A social paradigm in psychiatry – themes and perspectives

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Aims. Psychiatry as science is underpinned by paradigms. Considering whether a social paradigm may help to advance the current state of psychiatry, the review provides a reference to the rich, but fragmented past of related initiatives in the history of psychiatry and a personal view of themes, challenges and perspectives of using a social paradigm in psychiatry.

Methods. Major themes are the evidence on social determinants of mental health; the value-based importance of integrating people with mental disorders in society; options to overcome the social isolation and improve the networks of psychiatric patients; utilising a systemic approach for interventions in families and communities; and understanding group and one-to-one treatments in psychiatry primarily as social interactions. Whilst all these themes open up perspectives for future action and/or research, there are also conceptual challenges through the limitations of the current construct of mental disorders and the dominating terminology.

Results. Initiatives for using a social paradigm in psychiatry may refer to important achievements in the past, but need to go beyond this and consider on-going societal changes.

Conclusion. Innovation may benefit from close collaboration with social sciences and humanities.

Introduction

According to the Oxford Dictionary, a paradigm is 'a mode of viewing the world which underlies the theories and methodology of science'. Such paradigms are not necessarily right or wrong. They need to be useful to drive science forward in a given period of time. Scientific communities often share the same 'modes of viewing the world', and leave paradigms implicit and unchallenged. In everyday life, there is no need to explicitly refer to them. However, paradigms change over time, and in pluralistic societies there may be different paradigms at the same time, all of them more or less useful.

Paradigms in psychiatry

Psychiatry as a science is also underpinned by paradigms. Whether the paradigms are useful depends on the extent to which they help psychiatry to achieve

its aim. The ultimate aim of the science of psychiatry is not just to gain insights and generate knowledge. Psychiatry with its history, values and traditional link to medicine has a societal purpose and aims to diminish mental distress and – more specifically – to help people who mentally suffer. The current state of psychiatry may be a reason to re-consider the driving paradigms and their potentials to achieve the aims of psychiatry in the future.

It has been argued that psychiatry is in a critical phase. This is despite substantial improvements of practical mental health care in many countries over the last few decades: old-fashioned asylums have been replaced by care in the community, and more health professionals care for many more patients in more suitable environments. These improvements are the result of mental health reforms, and much more funding for mental health care.

However, there have been questions as to whether all the research conducted by the scientific community in psychiatry over the last few decades has contributed to these improvements and led to major advances in practice. As compared to 30 years ago, there have been no new drugs or other biological treatments that are clearly more effective than what was available

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then. All current major psychotherapy schools had already outlined their models, and the common service models, including community mental health teams and day hospitals, had all been introduced.

Progress in fundamental research, such as genetics and neuro-science, has been considerable, and their applications to practice are regularly presented as imminent. However, as of now, achievements in fundamental research have led to no obvious breakthrough in treatment. Linked to this lack of progress is a diminishing appeal of psychiatry as a profession. In many countries, recruitment into both clinical and academic psychiatry has become a major challenge (Fazel & Ebmaier, 2009; Katschnig, 2010).

The potential reasons for why the great volume of well-funded and high-quality research has produced so little are numerous and diverse. Yet, one important factor is the model that frames and guides the content of the research – the paradigm. Mental distress has neuro-biological, psychological and social dimensions. The prevailing paradigm in current psychiatric research suggests – explicitly or implicitly – a hierarchy between these dimensions, in which neuro-biological phenomena have a higher explanatory value than other dimensions for both the occurrence and treatment of mental distress (Bolton & Hill, 2004).

Neuro-biological processes are widely seen as the real cause of mental disorders and most important target of treatment interventions, a view that the psychiatrist and philosopher Jaspers termed the 'somatic prejudice' as early as 1913 (Jaspers, 1963). It has been argued that this dominating paradigm has made psychiatric research 'irrelevant to clinical practice' (Kleinman, 2012).

A social paradigm

So, is there an alternative paradigm to the arguably dominating biological one? The paradigm should be useful not only for understanding mental distress, but also for advancing how society can act to help people with mental distress, both within and beyond health and social care services as we currently know them.

