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Author(s): Bergström, Tomi

Title: From treatment of mental disorders to the treatment of difficult life situations : A hypothesis and rationale

Year: 2023

Version: Published version

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Please cite the original version:

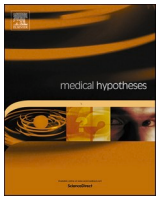
Bergström, T. (2023). From treatment of mental disorders to the treatment of difficult life situations : A hypothesis and rationale. Medical Hypotheses, 176, Article 111099. https://doi.org/10.1016/j.mehy.2023.111099

Medical Hypotheses 176 (2023) 111099

Contents lists available at ScienceDirect

Medical Hypotheses

journal homepage: www.elsevier.com/locate/mehy



From treatment of mental disorders to the treatment of difficult life situations: A hypothesis and rationale

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ARTICLE INFO

Keywords:
Mental health
Open dialogue
Ontology
Psychiatry
Psychiatric services

ABSTRACT

The group-level symptom-reduction model of mental health care emphasizes predetermined treatment guidelines for those mental and social difficulties that are diagnosable as mental health disorders on the basis of predetermined diagnostic criteria. The model have produced generalizable information to support medical decision-making for symptom reduction. However, it may have also increased the reification of diagnostic labels, and in so doing medicalized and stigmatized complex human-life experiences, with a lack of attention to a range of social determinants and existential factors associated with mental health. Since symptom-reduction model can easily lose sight of essential non-technical and contextual aspects of mental health care, including the quality of the interaction and other common factors needed to understand and treat mental health difficulties, there is doubts that the symptom-reduction model may actually decrease the effectiveness of mental health services, as compared to a holistic approach. Based on recent critiques of the group-level symptom-reduction model to mental health care, and research on common-factor perspectives on mental health treatments, holistic conceptions of humans, and naturalistic outcome studies from several holistic mental health services from different countries, I hypothesized that an ontological turn from the treatment of "mental disorders" to the treatment of "difficult life situations" will lead to a more personalized and comprehensive treatment approach, that mediates an improved effectiveness of mental health services.

Introduction

The United Nations (UN) [1] and the World Health Organization (WHO) [2] have expressed concerns regarding the current state of a mental health care. In many countries mental health services are facing substantial resource constraints and operating with outdated regulatory frameworks [2]. The management of mental problems is often stereotyped as symptom reduction via predetermined medical interventions, in preference to more personalized care approaches [3,4,5]. The treatment outcomes of severe mental disorders have not improved over decades [2,6,7], and many countries have witnessed a growth in mental health disability pensions [8,9,10]. Moreover, prevalence figures [7,11] and mortality rates [7] have not decreased for any mental disorder, and the longevity gap between people with severe mental disorders and the general population has been widening [12].

The current dominant model of mental health care, which focuses on reducing symptoms through medical interventions, may have limitations in addressing social determinants and existential factors related to mental health [2,13]. The UN [1] and WHO [2] have called for more holistic approaches to mental health care that take into account human rights and individual needs of service users. However, implementing such approaches within Western healthcare systems has been hindered by structural and ideological barriers [2,14,15]. One such obstacle may be the dominant group-level symptom-reduction model to mental health care [14], within which mental suffering is viewed in terms of universally diagnosable mental disorders, classifiable on the basis of variations on observable mental and social problems, that are then interpreted as symptoms of a medical conditions [13].

Hypothesis

On the basis of recent critique regarding group-level symptom-reduction model to mental health care [13], research on the common-factors of mental health treatments [16,17], holistic conceptions of humans [18] and naturalistic outcome studies from holistic mental health services [2] I hypothesized that an ontological turn from the treatment of "mental disorders" to the treatment of "difficult life situations" will bring about a more comprehensive mental health treatment

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https://doi.org/10.1016/j.mehy.2023.111099
Received 11 February 2023; Received in revised form 10 May 2023; Accepted 18 May 2023
Available online 22 May 2023
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approach that mediates with more effective mental health services, providing the following conditions are met:

