Tidsskriftet
DEN NORSKE LEGEFORENING

Psychiatry's crisis of expectations

PERSPECTIVES

ANDERS MALKOMSEN

anders.malkomsen@gmail.com
Anders Malkomsen, specialty registrar in psychiatry at Nydalen District Psychiatric Centre and PhD candidate at the Centre for Clinical Treatment Research, Oslo University Hospital.
The author has completed the ICMJE form and declares no conflicts of interest.

CARL TOLLEF SOLBERG

Carl Tollef Solberg, MA, MD PhD, senior researcher at the Centre for Medical Ethics, Institute of Health and Society, University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

The Norwegian discourse on mental health care has revealed a wide gap between expectations and realities. In somatic medicine, it is accepted that some diseases are chronic and terminal. Why is this different in psychiatry?

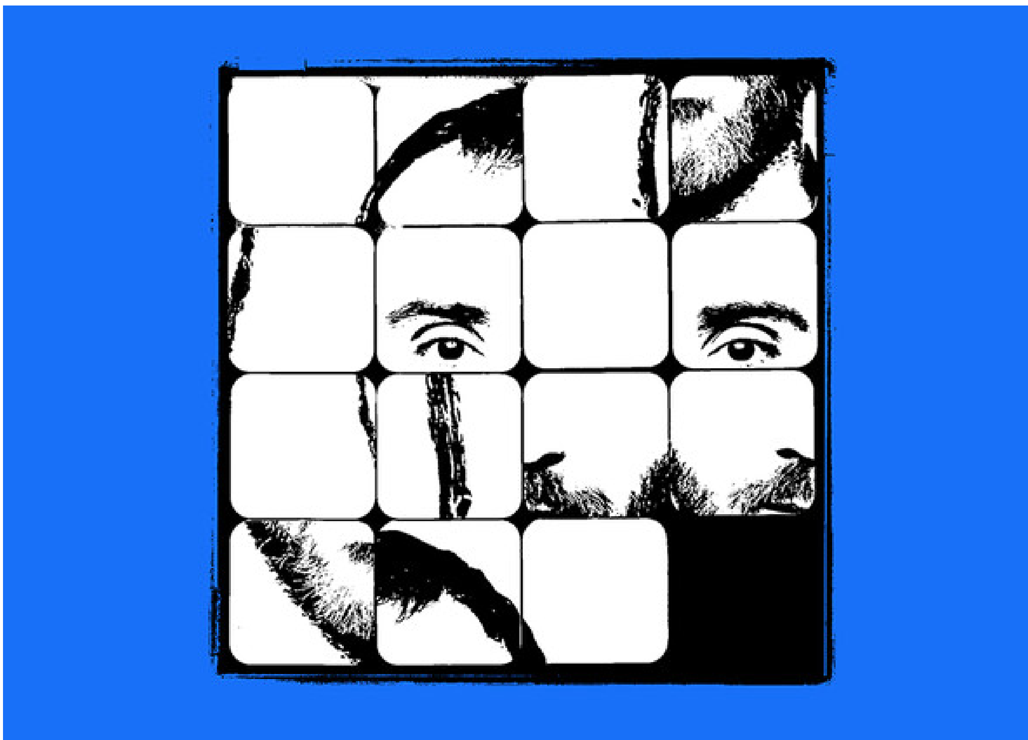

Illustration: DmitriyKazitsyn and Morsa Images, via iStock. Collage by the Journal of the Norwegian Medical Association.

There are still some people who become psychotic and commit murder. Such incidents are often referred to as 'disasters' and seen as a sign that psychiatry has 'failed' (1). There are still people addicted to narcotics, and some of them die from an overdose after discharge from treatment in an institution. In these cases, the newspapers conclude that 'the system has failed' (2). Some people with mental disorders still commit suicide, and it is not unusual for the media narrative to state that 'he could have been saved' – in other words: an error must have been made (3). Together, such media reports communicate a clear message: psychiatry is in crisis (4).

Defenders claim that the psychiatric services are underfunded (5), and it is argued that legislation does not make sufficient allowance for necessary coercive treatment of patients (6). Psychiatric staff report feeling powerless and unable to give patients the help they deserve (7). We believe that much could be improved if public discourse focused more closely on the basis of many of these controversies: different expectations for psychiatry. Our hypothesis is that the 'crisis in psychiatry' is also a crisis of expectations – the perception of a crisis caused by unrealistic expectations continually not being met.

Expectations and benefits

There is evidence that the expectations regarding mental health care are important. Patients are more satisfied when they receive the treatment they *expect* (8), which underscores the importance of realistic expectations. A systematic review shows that those who expect high-quality treatment report higher satisfaction with the service than those who expect poor- quality treatment (8). In other words, it is not important to lower the expectations for psychiatry as such – it could be an advantage for patients to expect high-quality treatment.

