Humane Alternatives to the Psychiatric Model

Edited by
Eric Maisel, Ph.D. and Chuck Ruby, Ph.D.

Humane Alternatives to the Psychiatric Model is the second Volume of the Ethics International Press Critical Psychology and Critical Psychiatry Series.

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EDITOR'S INTRODUCTION

Eric Maisel, Ph.D. and Chuck Ruby, Ph.D.

Welcome to Volume 2 of the Ethics International Press Critical Psychology and Critical Psychiatry Series. In this ambitious series, we hope to critique the many gospels and dogmas to be found in the areas of psychiatry, psychotherapy, psychological testing, research psychology, academic psychology, and the other domains that make up the world of "psychology and psychiatry."

In Volume 1, we critiqued the current pseudo-medical "mental disorder" paradigm, a paradigm created by psychiatry and employed by most mental health professionals, in a wide-ranging and compelling volume featuring more than a score of contributed chapters. In this volume, *Human Alternatives to the Psychiatric Model*, we present a diverse array of viewpoints that each takes as its starting point that the label-and-pill model is neither the only model or the best model—and may be the worst model.

In future volumes, we hope to critique the "mental disorders of childhood" paradigm, shine a bright light on the shady relationships between psychiatry and the law, look into the world of psychological tests, critique psychotherapy, examine the scientism of academic psychological research and its "evidence-based" claims, present points of view on the psychiatric survivor/service user world, and more. We hope that you will enjoy this series, benefit from this series, support this series, and communicate your thoughts with us, including your thoughts about possible future volumes.

Please enjoy this volume, *Humane Alternatives to the Psychiatric Model*.

Eric Maisel and Chuck Ruby

A ROAD NOT YET TAKEN: A MANIFESTO FOR MENTAL HEALTH REFORM

Peter Kinderman

We urgently need substantial improvement in our mental health care systems. But we should not assume that we should be investing in more of the same. We would be able to offer more if we were to do things differently.

Nobody denies the reality of the suffering of both children and adults. Criticising the disease model of psychiatry and its diagnostic approach does not mean 'domesticating' people's problems or pretending they don't exist. Quite the reverse; when we stop attributing real problems to mythical diseases, we will be better able to see and acknowledge the nature of the difficulties that adults and children face.

There are good reasons to support greater investment in mental health services - or, rather, in those public services that serve to protect and maintain our mental health. In 2018, the Organisation for Economic Co-operation and Development estimated that the direct costs of mental health problems to the UK economy are around £94 billion or 4% of gross domestic product per year (Boseley, 2018). Worldwide, the annual costs of mental health problems have been put at $2.5 trillion. The personal costs are even greater. In the UK in 2017, 5,821 people took their own lives (UK Office for National Statistics, 2018), and suicide is now the most common cause of death for women in the first year after childbirth (Knight et al., 2018). Worldwide, there are nearly a million deaths by suicide each year (World Health Organization, 2018).

In a dramatic and surprising comment, the former Director of the US National Institute of Mental Health, Thomas Insel, acknowledged that the biomedical framework (which he promoted and from which he benefitted) and $20 billion dollars in research funding failed to "move the needle" in improving our mental health and wellbeing (Henriques, 2017). There is real scepticism within the profession as to whether neuroscience has been valuable for psychiatry (Kingdon & Young, 2007). While thousands

of research papers discuss the biology of 'mental illnesses,' we still have no clinically useful 'biomarkers' or robust theoretical models; and while millions of people are prescribed medication and other physical treatments, we have also seen (perhaps even as a consequence) increased mortality rates and worsening outcomes (Saha, Chant, & McGrath, 2007).

Nevertheless, when David Kingdon (2020) recently tweeted that "*it is still not possible to cite a single neuroscience or genetic finding that has been of use to the practicing psychiatrist*", a former President of the Royal College of Psychiatrists (and, then, President of the Royal College of Medicine), answered: "*A small correction - should read "it is not *yet* possible …* " (Wessely, 2020). The clear wished-for inference is that, despite decades of failure, the success of the disease model of mental health is just around the corner.

In a very recent preprint paper, Nils Winter and colleagues (2021) examined the possible value of a wide range of biological variables "under near-ideal conditions" in identifying people experiencing serious depression. They found that such biological variables as neuroimaging and psychiatric genetics yielded only "remarkably small" effect sizes, whereas ("in stark contrast", as the authors say) self-reported environmental factors such as childhood maltreatment and perceived social support explained up to 48 times more variation in levels of low mood.