1. The mental and/or social suffering and/or maladaptive behavior is taken seriously, and is treated in matter-of-fact style rather than as an expression of a medical condition;
2. All mental health workers receive on-the-job process training on psychotherapeutic skills, the aim being to promote common factors of psychotherapeutic processes in every interaction with patients, and further, to adequately respond to people's difficult emotions, thoughts, and/or behavior, without the immediate need to reframe these as symptoms of a medical condition;
3. Access to services is organized via broad descriptive terms describing the quality and severity of the symptoms, the aim being to guide service intake and short-term medical decision-making;
4. Even if mental and social forms of suffering are not viewed as medical conditions, the service-user has the status of a patient, with access to medical services and to medical interventions to relieve human suffering. In this case, the psychiatric institution would act as a responsible facilitator of treatment processes;
5. Even if the psychiatric unit acts as a responsible facilitator of treatment processes, psychotropics are prescribed cautiously and in a need-adapted manner, primarily based on the acute symptomatology and the service-user's treatment preferences.

Evaluation of the hypothesis

The rationale for a group-level symptom reduction model in mental health care, and its limitations

As with medical research as a whole, a primary aim in research in psychiatry has been to detect linear causal relationships [13]. To achieve this, complex mental and social phenomena (i.e. maladaptive emotions, thoughts, and behavior) are operationalized via psychiatric diagnostic systems. Since the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) [19], the diagnosis of psychiatric disorders has been based primarily on the observation of predetermined symptom clusters, without the need to identify the etiologies of the observed conditions [20,21]. The aim of an observational and atheoretical approach to psychiatric diagnoses was to increase the reliability of diagnoses [22,23]. However, the validity and clinical utility of the nomothetic and symptom-based diagnostic system have been questioned [24].

Mental problems may be particularly difficult to capture within the medical diagnostic paradigm, given that mental difficulties represent highly variable clusters of *trans*-syndromal symptom dimensions, and may therefore not achieve the perceived value of medical diagnoses in separating individuals' conditions from other conditions [13]. In psychiatric classification systems, by contrast, people with the same psychiatric diagnosis are usually heterogeneous in terms of symptoms, treatment responses, and prognosis. Thus, the idea of comorbidity is misleading in the context of psychiatry, and there is a risk of artificially splitting complex clinical conditions into distinct diagnostic categories in such a way that a holistic approach to the individual is impeded, leading to diagnostic unreliability and the risk of inadequate treatment [25]. Given the validity problems, it is also understandable that there have been no breakthroughs regarding the etiological factors of mental disorders [26]. In fact, due to the heterogeneity and subjectivity of human emotions, thoughts, and behavior, it can be surmised that the etiological factors underlying mental and social difficulties are extremely heterogeneous, even if certain variations of emotions, thoughts, and behavior may appear equivalent within a given context. Thus, there seems to be no justification in assuming that observed mental and social difficulties can be universally reduced to common causes [27,28].

In response to validity problems, alternatives to conventional psychiatric classification have been proposed, such as transdiagnostic and dimensional approaches [26,28,29,30,31]. In these approaches, mental and social phenomena currently categorized as mental disorders would not be regarded as qualitatively different from other kinds of human emotions, thoughts, or behavior, but beyond a certain severity threshold, they would be treated as medical conditions requiring medical treatment [31,32]. However, many of these include unresolved conceptual issues and lack clinical utility [31,33]. Moreover, the threshold over which a certain emotion, thought, or behavior is maladaptive is highly dependent on the context, i.e., on current standards of what is "normal" or "ideal" and what societies expect from the individual. This being so, mental disorders are not disorders that can be reduced to particular characteristics or other common causes present within an individual [34].

The debate on whether mental problems should be considered "real" medical conditions has continued as long as psychiatry has existed. One of the most famous proponents of the idea that mental health problems are not "real" diseases was the psychiatrist Thomas Szasz, who argued [35] that the classification of psychological problems as medical diseases involves a conceptual error, since diseases are malfunctions of the human body or other conditions associating with cellular pathology, while "mental illness" is mainly a metaphor for mental states and/or behavior that is regarded as unwanted or maladaptive. However, this argument has been criticized because observable symptoms don't necessarily have to be reducible to cellular level to be treated as medical conditions [36]. The question nevertheless arises as to whether equating psychological and social problems with medical conditions is essential for organizing treatment that people require.

