

EDITORIAL

PSYCHIATRY IN THE 21ST CENTURY – ORIENTATIONS AND OPTIONS

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In volume 3(1) of this journal I, along with Dr. Lucena, a psychiatrist from Brazil, published a paper entitled, “Mindful Medical Practice and the Therapeutic Alliance.”¹ We stressed the importance of the relationship given it is crucial to all aspects of treatment. Recently I presented on Mindfulness in Medicine at a two-day Continuing Medical Education symposium for general practitioners where psychiatrists instructed them how to manage patients with mental health disorders. The topic that dominated the first day was medication. I noticed that little to nothing was mentioned about the relationship between the doctor and patient. This is not trivial since adherence to medications was noted as a problem (43% stopped in less than 1 month; 29% stopped after 1-3 months and only 28% continued after 3 months). Reasons for this are many: the trial and error approach to finding the right medication and dose, side effects such as weight gain, safety issues, cost, and I would add, not partnering with the patient in a way that engenders trust.

ORIENTATION #1: BIOMEDICAL APPROACH

Focusing on neuroscience, psychopharmacology and genetics has painted psychiatrists into a reductionist box. Moreover, this narrow view has blocked incoming data pertaining to important developments in the provision of care and support for people in distress. Take the excessive reliance on psychoactive medications as an example. Dr. Teboul² presented at the aforementioned symposium a critical examination of the evidence for antidepressants that failed to provide the desired effect in patients with Major Depressive Disorder. His two presentations addressed: Increase the dose? Wait longer? Change for another antidepressant? Add another medication (e.g. lithium, new-generation antipsychotics)? What struck me most was that the evidence failed to support current guidelines for increasing doses or switching to another type of antidepressant. Furthermore, data pertaining to the placebo response shed more doubt on the

psychoactive basis for the effectiveness of medications that, nonetheless, continue to be prescribed at record levels.

ORIENTATION #2: INTEGRATIVE APPROACH

One big step past the biomedical model is an integrative approach whereby a more holistic paradigm of mental health problems allows for inclusion of other modalities of care such as osteopathy, neuropathic medicine, nutraceuticals (botanicals and nutrients), mind-body therapies and lifestyle changes. Sarris et al.³ published a “White Paper” on the establishment of this paradigm through research, education and clinical guidelines. The authors from Australia, Europe and the United States point to person-centered care provided by compassionate clinicians as the cornerstone to the approach. Spurred on by limitations of conventional approaches and patients’ widespread use of complementary therapies, they call attention to the need to create guidelines for three models of care: complementary, comprehensive and primary care whereby GPs, nurses and internists coordinate services, based on the individual patient’s needs and circumstances. Rather than simply focus on symptoms, this approach takes into account social, cultural and spiritual influences that contribute to or maintain suffering in the person seeking care.

ORIENTATION #3: WHOLE PERSON CARE APPROACH

One may ask: What is the difference between Orientations #2 and #3? Whole Person Care does not necessarily advocate “adding to” conventional medical care one type of therapy or another. Rather, it purports that psychiatrists (in this case), physicians and allied health care professionals promote healing in their patients, whether or not an illness can be cured. Kearney⁴ defines healing as, “the process of becoming psychologically and spiritually more integrated and whole; a phenomenon which enables persons to become more completely themselves and more fully alive.” He proposes that while it is often spontaneous, it can be fostered by creating an environment that facilitates the natural process of healing. Furthermore, he stresses the importance of a trusting relationship in which the power differential does not hinder the patient’s ability to find the inner resources needed to go with rather than against his or her experience. In essence, Kearney points to the therapeutic use of the person of the healer, one who has undertaken him/herself the path of self-exploration.

In concert with these notions, 29 eminent psychiatrists co-authored a paper entitled, “Psychiatry Beyond the Current Paradigm”⁵; they argued that the technological paradigm to mental health; that is, that problems can be mapped, categorized and treated using the same causal logic used in allopathic medicine is misguided. The authors claim that good practice in psychiatry primarily involves the non-technical dimensions of work, such as relationships, meanings, and values.

ORIENTATION #4: RADICAL CHANGE REQUIRED

Kinderman wrote: “A Prescription for Psychiatry: Why we need a whole new approach to mental health and well-being”⁶, a book that is as provocative as it is radical. He argues that the disease model is fundamentally flawed and does more harm than good since it shifts focus away from social causes of distress. He notes that the biomedical model strips professionals of their capacity to empathize because when one believes the cause of illness is biochemical (e.g. neurochemical imbalances) then one fails to look for other reasons that the person may be feeling and acting as they do. In *Mindful Medical Practice* we call this premature closure, reflecting cognitive bias.

Throughout his book environmental causes of distress (e.g. poverty, racism, and trauma) are viewed as crucial to people’s failure to thrive in our society. Kinderman does not ignore the importance of biological factors (e.g., genetic predisposition for specific disorders); instead, he views them in a social context. Psychological and social services are purported to be essential to promote well-being and to treat people who require psychotherapy and support for their recovery efforts.

In Kinderman’s view, the psychiatrist would act as a consultant to a multidisciplinary team capable of addressing the full range of a person’s needs. Interestingly, he suggests that the GP may have a central role on the team – providing medical services and linking patients to psychological services. This takes us back to the symposium I attended that sparked the idea for this editorial. The difference is that scant mention was made of adjunct services such as community nurses, psychotherapy or social workers.

If Orientation #4 seems too idealistic then consider the case of Housing First for homeless people⁷. First tested in the United States and later adopted in Canada, the program is based on the idea that people with mental health and/or addiction problems need stable housing before they can begin to recover. It is based on the following tenets:

1. Immediate access to housing; not contingent on sobriety
2. Self-determination and consumer choice of housing (where possible)
3. Recovery orientation with necessary support such as educational, vocational training and harm reduction for those struggling with addictions
4. Individual client-driven supports such as case management, life skills training, mental health treatment
5. Social and community integration

These programs have proven to be cost-effective for a population typically labeled “treatment resistant”. The payoff is not only reduced suffering for those people housed, but also reduced costs to the medical

and judicial systems. Rather than shame and blame these unfortunate people, a benevolent approach helps them to regain their sense of dignity.

My intention for writing this editorial was not to convince the reader that one orientation is better than another. Rather, it was to show that there are options for working with people who suffer from mental health issues. Which is most effective? Compassionate? In my view, that is what matters most. ■

REFERENCES

1. Dobkin PL, Lucena RJM. Mindful medical practice and the therapeutic alliance. *IJWPC*. 2016;3(1):37-47.
2. Teboul E. Les stratégies de traitement après l'échec d'un antidépresseur : augmenter, attendre ou changer? *Fédérations des médecins omnipraticiens du Québec*, Montreal, Canada; 2016.
3. Sarris J, Glick R, Hoenders R, Duffy J, Lake J et al. Integrative mental healthcare White Paper: Establishing a new paradigm through research, education, and clinical guidelines. *Adv Integ Med*. 2016;1:9-16.
4. Kearney M. *A Place of Healing. Working with Suffering in Living and Dying*. Oxford, UK: Oxford University Press; 2000.
5. Braken P, Thomas P, Timimi S. et al. Psychiatry beyond the current paradigm. *B J Psych*. 2012;201:430-4.
6. Kinderman P. *A Prescription for Psychiatry: Why We Need a Whole New Approach to Mental Health and Wellbeing*. UK: Palgrave Macmillan; 2014.
7. Gaetz S, Scott F, Gulliver T (Eds.). *Housing First in Canada: Supporting Communities to End Homelessness*. Toronto: Canadian Homelessness Research Network Press; 2013.