A Reform Proposal for Psychiatry

Integrating drug-centered pharmacotherapy and need-adapted treatment

Sandra Steingard, M.D.

Many current ideas for reform of the mental health care system focus on the limited supply of psychiatrists. Some commentators argue that poor outcomes are attributable, at least in part, to limited access to psychiatric care – that it is a supply problem.

In this chapter, I suggest that there is a distorted demand for psychiatric care based on an ever-expanding notion of what constitutes psychiatric disorder, combined with an inaccurate gauge of the efficacy of psychiatric treatments, particularly pharmacological ones.

While I recommend that expertise in clinical psychopharmacology remain a core proficiency for psychiatrists, this chapter proposes contracting the scope of psychiatric concern, using a drug-centered approach to psychopharmacotherapy and, when psychiatrists do become involved in patient care, allowing the time necessary to understand the people who seek their care.

Need-adapted treatment (NAT) offers a way in which the challenges and uncertainties of the field can be openly acknowledged, discussed, and integrated into care and is suggested as a model that can help reform psychiatric care.

This chapter was written in early 2021, a year into the COVID-19 pandemic. It seems ironic that a retired psychiatrist who veered into critical psychiatry largely due to disillusionment wrought by the influence of the pharmaceutical companies on the practice of psychiatry finds so much fulfillment volunteering in the vaccination effort.

It is a reminder that the pharmaceutical industry remains capable of remarkable scientific achievement. Yet, in psychiatry, drug development has been more akin to disease or disorder development as a way to expand

markets for drugs of sometimes-questionable efficacy. Diagnostic categories have proliferated in recent decades, engendering increasingly promiscuous prescription of psychoactive drugs.

Proposals for reform of the mental health care system are often predicated on the assumption that the problem is fundamentally one of access; increasing screening for psychiatric disorders and providing greater availability of psychiatric care are considered of primary importance. There are recommendations that psychiatrists (and their surrogates) see ever more patients in shorter intervals.

In the collaborative care model advanced by the American Psychiatric Association, intermediaries consult with psychiatrists and share results of screening instruments. They then report back to the primary care clinicians with the psychiatric recommendations (Moran 2015). In this scenario, the psychiatrist, who has not met the patient, opines on optimal treatment as if the problems for which help is sought can be characterized adequately with rating scales and the like.

A different suggestion is offered here. Rather than increasing access, psychiatrists should constrain their purview. Many people who experience emotional distress do not require medical attention. They can often be helped by the many others who have considerable expertise in this area. Access to food, housing, and employment, and the development of meaningful social connections are not medical interventions but can be enormously important in reducing emotional distress.

Working with people who have their own lived experiences of such distress is another valuable resource. At the same time, there are people who benefit from psychiatric evaluation and many will seek out pharmacologic remedies, as they have for millennia. Psychoactive drugs will remain on the market. It makes sense to have a medical specialty that retains expertise in clinical psychopharmacology and for this proficiency to remain within psychiatry.

However, psychiatry has been hampered by its use of a disease-centered approach to psychopharmacotherapy (Moncrieff ref). In the modern era of

psychopharmacology, much has been learned about brain function, neurotransmitters, and drug effects on neurotransmission. These advances have led to hypotheses regarding the pathophysiology of psychiatric disorders. Because drugs that appeared to improve mood, for example, were found to increase levels of norepinephrine and serotonin in the synaptic cleft, depression was hypothesized to be caused by deficiencies in these neurotransmitters. So-called antidepressant drugs were thought to work by correcting this putative problem.

Similarly, schizophrenia was hypothesized to be caused by excess dopamine as a result of the observation that drugs that suppress psychotic symptoms block dopamine transmission. Consequently, individuals prescribed these drugs were instructed that such compounds were correcting a problem, colloquially referred to as a "chemical imbalance," and that without the drugs they were unlikely to find relief. In addition, they were often told that the drugs would be required indefinitely, lest the problem recur. And while evidence accrued that drug discontinuation was often associated with numerous problems, little attention was paid to the distinction between drug withdrawal effects and relapse of the underlying condition.

