The Neurobiology - Psychotherapy - Pharmacology intervention triangle

The need for common sense in 21st century mental health

Edited by

João G. Pereira
Romão de Sousa Foundation, Casa de Alba, Portugal

Jorge Gonçalves
Universidade Nova de Lisboa, Portugal

Valeria Bizzari
University Clinic Heidelberg, Germany

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Contributors

Birgitta Alakare, MD, Psychiatrist, Health District of Länsi-Pohja

João Albuquerque, MD, Clinical Director, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Sílvia Almeida, MSc, Clinical Psychologist, Champalimaud Research and Clinical Centre, Lisbon, Portugal

Pedro Amaro, Nurse, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Natália Andrade, Physiotherapist, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Claudinei Eduardo Biazoli Junior, MD, PhD, Professor, Universidade Federal do ABC, Brazil

Valeria Bizzari, PhD, Postdoctoral Researcher, Clinic for General Psychiatry, Centre of Psychosocial Medicine, Clinic University of Heidelberg, Heidelberg, Germany

Liberata Borralho, PhD Student, Department of Educational Sciences, University of Évora, Portugal

Inês Pinto Calisto, Research Fellow, Center for Research in Education and Psychology, University of Évora, Portugal

Chloe Campbell, PhD, Research Department of Clinical, Educational and Health Psychology, University College London, UK

Adelinda Araújo Candeias, PhD, Auxiliary Professor, Department of Psychology, University of Évora, Portugal

Giulio Caselli, MD, Psychiatrist, Policlinico Gemelli, Rome; Research Fellow, Catholic University of Sacro Cuore, Rome, Italy

Mário David, MD, Consultant Psychiatrist in CINTRA and Groupanalyst, Centro Hospitalar Psiquiátrico de Lisboa and Sociedade Portuguesa da Grupanálise, Portugal

Martin Debbané, Associate Professor and Director of the Developmental Clinical Psychology Research Unit, Faculty of Psychology and Educational Sciences, University of Geneva, Switzerland; Senior Lecturer, University College London, UK

Ana Carolina Florence, PhD Student, State University São Paulo, Brasil, Fellow with the Psychiatry Department at Yale University

Peter Fonagy, FBA, OBE, FAcSS, FMedSci, PhD, Anna Freud National Center for Children and Families, London, UCL; Research Department of Clinical, Educational and Health Psychology, University College London, UK

Alexandre Gomes, MD, Psychiatrist, Faro District Hospital, Portugal

Inês Gomes, Speech Therapist, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Jaime Grácio, PhD, Clinical Psychologist, Champalimaud Research and Clinical Centre, Lisbon, Portugal; Assistant Professor of Behavioural Medicine, NOVA Medical School, Universidade Nova de Lisboa, Portugal

Daniel Guerra, MSc, Psychologist in Training, Metalentejo, Portugal

Rex Haigh, MD, Consultant Medical Psychotherapist, Berkshire NHS, Honorary Professor of Therapeutic Environments and Relational Health, Nottingham University's School of Sociology and Social Policy

Robert Hinshelwood, Emeritus Professor, Center for Psychoanalyitic Studies, University of Essex; Fellow of the British Psychoanalytical Society and of the Royal College of Psychiatrists

Anabela Janeco, Social Worker, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Silvio Yasui, PhD, Full Professor, State University of São Paulo, Brazil

Margarida Morais, Nursing Director, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Tobias Nolte, MD, MSc, Wellcome Trust Center for Neuroimaging, University College London, United Kingdom; Anna Freud National Centre for Children and Families, London, UK

Albino J. Oliveira-Maia, MD, MPH, PhD, Head of the Neuropsychiatry Unit, Champalimaud Research and Clinical Centre, Lisbon, Portugal; Psychiatrist, Centro Hospitalar de Lisboa Ocidental, Portugal; Assistant Professor of Neuroscience and Psychiatry, NOVA Medical School, Universidade Nova de Lisboa, Portugal

Liliana Pacheco, Social Worker, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Dora Pereira, PhD, Auxiliary Professor, University of Madeira, Department of Psychology, Portugal

João G. Pereira, PhD, Clinical Director, Romão de Sousa Foundation, Estremoz, Portugal

António Portelada, PhD Student, Department of Educational Sciences, University of Évora, Portugal

Victor Amorim Rodrigues, MD, PhD, Clinical and Forensic Psychiatrist, Lisbon, Senior Lecturer, ISPA University Institute, Lisbon, Portugal

Célia Sales, PhD, Psychologist, Family Therapist, Researcher at the University of Porto, Portugal

Patrícia Santos, Psychologist, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Jaakko Seikkula, PhD, Professor of Psychotherapy, Department of Psychology, University of Jyväskylä

Elodie Toffel, Clinical Psychologist, University of Geneva, Switzerland

Pedro Valente, Psychomotor Therapist, Centro de Recuperação de Menores D. Manuel Trindade Salgueiro, Portugal

Josefa Ros Velasco, PhD, Postdoctoral Research Fellow and Teaching Assistant, Department of Romance Languages and Literatures, Harvard University

Foreword

Dr. Daniel J. Siegel
Clinical Professor, UCLA School of Medicine,
Founding Co-Director of the Mindful Awareness Research Center
at UCLA and Executive Director, Mindsight Institute

A plea for common sense in our modern age, *The Neurobiology - Psychotherapy – Pharmacology Intervention Triangle: The Need for Common Sense in 21st century Mental Health* is a book that provides an inspiring set of essays and summaries of cutting-edge science exploring the nature of our mental well-being and how we can embrace a complex array of frameworks as modern psychotherapists.

