The Ideal Psychiatry—A Utopia?

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Becoming a Psychiatric Patient

I started hearing voices in 2003, but my first real encounter with psychiatry wasn’t until 2011, when I was involuntarily admitted to a psychiatric closed ward. Having been floridly psychotic for a few months and having threatened my own and others’ existence in various creative ways (through a system of social and societal decay, for example), my family, the judge and the psychiatrist decided that there was a real danger, requiring me to be admitted to hospital.

My admission and its subsequent impact have been greater than my family, friends and maybe even the professionals at the psychiatric ward may ever have known. The first weeks at the closed ward were terrifying. The experience of being confined changed my meaning of freedom, something which lasted for years after discharge. Without explanation by any nurse or psychiatrist and a folder full of meaningless flyers, I had to survive in the chaos of the closed ward, experiencing that the persons interacting with me apparently were under the impression that I was incapable of reasoning.

I lived through the days by trying to settle in and enjoy the company of other clients. I adapted relatively quickly and even began to experience something akin to being on a “break” from my usual activities, helped by the relatively relaxed state of the closed ward during the summertime holiday season. Unfortunately, professionals were on real holidays, resulting in me having no clue as to what I should do, or what was expected of me, to get out of there and appear healthy. So I adapted and just made the best of it.

At some stage, however, there was an incident, which led to me, first, being isolated, and then receiving an involuntary injection with a major tranquilizer. This terrible experience perhaps paradoxically boosted my ambition that I should defeat the disease they call schizophrenia and continue with my life. It also left me with a deep fear to not end up in psychiatry; to not have this situation of dependence and lack of freedom represent the end stage of my life.

In those early years, psychiatry in Northern-Europe started to tilt, opening up towards a movement that already started in the 1960s, trying to empower psychiatric patients. Since the end of the 20th century, professional participation of people with lived experience was becoming a hot topic in the healthcare sector, and it was gaining ground. For government, health insurers, and other stakeholders, the message of empowerment, self-management, and participation of healthcare customers was not to be ignored any longer.

As a technical physician with lived experience of psychosis and psychiatry, I have struggled with these themes. I have attempted to dedicate my time to research bridging the gap between professional and user knowledge. This is what I have discovered.

Deviation vs Variation

Increasing levels of prosperity in Western society may have helped to expose deviations in the psyche from a “norm.” The number of people diagnosed with, among other things, depression, dyslexia, ADHD and “giftedness” increases. DSM diagnostics is organized in such a way that a person is diagnosed with a term indexing a higher order state of psychological deviation.

The urge to understand the human spirit and its biological mediation feeds research into the functioning of the brain. Exchanges of knowledge about the relationship between body and mind between medical professionals, scientists, philosophers, and, increasingly, people with lived experience defines psychiatric research. However, animal models and systematic research raise more questions about the functioning of body and mind than answers. Psychiatric science appears to be shifting from treatment of categorized deviations to guiding the way in which varying mental variations are treated.
In spite of there not being a medical-empirical explanation for psychiatric problems, for me, an important overarching aspect of mental variation is eminently clear: that it is about being human, accompanied by the primary need for love, appreciation, and recognition for each person. If there is an improvement in the level of understanding of each unique person, the position of the psychiatric patient is strengthened to a level where equity and connectedness are self-evident. In the context of human beings attempting to understand each other, psychiatry travels from a clinical body that studies and treats the psyche, to a human network that is closely interwoven with everyday concerns, goals, and meaning of each person.

The downside of the acceptance of mental differences as part of a human continuum shows itself in a progressive pressure to participate—as just another human. How do you live with your own variation? How do you position yourself in relation to other variations? Peer support and lived experience previously were keywords. The responsibility is accompanied by full appreciation, acceptance, and recognition, brings forward a new level in being a psychiatric patient. This responsibility can be terrifying and may result in a regression back into madness and psychiatry, as I experienced.

Living With a Mental Variation

After 2011, I recovered and recovered; it was all I wanted to do and all I did. As patient participation gained ground in health care, I combined my patient experiences with my background as a technical physician. I ended up contributing to (mental) healthcare by either coaching clients or patients in practice, or coaching management/directors/professors/professionals/whoever in the “patient perspective.”

Driven by the terrible experience of how deeply wrong psychiatry was and probably is, I tried to share my experiences and insights in the madness of mental health care as much as possible by lobbying for more humanity in the whole system of healthcare, and converting my own negative experiences into positivity.

How do you keep yourself alive in the turbulence of madness? By living day-by-day, step-by-step, finding your way through the swamps that insanity created inside yourself and in your surroundings of “shared reality.” The end goal was no longer to recover but to live with my own talents and vulnerabilities that mental variations are. I recovered from the traumas that admission, medication, and treatment did to me and the course of my life. I recovered from the traumas of my own thoughts. I ordered my life to a form of existence in which I can contribute with my mental variation and my experiences, but how do I cope with this new form of life, knowing that this history is mine and will be part of my life, and possibly that of my (future) children?

My societal participation has reached a deeply satisfactory high level since 2011, and I recovered enough to become a PhD student in patient empowerment and person-centered care. However, being a well-functioning young man has its side effects; psychiatry treated me as an endowed and healthy person, which led me to neglect my vulnerabilities. In order to learn, needed to “fall back” again to admission in a psychiatric hospital. This time, it was routine, I immediately went into a mode of contributing to the ward by showing and telling other clients and professionals how to recover and got out quickly without any damage. Compared to my first admission, I experienced another type of professional and atmosphere: recovery-aimed and more person-centered.

Utopia?

I think and hope that in the coming years, due to the current, inescapable trend of re-defining mental ill-health as human variation, psychiatric patients will be able to make the transition from “Alien” to fellow human being. By valuing variations in the psyche as qualities, albeit not without risk, the person with a particular mental variation will be given the empowerment that was already asked for in the 1960s and before.

The clinical and ambulatory setting of psychiatry will be affected by the changes in the definition of the psychiatric patient and the changes in the definition of psychiatry as a science and as a profession. Psychiatric treatment will enter the moral era of patient values and be guided by higher order principles of acceptance, understanding, and especially: humanization.

Psychiatry will synergize with other disciplines that focus on mental variation. Mental health care will be interwoven with social care and civic networks. The acquired humanities of the former psychiatric patient will expose the challenges of the “psychologically healthy man,” and mutual recognition will arise in daily life. The us-them culture between care providers and psychiatric patients, and society and psychiatric patients, will disappear. Mental health is everywhere and important for everyone.

The viral spread of mental problems in high-income countries has preceded the widespread presence of the need for and fulfillment of mental well-being in society. Acceptance, appreciation, and understanding determine practice and give strength to people. Mankind takes steps forward towards acceptance of the diversity in the experience of being human.

How does psychiatry develop after that? Does the bionic era, the synergy between man and machine, or human mind and machine, lead to new coping strategies and new insights into mental variation? Maybe, but as long as being human means anything, my utopia remains invariant.

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