A social paradigm emphasises the social nature of human life, and focuses on the social dimension of mental health and of mental health care (Priebe *et al.* 2013). 'Social' captures everything that happens between people, in brief contacts, various relationships, all types of groups, communities and societies at large. A social paradigm in psychiatry reflects that all mental disorders are defined in a consensus found in social interactions, are expressed in social interactions, i.e. in behaviour that is interpreted as a sign of a mental disorder in the given social context, and are diagnosed and treated in interactions of a patient with a professional, although these interactions can take very different forms. A social

paradigm – like most paradigms – does not have a detailed definition, and can in itself have various facets and specifications. Yet, it captures an overall approach to psychiatry and is distinct from other paradigms, such as a biological one which focuses on neuro-biological processes in the brain, or a psychological one, with an emphasis on processes in the mind.

History of a social paradigm and social psychiatry

A social paradigm is not new in psychiatry. Since the beginning of modern psychiatry about 200 years ago, there has been a rich tradition of very different protagonists of social perspectives both in terms of theoretical models and practical approaches (Burns, 2013). Protagonists of theories and models potentially linked to a social paradigm may include academics from different periods and distinct backgrounds such as Griesinger, one of the first chairs in psychiatry arguing for community approaches in the 1860s; Durkheim analysing suicide as a social phenomenon in the 1890s; Foucault, influencing anti-psychiatry as a philosopher in the 1960s; and Bateson, using systems theory as an anthropologist for a theory about the origin of schizophrenia in the 1970s. There have also been a range of practitioners who initiated new care models which reflected – at least in parts – a social paradigm. Prominent examples include Kolb who experimented with 'open care' in Germany in the 1920s; Querido who practiced first home treatment in Amsterdam in the 1930s; Jones who established therapeutic communities in the 1940s; and Basaglia who overturned hospital-based care in Italy in the 1970s.

A social paradigm has underpinned many of the initiatives in social psychiatry. The term social psychiatry featured – to my knowledge – first in 1904 (Ilberg, 1904) and has since had a chequered and fluctuating history. Over time, the term has been used to name a movement for mental health reforms, a practice of care that today is more commonly referred to as community psychiatry (Burns, 2014), and a field of science and research. There have been professional societies, university departments and chairs, national and international congresses, and scientific journals dedicated to social psychiatry (when this journal changed its title from Italian to English in 2011, it dropped the term 'psichiatria sociale' and replaced it with 'psychiatric sciences'). Yet, a social paradigm as a view underlying the science of psychiatry is not restricted to boundaries of social psychiatry, and – vice versa – not all what is understood as social psychiatry necessarily reflects a social paradigm. A social paradigm is a fundamental perspective influencing and shaping science, social psychiatry may be seen as a form of science and practice itself.

Despite the importance of a social paradigm throughout the history of psychiatry, its impact has been fragmented and disparate. There has been little continuity, and new initiatives have tended to start afresh rather than refer to – and possibly build on – similar approaches in the history of psychiatry.

The objective for this paper is to take stock and identify perspectives for potential progress. So, what does a social paradigm offer for the future of psychiatry? What follows is a personal, non-systematic and inevitably non-exhaustive view of major themes, challenges and potentials for progress.

Social determinants of mental health and political mission

The precise reasons for why some people develop mental disorders and most others do not, are still poorly understood, and scientific knowledge does not allow reasonable predictions in individual cases. However, much is already known about probabilities and risk factors for developing mental disorders on the population level. The major factors increasing the prevalence of mental disorders are social: difficult and disrupted upbringing, poor education, poverty, the experience of war and torture, social isolation, adverse living conditions and living in economically unequal societies.

These social factors influence not only mental health. A sound body of evidence shows that social factors determine a range of health conditions, including overall mortality rates (Marmot *et al.* 2012). And some of these factors influence both the incidence of mental disorders as well as their course of a disorder once it has been developed.

In the interest of prevention and improving the conditions for those already affected by mental disorders, psychiatry should aim to change these social factors, which means improving the conditions for parents so that they can bring up children in safe and favourable conditions; eradicating poverty, war and torture; providing good education, acceptable housing, and safe employment for everyone; and diminishing economic inequality. None of these tasks can be achieved by psychiatrists alone. They require wider societal actions and political decisions. It has been argued that a political commitment of psychiatrists for a society in which these social factors are improved might help effective prevention, and also provide psychiatry with the credibility as a science, that calls for actions in line with generated insights, and a societal relevance (Priebe, 2015).