In the field of Interpersonal Neurobiology in which I work, we combine the broad range of scientific disciplines into one framework for understanding the mind and mental health. By examining the common findings across usually separate approaches, we are able to articulate "consilient" (Wilson, 1998) principles with which to view fundamental properties of nature that underlie our human journey. Within that view we see the mind as having at least four facets: Subjective Experience, Consciousness, Information Processing, and Self-Organization (Siegel, 2017). With the fourth facet, this aspect of the mind can be proposed to be defined as:

"The emergent, self-organizing embodied and relational process that regulates the flow of energy and information."

This definition then enables a mental health practitioner, an educator, a parent, or others helping the mind develop to address the next, natural question: What might a healthy mind be? From the mathematics of complex systems, the question then becomes how the mind might optimize its fundamental facet of self-organization. The study of complex systems—clusters of entities with the characteristics of being open, chaos-capable, and non-linear—reveal an answer with surprising application to the field of mental health. Optimal self-organization emerges with the linkage of differentiated parts of the system—something simply called integration—creating a state of criticality which "is the constantly shifting battle zone between stagnation and anarchy, the one place where a complex system can be spontaneous, adaptive, and alive." (Waldrop, 1992, page 12). Criticality is the mathematical space of a metaphoric river of

integration that has a central flow of being flexible, adaptive, coherent, energized, and stable. That river of well-being is bounded on one bank by chaos, the other by the bank of rigidity.

Seen from this perspective, mental health arises from integration. Impairments to integration lead to chaos and rigidity. Integration then is the basis of health. Well-being, resilience, and flourishing arise from this common ground of integration. If differentiation or linkage, or both, are blocked, the flow of the system moves toward chaos or rigidity. An examination of descriptions of "mental dysfunction" and their symptoms can inspire a re-interpretation of deviations from well-being as consisting of chaos or rigidity or their combination. Health comes from integration; impairments to health result from impediments to integration and result in chaos and rigidity.

In this consilient approach, then, we can view the exciting discussions of this book as examples of this view even if these terms are not specifically utilized. For example, the brain is part of a larger neurobiological system in which energy and information flows. That is the neurobiological mechanism of energy and information flow in these discussions. Psychotherapy is a relational process in which energy and information are shared within the closely attuned interpersonal connections between therapist and client/patient. And psychopharmacology is sometimes needed to stabilize the neural flow of energy and information to stay within an integrative range of flexibility—that state of criticality—to enable the relational processes of integration to unfold. Seen this way, this book offers a natural unity across too commonly divided approaches to the individual within a social world.

The common finding among various studies of mental un-health or suffering and neuroscience studies can be seen as impaired integration in the brain. In bipolar illness, for example, linking inhibitory fibers between subcortical areas such as the amygdala are insufficient from the higher prefrontal regions (Chepinik et al., 2010). In the case of severe violations of attachment, such as with abuse and neglect, impaired integration is also found in a range of regions, including the prefrontal cortex, hippocampus, corpus callosum, and the interconnections of the "connectome" (See Teicher and colleagues).

The connectome is the term for the wide array of differentiated areas of the brain and how they are then linked to one another. The best predictor of well-being discovered in the Human Connectome Project was how interconnected the connectome is—how integrated the brain is predicts well-being (Smith et al., 2015).

From this line of empirical findings and this consilient thinking, the ways in which our inner energy and information flow (the "neurobiological" and the "psychopharmacological") is shaped interfaces with the interpersonal ways in which energy and information flow is shared within relationships, both with other people individually, and the environment of the social and natural worlds (see Siegel, 2017). Psychotherapy would entail a relational way in which the chaos and rigidity of mental life within and between were detected in the assessment and diagnostic phase of evaluation, and then therapeutic interventions would aim to take the identified impediments to integration and promote the necessary differentiation and linkage within the body and within the relational world (See Siegel, 2010a, and 2010b).

Taken from this Interpersonal Neurobiology perspective, this book offers exciting new discussions of how the field of mental health can blend the direct neurobiological and psychopharmacological interventions with psychotherapy assessment and treatment planning to create a consilient approach to the clinical field of mental health. For example, harnessing the power of practices that "train the mind" has been shown to enable a brain state to be repeatedly activated so that the neuroplastic changes in the brain can become traits of health in a person's life (Goleman and Davidson, 2017). Nothing excludes a therapist from utilizing this important discovery with medications used to stabilize self-regulation in dysregulated individuals to the sufficient state of equilibrium so that they can utilize mind-training practices that cultivate the research-established skills of focused attention, open awareness, and kind intention (Siegel, 2018). Medications alone may not cultivate integration in the brain, but they may at times be essential to stabilize a person's inner functioning so that they can then take part in therapeutic interactions and mind-training practices that can stimulate the growth of integration in the ever-growing brain.

The important discussions you are about to explore here offer an excellent way to consider these exciting times of integration in the field of mental health. Take in these new ideas and see how they fit with a new framework for understanding the mind and mental health in your own work and life.

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Chapter 1

The roots and Seeds of Humanistic Psychiatry

João G. Pereira
Romão de Sousa Foundation; Casa de Alba, Portugal

Jorge Gonçalves
Universidade Nova de Lisboa, Portugal

Valeria Bizzari
Centre for Psychosocial Medicine, Clinic for General Psychiatry
University of Heidelberg, Germany

In the 18th and 19th century, the Western World went through dramatic changes in the understanding of mental health and in the provision of services. William Tuke (1732 - 1822) in the UK and Philippe Pinel (1745 - 1826) in France were in the forefront of a humanizing movement known as "moral treatment".

