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Reflections from a Critical Psychiatrist: A way forward for my profession?

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A Moment of Gratitude

A critical psychiatrist can often feel demoralized.

Expressing gratitude is a part of self-care.

Thank you!

Overview

Part 1: Major critiques of modern psychiatry

- Relevant historical events and social influences

Part 2: Paradigms for understand drug action

- **Drug-centered** vs. disease-centered psychopharmacology

Part 3: Principles of **need-adapted treatment**

Part 4: Proposal for reform

- Examples of reform in practice

Where I am heading: Slow psychiatry

- Analogous to slow food movement: counter industrial agriculture
  - Industrial agriculture values production above all else
  - Slow food movement values environment, experience, cultural significance of food

- Not all human distress requires medical attention
  - "Fast" psychiatry predicated on assumption that we will improve outcomes if more people can see psychiatrists
  - 15-minute visits
  - Collaborative care – psychiatrist does not even meet with patient
  - Improves outcome if the "outcome" = number of patients seen

  - "Slow" psychiatry predicated on
    - Restricting our purview
    - When we do get involved, going slow, taking the time to acknowledge the complexity of the problems

Part 1:
What is water?
Critical psychiatry's major themes

- Flawed diagnostic system
- Conflicts of interest
- Minimization of voice/participation of those with lived experience

What is modern psychiatry?

- Categorizes experiences as illness
- Specializes in prescribing psychoactive drugs to treat those conditions
- Focuses on outcomes, rating scales, and treatment algorithms
- Fact: People have and will seek out drugs to alter mental state and mood.
  - It is a good idea to have medical practitioners who are experts at prescribing psychoactive drugs.

Relevant cultural history

- Many psychoactive compounds synthesized in 1950s and 1960s
  - Modern pharmacology
- 1962 U.S. Food and Drug Act
  - Response to thalidomide
  - Required demonstration that drugs effective for specific conditions
- Increased recreational drugs use in 1960s and 1970s
  - Psychiatry needed to legitimize its own work / "good" drugs vs. "bad" drugs
- Neoliberalism: reducing welfare state, needing everyone to work efficiently
- Countering moral arguments
  - Mental illness = weakness
  - Bad moms → bad brains
  - The hope: "broken brain" model reduces stigma
- Psychoanalytic vs. "biological/descriptive"
  - Change in power: DSM III published in 1980

Economies of influence

- A model for understanding institutional corruption developed by Lawrence Lessig
- Addresses multiple influences that result in institutions acting in ways that deviate from stated mission
- In psychiatry, this resulted in tendencies to conceptualize human distress as
  - Medical in nature
  - Chronic
  - Requiring drug treatments

Cosgrove & Whitaker, 2015

Broadened drug targets

Financial incentive to extend patents by expanding targets

Antipsychotic drugs

- Psychosis ⟶
- Mania ⟶
- Depression ⟶
- Mood stabilization
- Insomnia
- Anxiety

Psychostimulants

- Help for housewives
- Children with cognitive challenges ⟶ ADHD
- Adults
- Binge eating disorder
- Mild cognitive impairment after menopause
- Depression

The recovery/chronicity paradox

- On the one hand is the narrative of great advances in neuroscience, drug development, and psychiatric therapeutics.
- On the other hand, there has been a shift to conceptualizing most mental disorders as chronic.
- The result is promotion of continuing treatments for a very long time.

Recovery discounted: schizophrenia

- Kraepelin: dementia praecox
  - Chronic, deteriorating condition
  - Instantiated in DSM III schizophrenia
- Harding: The Vermont Study (1987)
  - Patients who did not respond adequately to chlorpromazine
  - 70% were recovered 25 years later
- Harding data ignored or discounted

Does “medicalization” reduce stigma?

- Increasing belief in the biomedical model increases desire to maintain social distance from those who are diagnosed.
- Psychosocial explanations reduce stigma and increase empathic responses from others.
- Patients who are not stigmatized have better overall outcomes, **self-efficacy**, quality of life, and improved chances of recovery

Makowski et al., 2016; Longdon & Read, 2017; Firmin et al., 2016

Part 2:

An alternative way of thinking about psychiatric drugs

Disease-centered vs. Drug-centered

Disease-Centered

- Drugs *correct* abnormal brain chemistry
- The beneficial effects of drugs are derived from their *effects on a presumed disease process*

Drug-Centered

- Drugs are *psychoactive substances*
- Drugs *create* abnormal brain states
- Drugs alter the expression of psychiatric problems through the *superimposition of drug-induced effects*

Moncrieff, *The Bitterest Pills*, 2013

Implications of drug-centered approach: Antipsychotic drugs and schizophrenia

Origins of antipsychotic drugs

- Synthesized in 1950s
- Dry secretions – used in surgery
- Laborit observed that they cause ***indifference***
- "In normal volunteers, neuroleptics [antipsychotic drugs] induce feelings of dysphoria, ***paralysis of volition***, and fatigue."