This means that mental health problems do not need to be seen as brain diseases. Mental health services must be based on the premise that our psychological wellbeing depends on the things that happen to us, how we make sense of those events and how we respond to them. The assertion that our distress is best understood merely as a symptom of diagnosable 'illnesses' is only one perspective, and a rather unhelpful one. Instead of relying on a 'disease model', which assumes that emotional distress is merely a symptom of biological illness, we need to embrace and implement a compassionate, social, and psychological approach to mental health and wellbeing that recognises our essential and shared humanity.

A paradigm shift

The pressure for a new framework of understanding mental health, and consequently for the reconfiguration of services, is certainly not merely

a fringe idea. The World Health Organization has argued that the way that we care for people with mental health problems across the world is "*a hidden human rights emergency*" (World Health Organization, 2015), and has also supported quite radical change. In June 2017, the United Nations' Special Rapporteur Dainius Pūras, a practicing child psychiatrist from Lithuania, issued a report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Pūras, 2017). Dr Pūras's report is clearly soundly based on psychological science, but is also ground-breaking in its honesty. It's worth quoting at length:

> "*For decades, mental health services have been governed by a reductionist biomedical paradigm that has contributed to the exclusion, neglect, coercion and abuse of people with intellectual, cognitive and psychosocial disabilities, persons with autism and those who deviate from prevailing cultural, social and political norms … (p. 4)*"
>
> And: *"Public policies continue to neglect the importance of the preconditions of poor mental health, such as violence, disempowerment, social exclusion and isolation and the breakdown of communities, systemic socioeconomic disadvantage and harmful conditions at work and in schools …* (p. 4)"
>
> And: *We have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions …* (p. 6)"
>
> The report pulled no punches, condemning; "*Reductive biomedical approaches to treatment that do not adequately address contexts and relationships can no longer be considered compliant with the right to health.* (p. 17)"
>
> And, finally: "*There exists an almost universal commitment to pay for hospitals, beds and medications instead of building a society in which everyone can thrive …* (p. 16)"

Dr Pūras' report constituted a stern warning about the dangers of any unrestricted international application of a Western, psychiatric, disease-

model approach to mental health, counseling against technical diagnosis, biological explanations, and a reliance on pharmacological interventions.

Drawing on a range of examples and resources, including the British Psychological Society's report (of which I was an author) 'Understanding psychosis' (Cooke, 2014), Dr Pūras's report emphasizes the need for a "*paradigm shift*" towards offering culturally-appropriate psychosocial interventions as the first-line approach; working in partnership with members of the public who use mental health services and carers; respecting diversity; and taking steps to eliminate coercive treatment and forced confinement. This all should – Dr Pūras argues - be backed up by firm commitments to social policies addressing the root causes of poor mental health across whole populations, such as poverty, discrimination, abuse and structural inequalities.

This is a radical shift, from seeing our difficult or troublesome thoughts and emotions as 'symptoms' of 'mental illnesses' to seeing these experiences as what they are—psychological responses to real-word challenges. Such a welcome shift would do away with ideas of disorder and pathology and abnormality. It would involve no longer thinking about the aetiology of 'major depressive disorder' and allow us to begin to think about what makes us depressed. Or, more radically still, what gives us a sense of meaning and purpose in life. It would mean that we would stop describing the completely understandable consequences of traumatic events as symptoms of a 'disorder' and instead understand and describe how those events impact on our lives.

And it could mean that we would stop seeing our helping responses as 'treatment.' We may well treat diabetes or Dupuytren's contracture, but we don't 'treat' racism or poverty; or, to be precise, when we use the analogy, we realize that it's an analogy. And, while we would clearly try to prevent these kinds of problems occurring in the future, there is absolutely no reason to believe that we have to think of these problems as 'illnesses' in order to do that. In fact, clearly, it would help to mitigate the problems of such challenges to our rights and wellbeing if we were to avoid sweeping the issues under a carpet of individualized hypothetical pathologies.

If we take the path of pathologizing our psychological wellbeing, we do not have to harbour uncomfortable thoughts about the human costs of poverty, inequality, loneliness, bullying, violence, abuse and exploitation. All these troubling issues – the real-world events of our lives that are the root causes of our distress – can then be kept comfortably at arm's length. Conveniently for anyone with vested interests in the current system, the focus of attention moves to so-called 'mental illnesses.' We then focus on looking for pathologies within the individual – whether genetic or biological abnormalities, or 'thinking errors.' An expensive system develops to 'treat' these 'illnesses,' with all the professional consequences. Multinational pharmaceutical companies step in to offer drugs – at a profit. In the UK, each year, we spend £800m on psychiatric drugs. And the 'disease model' also often strips professionals of their ability to empathize. When people are distressed and feel that their sanity, even their life, is threatened, they need empathy and compassion more than ever. But because the patient's behavior is seen as irrational, the symptom of an 'illness,' even of a disease, we stop trying to understand the human reasons why they might be feeling or acting the way they are.