However, to this day, the etiologies of psychiatric disorders remain murky at best; no clear pathophysiology has been identified for the vast majority of the disorders in the DSM. In a blog written when he was director of the National Institute of Mental Health, Thomas Insel (2012) wrote, "Terms like 'depression' or 'schizophrenia' or 'autism' have achieved a reality that far outstrips their scientific value. Each refers to a cluster of symptoms, similar to 'fever' or 'headache.' But beyond symptoms that cluster together, there should be no presumption that these are singular disorders, each with a single cause and a common treatment." Yet, diagnostic categories have expanded, increasing numbers of people are prescribed psychoactive drugs, and many of them continue to be told that the drugs are correcting underlying problems in their brains.

In contrast, a drug-centered model posits that these drugs work by altering mental states in ways that can be helpful to the person who takes them. For instance, a highly agitated person might benefit from a sedating drug. In this instance, the psychiatric drug's function is more analogous to that of

antipyretics in reducing fever; they bring significant relief but not because they are targeted at the root cause of the problem, such as infection.

A drug-centered model brings increased scrutiny to the fundamental psychoactive effects of these drugs, paying attention to their impacts on individuals who are not afflicted by psychiatric conditions. Many people, for example, experience benefit from the euphoriant and disinhibiting effects of alcohol but we do not assume that those who derive benefit from the occasional glass of wine at social events are helped because alcohol is correcting a psychiatric condition.

An examination of antipsychotic drugs helps elucidate the implications of adopting a drug-centered approach. When these drugs were first considered for use in psychiatric patients, it was because doctors noticed they produced a tranquilizing effect without putting people to sleep. Laborit, the French physician who first suggested that chlorpromazine might be of benefit to the people housed in France's mental hospitals, noted that neuroleptic drugs induce indifference (Moncrieff 2013). In the 2009 edition of the *American Psychiatric Publishing Textbook of Psychopharmacology*, the authors note that these drugs can induce "a state of relative indifference to the environment leading to behavioral inhibition and diminished emotional responsiveness" (Nasrallah and Tandon 2009, p. 538).

When given to a psychotic person, the drugs may reduce the distress caused by hallucinations and delusions by dulling the person's thoughts, but this is not synonymous with correcting the cause of psychosis. As we have learned more about the role of dopamine in brain function, it is not surprising that blocking dopamine transmission would result in a state of apathy. But it does not appear that individuals who experience psychosis have elevated or abnormal dopamine activity in their brains before taking these drugs.

A drug-centered perspective suggests a reappraisal of the drugs' long-term effects. The rationale for long-term use is predicated on what are referred to as relapse studies. In these studies, individuals are stabilized on drugs and then randomly and blindly assigned to either drug continuation or

placebo substitution. The two groups are then followed over time, usually for one to two years. In a meta-analysis of relapse studies for people diagnosed with schizophrenia and treated with antipsychotic drugs (Leucht 2012), 64% of those who were switched to placebo relapsed, as compared to 27% of those maintained on active drug.

Notably, a substantial minority of individuals (36%) do fine when drugs are stopped. Combined with those 27% who still relapsed despite continuing to take the active drug, it appears that only about 40% of patients derived benefit from taking the drug during the study period. The challenge in clinical practice is that there is no way of knowing into which group any given individual will fall.
While a recurrence of psychosis can be a serious and debilitating problem for many people and those who care for them, the recurrence that occurs when the drug is stopped cannot necessarily be attributed straightforwardly to the re-emergence of the chronic, persisting condition labeled as schizophrenia.