Is reframing mental and social problems as medical conditions essential for adequate treatment and support?

Current classification systems are unable to define specific factors at which psychopharmacological or other treatments could be targeted. Similar to the medication treatment of majority of medical conditions, psychotropic treatment aims to reduce observable symptoms, but there has been doubt as to what degree psychotropics have real effect on specific mental conditions [13]. In many trials there has not been adequate control for adverse medical effects [37,38] and other potential confounding factors, such as medication withdrawal, which could be confused with symptoms of an assumed disease entity [39–41]. Moreover, diagnosis-specific group-level guidelines on pharmacological treatment are based mainly on trials with patients who are unrepresentative of those encountered in actual clinical practices. In such cases, the ecological validity is questionable, underlining the need to personalize pharmacological treatment in such a way that it is aligned with multiple clinical features rather than a single descriptive diagnosis [3,4,5].

Even if psychotropics have evident symptom reductive properties, and many people benefit from both acute and maintenance psychotropic treatment, in practice the use of psychotropics does not follow diagnostic boundaries. Antidepressant medications are increasingly used to treat not only depression but a wide variety of other mood and anxiety symptoms [26]. In a similar manner, antipsychotics are used not only to treat psychosis, but also to reduce the intensity of other severe mental states and behavioral disorders [26,42]. At lower dosages they are commonly used in the treatment of anxiety and insomnia [43]. Based on the notion that psychotropics affect mental states even if predetermined diagnostic criteria are not fulfilled, a drug-centered model has been proposed. This emphasizes the idea that psychiatric drugs affect mental states and behavior by modifying brain processes rather by than correcting them [16]. Model can be viewed as better aligned with current evidence on the symptom-reductive properties of psychotropics, as compared to the disease-centered model, in which prescribing is driven primarily by diagnosis, including a hypothetical assumption of underlying conditions [44].

Like psychotropics, psychotherapeutic treatments don't depend on redefining mental and social problems as medical conditions via the current classification system. Effective psychotherapy focuses on producing multilevel changes by prioritizing the quality of human interactions, rather than attempting to achieve a homeostasis through predetermined interventions [45–47]. This aligned with the contextual model of psychotherapy [48]: *meta*-analyses consistently show that the effectiveness of psychotherapy is mainly associated with common factors such as the therapeutic alliance, empathy, expectations, rituals, cultural adaptation, and the characteristics of the patient and therapist, rather than model-specific therapeutic ingredients for specific disorders [17].

In current societies the reframing of mental, social, and behavioral problems as mental health disorders via diagnostic systems is nevertheless required for service intake, but this does not necessarily mean that services must operate solely on the basis of nosological classification systems. In many countries, access to services and other kinds of support is based more on physicians' descriptions of patients' situations rather than on specific diagnoses. Some early-intervention services may also use diagnostic categories mainly for administrative purposes, without requiring pre-assessments or referrals [49].

In sum, it may not be necessary to reframe people's complex experiences and situations as distinct disease entities via the current psychiatric diagnostic system for the provision of adequate support and medical help. However, such a reform may require modification of the legal and regulatory frameworks currently in operation. The question then arises as to whether the harms exceed the benefits within the dominant model, in which mental and behavioural difficulties are diagnosed as medical disorders that should be treated by applying evidence-based group-level guidelines.

Could the dominant group-level symptom-reduction approach to mental health care be harmful?

The multifaceted nature of the phenomena categorized as mental disorders challenges fulfillment of the main premises of evidence-based medicine (EBM) [13]. First, the likelihood ratios for etiology, treatment responses, and prognoses in current diagnostic categories are too low to be considered useful for EBM [13]. Secondly, in order to follow the main premise of EBM, the tendency is to frame mental health work as a series of mechanistic interventions targeted at observable symptoms [13,50]. This misleadingly decenters non-technical aspects, including the cultural, social, subjective, and relational factors of care which seem to be most essential in understanding and treating the complex human situations that are faced in mental health services [51].

