help, according to the principles of harm reduction. It argues that understanding drugs as psychoactive substances and studying the subjective effects they produce could lead to better utilization of medications and improvements in terms of conceptualizing and assessing treatment effects. Qualitative research could be particularly useful in that regard. It also advocates a radical departure from current diagnostic systems and proposes a synthesis of already existing alternatives to be used for both research and clinical purposes.

open dialogue approach soteria power threat meaning framework drug-centered approach systemic alternative

1. Alternative Theory and Research

1.1. Etiology—Problems in Living

The first thing that needs addressing is the question of the etiology of mental disorders (if we, for a moment, agree to call specific configurations of manifestations of suffering “disorders”), as this understanding projects onto all other domains. There is now a wealth of research highlighting the role of social, economic and other factors, such as adverse life events, on the probability of being diagnosed with a mental health problem, even psychosis. They have been shown to be causally associated [1]. Some of them have much higher relevance than any known biological or genetic correlates [2]. To mention just a few examples, financial and social status [3][4], belonging to an ethnic minority [5], or being a victim of child abuse and other adversities [6] have been shown to influence the frequency of particular diagnoses and prescription of psychiatric drugs. A longitudinal study revealed that financial problems of British students precede depression and alcohol abuse [7], and difficulty paying back debts precede common mental disorders in the adult population in the Netherlands [8], pointing to economic factors as causal. This clearly shows that cultural and social determinants must not be ignored or even that they should be given priority, and psychiatric disorders could be seen as consequences of frustrated human needs [9]. As Longden [10] puts it: “an important question in psychiatry shouldn’t be what’s wrong with you but rather what’s happened to you.”

Still, the prevailing narrative is one of the biological mechanisms or abnormalities that should be corrected with drugs (as biological illnesses need biological treatments), and this narrative, among many other issues, shapes the way mental health care systems and mental health awareness campaigns are designed and financed. One

particularly worrying consequence of this, in the context of individual suffering, is the fact that some people with psychiatric diagnoses may even lose the ability to understand their mental states as something that is directly connected to the lives they live, e.g., the suffering of somebody who was abandoned in a romantic relationship could be explained by themselves (and mental health professionals) as a “relapse of depression”—one caused by “chemical imbalances”—without realizing at all and disregarding the impact of the psychological or social situation [11]. The use of medication can also have a detrimental effect on identity [12].

Understanding psychiatric disorders as primarily consequences of various life circumstances and their meanings for individuals would require a radical reshaping of mental health care, but this could lead to improvements in terms of outcomes (to use medical language) or quality of life and life satisfaction in general (to use a more neutral one) for those suffering and societies as a whole. Improvements that biological psychiatry has largely failed to deliver, as current treatment outcomes for depression and schizophrenia are probably worse, especially long-term, than in the first half of the 20th century, before the era of pharmacotherapy [13][14]. It could also be argued that if the mental distress people experience is seen as problems in living instead of specific disorders, speaking of etiology or pathomechanisms becomes self-contradictory. However, individual psychological factors definitely play a role, which may explain why some people are affected more by adverse circumstances, and so it is not necessary to posit inherited (or inherent) biological differences to account for this. Even if they exist, they are not necessarily the primary cause, as they may well be a consequence of psychological and social situations—after all, brains are shaped by and adapt to the environment. Appropriate actions would have to follow this kind of understanding of mental distress, and perhaps the most important thing that should be addressed and changed is the way drugs are used and their action conceptualized in mainstream psychiatry.

1.2. Understanding and Using Medications

The prevailing narrative concerning psychiatric drugs is that they are “magic bullets” targeting disorder-specific biological abnormalities. This discourse is so strong that a refusal to use psychiatric drugs is often equaled to a lack of insight, even when a patient seems quite rational in all other aspects, while consent for drug use is equaled with better insight, even when patients express otherwise bizarre claims about themselves and their condition [15]. The dominating approach is what Moncrieff [16] calls a Disease-Centered Model of Drug Action, while advocating instead for a Drug-Centered Model of Action. In the latter, psychiatric medications are understood not as agents that correct some kind of pathology or cures for disorders but rather as something that actually creates abnormal bodily states. Their potential usefulness in alleviating suffering comes precisely from this quality, which allows them to suppress, blunt, alter or enhance subjective experiences. This means that psychiatric medications could be understood essentially as psychoactive agents, not that different from alcohol or illicit drugs and with similar potentially harmful consequences regarding both biological and psychological levels. If we look at psychiatric disorders as primarily meaningful reactions to life events, our goal is then not to cure a disease but to help in overcoming life difficulties. Psychoactive effects of drugs may be helpful in that.