Labels are for products: Alternatives to diagnosis

We deserve nothing less than a wholesale revision of the way that we think about psychological distress. We should recognize that distress is an unfortunate but nevertheless normal, not abnormal, part of human life. We experience many difficult circumstances in our lives, and often become distressed as a consequence. This needs to be reflected in the way we identify, describe and respond to that distress, recognizing the overwhelming evidence that severe distress or unusual experiences (which now attract the misleading label of 'psychiatric symptoms') lie at one end of continua with less unusual and distressing mental states. There is no easy 'cut-off' between 'normal' experience and 'mental health problems'.

Some people obviously report that diagnostic labels are helpful. It is, for example, important for people to learn that their problems have names. And, of course, they do – anxiety, loneliness, sadness, and anger can all be named. But beyond that, the idea that a diagnosis is more helpful or reassuring than such straightforward labeling of comprehensible real-

world problems is illusory. There is no greater understanding of the problems, no better knowledge of their causes or aetiology, or no more appropriate "treatment" or prognosis – because diagnoses simply can't offer that information. Instead, the sense of helpfulness associated with diagnosis seems to result from the person knowing that they have been listened to (and heard), that their problems have been recognized (in both senses of the word), understood, and validated, and that these problems can be explained (and are themselves explicable rather than simply 'mad'); and – of course - that some help can be offered.

But in the flawed world of present-day services, people often find that they are reassured by a diagnosis, but then find any real help is illusory. The diagnoses convey very limited useful information, will not explain things, will not guide treatment and will not help predict the future. Instead, a clear description of a person's real problems would be much more useful. A simple description of an individual's actual problems would provide more information and be of greater communicative value than any diagnostic label.

Non-diagnostic alternatives

Rather than offering pathologizing diagnoses, we could simply list a person's presenting problems (Kinderman & Allsopp, 2018). A simple list of problems would be more than sufficient as a basis for individual care planning, for communicating between professionals, as the basis for research, and for the design and planning of services.

It is easy to see how many of the diagnoses currently used could be replaced with more appropriate language. We all know what it means when someone is feeling low, has intrusive, anxious thoughts, or feels compelled to carry out certain actions such as checking or cleaning. We understand what it means to say that a child has problems focussing their attention or sitting still. We understand what it means when we say that someone is hearing voices, and so on. Much of the scientific effort of psychology (and other disciplines) is based on the practical identification and definition of such specific phenomena. The Oxford English Dictionary defines the scientific method as: 'a method or procedure that has characterized natural science

since the 17th century, consisting in systematic observation, measurement, and experiment, and the formulation, testing, and modification of hypotheses.' Scientists use precise operational definitions of relevant concepts in their everyday work. We develop hypotheses and collect data. There is no particularly difficult challenge to develop an alternative to diagnosis and the 'disease model'. We've had one since the 17th century.

A straightforward phenomenological approach - the operational definition of our experiences – would enable our problems to be recognized (in both senses of the word), understood, validated, explained (and explicable) and open a plan for help. This would meet the universal call for appropriate, internationally-recognized data collection and shared language use, and avoid the inadequacies of reliability and validity associated with traditional diagnoses. Such phenomenological codes offer a constructive, radical way forwards.

Moreover, both major diagnostic systems (DSM and ICD) contain within them the kernels of this alternative, phenomenological, system for identifying and describing psychological phenomena and distress (Kinderman & Allsopp, 2018). Within ICD-11, specific 'phenomenological codes' permit the recording of a wide range of relevant phenomena, including; non-suicidal self-injury (MB23.E), anxiety (MB24.3), depressed mood (MB24.5), elevated mood (MB24.8), feelings of guilt (MB24.B), and auditory hallucinations (MB27.20).

We may not yet have a complete taxonomy of phenomenological terms, and we may well need to agree on operational definitions. But we have the start of a workable system. It's a system already embedded in official diagnostic manuals. We don't need a new system; we can use the best elements (but the rarely used elements) of the existing system.