This humanization of services lost ground through the 19th and 20th centuries, giving rise to the maintenance and spreading of large mental health institutions where people suffering mental distress were severely separated/segregated from external reality and not given the rights of "normal" (adapted) people. A positive idea of asylum (with certain downsides – see below under "Critical Movements as base for a Humanistic Psychiatry") was replaced with segregation.

During the Second World War, a number of British doctors started the Therapeutic Community movement in the UK, in many ways returning to the ideas of Tuke and Pinel. They observed that transforming the environment of the "mentally ill" would also dramatically change their condition. A number of similar movements spread through Europe and the US giving rise to a new understanding of mental illness, sometimes even contesting the term illness itself, and often attempting treatment without medication.

Alongside the growing therapeutic community movement and the humanization of services another dominant trend was rising: the "technologization" and commodification of interventions based on value-

free science. Whilst not the aim of that trend, it often dehumanized relationships. There is an implicit tension between "being-with" (humanistic values) and "doing-to" (technical expertise).

A "doing-to" stance has often been rooted in psychiatric manuals like DSM (Diagnostic and Statistical Manual of Mental Disorders) or ICD (International Statistical Classification of Diseases and Related Health Problems) which suggest the existence of objective states which are value-free and where concepts such as "autistic" or "schizophrenic" entered daily discourse and gained legitimacy. Increasingly we find ourselves in a "quick fix" culture dominated by a technical-rationality model of science, a change nicely termed by some authors as the "McDonaldization of Society" (Ritzer, 1993).

How can Being and Doing coexist in the service of patients and families? The relational paradigm and the scientific postmodern era arose at the same time that positivism and empiricism are growing. There are disparate movements of integration and sectarianism; important differences between affective and cognitive neuroscience; large gaps between theory and practice; contradictory evidence for and against "broken-brain" models. Is it possible for science to go back to "the ordinary" and start being human again, acknowledging the impossibility of separating figure from ground?

Neurobiology can be significantly modified through medication and psychotherapy, but also through play and occupational therapy, and by diet and lifestyle. The right weighting of the components of mental health, and the right measures of it can only be known through secure and trustworthy therapeutic relationships, helping to give meaning to interventions. The establishment of epistemic trust within psychologically enabling relationships is perhaps the only non-controversial ingredient of change, as research and practice consistently confirm (Pereira and Debbané, 2018; Norcross, 2002).

With this volume, we propose to open the debate between three main themes: psychotherapy (including psychological and philosophical influences), neurobiology (including cognitive and affective neuroscience) and psychopharmacology. The three main themes are clinically applied in what we call the "Intervention Triangle". The book is first focused on epistemologically distinct frameworks and gradually attempts to consider the integration of these three fundamental vertices of practice.

The volume will be particularly relevant to practitioners working towards integrative frameworks. Although unidisciplinary integration has been a theme in several research and theoretical publications, this book offers an

interdisciplinary, comprehensive and reflexive view of mental health problems and approaches, avoiding developing into mere eclecticism.

Following a number of congresses, international meetings and the publication of Schizophrenia and Common Sense (Hipólito, Gonçalves and Pereira, eds. 2018) the first editor has decided to put together a second volume, grounded on the discussions undertaken during the Second International Mental Health Congress of Romão de Sousa Foundation. Several authors from this congress, and several others with an interest in the subject of integration and common sense mental health, agreed to publish and contribute towards the humanization and democratization of mental health services. This volume results from the honest effort of all the authors, editors, reviewers and assistants. We hope it can contribute towards common sense in 21st century mental health.

1.1 The "illnification" of mental distress

Biomedical views and the "illnification" of mental distress (see, for example, Szasz 1960) have dominated the field for some decades, many times tied up with socio-economic pressures, arising from a variety of sources, such as the pharmaceutical industry, health insurance companies, academia, the maintenance of professional status and power, and so on (see Florence et al. in this volume).

The biomedical model of mental health, alongside the "psychiatrization" and "psychologization" of mental distress, are parts of a wider sociocultural paradigm, the commodification of life in general and of mental health services in particular (see Hinshelwood in this volume). Mental distress, in this way, is viewed as a burden, an "illness" to get rid of, as quickly as possible and without pain. Medication fits very well into this "culture, providing hopes of "quick fixes". One possible problem arising from this view is that the "function" of mental distress is not fulfilled, the "message" it carries is ignored, and therefore the desired "quick fix" turns, in many cases, into chronicity and long term (dis)ability.

As mentioned further below in this chapter, opposition to reductionist biomedical and empirical views are not a new phenomenon, with the anti-psychiatry movement of the 60's and 70's being an example. A more balanced and integrative approach could be found in contemporary treatment systems such as the Finnish Open Dialogue (see Seikkula and Alakare in this volume), Mentalization-Based Therapies (see Nolte, Campbell and Fonagy, in this volume), or other rehabilitative programs, following WHO guidelines (see Gomes, in this volume). These models are strongly based in the therapeutic relationship as the central element, taking lessons from the vast amount of studies in the therapeutic alliance

as the single most important factor for promoting change (Horvath and Bedi, 2002; Norcross, 2002). Medication is used but cautiously and reflexively, most notably in a selective and needs adapted way (Bergström et al., 2017). They also have in common the strong engagement with families, communities and other social networks, as well as the attention paid to attachment security, ruptures and repair in the working alliance (Safran, Murran and Eubanks-Carter, 2011). The different treatment systems are supported by research, from experimental to naturalistic studies (see this volume), and the results are not just promising but, as many practitioners have mentioned, rather obvious. The importance of consistency within services and teams is paramount, as demonstrated by the Open Dialogue system which, to operate in its full potential, should be adopted by the entire geographical catchment area (see Seikkula and Alakare, in this volume).

