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Is ‘another’ psychiatry possible?

Diana Rose[1] and Nikolas Rose[1,2]

[1]Australian National University, Canberra, Australia and [2]Institute of Advanced Studies, University College London, London, UK

Commentary

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Author for correspondence:
Nikolas Rose,
E-mail: nikolas.rose@ucl.ac.uk

Abstract

In this paper, we examine a number of approaches that propose new models for psychiatric theory and practices: in the way that they incorporate ‘social’ dimensions, in the way they involve ‘communities’ in treatment, in the ways that they engage mental health service users, and in the ways that they try to shift the power relations within the psychiatric encounter. We examine the extent to which ‘alternatives’ – including ‘Postpsychiatry’, ‘Open Dialogue’, the ‘Power, Threat and Meaning Framework’ and Service User Involvement in Research – really do depart from mainstream models in terms of theory, practice and empirical research and identify some shortcomings in each. We propose an approach which seeks more firmly to ground mental distress within the lifeworld of those who experience it, with a particular focus on the biopsychosocial niches within which we make our lives, and the impact of systematic disadvantage, structural violence and other toxic exposures within the spaces and places that constitute and constrain many everyday lives. Further, we argue that a truly alternative psychiatry requires psychiatric professionals to go beyond simply listening to the voices of service users: to overcome epistemic injustice requires professionals to recognise that those who have experience of mental health services have their own expertise in accounting for their distress and in evaluating alternative forms of treatment. Finally we suggest that, if ‘another psychiatry’ is possible, this requires a radical reimagination of the role and responsibilities of the medically trained psychiatrist within and outside the clinical encounter.

To ask this question is to presume that something – maybe a lot – is amiss with current psychiatry or rather with the variety of approaches available within psychiatry today. There have, of course, been dozens of critiques of the ‘medical model’ and the ‘psychiatrisation’ of sadness, anxiety and other relatively normal variations of mood and affects, but we will not rehearse them here (Conrad, 1992; Horwitz & Wakefield, 2007; Lane, 2007; Pilgrim, 2019; Rose, Perry, Rae, & Good, 2017; Scull, 2015). Nor will we examine recent attempts to reshape psychiatric by adopting a ‘biopsychosocial approach’ (e.g. Savalescu, Davies, Roache, Davies, and Loebel, 2020). Rather, we shall look at those developments that call themselves ‘alternatives’ to psychiatry and compare them with aspects of mainstream psychiatry with two purposes. First, to highlight some of the shortcomings of current psychiatry and second to see how far these ‘alternatives’ really do depart from mainstream models in terms of theory, practice and empirical research. What is shared and what differs between these different approaches and ‘the mainstream’? If ‘another psychiatry’ is possible, what would be the role and responsibilities of the medically trained psychiatrist within and outside the clinical encounter.

The attempts to produce ‘another’ psychiatry range from social psychiatry to postpsychiatry. Social psychiatry is associated with figures such as Aubrey Lewis and Michael Shepherd and tried to situate the person in their social milieu (Bynum, Porter, & Shepherd, 2004; Lewis, 1953). But no developed theory of the ‘social’ was ever produced. The ‘social’ in social psychiatry was transformed into ‘the environment’, but this was weakly specified and often amounted only to a set of provoking or protective factors working on an underlying organic or biological constitution. As genetics and genomics once more came to the fore in psychiatric thinking, this relation was often specified in terms of simplistic formula – $P = G \times E$ – where the phenotype (P) of an individual – his or her psychiatric diagnosis – was a product of the interaction between genes (G) and environment (E), but this formula gave a scientific gloss to what was rarely if ever a clearly specified relationship (Caspi & Moffitt, 2006; Modinos et al., 2013)

Postpsychiatry

Postpsychiatry is associated with the work of two psychiatrists, Phil Thomas and Pat Bracken and, as the name suggests, proposes a link between post-modern thinking and a new psychiatry (Bracken et al., 2021; Bracken & Thomas, 2001). Bracken takes Foucault as his example of post-modernism which is unfortunate as Foucault was at pains to reject this description of his approach (Bracken, 1995). Postpsychiatry argued that psychiatry as we know it today is culturally and historically specific, rooted in Western Enlightenment ideas of the distinction between the normal and the pathological, and of the nature of the normal itself. Leaving aside the adequacy of this characterisation, there were two main implications of this argument for psychiatry, both of them focussed on practice. The first, based on their own work with the Bradford Home Treatment Service which was established in 1996 was to suggest that Home Treatment Teams were an alternative way of thinking and practicing, stressing the importance of context and culture, and the need to interpret symptoms as meaningful, opening a space for dialogue where the professional works with the patient to uncover the specific roots of her distress in her own life situation. In fact, Home Treatment Teams were not pioneered by post-psychiatry, but by Sashi Sashidharan and community activist Errol Francis in an attempt to address racism in services (Sashidharan & Francis, 1999). However as they have been implemented in practice, at least in the UK, they have changed the setting but not the interventions: they have become a way of coping with the lack of in-patient facilities, combining risk assessment in the patient's home – was the patient an immediate risk to themselves or others – and checking on medication adherence: the involvement of non-psychiatric professionals in the team is mainly a way of coping with the limited availability of medically trained psychiatrists themselves (Wheeler et al., 2015).