> *«The problems occur when the expectations are unrealistically high»*

The problems occur when the expectations are unrealistically high. In fact, studies have shown that therapeutic outcomes are negatively affected by unmet expectations, and that interventions that adjust the patients' expectations result in a more positive perception of the treatment quality. These findings also apply to patients committed to psychiatric institutions (9).

Patients and doctors will often have diverging opinions on what it means to provide treatment of high quality (10). A study conducted by Norwegian district psychiatric centres (DPS) showed that this also applies to Norwegian psychiatry (11). International studies indicate that many patients expect that their role is limited to talking with the therapist, that the therapist will guide the sessions, and that the therapy will provide a 'quick fix' without the patients having to do anything themselves between the therapy sessions (12).

Our hypothesis is that many staff members, relatives and patients have unrealistic expectations when it comes to what mental health care can do for its patients. By *unrealistic*, we mean all expectations that are not rooted in reality. Even optimal treatment cannot help everybody, a fact that we believe is more accepted in somatic medicine than in psychiatry. To illustrate, we will briefly compare some of the expectations placed on psychiatric and somatic health services, respectively.

> *«Even optimal treatment cannot help everybody, a fact that we believe is more accepted in somatic medicine than in psychiatry»*

Where is the limit?

In psychiatry, there are often no well-defined endpoints for treatment, especially in the most severe cases. How long should a therapy last, and when is the patient well *enough*? Some of the treatment guidelines include proposals for the duration, such as 16–20 hours of psychotherapy for moderate to severe depression, but for most severe conditions, the recommendations are vague and refer to 'adaptation' (13). Since the expectations for mental health care tend to be comprehensive and diffuse, and include treatment of the person's overall life view, often within the foreseeable future, conflicts arise. Unclear expectations and unclear guidelines tend to result in media reports claiming that the treatment was terminated prematurely (14).

A worsening of COPD is treated by stabilising the temporary exacerbation, and the treatment is considered successful even if the patient returns after a couple of months with a further exacerbation. If a psychiatric patient is treated with the same intensity, but suffers a relapse after a couple of months, the psychiatric treatment will quickly be considered to have failed. In the media, such cases are frequently referred to as psychiatry's 'revolving-door patients' (14, 15). This type of condescension is rarely applied to somatic patients. The premise for these narratives is that it is not the disorder that causes the lack of improvement, but the inadequate treatment provided to the patient. There seems to be little acceptance of the fact that mental disorders may also be chronic.

In the healthcare service we go to great lengths to prolong life and thereby postpone death. However, we also see illusions of a vision zero for deaths in psychiatry – and for suicides in psychiatry, in particular. It has never been a question of *whether* we will die, only *when* and from *what*. In Norway, more than 40 000 people die each year. Why has it been made an explicit goal that all these deaths should be attributable to somatic causes? A vision of zero psychiatric deaths is only rational if all psychiatric deaths de facto *could* have been avoided. Unfortunately, this is not so.

«A vision of zero psychiatric deaths is only rational if all psychiatric deaths de facto could have been avoided. Unfortunately, this is not so»

Over time, palliation has become a meaningful and important part of medical practice, as formulated in the well-known aphorism 'cure rarely, comfort mostly, but console always' (16). On the other hand, there is little tolerance for enough is enough for psychiatry. Nor are there any options for psychiatric palliation. The latter would require acceptance of the fact that even psychiatric disorders can be intractable and terminal. In somatic medicine, futile treatment tends to be discontinued. Such termination of life-prolonging treatment with limited benefits and a potential for harm is referred to as *limitation of treatment* (17). When futile or harmful treatment in psychiatry is discontinued, however, media reports give us headlines such as 'denied a second chance' – as if psychiatry wishes to kill its patients (18).

Different expectations

Those who claim that psychiatry is in crisis should first attempt to shift their expectations regarding psychiatry to somatic medicine. Let us ask: What forms of somatic treatment are required to envision zero deaths, fail to acknowledge chronic, incurable conditions, oppose palliation and limitation of treatment, and have the patient's entire life view in the foreseeable future as their endpoint? Neither psychiatry nor somatic medicine will ever be able to live up to the level of success demanded of psychiatry, not even if the entire Government Pension Fund Global were earmarked for mental health care. Accordingly, we should instead develop realistic expectations for psychiatry and dare to discuss what we might reasonably expect.

The road leading to realistic expectations for psychiatry is long. Where are these unrealistic expectations coming from? In this article, we provide no answer. Most likely, what is required is an open, honest and lengthy social discourse, as well as views on the nature of psychiatry from historical and sociological perspectives and in terms of the philosophy of science. As a modest start, we make two specific proposals for more realism.