So, if the knowledge and success exist, what is needed in 21st Century Mental Health to make this humanistic culture dominant within mental health treatment systems? We claim, as the title of the book suggests, that it is Common Sense. The "manipulation" of macro-economic forces and the “illnification” of mental distress resemble, somehow, a collective psychosis, turning the common citizen apart from the compassion, tolerance and understanding that mental disturbance needs.

If societies express their wounds and disturbances through "symptoms" (rise in the number of suicides or terrorist attacks, persecutory culture, economic collapses or the rise in authoritarianism) so thus the individual. This essential form of communication must be heard and not silenced; it must be understood so that transformation is possible.

1.2 The Subjectivity of the Mind

The analysis of mental disorders necessarily requires a careful and multilayered reflection: in fact, we can affirm that psychiatry owns a “subject-object”, since it is focused on a complex entity which we cannot reduce to a mere empirical, spatio-temporal one. As Basaglia underlined (Basaglia, 2000), consciousness or subjectivity is the real core of psychiatry, its horizon of meaning. Human Beings are not objective entities: they are social animals, individuals, and subjective entities. In order to account for such complexity, Basaglia argued for an integrative approach, meaning to incorporate both psychiatry and philosophy, the only perspective able to understand mankind in its deepest core, to face life’s struggles, to account for the peculiarity of each person and of their authentic being.

In this view, pharmacotherapy is not entirely forgotten but is evaluated as a nonexhaustive perspective which cannot be considered the only source of recovery. The clinical gaze which is aimed at finding biological diagnosis and general treatments, following only causal-effect ways of thinking and empirical evidences, does not grasp the specificity of pain, which is always different, expressing itself in several ways.

On the other hand, neither a neurobiological approach can account for the complexity of sufferance: as Schneider (1919) has clearly stated psychiatry is not just a ramification of scientific-natural medicine, since pathological histology will never manage to understand psychic manifestations. Focusing only on brain disruption inevitably cuts off the experiential domain from the clinical setting. Pio Abreu, Fradique and Freire Lucas (2010) go even further, stating that psychiatry is a branch of medicine dealing with "information systems", rather than a medical specialty. Medical Specialties deal with sub-systems of the organism, whilst psychiatry, or to say better, psychic events, are, one way or another, involved in all body systems.

It seems that, in the analysis and treatment of mental disorders, one should choose between a "biological psychiatry" (according to which psychic events are neural events that we should treat through a pharmacological therapy) and a psychiatry which considers every psycho(patho)logical experience in its complexity.

In this volume, we argue for a shift from the predominant biomedical, empirical and pharmacological paradigm towards an integrative, interdisciplinary approach where pharmacological treatments are not the only source of healing, since the object is not a malfunctioning machine, but a suffering person. Jaspers (1959) emphasized the epistemological gulf between a biological perspective which tries to explain mental symptoms in terms of neurobiological malfunctions, and a psychological approach meant to understand mental disorders in terms of other mental phenomena. What one should recognize is that it is possible to embrace both perspectives, since a unilateral approach will never manage to account for the complexity of the human mind. This multiperspectival approach is called "methodological pluralism". In this sense, the study of mental disorders must stop over-relying on medication and focus on a more human and person-centered approach to treatment, that puts emphasis on the lived experiences of the patients and on the need for community-based interventions. In fact, a biological, reductionist approach is based upon a positivist epistemology which claims that empirical observations and rules of logic are the only sources of knowledge.

For this reason, psychopathology should not be a kind of biology only, but also part of the Humanities (Jaspers, 1959), because "any serious study of the mind, or 'psyche' must involve the consideration of consciousness, subjectivity, or the first-person point of view". (Parnas et al., 2012, p. 5). In this process, phenomenology plays a key role. This philosophical method of analysis is primarily directed towards the study of the facts of consciousness. Accordingly, it is also applicable to psychopathological facts, allowing to consider the patient as a consciousness, and taking into account the complexity of psychic life, the real core of psychological disorders. Phenomenology could be efficacious in understanding the patient without forgetting biological constraints: a vision of person as a psycho-physical entity is very useful for not underestimating either the psyche or the natural organism. This method has been used in the field of psychopathology: Jaspers's work (1959), in particular, represented a real revolution in psychiatry, since he used descriptive phenomenology in finding the implicit structures of subjectivity. Then, Binswanger (1956) applied existential analysis to the life history of patients: his work was primarily directed to the study of schizophrenia, but we can easily claim that it could be helpful in the study of other psychological conditions.

The advantages of adopting a phenomenological approach are both methodological and practical. From a methodological perspective, phenomenology allows one to focus on subjective experiences and not only on symptoms. Furthermore, the real object of psychopathology is the person and her/his subjective experiences instead of biological symptoms. From a practical point of view, phenomenology is helpful in hypothesizing therapy (Doerr-Zeggers & Stanghellini, 2013) and in modifying the relationship between the clinician and the patient, which becomes an empathic attitude where clinicians' primary purpose is understanding what it means to be in a certain psychopathological state, not merely in terms of brain disruptions, but in a more existential manner. The neurobiological causality, which belongs to a descriptive account, works together with the explanation of the first person subjective experiences (Sass, 2010). The result is a person-centered approach (Stanghellini & Aragona, 2016) which prioritizes patients' experiences and allows the clinician to consider them as individual consciousness.