Recognizing causes in the real world

We know that childhood trauma, poverty, and social inequity are major determinants of our psychological health. Winter and colleagues (2021) estimated that differences in social factors such as childhood maltreatment and social support explained up to 48 times more variation in levels of low

mood than did biological or neurological differences. It was because of data such as this that the United Nations Special Rapporteur (Pūras, 2017) characterised mental health care not as a crisis of individual conditions, but as a crisis of social obstacles. It is important, therefore, that the circumstances that have given rise to distress – those 'social obstacles' – should be formally recorded alongside the distress itself. If we don't do that, we're in danger of returning to (or sticking with) a system that identifies 'illnesses' but fails to identify causes. Given that we're bombarded with messages about the likely biological and/or genetic causes of so-called 'mental illnesses,' there's every chance that we will simply assume that – with no identified external cause – the problem must be the result of some pathology or flaw within us.

As well as listing diagnoses, the ICD system was designed to permit health care planners to understand the root causes of ill-health. That means that the ICD system comes with a whole variety of vitally important healthcare indicators – issues that are not themselves illnesses, but which are necessary to record in order to help track and explain illness. You might not find it particularly funny if you have been the victim of an unfortunate accident involving a bite or a trip, but the ICD system does include some obscure and even amusing causes of injury. XE69N is the code to be used if someone has received an injury from a "parrot, parakeet, or cockatoo." and XE4AP is the code used if someone has injured themselves with "nightclothes, pyjamas, nightwear, underwear, undergarment, or lingerie." I should reveal that I did, myself, once trip over and break my own toe in a XE4AP-related incident. But the point of discussing these highly idiosyncratic determinants of ill-health is that the ICD is designed to collect data on the causes of injury.

This means that, although rarely mentioned or used, either in clinical practice or in the academic literature (Allsopp & Kinderman, 2017), both ICD-11 and DSM-5 include descriptive information about adverse life experiences and living environments. ICD-11 uses these quasi-diagnostic codes to document such factors as a personal history of sexual abuse (QE82.1) or a history of spouse or partner violence (QE51.1). That seems precise, clear and useful. Such events in our lives are of great causal significance in the development of psychological health problems, and, therefore, documenting them provides vital information both for clinicians, as we develop co-produced formulations, and for health service planners.

The ICD-11 system allows for recording of a long list of very significant factors: low income, threat of job loss, unemployment, poverty, homelessness, illiteracy, conviction and imprisonment, experiences of crime, terrorism, disaster, or war or other hostilities or, for example, one's removal from home in childhood or – very importantly – "*... a personal history of maltreatment*." These quasi-diagnostic codes document neglect, abandonment, and other maltreatment, homelessness, poverty, discrimination, and negative life events in childhood. DSM-5 generally mirrors the ICD system, and therefore includes codes for a wide variety of problems related to family upbringing, and housing and economic problems. These are all important, are all part of the recognition of the social context of mental health … and are all perfectly recordable, within the 'official' World Health Organisation and American Psychiatric Association's recommended statistical manuals.

The drugs don't work

In the USA in 2014, over 80,000 prescriptions were issued for antidepressants to be taken by children aged 2 and younger, with a truly alarming 20,000 prescriptions for antipsychotic medication for these toddlers (Schwarz, 2015). In the UK, nearly a million prescriptions for Ritalin and related drugs for attention deficit hyperactivity disorder (ADHD) were dispensed in 2017, more than double the number of a decade earlier.

Not surprisingly (since the diagnoses don't match any patterns of problems we recognize in the real world, and don't relate to any 'biomarkers' – indicators of underlying biological abnormalities), the drugs offer only minimal benefit. It's not surprising that pharmaceutical chemicals can affect our mood; the vast majority of us regularly buy mind-altering chemicals every day. Coffee, tea, alcohol and nicotine show both that chemicals can affect our thoughts, moods and behavior, and that these can have effects (both good and bad) without necessarily treating any illnesses.

Although almost one person in every five has now been prescribed antidepressant medication in the UK, there's plenty of evidence that antidepressants are much less effective than we would like. Careful research comparing the long-term outcomes for people taking antidepressant medication with people taking placebos suggests only at best a very marginal benefit.

The same concerns apply to the long-term use of so-called 'anti-psychotic' medication. These drugs often have serious, life-changing (and occasional very noticeable) adverse effects. Because they affect various physical systems, such as our heart, liver and kidneys, as well as our brains, and because one of the common adverse effects is a significant gain in weight, these drugs can significantly affect our physical health (Moncrieff, 2013).