Second, Postpsychiatry calls for the mental health survivor movement to be taken seriously, and for treatment to focus on the meanings and values of the recipient of mental health care. But while the emphasis was on the way in which such meanings and values should figure in the treatment encounter, the suggestion that this might enable power-sharing, allowing the patient to produce his or her own interpretation of their symptoms, ignored some fundamental asymmetries in the powers of patient and professional (Perestelo-Perez, Gonzalez-Lorenzo, Perez-Ramos, Rivero-Santana, & Serrano-Aguilar, 2011). We can see this in the UK's National Service Framework for Mental Health (Department of Health, 1999) which Bracken and Thomas cites as a further example of the aspect of 'post-psychiatry.' This stressed the crucial importance of the involvement of service users. Users expectations were to be core to its principles: the Service was to '(a) meaningfully involve users and their carers; (b) deliver high quality treatment and care which is effective and acceptable; (c) be non-discriminatory; (d) be accessible: help when and where it is needed; (e) promote user safety and that of their carers, staff and the wider public; (f) offer choices which promote independence….' (Thornicroft, 2000). While these values seem virtuous, the involvement of users themselves in the process of development of this Framework did not bode well for its implementation. One of us (DR) interviewed all 8 users who were involved in developing the NSF and all said they would never do such work again – indeed five did not last the course. The service users felt that they were not allocated work commensurate with their knowledge and skills. The Black users had a particularly torrid time and were distressed upon recalling it. They experienced racism from white users and were completely ignored by the Black professionals (Wallcraft, Read, & Sweeney, 2003). Of course, one cannot extrapolate from the problems in the development of the Framework to its implementation in practice, but they do demonstrate some of the realities of 'user involvement' in policy development. Genuine change must come from understanding what is implied by a genuine sharing of powers between professionals and users, recognising the importance of distinct forms of expertise – including expertise from experience of services themselves. Experience shows that, whatever the aims, such collaborations are often underpinned by a tacit assumption that, when it comes to making decisions, 'professional knows best' which almost always prioritises short term symptom management, because the time and resources to effect the radical change to personal, social and economic circumstances prioritised by users are usually absent.

A lesson here is that new ideas that seemed to have potential for a radical transformation of psychiatry, that is to say a shift in the power relations between professionals and users, and a recognition that symptoms are, often if not always, an intelligible response to context bound problems in the user's lifeworld and experience, seem doomed to be recuperated back into individualised treatment, even if accompanied by a greater openness to listen compassionately to the voices of those experiencing distress. Thus the 'Recovery' approach, started by service users like Patricia Deegan and Mary O'Hagan (Deegan, 1988) as a collective endeavour has been turned into an individual 'treatment' by workers such as Mike Slade and Larry Davidson (Borg & Davidson, 2008; Slade, 2009). And it is a normalising journey, that is to say, one that has as its aim the restoration of the client to a particular version of normal life set not by the 'client', but by the professionals involved (Landry, 2017; D. Rose, 2022). We can also see this pattern of initial radicalism followed by recuperation to normal practice in in the strategy of Patient and Public Involvement (PPI) in research and policy that was pioneered by the UK's National Institute for Health Research (NIHR). The PPI programme appeared to offer a radical promise, to involve service users in developing research priorities and to explore novel research methods. But in practice it did not challenge the traditional forms of 'evidence based medicine' with its narrow, symptom based criteria for success. Indeed, NIHR has now closed the PPI programme, and it has been argued that the strategy of involvement of the public and service users in health care was actually a technology of 'legitimation' for conventional psychiatric research (Harrison & Mort, 1998).

Psychological alternatives

Two other 'alternatives' have recently come to the fore: Open Dialogue and the Power-Threat-Meaning framework. Interestingly, these are not led by psychiatrists but psychotherapists and psychologists respectively. Nonetheless, they position themselves *against* conventional approaches in psychiatry so a comparison is in order.