Because most current psychiatric diagnoses do not address the etiology of the observed condition, and because primary outcome measures in randomized trials are mainly derived from changes in predetermined symptom checklists, the focus in evidence-based psychiatric treatments has remained on symptom reduction, which does not automatically correlate with more existential factors of human life, such as the subjective experience of wellbeing and the longer-term ability to function in one's current society [13,48]. Moreover, the pre-assessment of symptoms in order to determine the "correct" disorder and then the "correct" treatment paths and methods requires substantial time and resources, leading to fragmentation of care. In psychiatry this kind of an understanding of EBM is misleading from the outset, due to the heterogeneity of the symptoms categorized under current diagnostic constructs, and due to the non-specificity of both psychotherapeutic and psychotropic treatments. Additionally, emphasizing predetermined methods increases the likelihood of professional competition.

Reification of psychiatric diagnoses is another challenge, where instead of adhering to their original purpose as consensus-based symptom descriptions to assist research and medical decision-making, psychiatric diagnoses are assumed to represent "real" disease entities that exist independent of the observer's conceptualizations [28,52]. It is then possible that people will search for characteristics that are aligned with pre-existing ideas on particular diagnoses, increasing the risk of self-fulfilling prophesies [44]. Secondly, the pre-assumptions associated with certain diagnosis may lead to a situation in which people are unjustifiably viewed as suffering from chronic medical conditions, on the basis mainly of certain symptom expressions within certain contexts. These factors could partially explain the over-reliance on stereotyped medical maintenance treatment, with increasing iatrogenic medication effects.

It is nevertheless possible that in current Western societies people's distress is not taken seriously and they may be blamed for their life problems if their experiences are not reframed as a direct consequence of medical conditions. However, since most of the psychiatric diagnoses do not actually take a stand regarding the causes of symptoms – and were not developed for that purpose [28] – reification of psychiatric diagnoses may lead to a circular logic, where symptoms and problems are narrated as being caused by those very same symptoms. This makes it even more challenging to address the factors that are causing human suffering in given situations.

In contrast with the common narrative of anti-stigma programs, there is evidence that viewing mental disorders as similar to any other medical conditions could actually increase stigma, and be a cause of prejudice [53,54]. One explanation for this is the "othering" [55], meaning that if we use a certain symptom expression to group people into "us" and "them" (e.g., the mentally sane and the mentally disordered), it is easy to associate stereotypes with different outgroups, even if they are not applied at the individual level. In reality there are no objective measures to justify this kind of distinction, given that symptoms of mental disorders occur in the continuum of "normal" human experiences, and that whether or not certain human thoughts, emotions, or behaviors constitute a disorder is dependent on the context.

Reification together with the broadening of diagnostic criteria and anti-stigma programs focusing mainly on diagnoses, would at least partially explain why in many countries there is a significant increase in the prevalence of milder mental health disorders; it has been observed that people with a wide variety of life problems are seeking help from psychiatric institutions, and are thus categorized under the mental health disorder umbrella [56]. Mental health services, with their current funding and resources, are not prepared for this kind of "psychiatrization" of human distress. Moreover, there is no evidence on the risk–benefit ratio of current mental health treatment approaches regarding the treatment of all the problems currently categorized as "mental disorders" [56,57].

From a symptom-reduction model to a holistic perception of humans

The DSM's descriptive atheoretical approach aimed to distance itself from psychoanalytic theories, which were seen as having invalid etiological hypotheses on psychological distress [58]. However, there are other ways to approach humanity beyond psychoanalysis, and the atheoretical approach itself involves a strong theoretical commitment [59]. A closer look reveals that realism, naturalism, and reductionism are core ontological assumptions of the symptom-reduction model of mental health care and thus of psychiatric diagnosis [60]. This has heavily influenced mental health research, services, and practices for decades, even if the approach has been deemed atheoretical.

The holistic concept of human (HCH) [18] is an example of another ontological assumption that can be viewed as aligned with current evidence on the common factor perspectives of mental health care. HCH was originally based on a existential-phenomenological philosophical background [61] that has already been analyzed within various contexts in the field of psychiatry [62,63]. Nevertheless, the main premise of HCH as an ontological approach has been viewed as simpler for practical purposes [61], and thus for the creation of formal hypotheses that can be tested against other kind of ontological assumptions in psychiatry.