Integration of people with mental disorders

Integrating people with mental disorders in mainstream society with no separation, no discrimination and best possible support is foremost a matter of humanistic values. Evidence suggests that this is facilitated by a dimensional model of mental distress, i.e. that distress does not reflect a distinct illness, but lies on a continuum of potential experiences and behaviour on which the experiences of all other human beings are too. Seeing people with psychotic experiences as having an understandable reaction to difficult conditions rather than suffering from a distinct illness reduces the perception of them as being unpredictable and dangerous (Wiesjahn *et al.* 2012; Schomerus *et al.* 2013; Angermeyer *et al.* 2015). A dimensional model of mental distress has implications for research and campaigns to inform the public about psychiatry.

Much research has focused on how to get people with mental disorders back into regular employment (Burns *et al.* 2007). Economists have argued that good treatment, e.g. of chronic depression, would save overall costs when patients are maintained in employment and contribute to the societal productivity rather than rely on costly support through health and social care services (The Centre for Economic Performance's Mental Health Policy Group, 2006). Whilst such economic argument is important, there will also be a number of people with severe disorders with very limited chances ever to return to competitive employment and others who fail to maintain regular employment despite good support. A society that cares for those who struggle to care for themselves and are in need of professional help should provide the required support for them. Yet, this requires resources and on-going investment without direct economic savings. Indirectly, however, there may be wider benefits when a society manages to integrate a group of disadvantaged and otherwise marginalised people with mental disorders, as this may precisely help to reduce the social inequality that in turn increases the prevalence of mental disorders and other health and social problems.

Social isolation, social networks and social interventions

Of particular importance to mental health is the social connectedness of people and the quantity and quality of their social networks (Christakis & Fowler, 2009). Social isolation is an increasing problem in Western societies with unfavourable consequences for all sorts of health outcomes, with headlines such as 'the age of loneliness is killing us' in mainstream media (Monbiot, 2014). People with mental disorders tend to be even more isolated than others, and mental health community services have often failed to help patients overcome this isolation.

Research on social networks – and on related concepts such as social capital – comes with a number of

problems, e.g. how to define and assess a relevant social contact, how to measure the support available in a social relationship, and how to conceptualise relevant characteristics of relationships such as reciprocity. Thus, conceptual and methodological work is needed to advance the evidence. However, already existing studies suggest that simple interventions aiming to increase the social networks of patients directly – rather than indirectly through treating negative or depressive symptoms – can be effective and make a real difference to patients' lives. The evidence base for this is still limited, and more development work is required. Yet, the encouraging findings point towards the potentials of interventions that consider and target the actual social life of patients (Anderson *et al.* 2015).

When relationships of patients have been considered in psychiatric research and practice, the focus has conventionally been on close relationships such as links with family members, partners and good friends. As important as these are, concepts from sociology and economy suggest that so-called weak ties, i.e. looser relationships and acquaintances, are crucial to provide people with flexible access to contacts as and when helpful (Granovetter, 1973). As a consequence, service may try and enable patients to establish and maintain a wider network of weak ties with a range of different people and groups. Such work will have to consider the rapidly changing nature of social connectedness and communication. New communication technologies and contacts through social media may or may not replace personal encounters, but they certainly shape the way social interactions are established and used. Although numerous current studies try to understand how patients use the internet or develop apps to help them, it appears that psychiatric research is rather slow in considering the potentials of ever changing technologies for the social interactions of people with mental disorders.

Social context as a system

The impact of the social context goes beyond the general influence of well-established adverse social conditions such as social inequality, poor socio-economic status and social isolation. Changing the social context can have a major direct impact on the experience and behaviour of people with mental distress.