Open dialogue: engaging the community

Open Dialogue may be seen as a form of 'family therapy' or 'network therapy' which can also involve the community (Olson, Seikkula, & Ziedonis, 2014). The approach originated in the work of a team in a psychiatric hospital in Northern Finland: the 'client'-however distressed–their family, members of their social network and all professionals involved are invited to the first and subsequent meetings, which often take place in the client's home. A team is formed that seeks to understand what it is in the life of the client and their relations with others that has led to this crisis, and which develops usually non-medical-ways to resolve it. While this approach has shown some success in the specific biopsychosocial niche in which it developed, in small local communities in a sparsely populated region, it is not clear if it would work elsewhere. There is an ongoing Randomised Control Trial of Open Dialogue in England, but early results suggest that it meets various obstacles in inner-city settings (Pilling et al., 2022). Open Dialogue actually shares key features with conventional psychiatry – it involves the presence of therapist as expert and a focus on the individual patient albeit as seen as part of wider interpersonal system. The possibility of bringing community members into the therapeutic space is novel both conceptually and practically, although the idea of inviting peers to Open Dialogue sessions has received very ambivalent responses (Razzaque & Stockmann, 2016). More generally, the difficulty of transplanting this practice from one specific niche to other locations confirms the evidence from ethnographic work (Ecks, 2013; Han, 2012) that the fate of all 'interventions' is always 'context specific'. The crucial importance of context is as true for standard randomised control trials (RCT) of psychiatric interventions: these almost always rely on decontextualised categorical ICD or DSM diagnoses, which assume patients in very different lifeworlds are suffering from a discrete condition characterised by a given set of symptoms, and that psychiatric drugs will work in similar ways in radically different contexts. While much earlier transcultural psychiatry argued that in most cases, cultural variability lay in in the *expressions* of mental disorders, rather than in underlying disorders themselves, there is much ethnographic evidence to show that this is not the case, and that forms of mental distress are specific to particular biopsychosocial niches. We would point, for example, to the work of Lawrence Kirmayer and Allan Young (Kirmayer & Young, 1998), or that of Stefan Ecks in India, (Ecks, 2005, 2013), or to Joseph Gone's research on the very specific form of intergenerational trauma amongst First Nation Canadians (Gone, 2013).

Gone issues a general 'provocation' to community psychology to move away from 'ego centric' notions of the person, and to recognise that other knowledge traditions have alternative healing practices based on quite different and often non-individualised understandings of mental distress (Gone, 2016). This recognition, that both mental distress and responses to it are specific to what we are terming 'biopsychosocial niches' poses fundamental challenges to the idea of 'scaling up' which is so prevalent in much Euro-American psychiatric research, including the Movement for Global Mental Health, that approaches which may seem effective in one particular location can be 'scaled up'. Gone's specific research may be very local, but his 'provocation' requires us to consider how we can truly incorporate an understanding of 'social context' on practices to alleviate mental distress.

Further, the move from the individual to engage 'the community' in practices such as Open Dialogue, does not address the longstanding, complex, social shaping of adversity – precarious lives in poverty, poor housing, polluted environments, social exclusion, isolation, stigma, racism and more – which many users of mental health services have experienced, often over years and indeed generations. While most psychiatrists are aware that there are 'social determinants' of mental distress, they are invoked, if at all, as background to their clinical priority of an intervention on the troubled individual. If psychiatry remains, fundamentally, an individual clinical practice, however much it makes reference to 'context' it will never be able to address, let alone redress, those social determinants that bring individuals to the clinic in the first place. It may be argued that it is not the role of psychiatrists to address such determinants. We will return to this point in our conclusions. It is true that there has long been a regrettable divide in medical practice and thought – and in medical prestige – between clinical practice and public health or prevention. Despite the impassioned cases made by physicians such as Thomas McKeown (McKeown & Lowe, 1966), Paul Farmer (Farmer, 1996; Farmer, Nizeye, Stulac, & Keshavjee, 2006) and Michael Marmot (Marmot, 2015; Marmot & Bell, 2012), the lessons of social medicine dating back to Virchow in the mid nineteenth century have not proved palatable to many of those who teach and practice medicine. Although there are signs of change (Adams, Behague, Caduff, Löwy, & Ortega, 2019), most public health messages still focus on individual behaviour change – stop smoking, avoid 'fast foods' – rather than attacking the conditions – such as price differentials between 'fast' and 'healthy' foods' that are well-known to promote such behaviours and to advantage those who profit from them. Indeed, when it comes to most mental health service users, healthy lifestyles, even if they were affordable, may be powerless in the face of the 'side-effects' of psychiatric drug treatment itself.

Power, threat and meaning?