The basic dimensions of HCH consist of a body, a mind, and a situation; these are viewed as intertwined with each other, forming a holistic entity [18]. To simplify the model, even though the human body and its organic processes are a necessary condition for psychological and social phenomena to occur, psychological and social processes are not entirely reducible to organic processes, since the phenotypic expressions and meanings given to mental and social phenomena are reciprocally dependent on situations, which include the present life situation, previous life events, cultural, historical and social contexts, and so on. Since the meanings given to certain phenotypes are dependent on people's constantly-changing situations, maladaptive or other unwanted experiences and behavior are not universally reducible to certain characteristics of an individual, certain pathogenetic processes, or certain social events. Therefore mental health treatment should emphasize joint understanding and need-adapted help based on each person's unique life situation, rather than focusing on detecting and correcting hypothetical common causes of mental and social deficits at the group level.

The holistic approach does not exclude the notion that maladaptive emotions, thoughts, and behaviors may be a causal consequence of malfunctions of the body, or of other kinds of diseases. The maladaptations may be reducible to an individual's mental, social, and biological characteristics, and people may benefit from medical interventions. However, the holistic approach does not mandate the assumption that certain predefined variations of emotion, thought, or behavior must be redefined as medical conditions in order to effectively treat those who are suffering. HCH thus allows for the development of mental health services that comprehensively address mental and social problems as complex systems, thereby avoiding the potentially stigmatizing effects of medicalization on complex mental and social phenomena.

Real-life examples of services aligned with the holistic concept of human

The first example of a holistic approach to treating severe mental problems is the Soteria model, developed in the USA during the 1970 s [64]. The model emphasizes compassionate ways of being with clients, in preference to intervening in their lives. The characteristic features of the model included the 24 h-per-day application of interpersonal interventions by non-medical staff in a home-like environment. Efforts were made to minimize the use of antipsychotics and coercive methods, emphasizing instead the subjective meanings given to experiences interpreted as psychosis [65]. Both the original model [65–67] and its later replications [68] have produced better outcomes in the treatment of schizophrenia-group psychoses as compared to standard care [69].

The second example is the Trieste community mental health service network [70], systematically developed in the City of Trieste, Italy, since the 1970 s. Community mental health centers in the area operate round-the-clock services without waiting lists or the need to predefine the situation as involving a mental disorder [2]. The main goal for the services is to coordinate and integrate the care system with the person's everyday life, actively collaborating with the rest of the community [2,70]. The aim is to ensure that people, despite their problems, can live a meaningful life and participate fully in the community [70]. The first follow-ups on the whole-system approach of Trieste showed better psychosocial outcomes with people diagnosed with schizophrenia [71]. There are also national statistics demonstrating less involuntary treatment than in any other western European country [2]. Other research indicates that Trieste's comprehensive and community integrated services are associated with better clinical and demographical outcomes in long follow-ups [72,73], including savings in costs [2].

The third model is the need-adapted Open Dialogue approach [74] to mental health care, developed in the 1980 s in nationwide research projects conducted in Finnish mental healthcare services. The original idea of need-adapted care was that instead of group-level treatment guidelines, the integrated treatment of psychoses would be tailored to patient's individual and constantly-changing needs [50,75,76]. In one catchment area, consisting of the southwestern parts of Finnish Lapland, the need-adapted approach was further developed towards the Open Dialogue (OD) approach, which eventually covered the entire regional mental healthcare system of Western Lapland [74]. In OD-based services, irrespective of the diagnosis, all relevant people are gathered together in joint network treatment meetings. This is done as soon as possible in order to create a shared understanding of mental health crises within reciprocal dialogues [77,78]. The available treatment methods are then flexibly integrated, based on a joint understanding of each unique situation [78,79]. Those service team members who have participated in the first meeting are responsible for ensuring the needs-adapted nature of the treatment over the entire treatment process [78]. Referrals or diagnoses are not required; moreover, the psychiatric service has its own emergency services, and is able to arrange the first network treatment meeting within 24 h from service contact if necessary. Thus, the psychiatric service in OD acts mainly as a facilitator of integrated care, mobilizing treatment to the person's own living-environment.