«Neither psychiatry nor somatic medicine will ever be able to live up to the level of success demanded of psychiatry, not even if the entire Government Pension Fund Global were earmarked for mental health care»

First, vision zero should mainly be avoided. In particular, we should rescind the vision of zero suicides proposed by the former Norwegian Minister of Health Bent Høie in 2020 (19). Some decades ago, Professor Per Fugelli confronted the idea of a vision zero, and his criticism remains relevant today (20). A vision zero implies that we have a moral obligation at the societal level to avoid all cases of a specific negative incident. The main problem with vision zero is that it disregards economic and moral costs. The amount of coercion and overtreatment needed to achieve a vision zero of psychiatric deaths probably exceeds what our society really wants by a large margin.

Accepting that some people are so severely mentally ill that they succumb to the disease and that this can happen without any failure on the part of psychiatry is a wiser approach to this complex area. Just as we say that patients 'lost the fight against cancer', we ought to be able to say that some patients 'lost the fight against depression'. We can also discern the

contours of a trend towards a vision of zero coercion in psychiatry (21). An exemplary counterargument to this was published in an op-ed article arguing that we need to better accept some of psychiatry's 'uncomfortable truths' than we do today (22).

Second, psychiatry should involve itself in the 'Make wise choices' campaign launched by the Norwegian Medical Association, where the goal is to ensure that health professionals and patients jointly make wise choices in diagnostics and treatment (23). The Norwegian Psychiatric Association is set to become the only medical specialist association that has yet to propose measures to reduce the amount of overtreatment within their own speciality. This is hardly coincidental but rather symptomatic of a specialty that lacks a thorough internal clarification of expectations. Most doctors are probably fully aware of the realities described in this article. However, there is still some way left to go before psychiatry is able to use this insight to make wise choices. 'Cure rarely, comfort mostly, but console always' should apply to the entire field of medicine.

Realistic expectations

Some may suspect us of having low ambitions on psychiatry's behalf. That is false. Psychiatry can help lift a person out of deep depression and thereby change his or her entire life view. Psychiatry can help a person out of psychosis and thereby bring him or her back to reality. Compared to somatic medicine, this can almost be regarded as hubris – but nevertheless is frequently successful. We dare to claim that the treatment of severe mental disorders is one of the most important and outstanding services that the healthcare system has to offer.

Still, we need to keep two thoughts in our head, because realistic expectations are a prerequisite for optimised treatment. And, we have valid reasons to suspect that unrealistic expectations held by patients, relatives, and politicians regarding psychiatric treatment results in poorer treatment than it otherwise could have been. One example of this is the establishment of so-called drug-free therapy in psychiatry. A Norwegian study showed that the majority of the patients in the Jæren District Psychiatric Centre wished to receive drug-free therapy. The authors wisely interpret these findings such that this can be 'seen as a reflection of frustration caused by persistent symptoms, adverse effects and a large burden of suffering despite the use of medication' (24).

Often, the desire to avoid medication is likely an expression of unrealistic expectations, a hope to elude the disorder. Unfortunately, it is not always the case that if only the help had come earlier, or if a patient had been provided with the therapist or the type of therapy they wished for, all would have been well. Because psychiatric disorders can also be incurable and deadly. We need to accept this. Only then will we be able to take psychiatric patients seriously.

The authors wish to thank Julie Evensen, Jacob Jorem, Borgar Jølstad and Jan Ivar Røssberg for their useful input.

REFERENCES

1. Haugan B, Ertesvåg F. Frp etter Kongsberg og Bislett: – En katastrofe. VG 14.11.2021. https://www.vg.no/nyheter/innenriks/i/Kzb1XM/frp-etter-kongsberg-og-bislett-en-katastrofe Accessed 12.1.2022.

2. Fjelldalen H. Jannes mann døde av overdose – flere dør med legemidler som «oxy» enn heroin. NRK 26.9.2020. https://www.nrk.no/norge/jannes-mann-dode-av-overdose-_-flere-dor-med-legemidler-som-_oxy_-enn-heroin-1.15171835 Accessed 12.1.2022.

3. Hovland J, Moland A. Monika mistet sønnen i selvmord: – Han kunne vært reddet. NRK 28.8.2016. https://www.nrk.no/norge/monika-mistet-sonnen-i-selvmord_-_-han-kunne-vaert-reddet-1.13107998 Accessed 12.1.2022.

4. Helsepartiet. Nok festtaler: Psykiatri og psykisk helsevern er i krise! https://helsepartiet.no/wp-content/uploads/2020/09/Psykiatrien-er-i-krise-Nok-festtaler-2020-LA.pdf Accessed 12.1.2022.