Outcomes for patients suffering from 'schizophrenia' have scarcely improved since the Victorian age and an increasing number of people are disabled by mental health problems. This contrasts with what has happened in physical medicine, where genuine advances have led to improved outcomes and reduced disability (Bentall, 2009; Whitaker, 2010). It does seem that some forms of pharmacological medication may be helpful in the short term for people in great distress (Moncrieff, 2009; 2013). That should not surprise anyone. Drugs that act on the brain are not new in human history, and we are well aware of their effects on mood and behavior of a variety of psychoactive substances. But – outside of the world of biological psychiatry – nobody regards these effects as 'cures,' or even 'treatments,' and we all know that such substance use can have significant negative effects in the longer term.

Drugs have effects on the brain. That's why we buy them, and that's why they are prescribed. But such an observation has no real bearing on the argument that our distress should be seen as a symptom of an 'illness' and 'treated.' In short, we need to be much more critical, sceptical, logical and cautious about the use of drugs. And all this is without mentioning ECT (electroconvulsive therapy).

A legal system that actually protects our human rights

At any one time in the UK, nearly 20,000 people are being detained in psychiatric hospitals against their will, 'sectioned' under the Mental Health Act. The use of mental health legislation does not appear to be restricted to extreme or rare circumstances; people with a wide range of problems can find themselves detained (Care Quality Commission, 2014). The history of mental health care is an unfortunate history of coercion, with many mental health treatments clearly rooted in moral judgements and punitive approaches (Porter, 2002; Shorter, 1997). Today, those concerns remain.

We do need to think about the legal context. Sometimes, our extreme low mood, risk of suicide, confusion or disturbed behavior puts us at extreme risk or, in very unusual cases, renders us a risk to others. It is important that our laws make appropriate provision for people whose difficulties put them at significant personal risk, or who pose a risk to others. But these are social and psychological problems, not medical issues. Diagnoses and even the "severity" of so-called 'illness' do not relate to risk and dangerousness. Once again, our decisions about how to keep people safe are inappropriately yoked to a system predicated on a 'disease model.'

A more coherent and fair approach, an approach more consistent with basic human rights, would be to agree to take decisions on behalf of other people if they are unable to make decisions for themselves, regardless of whether they have a diagnosis … and to make judicial decisions in the criminal justice field on the same basis. In practical terms (and from a UK perspective), that means basing our mental health legislation on something much more similar to the Mental Capacity Act than the current Mental Health Act. This doesn't mean 'letting people off,' and it doesn't mean ignoring someone's mental health, it means making appropriate decisions on a rational basis, and on premises that apply to everyone.

Prevention

The application of a psychosocial understanding of mental health and wellbeing allows us to envisage a future beyond the 'disease model.' First, and perhaps most importantly, we may be able to get traction on addressing the root causes of distress. My personal philosophy is humanistic; I place the person at the center of their universe, and emphasize individual agency. But this does not imply that people (or their thinking) can be blamed for their distress. A colleague of mine described this as the "social determinants of perception." That means that the way that we make sense of what happens to us plays an important role in determining our mental health, but is – itself – a product of circumstances. This means that, both directly and via their effects on our psychology, the most important determinants of mental health are the events and circumstances of people's lives. If, then, we are to protect people's mental health, we need wider social or even political change. This is often a neglected topic, but social and political changes are

likely to make much more difference overall than anything individuals can do alone.

For example, many people diagnosed with 'psychosis' have experienced poverty. Addressing poverty is rightly the cornerstone of government (although, these days, right-wing governments seem to ignore that fact). With a very specific focus on mental health, then, measures to reduce or eliminate poverty, especially childhood poverty, would be hugely beneficial. Moreover, absolute income is not the only important issue. A major contribution to serious emotional distress seems to be income inequality – the growing gap between the richest and poorest people in society. Mental health problems are highest in those countries with the greatest gaps between rich and poor, and lower in countries with smaller differences (Wilkinson & Pickett, 2009). This suggests that our mental health, at least in part, depends on a more equitable society.

Experiences of abuse in childhood are also hugely important. Rates of mental health problems would undoubtedly fall if we were able to find better ways of protecting children from abuse. This means working with teachers, social workers, community nurses, GPs and the police to identify and then respond to early warning signs that children might be exposed to sexual, physical or emotional abuse or neglect. It also means taking a serious look as a society at what we can do to bring down overall rates of abuse. Bullying – that is, peer-on-peer bullying in school and in leisure settings – is also important, and again here teachers and youth leaders could help … and thereby help prevent later mental health problems. Here, as well as responding as clinicians to children in distress, we need to prioritize action at a systems level to create a different culture.