1.3 Critical Movements as base for a Humanistic Psychiatry

1.3.1 Antipsychiatry

Although antipsychiatry in the general sense of the term is as old as psychiatry itself (Quétel, 2012), which emerges in the early nineteenth

century, it is in the 1960s and 1970s that a movement known as “Antipsychiatry” emerges. Though some did not accept the label of "antipsychiatrist", the names of Michel Foucault, Thomas Szasz, Franco Basaglia, David Cooper and Ronald Laing among others were associated with this movement. We will not give a detailed description of the movement here, but only its general characterization insofar as it poses problems that would significantly influence the evolution of psychiatry.

Although there are several antipsychiatries, the common denominator to all of them is the struggle against the psychiatric institution synthesized in the figure of the physician and his power (Foucault, 1967; Rose, 2006). In this, anti-psychiatry met the anti-establishment movements of the time. We think that this critique of repressive psychiatric power is the most essential of the movement and its criticism of the concept of mental illness and of pharmacological therapies derived from this fundamental position.

"It seems to me that we could situate the different forms of anti-psychiatry according to their strategy in relation to these games of institutional power: to escape them in the form of a dual contract, freely consented to by both parties (Szasz); establishment of a privileged location where they should be suspended or refused if they are reconstituted (Kingsley Hall); blasts them one by one and destroy them progressively, inside a classic type institution (Cooper in Hall 21); to link them to other relations of power which, from outside the asylum, could already determine the segregation of an individual as mentally ill (Gorizia). Power relations constituted the a priori of psychiatric practice. "(Foucault, 1975, our translation, p. 102)

We will briefly mention here two philosophers, Michel Foucault and Thomas Szasz, who have clearly defined the ideas of the movement in theoretical terms. We will not present here the practices performed by the antipsychiatrists. *Madness and Civilization* (Foucault, 1967) was a book that influenced anti-psychiatrists, although Foucault's concerns were initially more epistemological. He argued in this book that the interpretation of madness as "mental illness" only occurs with the emergence of psychiatry in the early nineteenth century. The mentally ill persons are separated from other transgressors of the established order and locked up in asylums. Foucault does not see, however, in this movement any liberation but rather an attempt to adapt the patients to bourgeois society by psychological methods, the so-called "moral treatment." There appears a new figure, the doctor, a mixture of Judge and Father who is selected more by his moral capacities than medical. Later, under the influence of the positivist philosophy, a psychiatric knowledge

will be elaborated, which serves essentially to justify the doctor's power over the sick. Anti-psychiatrists aimed to challenge the power of the institution, incarnated in the doctor's figure. They wanted to give the patient the right to take their "madness" by removing the doctor from the role of the one who knows what it is to be mad and to be normal.

Seeing that his book was having a lot of influence, Foucault took up the subject again, but in the meantime, he turned away from his initial conception of power, which he came to call the "repressive hypothesis." According to this conception, the psychiatric institution would be a microcosm of the society, being the power centered on the doctors. In *Psychiatric Power* (2006), Foucault reformulated this idea and maintained that power is not centralized in a subject (in this case, the medical class) but it is something diffuse and anonymous. Psychiatry is one of the devices of power that shapes individuals by "normalizing" them. Power is not only externally exercised over subjects because the subject is already a production of power (for example, the woman who "wishes" to submit to the patriarchal order). With this new version of power, however, becomes more difficult to understand the scope of Foucauldian criticism. Its first version was more linked to the anti-psychiatric movement giving a more concrete aim of action. In any case, in all of his critiques, Foucault does not deny the existence of madness, it only circumscribes it to a specific and contingent historical configuration.

Szasz (1960) directly attacked the concept of "mental illness", considering that it is a myth and a categorial error. There is psychological distress, living problems and moral conflicts, but none of these are "illnesses." "Illness" is a physiological concept that is described in a causal-mechanistic language while the so-called "mental illness" belongs to the domain of rationality and intentionality (Creswell, 2008). Even if the correlations between brain and mental illness are to be identified one day, it is defined in terms of behaviors that only make sense in a social value context. For example, a person only suffers from depression because she lives in a society where one thinks that life is something good and joyful. It is a value, not a natural fact. Thus, Szasz thinks that any power of the psychiatric institution on the individual is unjustifiable, defending contractual psychotherapy. Here, two individuals can come to an agreement on a job to do of psychological transformation without enforcing values.

We think that the antipsychiatric movement exerted considerable influence on psychiatric thinking. On the one hand, it elicited a response from neurobiological psychiatry that sought to reduce psychiatry to neuronal deficit factors by neglecting motivational and social factors.

However, we believe that it has also had an influence in the centralization of psychiatry in the medical value of harm for an individual and not so much in the deviation of social norms (Telles-Correia, Saraiva & Gonçalves, 2018). An example would have been the elimination of homosexuality from the catalog of mental illnesses, as it may be a deviation from dominant social values, but not an illness. By revealing how the so-called "mental illness" depends to a large extent on social values, anti-psychiatry will have inspired the creation of movements that aim to increase the power and freedom of patients, against a psychiatric institution that aimed primarily at social control.

1.3.2 Critical Psychiatry

Mainstream Psychiatry continues to be criticized nowadays, under various degrees of severity. A similar movement to antipsychiatry but also with important differences is called “Critical Psychiatry”. This movement arose from a response against the proposals of the British Government to amend the 1983 Mental Health Act. A group of British psychiatrists met for the first time in 1999 expressing concerns about the implications of the proposed changes for human rights and the civil liberties of people with mental health problems. The Critical Psychiatry Network arose from here, and since then hundreds of peer-reviewed articles and dozens of books have been written, accumulating evidence on the following themes:

- The problems of diagnosis in psychiatry;
- The problems of evidence-based medicine in psychiatry and, related to this, the relationship between the pharmaceutical industry and psychiatry;
- The central role of contexts and meanings in the theory and practice of psychiatry, and the role of the contexts in which psychiatrists’ work;
- The problems of coercion in psychiatry;
- The historical and philosophical basis of psychiatric knowledge and the practice of psychiatry.