Perhaps one can find some bases of an alternative approach in the relatively recent history of mainstream psychiatry. Adolf Meyer, at one time the most prominent psychiatrist in the US, was one of the earliest proponents of an approach to understanding the ailment of patient through the practice of 'Formulation' in which he sought to bring together all the biographical, social and psychological influences that had shaped the life of the patient, and which he believed were necessary to understand before attempting a diagnosis and developing a treatment plan (Lamb, 2014). From his 'psychobiological' perspective, social and biological factors that affect someone throughout their entire life should be considered when understanding and treating a patient (Lief, 1948). His approach also stressed the need to engage with the external environment of the patient, for example by advocating community support and occupational therapy. Despite the fact that 'formulation' is still a part of the training of many psychiatrists, it tends to be the medic's account of potential diagnoses for the presenting disorder. Thus trainees are advised that a formulation should include an account of the patient's background and living situation, a summary of relevant features of the patient's history and current situation, a proposed plan of treatment and prognosis. Since the 1980s, the Meyerian approach, which situated the very roots and character of the expression of distress, as well as the potential opportunities for treatment within the lifeworld of the patient, has been largely relegated to history. This is when we see the general acceptance of the belief, most famously inscribed in American Psychiatric Association's Diagnostic and Statistical Manuals, but also present in the International Classification of Disease's approach to mental disorders, that mental distress could be compartmentalised into a number of specific disease entities (Rosenberg, 2002; Rosenberg, 2006). The corollary was that that identification of the relevant disease entity was the key task of diagnosis, and one from which treatment – these days either targeted pharmaceutic or psychological intervention on the individual – would follow.

However, the formulation approach, or at least the centrality of what is called formulation, has recently been revived in the Power, Threat Meaning Framework (PTM) developed by clinical psychologists in the UK, and explicitly pitted against an particular image of contemporary, exemplified by the APA's Diagnostic and Statistical Manual (Johnstone & Boyle, 2018). Given the belief embodied in versions of the DSM from the 1980s that universal neurobiological abnormalities underpinned each diagnostic category, one might expect, then that those who developed this alternative would be critical of attempts to find universal biological bases for expressions of mental distress. But in fact biology, albeit in a different form, is central even though it is situated as a 'mediator' rather than as a primary cause of mental distress. PTM argues that nearly all expressions of mental distress are underpinned by evolved, pre-conscious, universal 'threat' responses such as the 'fight or flight' response' The proposition that distress is, in many if not all cases, a response to 'threat' is highly controversial (Duntley & Buss, 2008). Contemporary approaches to human evolution emphasise the ways in which evolved human behavioural and mental capacities are not fixed, but highly plastic, and shaped by, and enacted within, their specific biopsychosocial milieu (Clark, 1997; Ginsburg & Jablonka, 2019; Laland, 2017; Sterelny, 2003). As neurobiologists working on stress and its consequences have pointed out, whether or not a particular experience triggers to cascade of hormones commonly understood as the 'threat response' depends almost entirely on whether a particular situation is perceived as dangerous, threatening or stressful by the individual concerned at the time, and this is highly dependent on the external environment in which the individual finds themselves (McEwen, 2012). But the practical application of the PTM framework seems to entail reinterpreting events in a person's present and past in terms of threats even if they may not have perceived them as such themselves. These recurrent patterns identified in this Framework may not be classical 'disease entities' but the proposition seems to be that mental distress can be accounted for in terms of a small number of fixed patterns that can be identified by experts in the distressed person's life history. While the claim is that the mentally distressed person is included in the process of formulation, it seems that the answer – that their distress is to be accounted for as an the activation of an evolved response to a threat that they have experienced from some powerful person or institution – is known to the therapist in advance.

Both Open Dialogue and the formulation approach of PTM share an interest in psychological treatment; indeed, it seems that the psychologist or psychotherapist is to displace the psychiatrist as the leading expert in mental distress, its causes and treatments. It is usually thought such treatment is 'softer' because it does not entail the 'side effects' that come with medication. However, psychological therapies can involve their own forms of power. For example, some approaches place the onus for 'recovery' on the individual themselves and those who have experienced them often find that they instil guilt if you 'fail to get better' (Jackson & Rizq, 2019). Indeed, some approaches explicitly aim for 'responsibilisation' and thus, even if implicitly, accord blame to those who cannot 'succeed' in taking responsibility for the management of their own lives (Howell & Voronka, 2012). Such treatments can also be administered coercively or at least with the threat of removal of welfare benefits if you refuse, as for example in the role that CBT practitioners have acquired in the benefit system in the UK. The placement of psychologists in Job Centres with non-attendance for therapy resulting in loss of income has been called 'psycho-compulsion' in that it is a way of obliging people to attend for therapy, with the threat of loss of benefits if they refuse (Friedli & Stearn, 2015).