In that context, we also know that experiences of discrimination are important – people who have survived racism, homophobia and sexual discrimination are often adversely affected by these experiences. Society – and leaders – can help. We can perhaps think of ways in which community leaders could help make communities more trusting, more open to help one another – more 'prosocial.'

Finally, many recreational drugs are associated with mental health problems. Alcohol is unquestionably the most serious substance-related

public health issue, but cannabis and other more traditional 'drugs' have been associated with mental health problems. This certainly doesn't mean that we need more regressive legislation; the so-called 'war on drugs' does not appear to have been won, and many people argue that de-criminalising the possession and use of psychoactive substances would be an important positive step towards protecting people's health.

A manifesto

If we are to continue to improve mental health care, we need to shift from a 'disease model,' which assumes that emotional distress is merely a symptom of biological illness, towards social and psychological approaches to mental health and wellbeing. While all of our thoughts, behaviors and emotions emanate from the biological activity of our brains, this does not mean that mental health problems need therefore to be regarded as brain diseases.

Mental health services would better meet our needs if they were based on the premise that our psychological health and wellbeing depends on the things that happen to us, how we make sense of those events and how we respond to them. The assumption or assertion that our distress is best understood merely as a symptom of diagnosable 'illnesses' is only one perspective. Rather than employ medical, pathologizing language and methods, we can and should use effective, scientific, understandable alternatives. To understand and explain our experiences, and to plan services, we need to develop co-produced 'formulations' and sharply reduce our reliance on medication.

Hospitals could be replaced with residential units designed and managed from a psychosocial perspective, and mental health legislation must respect our rights to make decisions for ourselves unless we are unable to do that; and also to provide for much greater judicial oversight. Teams best meet our needs when they are multidisciplinary, democratic and aligned to a psychosocial model, and psychological health services may best be managed as social services, alongside other social, community-based, services.

This is a manifesto for reform. While biomedical research is valuable, we must reject claims that overstate or misrepresent the evidence base. This

means no longer treating mental health issues as predominantly caused by brain pathology, but rather embracing evidence that psychological health issues are usually responses to social and environmental factors. This change will reduce stigma, more accurately capture the nature of distress, reduce the emphasis on pathology in our mental health discourse and promote the research and implementation of more effective non-biomedical alternatives.

Psychiatric drugs are now prescribed to over 20% of the adult population. Antidepressant use has doubled over the past ten years, as has the average duration of antidepressant use. While we need to recognize the role drugs can play, we need to reduce excessive and unnecessary long-term prescribing due to the associated harms of dependency and withdrawal. As recent research also shows that long-term use leads to worse outcomes (and can be linked with rising levels of disability), doctors could prioritize short-term prescribing, always with a plan for coming off. Additionally, patients must be properly informed regarding potential harms as well as benefits and must no longer be misled by unsubstantiated rationales for prescribing, such as notions of brain chemical imbalances.

We must reform the essential structures of psychological health provision delivery. While psychological health care requires appropriate funding, and healthcare professionals will continue to play valuable roles, we should not increase funding for services with poor outcomes, nor assume that current models of leadership, management, governance and service commissioning are always preferable. Instead, we should prioritize investment in more effective alternatives, and move funding from fragmented biomedical services to integrated, whole-person, and community care. As psychological health issues often have social or environmental causes, psychological health services would most effectively meet our needs if they were able to prioritize prevention and early intervention and be more closely integrated with both physical health services and local authority social and educational services.

We must reform our public mental health campaigns, moving from biomedical messages to a psychosocial perspective. The general public, the media, and mental health professionals require accurate information about the nature, origins and resolution of psychological issues. We must

de-medicalise and de-pathologize public discourse, helping to promote a more constructive and less-stigmatizing public relationship to behavioral and emotional difficulties, and encouraging people to take more active steps to protect and improve their psychological health.

We must reform those institutions that uncritically maintain and promote the current unsuccessful approach to psychological health provision. This will involve substantial transfers of power, from individual clinicians to teams, and from professionals to service users. We must ensure that there is proper representation of service users on expert groups and promote a person-centred approach to psychological health care, which emphasizes fundamental human rights and personal autonomy.