The effectiveness of OD in the treatment of first-episode psychoses has been studied via a quasi-experimental design [80] and historical comparisons within the Western Lapland catchment area [74,77]. In these studies, OD was associated with favorable long-term demographical and clinical outcomes. Later nationwide register-based studies have confirmed the sustainability of these findings as compared to the standard treatment of psychosis in other Finnish services [81,82]. No difference in suicide mortality has emerged in longitudinal register studies; however, the standardized all-cause mortality ratio in the OD was found to be lower than under treatment-as-usual [81]. Even though concerns regarding research allegiance bias have been raised [83], longitudinal studies and nationwide surveys conducted by other research teams have demonstrated similar mortality ratio figures in the Western Lapland catchment area [84,85]; they have also found less time spent on psychiatric inpatient services and on psychotropic medications than in the rest of Finland [84,85], lower treatment costs [84], and the lowest risk of disability allowances for psychotic disorders [85,86]. There is also constantly increasing evidence on the OD from outside Western Lapland [2]. This has demonstrated good clinical and demographical outcomes at service level [87–90], cost savings [87], and good service-user satisfaction [91–94].

In a nationwide register-based study [49], covering all first-onset adolescent patients in Finland in the years 2003–2008, only 5% of adolescents in OD-based system were diagnosed with a psychiatric disorder within the first treatment year, as compared to 65% under standard care. So far, this is the strongest indication that an entire regional psychiatric service within an existing Western service structure has been able to operate for many years with minimal medicalization of service users' experiences via formal psychiatric diagnoses. Moreover, as compared to standard care, the practice was associated with more favorable clinical and demographical outcomes and cost savings over the long-term [49]. However, due to the observational nature of the study, the causality of the observed association could not be determined.

Proposal for testing the hypothesis

The hypothesis that a shift from treatment of "mental disorders" to the treatment of "difficult life situations" will lead to a more personalized treatment approach can be tested via a multisite cluster randomized controlled trial. A similar design has been used in ODDESSI-trial to study the effectiveness of Open Dialogue-approach in UK [95]. However, instead of testing a predetermined treatment model, the design proposed here aims to test whether approaching people's mental and social problems from a different perspective is associated with a more comprehensive model of care, which mediates with treatment outcomes. In a similar manner to the ODDESSI protocol [95], research clusters are defined in relation to general practice, and there should be a shared referral pathway to a community mental health service. Once the

services are recruited, they will be randomly allocated to the experimental unit and to the treatment-as-usual unit (TAU).

Experiences from Western Lapland have indicated that in order to effectively approach people's complex difficulties in a holistic manner, all staff members conducting the treatment should have many years of process-based on-the-job training, with supervision aimed primarily at improving their psychotherapeutic skills [80]. Hence, all staff members in the experimental unit should receive (at a minimum) two years of process-based on-the-job training and supervision on dialogical and contextual psychotherapeutic approaches; these will emphasize the need-adapted and common-factor perspectives of care as well the drug-centered model of medical treatment. All staff members in TAU should receive same amount of on-the-job training on disorder-specific evidence-based interventions, to ensure that the potential outcomes are not due to the amount of the training or supervision of the staff.

After the training period, all patients who are referred to services within a predetermined time-frame will be recruited, then randomized either to experimental units or to TAU. Structured diagnostic criteria will be used for research purposes, but the diagnoses will not be actively used in the experimental units. Instead, staff members will be advised to approach each treatment process in a need-adapted manner, based on the current life situation and characteristics of patient and their close networks, defined in joint psychotherapeutic processes at the start of treatment contact. If patients themselves prefer to narrate their current problems as a mental disorder, this will be allowed, but staff members in the experimental units will actively avoid reification by not strengthening the idea that observable symptoms are caused by a mental disorder, and they will not provide disorder-specific psycho-education. Instead, they will emphasize multiple perspectives and the shared understanding of unique situations. If psychotropic medication is deemed necessary to alleviate acute symptoms and facilitate other forms of treatment, it will be prescribed with careful consideration using the drug-centered model [16], focusing on observable symptoms that can be grouped into broader symptom clusters for administrative purposes. These symptom clusters may thus correspond to the characteristic symptoms of existing primary diagnostic groups, providing guidance as to which psychotropic medication may or may not be effective. If patients in the experimental unit require financial or other social support, it will be granted on the basis of the physician's recommendations rather than on a diagnosis.