Conceptualizing medications this way has many consequences for the way they should be used in clinical practice and how their action should be studied. Research could rely more on qualitative methods in order to understand

what is really the subjective experience of taking psychiatric drugs (and what is really the experience labeled as a disorder requiring drugs). Currently used instruments focus on predefined outcome measures related to the symptoms that diagnostic categories consist of, and these may not really correspond to the actual psychoactive effects the drugs exert. Moreover, a predefined set of criteria/symptoms streamlines both the researcher and the patient into a presupposed mode of understanding and forces distortion and deformation of actual phenomena in order to fit them into ready-made check-boxes. If there is no box for something, it gets overlooked, as if it was not there.

Thinking of drugs as acting on symptoms can be misleading also because of other factors, e.g., in the case of antihistamine drugs, the same effect—sedation—can be regarded as a side-effect (in the case of treatment of allergies) or as a desired therapeutic effect (in the case of reducing the expression of symptoms of psychosis). For drugs used in psychiatry, the important question, in this case, should be how much the “symptom reduction” in fact depends on the psychoactive effect of sedation, how does the sedation make the patient feel and if the effect is perceived as beneficial and desirable or if the opposite is the case: as harmful and unwanted, especially with regards to social and interpersonal functioning. The subjective psychoactive effect of a drug should be at the center of our attention. The same applies to “energetic,” “numbing-down” or other properties of antidepressants and different classes of psychiatric drugs. In general, the focus should move away from research about symptoms towards questions about how the drugs actually make people feel.

These differences in perspectives are well pictured in the following quotes of psychiatric survivors:

“I did not manifest any of my internal distress, because I did not show any evidence of internal life at all. This is not the same as the absence of madness. Yet it was the gauge by which the success of treatment was measured.”[17]

“I found the medication made me feel empty and soulless, I could not think past considering my basic needs. The psychiatric drugs made me physically weaker and affected my hormones so I became during this time impotent. I was concerned about this. However, to the outside world because of the mind-numbing effects of the drugs I was less focused on my spy and spiritual beliefs. The doctors pronounced that I was responding well to the medication.”[18]

Standard clinical instruments would probably show an improvement, perhaps even a remission, while, obviously, the patient, the subject, could, in fact, be even more miserable. The same applies to the study of treatment outcomes in general, often failing to include patients’ perspectives on what constitutes an improvement and using imposed and often prejudiced criteria of what counts as a therapeutic success [19]. A striking example of this fact is that in the Hamilton Depression Rating Scale, attributing depression to social causes is understood as poor insight and worsening of depression [20]. It seems that in other branches of medicine, patients’ opinions are given more

importance than in psychiatry in terms of assessing patients' condition and treatment outcomes, even though psychiatry lacks objective measures (e.g., glucose levels, X-ray pictures, etc.) that are available elsewhere. Paradoxically, while the dominant model in psychiatry deals mainly with the brain and private phenomena, it relies almost exclusively on a subjective third-person perspective (of physicians, family members, society in general) for assessment, especially in short-term clinical trials.

However, from the utility point of view of clinicians and patients, particular nerological and biological mechanisms are secondary, even though they may be also important, especially for understanding the effects of long-term exposure to drugs and withdrawal [21]. In practice, clinicians often try to match "symptoms" with the supposed psychoactive effect of drugs, anyway, by relying on their pharmacological profile and assumed relation between the mechanism of action and subjective effects they may produce [22]. This kind of research agenda would, then, fit the actual practice better and allow for better utilization of drugs.