Finally, because our mental health—our psychological health—and wellbeing are largely dependent on our social circumstances, we must work collectively to create a more humane society: to reduce or eliminate poverty, especially childhood poverty, and to reduce financial and social inequality. This is indeed a manifesto for change. It might even be revolutionary. But it's also achievable.

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APPLES, ORANGES, APRICOTS AND PEARS

Eric Maisel

In Volume 1 of this series, and throughout Volume 2, we've presented good, solid deconstructive critiques of the psychiatric model. I hope that we've convinced you that the psychiatric model is misguided at best and infuriatingly scandalous at worst. You may now find yourself somewhere on the continuum from "reform is needed" to "psychiatry ought to be abandoned." Let me welcome you to that continuum and invite you to become an advocate for reform.

But what about the second part of the equation, the "humane alternatives" part? The mental disorder paradigm may be wrong-headed and worse, but how are we supposed to help the hundreds of millions of people worldwide who are experiencing life in ways that have earned them, or could earn them, a psychiatric label? If, for instance, a chemical fix isn't the best answer for the millions upon millions of people who are "depressed," what are the better answers? Or is that question too large and must we just throw in the towel? But if we do that, aren't we letting the chemical answer stand—and win?

In this volume, and throughout this series, we are asking but not adequately answering three huge, messy, all-over-the-place questions: what do we mean by "humane," what actually helps, and, fundamentally, humane help for *what*? What is the problem that we are looking to solve? It would be lovely if we were just talking about brain chemistry, but we know that we are not. We are talking about nothing less than human life in its totality, about the nature of our species, and about the intersection of all those subjects that at university have separate buildings: psychology, philosophy, religion, sociology, anthropology, political science, counseling, and more.

We are talking about ninety-nine different problems with dozens of possible solutions for each, solutions that range from "up from poverty" to

"spiritual release" to "social overhaul" to "I don't have the problem, you do." Between the lines we are asking—or dodging—questions like "What is normal?" and "Is normal a particularly good thing, if the majority of normal people can be led about by the nose like sheep?" We are asking, "Who gets to decide about normal?" and "What good is our language if we use a word like 'depression' to stand for everything from 'what I feel because my life is miserable' to 'what I feel because my country is occupied' to 'what I feel because I've chosen the wrong career path' to 'what I feel because I no longer believe what I once believed and find myself still trapped in an oppressive environment'?"

Aren't we simply asking too much? Maybe. But this effort is needed. If our initial results look to be all over the map, such that we are talking about a humane residential treatment center in one breath, and the relationship between indigenous peoples and their confiscated land in the next breath, and alternative ways of "diagnosing" or describing a distressed person's distress in the third, so be it. Hopefully, we will tease apart these questions over time, volume by volume. That is our hope and our mission.

There is of course the open question as to whether we can make any sense, or enough sense, of the problems under discussion. Then there is the question of what we mean by the phrase "humane help" and what amounts to "humane help." Do we mean "effective help," even if, for example, the most "effective" thing to do in a given instance is to tranquilize an agitated, violent person with powerful chemicals? Does "humane" mean "effective," if that's what "effective" looks like. If not, then what do we mean by the word in this context?

Do we essentially mean something like the following: providing a distressed person with something relatively non-intrusive and non-invasive, that the individual agrees with and agrees to under some true sense of informed consent, that matches or aligns with the problem, and that isn't the ninth-best or eighth-best thing that we can dream up but something closer to the best? Or do we mean something like that and do we *also* mean overhauling society along socialist lines, for instance, so that people can share better in the pie and can worry less about their basic survival needs? Or do we mean both of those and *also* something about a basic philosophy of life, a way of

looking at life that helps them better weather inner and outer difficulties, something along the lines of a deep stoicism or an updated existentialism?

To repeat, what do we mean by "humane help"? Say that you hate your job and as a result you are "depressed." A politician might frame your problem as "illegal immigrants." A psychiatrist might frame your problem as "chemical imbalance." A cleric might frame your problem as "separation from God." A psychoanalytic therapist might frame your problem as a "conflict between your id and your superego." A Jungian therapist might frame your problem as "a thwarted spiritual awakening." A family therapist might frame your problem as "the stress caused by family responsibilities." A friend would likely come closest to the truth of the matter by saying, "You hate your job and that's depressing the hell out of you."