Linked to critical psychiatry is the more theoretical “wing” called Postpsychiatry (Thomas and Brecken, 2004), who use similar principles to Critical Psychiatry whilst grounding their work more specifically in Heiddeger, Merleau-Ponty, Foucault and Wittgenstein.

1.3.3 Therapeutic Communities

Arising from an amalgamation of critical movements, Therapeutic Communities (TC´s) have been, and continue to be, a counterculture for mainstream mental health services. TC´s developed from models of treatment that broke from traditional practice and posed profound challenges to dominant thinking at various times: at the end of the eighteenth century (Tuke, 1813), during the Second World War (Bion, 1961; Harrison, 1999), and in the 1960s (Foucault, 1965; Goffman, 1968; Laing, 1967; Rapoport, 1960 cited in Haigh, this volume). More recent descriptions encourage medication reduction and use of other radical ideas (Haigh, 2007). Pearse and Haigh (2017) have recently published an entire volume dedicated to democratic therapeutic communities, including past references, present status quo and ideas for the future. This book also includes a recent RCT comparing personality disorder treatment in TC´s and treatment-as-usual, showing superior results for TC treatment.

Contrasting to many mainstream services, the clinical work of Therapeutic Communities takes account of the interface between the individual and their social and cultural setting (Jones, 1956). Democratic Therapeutic Communities use the concept of fluid hierarchy (Clarke, 2015) to sustain shared decision making and shared tasks in the day to day running of the community. Problems are believed to be of relational nature (Pereira, 2015; Pereira and Debbané, 2018) and symptoms are not exempt of meaning. Peer therapy, rather than only therapist-patients traditional therapy, ends up occurring as a consequence of the flattened hierarchy structure (See Haigh, in this volume). An example of user involvement in research in the context of a mental health therapeutic community is also given in this volume (Guerra, Pereira and Sales).

1.3.4. Other Critical Movements

In the US, Robert Withaker´s book *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (Withaker, 2010) set the scene for another counter-movement that mainly criticizes the current drug-based paradigm of care. In their "Mad in America" website mission they claim that this model has failed society and that scientific research, as well as the lived experience of those who have been diagnosed with a psychiatric disorder, calls for profound change.

Also concerned with the dubious evidence about the efficacy of (long-term) pharmacological treatment, the Norwegian minister of health has recently advised that all psychiatric services should offer drug free wards, according to patient choice. The nordic city of Trömso has been the first to attempt this challenge, opening a 6-bed drug free ward for severe

psychiatric disturbances. Patients and staff from this ward have recently reported on the 22nd International Meeting for the Treatment of Psychosis on what seems to be, thus far, a positive experience.

Close to Norway, the Finnish Open Dialogue system (see Seikkula and Alakare, in this volume) has, for long, been critical of mainstream psychiatry and abusive psychopharmacological treatment. They do not advocate against medication but instead promote a robust psychosocial structure in the psychiatric services and an organized, network way of approaching problems. By working in this way, they dramatically observe the reduction of coercive treatments and hospitalizations and well as the need for pharmacological treatment.

1.4 General Overview of the Book

In this volume, we bring together several contributions that address mental disorders from different but not divergent perspectives. In fact, our aim is to show that a more humanized, person-centered approach does not exclude neurobiological and pharmacological studies, but opens up the possibility for new integrative and transdisciplinary perspectives, where biological data and lived, first person experiences are equally useful for the treatment of mental disorders.

This emerges already in the first part, "Neurobiology and Pharmacology", where it seems to be evident that we need a Gestaltic vision of subjectivity and mental functions. In *Neuroscientific Questions about Intrapsychic Phenomena and Interpersonal Processes*, M. David emphasizes the existence of interesting correlations between events that occur in the brain (conceived as a neurobiological organ) and intrapsychic phenomena and interpersonal processes of the mind. In his view, non-conscious communication phenomena are interfaces between neurophysiological processes and interpersonal dynamics. In fact, the brain is a plastic, dynamic organ that is shaped by the everyday functions of the human body, to such an extent that we can define it as a "mediating organ" (Fuchs, 2018). Arguing for an intertwining between neural processes and phenomenal ones, David claims that psychotherapeutic interventions can actually influence the neuroplasticity of the brain. In other words, psychotherapy has impact on patients' brains, following a circular mechanism according to which the brain, the mind and the body holistically influence each other.

The importance of a multilayered therapy is also at the center of A. Florence et al.'s chapter, *Towards recovery-based practices in mental health: reframing long-term effects of neuroleptics and presenting alternatives*, where the authors critically analyze the outcomes of neuroleptic use in the treatment of individuals with psychosis and

schizophrenia. They observe that there is limited evidence for the effectiveness of similar treatments in the long-term, and they argue for recovery-oriented strategies (such as the Open Dialogue approach) that make a selective use of pharmacological treatment, which involves network aspects and dialogue as the primary therapeutic components.

Among these components, as J. Grácio et al. remember us in the article *Embracing the Placebo effects in the treatment of depression: from neuropsychiatry to psychotherapy,* we should not undervalue placebo effects and the power of its healing-promoting properties. Through a careful review, the authors note that in pharmacotherapy and psychotherapy there are small differences between real treatments and placebo. Accordingly, they suggest considering placebo as a promotor of clinical improvement which should be used together with other therapeutic approaches. The efficacy of placebo is shown through the case of depression, a mental disorder where placebo seems to have a powerful, healing effect.