Systems theory suggests that mental distress in form of pathological behaviour can be developed and sustained only if it fits the given context, e.g. the given communication pattern in a family. If pathological behaviour did not fit, it would not be there (in analogy to animals fitting their environment in Darwin's evolution model). Thus, if a therapeutic intervention

managed to change the crucial characteristics of the family interaction, the disordered experience and behaviour of the patients may be made redundant. The family would be left to find alternative patterns, and these alternatives may come with less distress to everybody involved. These systemic ideas guided different forms of family therapy, types of solution focused therapies, and interventions to organise and supervise psychiatric wards and other services. Such interventions using systemic ideas have been widely practised, but less systematically evaluated in research than treatments focusing on individuals. Future research may not only take up some of these ideas for further development and evaluation, but also assess the impact of wider social contexts – beyond the family or a service, e.g. in local communities – on the mental distress of affected people, a task with potential overlaps with community psychology (Orford, 2008).

Treatments as social interactions

A traditional model in medicine suggests that treatments should primarily target an identified deficit or dysfunction. However, the history of psychiatry has also seen a range of therapeutic approaches that instead of focusing on a deficit aim to utilise existing strengths and resources of the patient. A conceptual review of very different such resource-oriented treatments suggests that they have all one characteristic in common, i.e. that they enable patients to find and mobilise the resources in social relationships (Priebe *et al.* 2014). The types of these relationships vary and include families, groups and dyadic interactions. Often, the interactions are created in a therapeutic context, i.e. in therapeutic groups and in one-to-one patient–clinician relationships.

Therapeutic groups have a long tradition in psychiatric care, ranging from open groups on wards and therapeutic communities to closed groups following specific psychotherapeutic models. The extent to which such group treatments have been evaluated in rigorous research varies, with some rather positive evidence. For example, whilst there is a general scepticism about the chances to improve negative symptoms of schizophrenia through psychiatric treatments (Fusar-Poli *et al.* 2015), a review of group treatments, shows an overall positive effect (Orfanos *et al.* 2015). Yet, this effect was found across different therapeutic schools and did not differ from the improvements in so-called sham groups, i.e. groups that did not follow a manual for a specific therapeutic model. These findings suggest that the positive effect is due to non-specific factors such as group interactions that have little to do with the specific theory of a given psychotherapeutic school.

The importance of non-specific factors has also been emphasised for one-to-one psychological treatments. Wampold (2001) argues that the quality of the interpersonal relationship and the patient expectancy are indeed the only beneficial components of psychological treatments.

Finally, non-specific factors appear also important in patient–clinician interactions in different psychiatric settings outside formal psychotherapy (Priebe & McCabe, 2008). They have been suggested to explain more of the outcome variance in antidepressant pharmacological treatment than the difference between a genuine drug and placebo (McKay *et al.* 2006). With respect to mental health care in the community, a recent trial targeted routine meetings in existing relationships between clinicians and patients with psychosis. A simple intervention – based on quality of life research, concepts of patient-centred communication and principles of solution-focused therapy – changed the communication in these routine meetings and lead to substantial benefits for patients' quality of life, symptoms and objective social situation (Priebe *et al.* 2015).

All these findings point towards a perspective of psychiatric treatment as a beneficial social interaction, i.e. with other patients in a group, with a psychotherapist, or with a clinician in the community. Rather than regarding these interactions as an irrelevant placebo-effect and as something that needs to be controlled for in trials on more specific treatments, research should focus on how to understand the helpful aspects in these interactions and how to improve them for better outcomes.

Mental disorders as social constructs

A social paradigm that aims to lead to substantial progress in psychiatry is faced with conceptual challenges. One of them is the understanding of mental distress and the nature of mental disorders.

Mental disorders are social constructs. This is as obvious as it is perceived as provocative by many psychiatrists, possibly because the statement might be seen as questioning the position of psychiatry in medicine. Yet, there is no objective test – biological or otherwise – for any psychiatric disorder. All diagnostic categories including the definition of a mental disorder as such are socially constructed in complex discourses and consensus seeking exercises. Subsequently, the distinctions between mad and bad, shyness and social phobia, normal and pathological sexuality, appropriate sadness and depression – just to name a few – change over time, and cannot be based on any type of scientific evidence. Recognising mental disorders as social constructs does not render them useless.