What help might the politician offer? "I'll stop the flow of illegal immigrants." And maybe hearing that will make you feel better. The cleric might offer you God, as in "Go with God, my son," and maybe that will make you feel better. The Jungian therapist might invite you to create a personal mandala, and maybe that will make you feel better. Your friend might invite you to have a drink or two, and maybe that will make you feel better. Not a single thing about your job or the real world would have changed by virtue of these "interventions," but maybe you will feel better. Or, of course, quite likely you won't, given how essentially inadequate are "helping hands" of this sort.

If you hate your job, as 75% of Americans report they do, and if, as a result, you are "depressed," then you need a different job, not talk about why you hate your current job or chemicals to make you feel numb. Yes, talking about ways to cope with your current job, maybe as you plan your exit strategy, might prove useful. And numbing has always worked in its own way as a kind of "help." But if it were in my hands to do the most humane thing for you, it would be to hand you a more fulfilling job. That's the real help you want and need—and, for the vast majority of people, can't have.

So, what I dream up to offer you, including and maybe especially talk, may well prove a third-rate or third-best helping hand. Maybe I'll be able to provide some wise or warm or comforting words instead of what you

really need, which is a better job and a better life. You are sad, in despair, or, in the vernacular, "depressed," and the only help I may be able to offer you is to take your mind off your troubles, or to give you the chance to talk about your troubles, or to offer you up a scapegoat for your troubles (those "illegal immigrants"), or to invite you to believe that your troubles will be followed by an eternity of bliss.

Let's take a second example, one where the problem is "psychological" rather than practical. Say that you are in extreme and almost ceaseless psychological pain because you momentarily failed to watch your child at the beach, and she drowned. I doubt that even the most cynical psychiatrist would dare to say that the cause of your despair is a chemical imbalance in the brain. Every single person on earth knows that there is nothing to offer you to "make you well" or to "treat your depression." Every single person on earth knows that all that can be hoped for is that "time will heal" that impossible wound. Every single person on earth knows exactly what is going on.

The politician will continue to say, "illegal immigrants." The cleric will continue to say, "She's in a better place." The therapist will continue to say, "Do you want to talk about it?" And maybe such responses will help a bit. But every single person on earth knows that what is really required here is a do-over, which is for the drowning not to have happened. And everyone knows that that can't be had. That mother will somehow need to live with that pain, if she can. In short, there is no adequate help for her—and we are obliged to look at that possibility, that for so much of what we consider our subject matter, we may land on the conclusion that no adequate help is available or even possible.

But maybe the following is always available and genuinely useful. It might be argued that "the right" philosophy of life might amount to true help for all human distress and any possible human situation. For instance, if you truly believed in Heaven and in a loving God who operates in mysterious ways, that might actually and truly lighten your burden and make it easier for you to survive your child's drowning. It seems plausible that a philosophy of life that is so robust that it can make all circumstances bearable, if adopted, would amount to a super-helpful all-purpose mental health aid.

In everyday language, we would call this a philosophical, spiritual, or religious solution, and whether it was rooted in Stoicism, existentialism, Christianity, Buddhism, some little-known philosophy, or a personally-created philosophy, if it managed the rather amazing trick of immunizing you from psychological pain, well, wouldn't that amount to *the* vaccine?

These are the fascinating questions and the possible answers before us. First, we are asking the hard questions. What exactly are the problems? Can they be named, distinguished one from another, put into categories, and so-to-speak intellectually contained? What do we mean by help? What do we mean by humane, effective, or best help? Wouldn't it be lovely if one day we could say, if this is the problem, then this is the help, and not just the ninth-best or eighth-best thing we can think of to offer but actually the very best thing: an airlift out of the desert for a man dying of thirst, and not just a jug of water.

So, yes, we have not yet come close to doing an adequate job of painting a picture of what the phrase "humane alternatives to the psychiatric model" means, implies, or encompasses. We could charmingly opt for metaphor and say that we have "presented a mosaic" or that, as in the famous Sufi tale, we have "explored different parts of the elephant." But charming metaphor aside, we simply haven't done justice to this subject yet. But I do believe that we are honorably exploring the territory, the territory of apples and oranges and pears and apricots and all those odd tropical fruits that we have no names for.

And these are genuinely apples and oranges and so forth. How chemicals work to alter a person's biology is a different subject from how neoliberalism supports a capitalist approach to mental health is a different subject from conceptualizing psychodynamics, the individual psyche, and the indwelling world of the individual is a different subject from the mental health benefits of connecting to one's ancestral land is a different subject from hallucinations that may result from serious physical illness.

The place of disappointment, envy, shame, grief, and everything else human in any mental wellness equation is a different subject from the disastrous results of abuse on the psyche or the disastrous results of civil