The complexity of facing mental disorders and the necessity of an integrative approach is emphasized by A. Gomes, who describes *Psychiatric rehabilitation: the efforts for conceptualization and meaning construction - a review.* He provides a historical understanding of the concept "rehabilitation" through a non-systematic review based on national reports, finding out that the origins of psychiatric rehabilitation mainly lay in historical and sociocultural events. The multidisciplinary nature of this therapy is based on two axes: the person and the environment, elements which are conceived in a dialectic relationship. In other words, the psychiatrists should consider both of these spheres and involve the patient in the community life, creating a support system able to improve patient's life.

Pharmacological, neurological, social and person-centered approaches work in a non-exclusive manner for improving the quality of patient's life, a patient who is not a disrupted brain, but a person who lives in a culturally-socially shaped environment which influences his behavior and his neural structures.

The intertwining between social elements, neural structures and behavioral components is at the center of the second part of the volume, which hosts contributions that interestingly testify the possibility of approaching mental health in a more human manner, focusing not only on the subjectivity of the patient, but also on the importance of the social, collective dimension. This involves the arising of new theoretical research directions and of new, innovative services. In fact, the dimension of the cure has enlarged its horizons from the study of the individual brain to the

development of therapeutic communities. R. Haigh's chapter on *Therapeutic communities for the future: surviving modernization and staying at the radical edge* explains how a treatment which was seen at the forefront of progressive and radical practice in the mid-20th Century has survived and developed in very different sociocultural times and kept its critical stance in regard to mainstream psychiatry. Therapeutic communities encourage medication reduction and take into account the interface between the individual and their social and cultural setting. The chapter focuses on how group processes have been harnessed across the network of therapeutic communities to influence quality, training, research and innovation – and how the underlying therapeutic philosophy is now being used in new settings.

A concrete example of a similar practice is furnished by J. Seikkula and B. Alakare in *Open Dialogue principles and dialogical meetings for psychosis*, where they illustrate this innovative, family and social network-centered treatment approach that was initiated in 1984 in Finland (but only named as "Open Dialogue" in 1995). Open Dialogue involves two elements: first, open meetings in which all relevant members in the actual situation – including both the social network of the client and the professionals working as a team - participate from the outset to generate new understanding by dialogue; second, the guiding principles for the entire system of psychiatric practice in one geographic catchment area. The main forum for dialogues is the open treatment meeting where all management plans and decisions are made with everyone present. This kind of treatment seems to guarantee—among other benefits—psychological continuity, immediate response and long-term effectiveness for severe mental health problems. The positive outcomes presented may indicate that psychosis no longer needs to be seen as a sign of illness but can be viewed as one way of dealing with a crisis and that after this crisis many or most people are capable of returning to their active social life.

The continuity between what can be considered as "pathological" and "non pathological" is also described by M. Debbané and E. Toffel in *Mentalizing the early stages of the Psychosis Continuum,* suggesting that psychotic phenomena are expressed along a continuum ranging from non-clinical to more serious clinically psychotic manifestations. They focus especially on trauma and attachment insecurity, conditions that influence a developmental trajectory that strays away from investing in mentalizing skills, and that promotes a dissociative coping style in individuals having experienced hostile and sometimes traumatic early environments. This perspective could be useful in the prevention of risk. The enlargement of the horizon by putting attention not only on

pharmacological treatments but also on the prevention is underlined by Nolte, Campbell and Fonagy in the paper *Social communicative processes in severe personality disorder*. At the center of their analysis, there is the so-called "p-factor", a general vulnerability index that captures the tendency of some individuals of being more prone to persistent and more severe psychopathology. Combining computational neuroscience and contemporary models of psychopathology, the authors shed light on the fact that "p" is strongly associated with high levels of childhood maltreatment and low mentalising capacities and emphasize aspects of brain structure-function relationships underpinning resilience processes. In other words, they account for a multilayered approach where neurobiological data and social, developmental structures have the same importance for the understanding of the pathology: broader social networks and the wider social environments also have neural structures, in a circular mechanism where the brain, the mind and the environment constitute a whole.

But how can we face this complexity in the clinical practice? In the third part of the volume we can find some examples: in *Multidimensional study of the infant population with severe and profound intellectual developmental disorder,* A. Janeco et al. take into account the case of mental deficiency, referenced as Intellectual Developmental Disorder (IDD). They present their work at the Center de Recuperação de Menores D. Manuel Trindade Salgueiro, which hosts 120 female residents aged from 3 to 17 years old. Their approach tries to assess the global needs of IDD population, evidencing the relevance of an integrated model of intervention, as well as illustrating how to organize a similar intervention in all technical areas in a structured and coordinated way. While the areas of intervention include psychiatry, nursing, social services and psychology— which are used especially in the diagnostic phase— the therapy areas include physical therapy, psychomotricity, speech therapy and occupational therapy, without forgetting patient's interests and needs.

A patient-centered approach is presented by D. Guerra et al. in *Practice based research at Casa de Alba: the perspective of service users*. Casa de Alba is a residential therapeutic community which adopts a participatory research approach, involving residents in planning and conducting research; and carries on therapies with patients and their families. In other words, it is a relational environment where everything is aimed at giving voice to patients in order to allow their opinions to influence future research and therapeutic priorities. The same happens to evaluation tools: in fact, the paper presents a participatory research study where, by carrying out a focus group, they explore the residents' views on the

outcome measures used in the routine assessment of patient progress. Participants were asked to give their opinions on the advantages and disadvantages of two nomothetic measures and two client-generated outcome measures (CGOMS). Results provided valuable insights into the complementary nature of nomothetic measures and CGOMs, as well as into the effect that weekly progress monitoring can have on patients in residential psychiatric care.