Alternatives to coercion

None of the alternatives we have discussed so far address the issue of compulsory detention in psychiatry. Yet many service users and some professionals argue that what marks psychiatry out from the rest of medicine is its power to detain and treat involuntarily, and that this should cease. Others argue that, however residually, psychiatrists must retain this power to prevent psychiatric patients harming themselves or others when under the sway of their illness. In this debate, which often concerns rare cases of violence towards others, one rarely hears the voice of the patient. One study (D. Rose, Evans, Laker, & Wykes, 2015) analysed focus groups of patients who had recently been on inpatient wards as well as focus groups of nurses. The two dominant themes were (lack of) communication and coercion. When it came to instances of coercion, the two groups, saw the 'same event' differently. If a situation looked to be getting out of control, for the patients this was because they 'were caged like animals'; 'locked in a tiny space for weeks' – there was a reason why they were 'kicking off'. The nurses however saw this as an expression of the illness, a symptom – to be medicated away by force if necessary. Can this use of force be justified in the name of the 'best interests of the patient', or, if force was not an option, could other non-coercive means be used to calm the distressed person? Many people who use services live in violent surroundings, and this often leads to violence becoming normalised. But the fact that violence can be normalised does not make it right nor excuse it. Indeed, we know that those with a psychiatric label are more likely to be victims rather than perpetrators of violence (Carr et al., 2017; Keating, Robertson, McCulloch, & Francis, 2002). Surely a hospital should be one place where those who are mentally distressed can recover free from the threat of violence and coercion. But the current state of inpatient wards in the UK at least does nothing to break this cycle of violence or, as Keating et al., put it, when talking of the experience of Black service users, *Circles of Fear* (Keating et al., 2002). For all the calls to treat people 'with respect' this is incompatible with holding them down and injecting them with strong sedative drugs.

In fact, incidents of violence perpetrated by those with a diagnosis of mental disorder are rare, and, in the absence of drug or alcohol use, their incidence is no greater than within the population as a whole (Ullrich, Keers, & Coid, 2014). But what is to be done when these rare events do happen? Some argue that, whatever their psychiatric diagnosis, those who perpetrate such acts should be treated as any other criminal and jailed. Others call for the increase of forensic provision. These are terrible alternatives. At least most prison sentences are time limited, where diversion to a psychiatric institution seldom involves a time limit. In our view, this problem should be seen as part of the structure of incarceration as such. We need a break with the whole system of acute wards for those experiencing a crisis of mental distress, and a move towards the use of crisis houses in these situations. It will be objected that crisis houses cannot take patients detained under mental health legislation. This is an enormous obstacle. Detention is vastly over-used but the possibility of a short stay under conditions of control, in a radically different environment, just might persuade the person who has been driven to violence that they should give the place a try, and even accept medication to alleviate the crisis in the short term.. Many psychiatrists, no doubt, will see this as wishful thinking or 'impractical' (like alleviation of poverty). There has been research on the use of crisis houses (Gilburt et al., 2010; Gilburt, Rose, & Slade, 2008;

Johnson et al., 2004; Venner, 2009) but the results are ambiguous, and this approach has not been widely implemented, perhaps because the issue is surrounded by fear on all sides – including fear of litigation. As we have said, the issue is made even more complex by the role of substance use in violence by those with a psychiatric diagnosis. But there are alternatives that could be tried, and have not been, through lack of imagination and because of fear. Any true alternative to current practices in psychiatry must include a radical re-think of the whole practice of incarceration, which places violence to and by patients within this context.

Public health psychiatry

In these examples of 'alternatives' there seems to be an unresolved problem of the 'social' – lurking in the shadows but never explicated in a satisfactory way. What about what could be called 'Public Health Psychiatry'? (Mezzich, 2007). This has many meanings and many potential components: social determinants of distress, community interventions, population prevention. There are signs of an emerging recognition of the need for 'prevention' in psychiatry, especially focussed on children and young people and this is welcome (Fusar-Poli et al., 2021); we return to this in our conclusions to this paper. But even those who accept the need to address population level issues through strategies of prevention tend to regard most 'social determinants' – such as poverty, racisms and social exclusion – as outside the purview of medically trained psychiatrists. Instead, some seek to target specific, individualised, sites of risk, for example in the strategies that focus on early parenting behaviours or 'adverse childhood experiences (ACEs) (Barker, 2007; Shonkoff, Boyce, & McEwen, 2009). Others seek to emulate the anti-smoking strategies in cancer prevention by targeting the use of highly potent cannabis that is a risk factor for psychosis (Murray & Cannon, 2021). In such approaches, it remains the behaviour of the individual – the inadequate mother, the cannabis smoker – who is the target of treatment and of prevention. Public health psychiatry still tends to frame the problem it addresses in terms of specific diagnostic categories – even when it is aware of the issue of 'comorbidities' – and aims to change the attitudes, behaviour and choices of the individual even where the intervention includes, for example, placing treatment resources in the community and building community based support mechanisms. So the 'public' in Public Health Psychiatry is an aggregate of individuals, not something *sui generis*.