In line with the ODDESSI protocol [95], the follow-up time will be minimum of two years. For comparative purpose, the primary outcome is the time to relapse following recovery, with recovery defined as the absence of significant symptoms and the presence of adequate social functioning. Secondary outcomes include clinical and demographical outcomes, and the personal experiences reported by service users themselves. It is hypothesized that in the experimental units the time until relapse will be longer, the overall usage ratio of services lower, and patients' satisfaction higher, and that the treatment and relational factors will mediate to the strength of the observed associations.

Consequences and limitations

Due to the lack of research, it is unclear whether successful implementation of holistic approach requires the adoption of the kind of ontological standpoint suggested in this paper. For example, in the region of Western Lapland, where the Open Dialogue approach originated, the practice was developed on the basis of naturalistic research conducted within everyday clinical practice, rather than on the basis of a particular ontological approach. Then again, previous attempts to implement OD within existing service structures have proved challenging, given that the approach has had to adapt within the dominant medical framework. Thus, it is possible that effective implementation of holistic approaches requires service-level transformation concerning how symptoms – currently defined as indications of mental disorders – are primarily approached [79]. The upcoming results of the ODDESSI trial [95], together with its anthropological analysis [96], should provide a reference point for the trial proposed in this paper. This will help in further evaluating whether the ontological turn precedes or follows holistic treatment approaches, or whether this is irrelevant for improving the effectiveness of services.

There remain many obstacles in testing the hypothesis, including substantial requirements of time and resources, but most importantly, if the hypothesis gains support, it could lead to a professional and academic crisis throughout psychiatry. Nevertheless, given that in many countries mental health services are already in crisis and unable to provide adequate services for people in distress, and that no breakthroughs are expected regarding better treatments or a stronger understanding of mental disorders, there is justification for testing the main premises of our current approaches to mental health care. Moreover, the treatment approaches described in this paper are already recommended by the WHO [2], and to evaluate the risk–benefit ratios they should be adequately evaluated within current service structures.

The hypothesis also poses a scientific challenge because it involves multiple conditions that may affect complex human life phenomena in non-linear ways. However, the preconditions of the hypothesis are based on existing research indicating that certain factors are essential for minimizing possible iatrogenic effects. First, if access to services is only granted if a person has a diagnosed mental disorder, there is a risk that they will not receive adequate help from the services described in this paper. Secondly, if professionals do not receive adequate training on the approaches that seek optimum ways to address complex situations, there is a risk that their responses to people's distress will be maladaptive. Thirdly, there is a risk of increasing the medicalization and overtreatment of ordinary life challenges if the treatment of complex life situations is facilitated by psychiatry without changing the ontological basis of psychiatry. Finally, ethical questions arise regarding whether medical treatment should be given at all if symptoms are not caused by medical conditions. However, as noted above, the line between normal and abnormal mental states in psychiatry is already highly artificial. Moreover, in other medical disciplines, it is possible to relieve symptoms through medical interventions without addressing the causes of the symptoms.

Finally, it is important to note that the hypothesis may involve a sensitive topic for many service users. For some, psychiatric diagnosis may have become a way for them to describe their life experiences and behavior. Note, that the hypothesis does not require that service users should avoid medical terms to describe their experiences, if they have found these terms helpful, and if they themselves have chosen to use them. However, in testing the hypothesis, mental health services and professionals should avoid presenting these terms as the primary explanation for problems and instead actively seek alternative explanations. This is scientifically justified, as psychiatric diagnoses do not describe the etiology of an observed condition, even if they might have utility for medical decision-making [28]. By organizing services according to broader symptom clusters and incorporating severity levels that primarily indicate which types of medical treatment may or may not be effective, the diagnostic practice in psychiatry can realign with its original purpose, while minimizing the problematic reification of diagnoses. This aligns with recent developments in understanding mental health problems [27–29,32] and enables better clinical utilization of integrative approaches, including personalization of treatment [3,4,5] based on observable clinical characteristics.

Funding

Funding not received for the study.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence

the work reported in this paper.

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