1.2.1. Drugs as Short-Term Help

Certainly, in some circumstances, pharmacologically induced sleep, for example, is better than no sleep at all, but that does not necessarily mean that prolonged use of hypnotics, sedatives or neuroleptics is indispensable or beneficial. Drugs could be then primarily used as short-term solutions helping to overcome specific temporary difficulties, in a somewhat similar way as one can drink a cup of coffee to fight fatigue or have an alcoholic drink to relax. Research on the psychoactive properties of psychiatric drugs could provide important information on when and how these drugs could be used this way. An important fact to consider is that promoting drugs as correcting biological abnormalities may promote life-long use and hinder discontinuation of treatment even when it is no longer necessary [23] while thinking of medications as psychoactive substances could have the opposite effect and promote shorter use. Regardless of the way drugs are actually used and studied, more research addressing the question of the methods of safe discontinuation of psychiatric medications is urgently needed, as withdrawing from psychiatric medication is poorly understood and confounds the results of maintenance trials [24]. This, as well as the study of iatrogenic effects of psychiatric drugs, may be the area of biological studies that would be particularly useful.

1.2.2. Drugs as Facilitators of Psychotherapy

Another way of looking at psychiatric drugs would be to think of them as substances that may facilitate psychotherapy and/or as agents inducing lasting changes thanks to the subjective psychological states they produce. Examples of such an approach would be the current studies on the use of 3,4-methylenedioxymethamphetamine (MDMA) for the treatment of Posttraumatic Stress Disorder, where the psychoactive effects of MDMA are thought to allow for a specific therapeutic relationship to be established [25][26]. Other examples would be the use of psilocybin [27], LSD [28], ketamine [29][30] or ayahuasca and other substances for various disorders. It is important that the effects of such interventions are not reduced to the neurobiological level only. This seems to be already the case with the, patented in the form of a nasal spray, enantiomer of ketamine, which was recently approved for the treatment of treatment-resistant depression, despite poor evidence of effectiveness [31]. As one of the authors of a recent trial [32] comparing psilocybin and escitalopram commented:

“if psilocybin becomes just another drug, it will be as uninspiring and ultimately disappointing as SSRIs have been for many” [33].

The relation between the neurobiological and psychological or subjective is another complicated philosophical problem, but the insistence on interpreting the action of psychedelic substances on the physiological level, which leads to the goal of avoiding altered states of consciousness in therapy, could explain the poor results of ketamine nasal spray. In fact, it is precisely these states that may carry the therapeutic potential or effect [34][35]. It is important that in the process of implementation of this kind of therapies the traditions from which some of these substances and practices were appropriated are not erased and indigenous knowledges treated as equal contributors, especially as they can provide a much wider social and cultural context for the interpretation and the consequences of the experience [36]. However, it may also seem that the particular psychological and cultural frameworks of interpretation are secondary, i.e., similar insights could be successfully articulated within Western discourse.

Generally, our thinking about using psychiatric drugs could follow the principles of harm reduction, as in the case of illicit drug use, not only in the cases of withdrawing [37] but as a guiding principle. Drugs should be used voluntarily (as all other services—otherwise speaking of “service users” is merely a linguistic distraction; someone who is treated against their will is neither a “user” nor a “consumer” [38]) and rely on an actual informed consent.

1.3. Diagnosis

Kinderman [39], a former President of the British Psychological Society, goes as far as describing the current diagnostic systems as “invalid and inhumane and even bizarre,” and he is not alone in this opinion. Critique of current diagnostic systems from many different perspectives and backgrounds is abundant [40][41]. A recent study concludes that DSM-5 diagnoses are so heterogenous it makes them practically useless [42]. It is important to remember that the same complaint (e.g., anxiety) can be associated with different causes, as well as that the same cause (e.g., death of a loved one) can lead to completely different complaints or involve different psychological mechanisms. This holds also on the biological level and the causal relation between different brain states and subjective phenomena—similar experiences may be caused by different brain states and vice-versa.

What is crucial is that diagnoses could be considered to be the primary source of stigma, self-stigma, power imbalances within the psychiatric system and an excuse for forced treatment and violations of human rights that effectively produce second-class citizens [43][44]. Some studies suggest that using another terminology, e.g., psychosis instead of schizophrenia, could be beneficial and reduce stigma and discrimination [45]. However, it is unlikely that such an effect would be longstanding. It is reasonable to assume that as soon as the new label is understood to refer to a similar construct, discriminatory beliefs will be added also to the new word. Language in psychiatry is important [46], yet changing the terms alone will not help if the meanings and practices associated with them stay the same. As one patient said: “(.) since I got sick I still think that it shows and that I have to be careful not to give myself away” [47]. It is possible that this stress, even according to the stress-vulnerability model, can lead to worse outcomes playing the same role minority stress does for the LGBTQ population [48]. Framing mental

distress not as a deficit or a “malfunction” but as primarily a sign of human potential and opportunity to grow, as in Kazimierz Dąbrowski’s theory of positive disintegration, could mitigate this stigmatizing and self-stigmatizing effect [44].