Public health psychiatry does not seek to replace clinical psychiatry. It is argued, and we agree, that some will suffer so extremely that they need individual attention, although we would argue that this should always be combined with a strategy to address at least the proximal social and environmental pressures that have triggered extreme distress, such as appalling housing, domestic abuse, poverty or the experience of racism before making a psychiatric diagnosis and prescribing medication. Instead of reading complaints about such matters as symptoms, or as simply contexts beyond their remit, psychiatric professionals could use their authority to intervene in such matters, both individually and at community level. No doubt some committed professionals do so, contacting the relevant social authorities on behalf of their patient. But the *absence* of almost any recognition of the constitutive role of 'social conditions' in the standard psychiatric interview, or the reduction of these to matters of external context in the reduced form that formulation now takes, means this would require a fundamental shift in perspective, though not an impossible one.

We are then, again, left with the issue of how social determinants are to be conceived. The approach tends to regard social determinants as variables which can be assessed with regard to their contribution to the whole (regression analysis or other models which disaggregate the social and look for 'key ingredients (Brooke, 1959). While some anthropologists of mental health have focussed on the key role of 'social suffering' (Kleinman, Das, & Lock, 1997), and clinicians like the late Paul Farmer (Farmer, 1996; Farmer et al., 2006) have pointed to the causal role of structural violence, such language is usually regarded as unacceptable to psychiatry because it is 'value-laden', and even 'political' (Rylko-Bauer & Farmer, 2016). But mental distress needs to be understood as arising from the actual, social and material experience of individuals as they make their lives enmeshed with others in the spaces and places they live – what one might call their 'biopsychosocial niches' (Rose, Birk, & Manning, 2021). It arises out of their everyday experiences, as they negotiate their life, manage their living conditions, find foods for themselves and their families, cope with multiple material, familial, bureaucratic and social stressors, often in deeply impoverished environments, saturated by memories and meanings, suffused by fears of violence, by pollution, and multiple exposures to small and large traumatic events. While these are often effaced in the correlational styles of thought of psychiatric epidemiology, people make their lives in these small scale worlds and we are beginning to have a clearer understanding of how such multiple pathogenic exposures get under the skin and afflict body and soul across time. To address these requires more than community support and easy access to mental health services. But it does not require us to imagine utopian cities but to listen to the voices of those who experience distress about what they find pathological, and what might be potentially salutogenic, in the reality of their everyday lives – maybe fewer pawn shops and bookmakers, better food stores, small parks, safe spaces for children to play, cheap and readily available early childcare and sure-start facilities, and, of course, some financial security perhaps through such methods as unconditional cash transfers or universal basic income (Roe & McCay, 2021; N. Rose et al., 2021; N. Rose & Fitzgerald, 2021). Perhaps many years of medical training does not equip psychiatrists to understand such matters let alone engage in them. But it should.

The voice of the patient

If a developed concept of the social is missing from all these approaches, then so is something else – the voice of the patient. The obverse of the missing social is the spotlight on the decontextualised individual. Even the radical movement *Psychiatrica Democratica* which sought to close the Italian psychiatry hospitals, did not allow for autonomous user groups (Scheper-Hughes & Lovell, 1987). Anti- psychiatrists found meaning in their patients' delusions – but it was *their* meaning, not the patients. Current uses of formulation reframe the patient's experience in the categories and explanatory frameworks of the professionals. Some psychological approaches take this to greater extremes than psychiatric ones, as in current developments in the 'Recovery Approach' (D. Rose, 2022).

There are many reasons for this absence: above all the lingering doubt that patients have anything sensible to say, a moral as well as cognitive position. Their symptoms are who they are and their symptoms are meaningless or, much less often, accorded meaning – interpreted – by experts. We argue that to fully situate this patient, to take account of their lives, requires more both in research and in the clinic. This is because the 'voice' of the patient exists in a different epistemic space to that underpinned by classification, diagnosis and the idea of intervention. None of the 'alternatives' we have looked attempt to grasp that epistemic space. This space can be called 'experience', but while it is now common to talk of 'lived experience' as raw, immediate and authentic awareness, from our perspective, experience needs to be understood as a concept, and its exclusion needs to be placed in the context of relations of power.

To understand what we mean by this, we need to recognise that, in addition to the power imbalance in the psychiatric encounter, the voice of the patient is excluded because of what Miranda Fricker calls 'epistemic injustice' – an ethical as well as a social subjugation (Fricker, 2007). First, patients are not seen as credible at the level of knowledge – the (perceived) incoherence or meaningless ramblings of the mental patient lead to a general doubt about the veridicality of anything they say. This is a formidable form of power, exercised over what can count as valid knowledge. Second there is what she calls 'hermeneutic injustice' which means there is no publicly available discourse in which to articulate the situation of the mental patient and all that follows from this. There is a 'hermeneutic lacuna'. In the case of post-psychiatry, which we discussed earlier, Pat Bracken allies his hopes for dialogue between patients and professionals with what Jurgen Habermas terms an 'ideal speech situation' (Habermas, Honneth, & Joas, 1991). But Habermas does not take account of the fact that language is not a neutral or universal means of communication; language comes in different registers and may even contain important gaps that prevent communication or even representation. Any dialogue must draw on systems of meaning that people may or may not share. If they are not shared then the question of which will prevail and permeate social understanding and decisions about action is one of power and the relation of professionals to their clients, however committed to equality, always entails power because one party can make decisions to which the other is subject.