The functioning of societies depends on some consensus on social constructs, e.g. on what is seen as criminal behaviour. The constructs are necessary, but they also need to be useful for enabling acceptable and effective actions to help people in distress and for conducting research.

Recognising mental disorders as constructs challenges much of the widely accepted evidence on prevalence rates and opens up new ways of thinking about potential interventions.

With respect to prevalence rates, established figures – such as that 25% or more of the population have a mental disorder requiring treatment – have been criticised as excessive (Summerfield, 2008; Burns, 2013). However, this leads to the question as to what overall prevalence rate of mental disorder would make more sense and be more useful. Defining a different rate as more meaningful and useful requires a criterion for the usefulness of different constructs, and discussing such criteria for the usefulness of constructs requires a discourse about the societal purpose and potentials of psychiatry as a science and practical mental health care.

Concerning interventions, current research approaches are required to follow established diagnostic categories. Although there is hardly any diagnosis specific treatment in psychiatry at all, all treatment guidelines and research on new interventions has to refer to target groups defined by diagnostic categories, and research on diagnostically heterogeneous patient groups is rather difficult, although such diagnostic heterogeneity might be beneficial, e.g. to facilitate helpful interactions in therapeutic groups. Whether one should stay with the current approach of numerous diagnostic categories – and patients having several diagnoses at the same time –, or rather just refer to madness as Fouceault did, or find completely different ways of categorising mental distress, is a fundamental conceptual problem.

The terminological challenge

Even more difficult may be the challenge to find a terminology that would be appropriate to advance and utilise a social paradigm in psychiatry. Even this paper is full of terms such as disorder, symptom and treatment, because it is virtually impossible to avoid them in a communication about psychiatry. All these terms make much sense in conventional medicine. A 'symptom' is a sign of an underlying real illness, and 'treatment' is a uni-directional action that the doctor applies to the patient. E.g. in surgery, pain may be a symptom of an appendicitis, and the doctor applies a treatment, i.e. the appendectomy. The terms may also have their place in a more neuro-biological paradigm of psychiatry, but they are not conducive to a social

paradigm. As outlined before, following a social paradigm 'treatment' can be seen rather a social context in which people interact in a way that may facilitate experiences with less distress in the patient. What is required is not questioning and changing terms as a matter of rebalancing power (and political correctness), but as an exercise to arrive at a precise and appropriate terminology that can foster progress using a social paradigm.

Ways forward

In a social paradigm, the importance of non-social factors such as a genetic disposition for types of experiences can still be considered, in the same way as a neurobiological paradigm can still consider the influence of social factors. A social paradigm is not in opposition to other paradigms in psychiatry, but it is distinct, with a focus and a way of thinking about mental health that is different from other paradigms. A mere criticism of alternative paradigms, most notably the neuro-biological one, might be a starting point, but not more. The criterion for the usefulness of a social paradigm will be what it has to offer constructively and the extent to which it helps to generate new ideas, hypotheses and eventually findings that move psychiatry – in a wide sense of the word – forward. This applies to interventions in health care services as we know them, a further development of the scope and form of such services, and societal actions beyond professional health care to prevent and reduce mental distress.

Using a social paradigm for future progress can and should refer to historical initiatives and achievements. However, it cannot be only a nostalgic return to initiatives of the past, no matter how attractive and successful they may have been. A social paradigm that helps psychiatry to overcome the current crisis, should consider and appreciate the vast amount of evidence for social factors and interventions in psychiatry, but also move to a rethinking of established concepts and developing innovative approaches with a focus on various forms of social interactions. The dominating mechanisms of academic funding and career success may not help creativity and innovation in psychiatry, but this can be no excuse for not trying.

As indicated in this paper, a social paradigm can lead to very different theoretical and practical approaches, and future developments will also benefit from a variety of concepts and methods. Conceptual and methodological progress in psychiatry requires the collaboration with fundamental sciences. While the neuro-biological paradigm obviously emphasises the importance of 'neurosciences', researchers using a social paradigm may search social sciences and humanities for new approaches. Not only sociology and psychology, but also other academic disciplines such geography, economy, philosophy, linguistics and arts may be promising partners on a journey towards improving psychiatry.

Conflict of Interest

None.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

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