Bearing in mind all the negative consequences associated with the reliance on diagnostic classifications and the explicit and implicit meanings behind them [49], it might be best to replace them with another approach. Diagnoses are already neither necessary nor sufficient for the provision of services [50], so even the common response that they are indispensable because of administrative reasons or the interests of insurance companies does not seem justified. Services could be provided in a model more resembling social care, where labeling is not necessary. For clinical and research purposes, focus on specific complaints [51], and the Power Threat Meaning Framework could be utilized [52]. That is, we should be asking questions such as: what has happened to you? how did it affect you? what sense did you make of it? what did you have to do to survive? instead of going over symptoms checklists to arrive at a diagnosis. This would go in tandem with the focus on the psychoactive properties of drugs sketched earlier, as specific problems could be matched with specific psychoactive properties. It could also help the patients to conceive themselves as active and responsible agents, which would have an empowering effect, in contrast with being a passive victim of an externalized, yet internal and biological abnormality.

2. Alternative System—Clinical Practice

Practical clinical solutions that would fit the propositions described above and allow for the development of an appropriate mental health system already exist. Such a system could be founded on several basic elements: 1. The Open Dialogue approach serving as the basis and first contact or referral point; 2. Soteria houses for people needing stationary care; 3. individual and group psychotherapy of different modalities in cases where Open Dialogue or Soteria are not necessary; 4. regular screening for adverse reactions for people using drugs and services allowing safe withdrawing; 5. self-help and peer-run services funded by the system as continuous support and rehabilitation; 6. individual social care regarding housing, everyday activities and supportive employment services.

2.1. Open Dialogue Approach

Firstly, the Open Dialogue Approach [53] developed in Western Lapland, Finland, could serve as the basis for such a system. It is important to remember the approach is not only a therapeutic modality but, originally, also a pragmatic and practical systemic solution to the institutional side of the organization of mental health services—it may be an important contribution to its success as the specific techniques and recommendations concerning therapy.

Open Dialogue could be described as a crisis intervention that takes the form of a unique narrative and systemic approach to family therapy delivered by mobile teams of professionals. Its main principles are: 1. the provision of immediate help—an initial network meeting convened within 24 h of first contact; 2. social network perspective—all key members of the social network are invited to the first meeting (including important people or officials who are

not part of the family); 3. flexibility and mobility—no exact treatment plans are made during a crisis, methods are adapted to each case and change in response to current needs; 4. responsibility—the staff member who is first contacted is responsible for organizing the first meeting and the whole team is then responsible for the entire process; 5. psychological continuity—the same team is responsible for the treatment; 6. tolerance of uncertainty—for the first two weeks, frequent (daily) meetings are necessary to build a sense of security and avoid premature conclusions and decisions about treatment, especially regarding utilization of drugs; 7. dialogism—the goal is to foster a dialog that will increase patient's sense of agency and allow development of a new understanding of the situation [54][55]. This approach corresponds to the framework regarding diagnosis presented earlier, and though it was developed as an intervention for psychotic disorders and is successfully used in these cases [56], it is safe to assume that it could be appropriate and beneficial in most other situations or diagnoses [57].

In this approach, diagnostic labels become secondary or even irrelevant as problems are seen as socially constructed narratives, not diseases. The central idea behind the principle of "dialogism" is the notion of "polyphony of voices," both within subjects and between them. In this way, the focus is not on classifying and intervening but on fostering a dialogue in which all participants are treated equally in order to mobilize the resources of families and other social networks of the patient. The inclusion of different perspectives in order to allow for the development of healing, instead of pathologizing and disempowering, meanings of the situation is crucial. There is, however, no preplanned map for the stories or a predefined goal that the team is directing the system to achieve. Instead, the clinicians, understood as embodied emotional agents present in the moment, are focused on responding to clients empathetically while making sure that everyone is heard and does not feel abandoned, excluded or ignored, and communication is reestablished [58]. This approach is consistent with the research agenda and the assumptions of the Power Threat Meaning Framework [52] described above.