  Schatzberg & Nemeroff (eds.), *Textbook of Psychopharmacology,* 2009

Current treatment standards

- Initiate drug treatment early
  - Drugs thought to prevent further disease progression
- Continue drug treatment indefinitely
  - Drugs prevent relapse
- Poor outcomes attributed to underlying psychopathology
  - Schizophrenia is a chronic illness

Recent findings on long-term schizophrenia outcomes:

Paradoxical from disease-centered orientation but
Predicted by drug-centered orientation

Recovery in remitted first-episode psychosis

- 128 cases of first-episode psychosis stabilized on drug therapy for 6 months
- Initial study compared maintenance drug therapy (MT) vs. dose reduction/discontinuation (DR)
- Higher relapse rate in DR group after 2 years
- Followed up 7 years after study entry

Wunderink et al., 2013

Seven-year outcomes

- 103 subjects available at 7-year follow up
- Relapse rates similar between groups
  - Drug continuation appeared to delay relapses
- Recovery rates
  - **DR 40% vs. MT 17%**
  - Difference related to ability to work and maintain social connections

Outcome data

	Open Dialogue*	Stockholm**
Schizophrenia	59%	54%
Other diagnosis	41%	46%
Antipsychotic used	29%	93%
Antipsychotic at follow-up	17%	75%
GAF at follow-up	66	55
On disability	19%	62%

*Seikkula & Arnkil, *Dialogical Meetings in Social Networks*, 2006, p.164

** Svedberg et al., Social Psychiatry 36:332-337, 2001

Antipsychotic drugs
Disease-centered vs. Drug-centered

- Drugs target specific pathophysiology

- When drugs are stopped, illness recurs
- Long-term apathy is due to the natural course of the underlying illness

- Drugs induce indifference
- This might be helpful at times when a person is psychotic
- When drugs are stopped, think about withdrawal affects
- Drugs might be inducing apathy

Part 3:
How can we use drugs without starting with a diagnosis?
How can we promote agency?

Integrate drug-centered pharmacology with need-adapted treatment

Need-Adapted Treatment

- Forerunner to Open Dialogue
- Developed in Finland in 1980s
- Multiple models/treatments for psychosis
  - Biological
  - Psychological
  - Family
  - Social
- Each has value: not every approach worked for every person
- Invited families into team meetings
- Shared the dilemma with patients and their families

Alanen, 1997

Need-Adapted Treatment

- For many, this led to resolution of the problem
- Basic psychotherapeutic attitude
  - Acknowledges value of different paradigm
  - Values uncertainty, humility
  - Is flexible, democratic, less hierarchical

Open Dialogue/NAT	Standard treatment
Needs of the system drive the treatment	Medical model: *diagnosis* drives treatment
Longitudinal care/continuity	Crisis intervention/referral fragmentation
Social network	Individual
Tolerance of uncertainty Flexibility Mobility	Experts hold epistemic authority Psychoeducation Pre-existing menu of services
Person has agency/voice	Person is the object of therapeutic action
Experiences have meanings	Experiences are symptoms

Part 4:
Applied critical psychiatry

Vermont Collaborative Network Approach

- Flexible application
- Sustainable
- Minimizes costs
- Embeds trainers within agencies
- Trainers from Germany, Norway, Finland, and US
- Level I: Five 3-day sessions
- Level II: Five 2-day sessions
- Train-the-trainer track

Collaborative Network Approach

~90 people have participated over three years

- Physicians, social workers, nurses, peers
- Inpatient, outpatient, crisis services, residential
- Mental health, developmental services, substance use

Community Mental Health Journal
https://doi.org/10.1007/s10597-018-0313-1

ORIGINAL PAPER

Five Year Outcomes of Tapering Antipsychotic Drug Doses in a Community Mental Health Center

Sandra Steingard[1]

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Abstract

There is evidence that many individuals are on higher doses of antipsychotic drug than is required for
there are limited guidelines on how to reduce them. This paper reports on 5 year outcomes for sixty
received treatment at a community mental health center and were offered the opportunity to gradual
antipsychotic drug in collaboration with the treating psychiatrist. Over a period of 6 months, the autl
were clinically stable and able to participate in discussions of potential risks and benefits to begin g
Initially, 40 expressed interest in tapering and 27 declined. The groups did not differ in age, sex,
group who chose to taper began on significantly lower doses. Most patients succeeded at making mo
5 years, there were no significant differences in the two outcomes measures, rate of hospitalization
Many patients were able to engage in these discussions which did not result in widespread disconti
a naturalistic, small study of a topic that warrants further research.