As early as the 1980s, some psychiatrists wondered whether the brain alterations caused by antipsychotic drugs might render people more vulnerable to psychosis when the drugs are stopped (Chouinard 1980). This phenomenon, called supersensitivity psychosis, was thought to be a product of the alterations in the brain brought on by protracted exposure to antipsychotic drugs. There is good evidence that when post-synaptic dopamine receptors are blocked, the brain adjusts by producing more receptors (Samaha 2007). When the drug is no longer present, the dopamine system becomes hyperactive (as it is now unopposed by dopamine-blocking agents), which may increase an individual's vulnerability to psychosis (Chouinard 2017). Supersensitivity psychosis remains a potentially underappreciated phenomenon. Almost no research has been done on ways to mitigate its impact on recurrence of symptoms.

Relapse studies available to us have a further limitation. They only study people for up to two years, with the majority of studies following subjects for less than a year. Many people take these drugs for decades. In recent years, several studies have suggested a paradox: While over the short-term there might be benefit from drug treatment, over a longer period of time

this benefit wanes and for many the risks of the medication might come to outweigh the benefits.

Martin Harrow and colleagues recruited 139 people who experienced initial episodes of psychosis and then followed them over the course of twenty-years, conducting assessments at two- to five-year intervals. The researchers found that medication adherence was associated with inferior outcomes and this effect remained after controlling for differences in pre-morbid function (Harrow 2014, 2021).

Harrow's study has the limitation of being naturalistic. Individuals were not randomly assigned to receive any particular treatment. However, several randomized, controlled studies also suggest that continued use of antipsychotic medications might result in poorer outcomes, particularly with regard to indicators of functioning (Johnstone 1990; Gleeson 2013).

Wunderink (2013) studied a group of people experiencing initial episodes of psychosis who were stabilized on antipsychotic drug therapy for six months and then randomly assigned to one of two treatment groups. One maintained drug therapy (MT) while the other stopped it (DR), resuming if there was a recurrence of psychosis. The groups were followed for 18 months initially. At that point, the DR group had a higher relapse rate and there was no apparent advantage to this approach (Wunderink 2007).

However, the cohort was assessed five-and-a-half years later. At that time, the DR group had a much higher level of recovery (40%), defined as remission of psychotic symptoms (symptomatic recovery) along with engagement in work and social relations (functional recovery), as compared to the MT group (17%). Furthermore, the difference was accounted for by the difference in functional outcome – the ability to work and have friends. The rate of symptomatic recovery – the proportion of each group to achieve an absence of psychotic symptoms – was similar (~67%). In addition, at the seven-year follow-up assessment the overall rate of relapse was similar between the two groups; early maintenance of drug appeared to postpone but not prevent relapse indefinitely.

If one is trained in a disease-centered model and observes patients who appear calmer and less bothered by voices after taking antipsychotic drugs, it is easy to conclude that the drugs target some pathophysiology specific to psychotic experiences. When the person stops the drug and seems more bothered or influenced by the voices, it is easy to assume that that person is now experiencing a recurrence of the disease that that the drug had once treated effectively. A drug-centered paradigm, however, predicts the results of the Wunderink study. These findings support the hypothesis that the drug-induced indifference observed by Laborit and others might, over time, result in impairments in functioning, such as being unemployed and having fewer meaningful relationships.

While a drug-centered approach to pharmacotherapy has advantages for care, it does not diminish the fact that the problems experienced by the people psychiatrists are asked to evaluate, as well as the considerations psychiatrists face regarding the conceptualizations and suggested therapeutic approaches to those problems, are complex. This process requires thought, care, and time. The framework of need-adapted treatment (NAT) is suggested as a model that can help psychiatrists incorporate these values into their practices. NAT offers a way by which the challenges and uncertainties of the field can be openly acknowledged, discussed, and integrated into care. When integrated with drug-centered psychopharmacotherapy, it offers a more democratic way of working that allows for multiple epistemic perspectives to be both acknowledged and respected.