Research

Psychiatry, after all, aims to practice evidence-based medicine. It claims an epistemology of empiricism but that apparent neutral search for facts is underpinned by strong orienting frameworks such as diagnosis, mental pathology, neurochemical anomalies and treatment (the intervention). Evidence from RCTs is prized above all else, despite the fact that many RCTs have historically been funded by the pharmaceutical industry which has an influence on the publication of their results (Turner, Cipriani, Furukawa, Salanti, & de Vries, 2022; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Despite the many criticisms of the applicability of evidence from RCTs to the experience of the products tested when they are used in everyday life, they continue to have a key place in psychiatric research, in large part because of the hierarchy of knowledge within the academy (Kaplan et al., 2020; Slade & Priebe, 2001). Further, the conclusions of RCTs are driven by a very particular use of statistics, in which one outcome measure is selected, and behavioural independent variables are chosen to enter into the calculations, because of the need to 'power' the sample to give statistically meaningful results. Public health psychiatry may have some different orienting categories but social determinants are still largely seen as variables, amenable to disaggregation (class, ethnicity, age, gender…) and framed as if they themselves were value-free. And these variables are only as good as is their representation of the world. For instance, socio-economic status is still widely used in studies of the effects of social class on mental disorder but the 'world' has outstripped that system with the changing nature of employment, the rise of a knowledge and service economy and increasing precarity in the form of zero hours contracts, multiple jobs, in-work welfare benefits and so on (Neilson & Rossiter, 2008). Again, while research studies using methods such as RCTs think in terms of 'pure' samples (for example, subjects with an homogeneity of diagnosis), as evidence on 'multimorbidity' shows, this is not the way people and populations, healthy or sick, are made up. The heterogeneity that is our *common* reality is excluded.

Once again, in this kind of research, 'subjects' usually have no voice either in the conduct of the trial itself or in decisions about research methodology, study design and outcome measures. But if service users, even when 'involved' as in PPI, they have no influence over what are considered to be appropriate methods and measures, and their involvement amounts to mere tinkering at the edges (D. Rose, 2015). Indeed, research findings from participatory methods have the lowest ranking in the much-vaunted hierarchy of evidence (Evans, 2003). The survivor voice is thus erased in the methods of research as such, even while it is claimed at the same time that involvement of mental health service users, in consultations and the like means that the silence has been broken.

Ecological and social niches

As we have said, we propose a way of thinking about mental distress as embodied and emplaced within 'niches', the actual conditions of existence that characterise the lives of different groups, infused by a range of often toxic exposures, suffused by meanings and memories, hopes and fears. A 'niche' cannot be disaggregated into component parts or factors which can be given weights in an equation – they are lived as one specific mode of existence. Even attempts to adopt such a broad vision of all those potential damaging 'exposures' that impinge on the lives of individuals – such as the exposome – tend to assume that these can be isolated and measured, perhaps even added into a score, somehow eliding their subjectively experienced and lived character (see N. Rose & Fitzgerald, 2021, Chapter 5). How, then, beyond epidemiological correlations, can it be researched? We would propose research that uses ethnographies, mental maps, video diaries, even apps that 'sample' experience in real time – the many ways now available of seeing that capture how adversity gets under the skin in multiple ways. We need to consult with communities to find out their priorities for research and the way to do it. We need to see how structural factors such as racism and poverty operate in those forms of life. Racism and poverty both operate in ways ranging from the brutal to microagressions and so we require concepts that can encompass this variety and see these not as causal structures with measurable effects but a series of loops over time. Time is important in mental health because 'chronic' conditions are not a biological inevitability but a product of repetitions over time, in the spaces and places that constitute and constrain the everyday lives of those with these diagnoses just as surely as did confinement in a psychiatric institution (Bister, 2018; Bister, Klausner, & Niewöhner, 2016). The temporal and cumulating consequences of the psychiatric medication, stress, poor diet, inadequate housing, social stigma and poverty experienced by those with such diagnoses challenges the idea that these conditions are inherently degenerative (Murray, Bora, Modinos, & Vernon, 2022). To understand the temporal accumulation of these material and symbolic harms in this way would offer up possibilities of intervening to change trajectories.