A more human approach to mental disorders has the effects of changing treatments —as Casa de Alba and Centro of Recuperação de Menores D. Manuel Trindade Salgueiro testify— but also of modifying our view of mental illness. The changes involve the shift of attention from the patient conceived as an individual to the suffering person as being part of a community, and from the pathology as a specific, severe situation described by manuals that follow strict definitions, to a continuum state which can vary in its intensity and expressions. In this sense, mental health research and practice should be committed to creating new research paths, and a renovate social responsibility towards every citizen. A. Candeias et al. describe *Burnout in teaching: the importance of personal and social variables,* where they take into account a phenomenon often undervalued: the level of burnout in teachers. They present a study made on teachers of Portuguese public schools, using the Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996), which allows a three-dimensional characterization of burnout: personal accomplishment, emotional exhaustion, and depersonalization. The result leads to conclude that there is a strong need for an intervention promoting the health and wellbeing of teachers, oriented towards the training and professional valorization and the prevention of the emotional exhaustion that happens with the career advancement and years of experience.

The centrality of social dimensions in mental health is underlined by D. Pereira in *Parenting and/or Mental Health?* where she notes the difficulties in assessing parenting capacity evaluation. In this chapter, she argues for a flexible and dynamic approach, able to find a pattern through the difference gathered from multiples sources of information - parents, family members, neighbors, friends, professionals – and methodologies – home visits, interviews, psychological assessment, observation of interactions and contact with other professionals. Then, she presents the Parenting Capacity Assessment Guide as a tool that could help professionals in clinical judgements about parenting behavior.

The need for a new approach is also felt in research, where what is discussed is not only the right kind of treatment and the links among the different approaches, but also the nature of mental disorders themselves.

PAGES MISSING

FROM THIS FREE SAMPLE

List of Acronyms

AD	Antidepressant
AD	Anxiety Disorders
ADHD	Attention Deficit Hyperactivity Disorder
AIQ	Achievement Intellectual Quotient
ANS	Autonomous Nervous System
ASD	Autistic Spectrum Disorder
ATC	Association of Therapeutic Communities
AVHs	Auditory Verbal Hallucinations
BS	Basic Symptoms
BSI	Brief Symptom Inventory
BPD	Borderline Personality Disorder
BPRS	Brief Psychiatric Rating Scale
CBT	Cognitive-behavioral therapy
CGI-C	Clinical Global Impression - change scale
CGI-S	Clinical Global Impression - severity scale
CGOM	Client-generated Outcome Measure
CGOMS	Client-Generated Outcome Measures
CHD	Coronary Heart Disease
CHERRIES	Checklist for Reporting Results of Internet E-Surveys
CHR	Clinical High Risk
CORE IMS	Clinical Outcomes in Routine Evaluation Information Management Systems

CORE-net	Clinical Outcomes in Routine Evaluation - Net
CORE-OM	Clinical Outcomes in Routine Evaluation – Outcome Measure
CRM	Centro de Recuperaçao de Menores
DD	Double Diagnosis
DLD	Delayed Language Development
DIR	Developmental, Individual difference, Relationship-based
DIRE	Developmental, Individual difference, Relationship -based, Embodied
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive Therapy
FDA	US Food and Drug Administration
FEP	First Episode of Psychosis
FSIQ	Full Scale Intellectual Quotient
HOC	Higher-Order Cognition
HPA	Hypothalamic-Pituitary-Adrenal Axis or System
HRSD	Hamilton Rating Scale for Depression
ICD	International Classification of Diseases and Related Health Problems
IDD	Intellectual Developmental Disorder
IIF	Interpersonal Interpretative Function
IIF-A	Interpersonal Interpretative Function – Affective-Oriented Processes
IIF-C	Interpersonal Interpretative Function – Cognitive-Oriented Processes
IIHSCJ	Irmãs Hospitaleiras do Sagrado Coração de Jesus
IPPS	Individualized Patient-Progress System
LLE	Living-Learning Experience

MBI	Maslach Burnout Inventory
MRI	Magnetic Resonance Imaging
NHS	National Health Service (in the United Kingdom)
NICE	NICE National Institute for Health and Care Excellence
OT	Occupational Therapy
PANSS	Positive and Negative Syndrome Scale
PAS-ADD	Psychiatric Assessment Schedules for Adults with Developmental Disabilities
PASTOR	Positive Appraisal Style Theory of Resilience
PD	Personality Disorder
p factor	psychopathology factor
PM	Psychomotricity
PQ	Personal Questionnaire
PSYHLOPS	Psychological Outcomes Profiles
QI	Intelligence Quotient or Level
RCPsych	Royal College of Psychiatrists (London)
RCT	Randomised Controlled Trial
rTMS	Repetitive transcranial magnetic stimulation
SCL-90-R	Symptom Checklist - 90 – Revised
SIPS	Structured Interview for Prodromal Syndromes
SLI	Specific Language Impairment
SPSS	Statistical Package for the Social Sciences
ST	Speech Therapy
TC, TCs	Therapeutic Community, Therapeutic Communities
TRD	Treatment-resistant depression
UHR	Ultra High Risk approach

VIQ	Verbal Intellectual Quotient
WHO	World Health Organization
WISC-II	Weschler Intelligence Scale for Children

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