Need-adapted treatment was developed in Finland in the 1970s and 1980s. This approach was the forerunner of Open Dialogue that evolved in Tornio, Finland. Seikkula and colleagues have written extensively about this work (Seikkula 2006). Relevant to the discussion of psychopharmacotherapy, in Finnish Open Dialogue drugs are not considered critical to the treatment of psychosis. In a series of long-term outcome studies, they reported outstanding outcomes – only about 20% of their cohort was on disability after five years – while their use of drugs was much lower than in other western countries: only about 30% were ever treated with antipsychotic drugs. Over time, a broader array of practices has evolved in Scandinavia and northern Europe and there is increasing interest in these approaches

around the world. In the discussion that follows, the expressions “need-adapted treatment” and “dialogic practice” will be used to refer to this growing movement.

While there are variations in practice, what is shared among them are common values. Chief among those is a deep appreciation of the importance and worth of social networks in helping both to develop understandings of human problems and to support people through their crises. Diagnosis – and the diagnostic process – is held lightly in these models. Uncertainty is not only acknowledged but valued. Treatment proceeds from individual and network needs rather than from expert-derived diagnoses.

Treatment remains flexible and the system evolves in its understanding of problems. This psychotherapeutic attitude is considered at least as important as the technical aspects of the treatment. In keeping with the value placed upon relationships, there is also a recognition of the benefit of psychological continuity. Thus, to the extent possible, the team involved remains constant.
At the same time, there is nothing in this model that precludes the introduction of other therapeutic interventions. Pharmacologic treatment, cognitive behavioral therapy, and supported employment, for example, can all be incorporated. The distinction with more conventional approaches is in how they are introduced and suggested. The clinician may bring them up and network members can talk together about their potential benefits and risks. If professionals disagree, they share these perspectives openly with other members of the network.

A drug-centered approach to pharmacotherapy aligns with NAT because it is not predicated on expert-assigned diagnosis. It acknowledges that we understand more about drug action than we do about the underlying causes of peoples’ troubles, although our knowledge is certainly incomplete on the former subject as well. A need-adapted approach provides a framework in which we can talk about psychiatric drugs, acknowledge the many uncertainties involved, and support a person in deciding whether to take them.

It acknowledges that this is likely to be an ongoing process that may be revisited from time to time. It allows for the person's own values and understanding of the problem to be both recognized and respected, and it offers the space for many views to be heard. It acknowledges that what psychiatrists consider "symptoms" might not be the most important focus for a person seeking help. It provides opportunity for people to identify what is most important to them and places the discussion of drug treatment, or indeed any treatment, within that context.

It allows for a physician to be on the team but not necessarily as the leader. There may be discussion of drugs, the brain, what the physician has observed in others in similar situations, and whether there are studies potentially relevant to the patient's situation, but it does not require that the physician be the only expert or authority. If there is discussion of brain function and dysfunction, this in no way precludes a person finding additional sorts of meaning in the experience. It allows for a frank discussion of what psychiatric nosology is (a classification system) and is not (a reflection of deep understanding of the nature of the problems it classifies). And it accepts that all of this occurs in the context of a relationship – usually multiple relationships — that will exert their influences on this process.

Because psychiatric assessment relies on verbal communication, psychiatry as a profession has long valued clinical interviewing skills. Dialogic practice challenges the notion that psychiatrists are as careful at attending to their patients as they might believe themselves to be. When psychiatrists enter the room as experts and move quickly to characterizing the patients' experiences as symptoms, that might interfere with the opportunity to help patients fully communicate experiences in their own ways.

Even with therapeutic practices that value careful listening while employing interpretation, such as psychodynamically-oriented psychotherapy, responding to a person's utterances with interpretation transforms what has been said into the structure of the therapist's theoretical framework. In contrast, with NAT and dialogic practice, careful attention is given to the nature of communication but clinicians try to avoid imposing their own implicit or explicit models, whether these are conceptualized in biological,

psychoeducational, psychodynamic, or any other frameworks, and whether on the patient or others in the network. Therapists are encouraged to listen to each person's utterances, use each person's language, and stay in the present moment. Multiple perspectives and viewpoints are elicited.