Sometimes it seems as if such changes can only happen at a large-scale level, with the enactment of political and economic policies that could, over time, create more equality and social justice across society as a whole. We would argue that those who take 'social determinants' of mental health seriously should certainly campaign at that level, despite the unpardonable lack of action on these issues by the major psychiatric organisations, who inexplicably carry on blithely as if the diagnostic abilities, explanatory models and treatment capacities of their profession were not in crisis (N. Rose, 2016, 2018; Scull, 2021) But just as niches are local, so small changes can alter people's lives especially if they are the focus of collective action, which requires transcending psychiatry's individualisation to recognise that it is actually therapeutic for individuals to come to understand their own distress as not a matter of individual pathology, let alone personal failing, but arising out of shared experiences. But these small changes are not easy because the everyday practices that are its targets are interlinked and consolidated in everything from architecture to language-in-action. Change can function as an exemplar – if we can show that something can change it is more likely to change again. If we know what makes for change and what makes for stasis we can multiply the first and abandon the second, at least for that context. But conventional approaches, such as 'Theories of Change' or 'logic models' do not help us here, because they are linear, play down context and, as with RCTs, when they are researched they usually have a single primary outcome (Horwitz & Scheid, 1999). Intervening in multiple dimensions of 'the context' is more likely to make things better. While some forms of expert support may indeed be empowering, some do the opposite, consolidating what, in the old language of the sociology of deviance, used to be understood as a career as a mental patient, where that diagnostic label loops back and reshapes the identity of the individual themselves. In this way, psychiatry – and many alternatives offered by the allied psy professions – may actually entrench the problems which they try to 'treat'.

So is another psychiatry possible?

A genuine alternative would attend as much to what is missing in contemporary psychiatric thought and practise as much as what is present. But if structural violence, intergenerational trauma, social suffering, exclusion and the voice of the patient collectively conceived were recognised as foundational to the experience of both common and severe mental distress, would the medical discipline of psychiatry still be allotted the key role in understanding and treating mental disorders.

At the least psychiatry would no longer be able to claim, or pretend, that it has a monopoly of scientific knowledge of these ailments or of methods of mitigating them. We are not here referring to the 'turf wars' currently ongoing between some psychiatries and some psychologies. And, of course, we recognise that psychiatrists themselves are working in 'cramped spaces', their decisions are constrained by the policies of insurance companies, hospital trusts, and the shadow of the law, and hospital managers, and often negotiated with psychologists, nurses and even, sometimes with patients. But what we are suggesting would require them to work with, and often be subordinate to, the many other professional and non-professional forms of expertise that are required to support people in the real world in which they live which for some is a maddening world. Experts in housing, finance, hostility of different kinds (racism, patriarchy, homophobia) and the manifestations of the political and economic configurations which characterise different parts of the world variously are needed. Neither psychiatry as currently constituted, nor any of the proposed 'alternatives' incorporate this range of expertise. Jonathan Metzl has proposed that the psychiatric curriculum should be built around ideas of 'structural competency' (as opposed to cultural competency') – that is to say it should focus not on the medics understanding the cultures of their patients but on them understanding the social conditions that have shaped their lives (Metzl & Hansen, 2014, 2018). To achieve this would not simply mean refiguring the 'multi-disciplinary team' because these disciplines are themselves limited: each operates in its own silo, no matter how genuine is the attempt to build conversations between them. Nor would it simply be that engaging the expertise of patients would bring a fundamentally different discourse into the whole, although it would radically alter the whole because it would inflect and change each component. More fundamentally it would invert the gaze thorough which distress was to be understood; it would require that all those professionals tried, in whatever way they could, to take the patient's point of view, to try to imagine the world as it is experienced by the patient. A move to epistemic justice demands that the voice of the patient and the experienced reality of the patient, is central to any system of supports and the holistic knowledge of actual lives that this would bring would render the idea of distinct 'components' redundant. Another psychiatry would be one that turns 'patient involvement in research' to 'researcher involvement in patient-led systems.

Many psychiatrists would agree with much of what we have argued, but feel constrained to work within the boundaries of the clinical encounter, however aware they are of the kinds of systematic and structural forces we have described. Some psychiatrists are making important steps to challenge and change psychiatric orthodoxy in the direction we have indicated. But we wonder how many psychiatrists would accept the consequential reduction in their claims that they are the exponents of highly effective, neurobiological based, targeted treatment of brain disorders, like their peers in other biomedical specialities. The leaders of the psychiatric establishment are likely to resist such a reconfiguration of their profession. But then paradigm shifts are aways resisted precisely because they signal a fundamental problem with 'normal' science. As Kuhn recognised, the time before a paradigm shift is replete with dangers (Kuhn, 2012). There is a long march ahead, but we believe that another psychiatry, along the lines we have tried to sketch here, is possible.

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