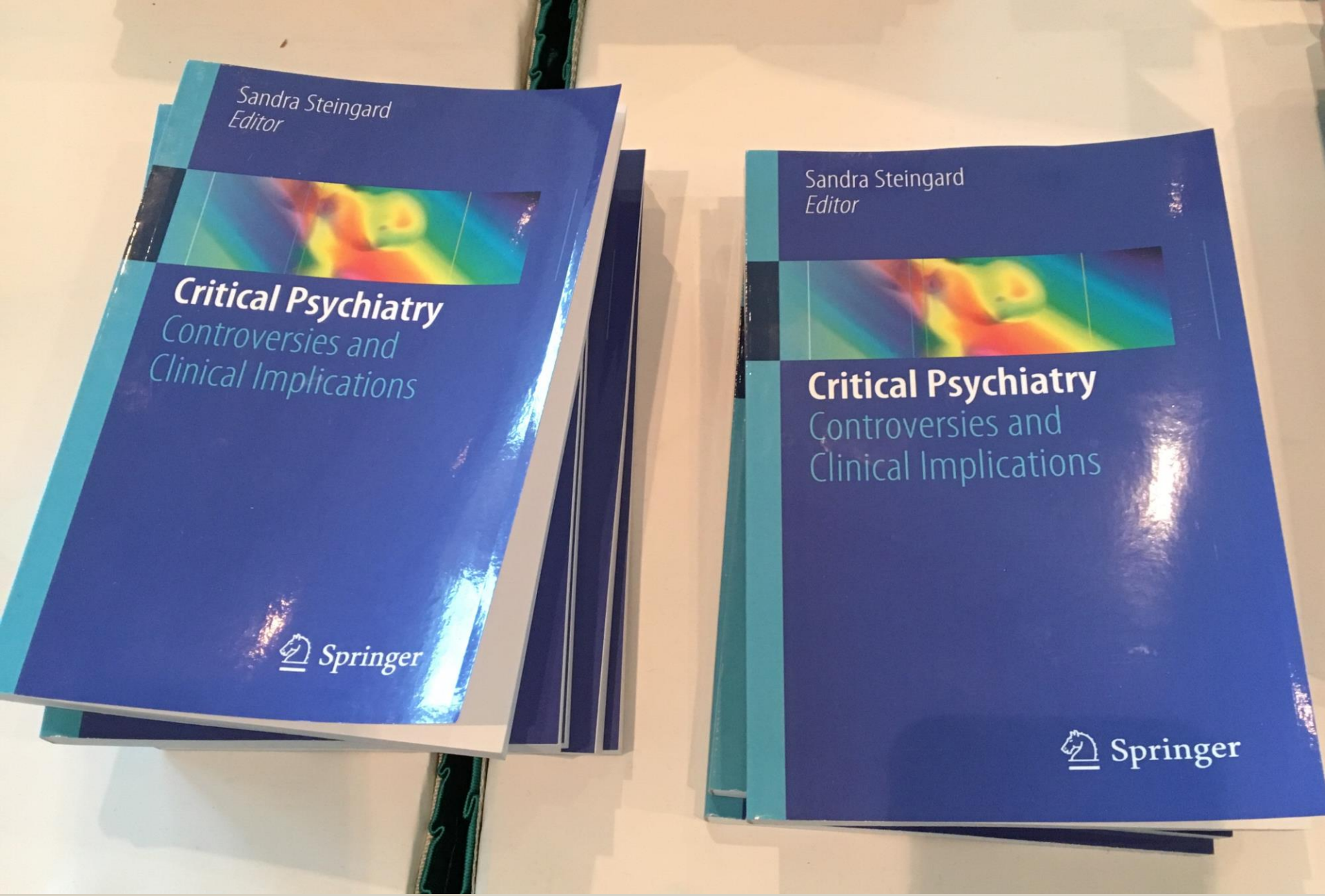
When people don't want our drugs

- First episode psychosis
  - Does not require a person to accept our narrative
- Helping families
  - Offers support to families when person at center of concern is not interested in "treatment"
  - Problem defined by caller
  - A preferable alternative to "Call us or the police when they are violent"

What's Psychiatry Got to Do With It?

Integration of drug-centered and need-adapted approaches

- Maybe there are enough psychiatrists but demand is distorted
  - Let's not solve the problem with 15-minute visits
- When we do get involved
  - Take the time to acknowledge complexity
  - Recognize the limitations of psychiatric diagnosis
  - Accept that drugs are tools and not cures
  - Listen to what the person wants and values
    - "Symptoms" may not be the highest priority targets
- Embrace humility and uncertainty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