In recent years, some models of NAT have incorporated individuals with lived experience into their teams. The presence of peers as valuable team members – and not just as surrogates of the professionals – signals another important aspect of this way of working. In NAT, epistemic authority is shared among team members. While the psychiatrist is acknowledged as having a certain kind of expertise, it is accepted that psychiatric conceptualizations are not the only ways to make sense of the situation. The peer in the NAT setting may be able to help the person in the patient role to articulate her or his own understandings of the problem. By including the peer in the meeting, the psychiatrist demonstrates that other perspectives are valued.

Practicing with humility while openly and actively loosening the authority society has given to psychiatrists is a core recommendation for reform. This is not anti-drug or anti-psychiatry but pro-humility. Psychiatrists need to be active in exercising that humility. Integrating a drug-centered approach with NAT allows a psychiatrist to work comfortably within a network that values humility, uncertainty, and respect for multiple perspectives. It offers psychiatrists the opportunity to be important and supportive members of treatment teams.

Why This Matters

Psychiatrists are distinguished from most others in the mental health services complex by their medical training. In the modern era, their role has evolved to be primarily focused on prescribing psychoactive drugs. It is likely that these drugs will continue to be both available and sought after. Yet the proliferation of psychiatric diagnostic categories and overpromotion of psychiatric drugs has resulted in a promiscuous use of these agents that does not adequately attend to their therapeutic limitations and potential harms.

Psychiatrists are well-positioned to offer expertise in how these drugs are best employed. However, the role of psychoactive compounds in clinical care has been compromised by their being embedded in a flawed, disease-centered approach. By implementing a drug-centered approach to pharmacotherapy combined with a need-adapted psychotherapeutic frame, psychiatrists can move toward a more thoughtful, humble, and transparent model of care.

References:

1. Alanen, Y. O. (1997). *Schizophrenia, Its Origins and Need-Adapted Treatment*. London: KarnacBooks Ltd.
2. Anderson, T. (1987). The reflecting team: Dialogic and meta-dialogue in clinical work. Family Process, 26, 415-428.
3. Crichton, P., Carel H., Kidd J. (2017) Epistemic Injustice in Psychiatry. British Journal of Psychiatry, 41:66-70.
4. Håkansson, C. (2009). *Ordinary Life Therapy: Experience from a Collaborative Systemic Practice.*Chagrin Falls, OH: Taos Institute Publications.
5. *Harrow, M., Jobe, T.H., Faull, R.N. (2014). Does treatment of schizophrenia with antipsychotic medications eliminate or reduce psychosis? A 20-year multi-follow-up study. Psychological Medicine, 44(14), 3007-3016.*
6. Harrow, M, Jobe, Tong, L. Twenty-year effects of antipsychotics in schizophrenia and affective psychotic disorders. Psychol Med, 2021 Feb 8;1-11. doi: 10.1017/S0033291720004778
7. Insel, T. (2012). Words Matter. https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2012/words-matter.shtml. Accessed August 19 2018.
8. Leucht, S., Komossa, T.M., Heres, S., et al. (2012). Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: a systematic review and meta-analysis. *Lancet,* 379(9831), 2063-2071.
9. Moncrieff, J. (2013) *The Bitterest Pills*. London: Palgrave Macmillan.
10. Moran, M. (2015) APA urges creation of payment codes specific to collaborative care model. Psychiatric News. https://doi.org/10.1176/appi.pn.2015.10a13

11. Potter, N. (2016). *The Virtue of Defiance and Psychiatric Engagement*. (pp.137-171). Oxford: Oxford University Press.

12. Seikkula, J. and Arnkil, T. E. (2006). *Dialogic Meetings in Social Networks.* London: Karnac Books Ltd.