Even though on the surface it may seem that the principles of Open Dialogue are already widely present in mental health practice, at least in highly developed countries, a recent study describing experiences with the implementation of an approach based on the Open Dialogue in the USA has found the staff to report "powerful changes in clinical practice, such as being more curious to listen, not having an agenda, realizing the answer to problems lie within the network, slowing things down and generating more dialogue" [59]. This way of working was perceived as weird by other mental health professionals, and this, as well as resistance to change of organizational culture, was reported as a challenge to implementing Open Dialogue. The participants also mentioned less burnout and better relationships among staff, clients and their families.

2.2. Soteria Houses

However, it may not always be possible to act accordingly with the Open Dialogue Approach, if, for example, the situation may be too difficult (it could be argued that, e.g., in rare cases of catatonia, a dialogue would be impossible), the system unwilling to cooperate (in order to, e.g., reestablish communication with somebody classified as having a "gross thought disorder or "incoherent speech") or the provision of basic needs such as a safe place or food must take priority. In such cases, stationary care is necessary, and it could be based on the Soteria House model [60][61]. The Soteria approach shares some similarities with the Open Dialogue approach, both

theoretically and practically: the metaphor of illness is rejected, problems are seen primarily as consequences of interpersonal or systemic relationships, the meanings attributed to them, and as developmental crises.

Essentially, Soteria is a home-like facility, with two members of the staff and up to eight patients, partly run by peers, with minimal hierarchy, where “being with” people in distress (instead of “doing to”—as in the Open Dialogue Approach, the staff primary responsibility could be described as facilitating a dialogue leading to a new understanding of the situation) and the importance of interpersonal relations are emphasized. Patients are responsible for the day-to-day functioning of the home, which provides a safe space that allows facing the crisis while preserving personal autonomy. The approach to drug use described earlier fits well with both Soteria and Open Dialogue models and is, in fact, close to what was practiced in the original Soteria [62] and is practiced today in Western Lapland [55]. Specifically, drugs are seen as agents that can provide temporary relief, not as curative agents, and are never used without a patient’s consent.

2.3. Individual and Group Psychotherapy

It may also be the case that intensive, system-wide intervention is not necessary, and the problem could be solved with fewer resources engaged or that the patient prefers another approach. Thus, the Open Dialogue team could decide to refer the patient to individual psychotherapy, and the meetings would provide the opportunity to jointly decide with the patient what kind of help or which therapeutic modality could be most beneficial. Trauma-Informed-Services could be particularly useful [63]; however, all approaches that allow for developing a personal meaning and ways of overcoming the problem, stemming from diverse theoretical backgrounds, could be helpful as long as the service user is free to choose and find the one that suits him or her [64]. This should enable a pluralistic approach to different problems and prevent a shift from one narrow range of options to another. It may seem that, in reality, the possibility to have a comfortable, caring, respectful conversation with another person is what is most important and helpful in a vast majority of cases [65][66].

2.4. Screening for Adverse Effects of Drugs, Services Helping with Discontinuation, Peer-Led Services and Social Support

In cases where a patient decides to use drugs long-term on a regular basis, the system should also offer regular screening for possible side and adverse effects and services to those people who later decide they would like to reduce doses or discontinue drug use. In developing and providing these, a close collaboration with service user initiatives is crucial [67].

Another important part of the system that could replace current rehabilitation schemes could be based on peer-led or peer-run services funded by the system. These could include self-help groups, such as Intervoice [68]. The goal of such interventions should move away from the elimination of “symptoms” towards learning to cope, attaining a better quality of life, developing an individual understanding of the situation and empowerment. It is important that peer-led initiatives stay as autonomous as it is possible, with minimal input from the professional administration regarding training, supervision, recruitment, etc., to avoid imposing an institutional view and character of these services [69]. Clubhouses [70] could form another part of this segment of the system. Organized help with ordinary

duties of everyday living is also necessary, and it could be provided by social workers in a “social care” model. Provision of independent housing (with no live-in staff) and supportive employment services are also necessary [71], as are income support and occupational and financial assistance [72].

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