5. Flor J. Bærebjelken i psykisk helsevern er råtten. Aftenposten 19.8.2020. https://www.aftenposten.no/meninger/kronikk/i/qLz1Ae/baerebjelken-i-psykisk-helsevern-er-raatten-joergen-flor Accessed 12.1.2022.

6. Rasmussen K, Rosenqvist R, Melle KH. Vi vet hva som trengs i det psykiske helsevernet. https://www.aftenposten.no/meninger/kronikk/i/oGrdG2/vi-vet-hva-som-trengs-i-det-psykiske-helsevernet Accessed 12.1.2022.

7. Dieset I. En vanlig dag på akuttpsykiatrisk avdeling. NRK 19.11.2021. https://www.nrk.no/ytring/en-vanlig-dag-pa-akuttpsykiatrisk-avdeling-1.15733821 Accessed 12.1.2022.

8. Crow R, Gage H, Hampson S et al. The measurement of satisfaction with healthcare: implications for practice from a systematic review of the literature. Health Technol Assess 2002; 6: 1–244. [PubMed] [CrossRef]

9. Noble LM, Douglas BC, Newman SP. What do patients expect of psychiatric services? A systematic and critical review of empirical studies. Soc Sci Med 2001; 52: 985–98. [PubMed][CrossRef]

10. Shannon SE, Mitchell PH, Cain KC. Patients, nurses, and physicians have differing views of quality of critical care. J Nurs Scholarsh 2002; 34: 173–9. [PubMed][CrossRef]

11. Bjørngaard JH, Ruud T, Garratt A et al. Patients' experiences and clinicians' ratings of the quality of outpatient teams in psychiatric care units in Norway. Psychiatr Serv 2007; 58: 1102–7. [PubMed] [CrossRef]

12. Armstrong S, Wammes M, Arcaro J et al. Expectations vs reality: The expectations and experiences of psychiatric treatment reported by young adults at a mood and anxiety outpatient mental health program. Early Interv Psychiatry 2019; 13: 633–8. [PubMed][CrossRef]

13. Helsedirektoratet. Nasjonale retningslinjer for diagnostisering og behandling av voksne med depresjon i primær- og spesialisthelsetjenesten. https://www.helsebiblioteket.no/retningslinjer/psykisk-helse/depresjon-nasjonale-retningslinjer-for-diagnostisering-og-behandling-av-voksne-med-depresjon-i-primaer-og-spesialisthelsetjenesten?lenkedetaljer=vis Accessed 12.1.2022.

14. Pedersen TL. Gunhild er svingdørpasient. Bergens Tidende 23.9.2003. https://www.bt.no/nyheter/lokalt/i/AbzRA/gunhild-er-svingdoerpasient Accessed 12.1.2022.

15. Eliassen H. Stortinget stanser nedbygging av psykiatrien. Tv2 Nyheter 15.2.2021. https://www.tv2.no/a/11951359/ Accessed 12.1.2022.

16. Hem E. Tilbake til Hippokrates? Tidsskr Nor Laegeforen 2003; 123: 3577–8. [PubMed]

17. Materstvedt LJ, Førde R. Fra aktiv og passiv dødshjelp til eutanasi og behandlingsbegrensning. Tidsskr Nor Legeforen 2011; 131: 2138–40. [PubMed][CrossRef]

18. Sandvig H. Caroline ønsker å leve, men får ikke flere sjanser i psykiatrien. NRK 17.12.2020. https://www.nrk.no/dokumentar/xl/caroline-fra-_helene-sjekker-inn_-far-ikke-flere-sjanser-i-psykiatrien-1.15259446 Accessed 12.1.2022.

19. Regjeringen. Handlingsplan for forebygging av selvmord 2020–2025. https://www.regjeringen.no/contentassets/ef9cc6bd2e0842bf9ac722459503f44c/regjeringens-handlingsplan-for-forebygging-av-selvmord-2020-2025.pdf Accessed 12.1.2022.

20. Fugelli P. 0-visjonen – essays om helse og frihet. Oslo: Universitetsforlaget, 2003.

21. Tvangsbegrensningsloven NOU. 2019: 14. https://www.regjeringen.no/contentassets/78974ebb760a412cb646611ad2e57b9d/no/pdfs/nou201920190014000dddpdfs.pdf Accessed 12.1.2022.

22. Gardsjord ES. En ubehagelig sannhet. NRK 18.10.2021. https://www.nrk.no/ytring/en-ubehagelig-sannhet-1.15694010 Accessed 12.1.2022.

23. Legeforeningen. Gjør kloke valg. https://www.legeforeningen.no/kloke-valg/til-helsepersonell/ Accessed 12.1.2022.

24. Heskestad S, Kalhovde AM, Jakobsen ES et al. Medikamentfri psykiatrisk behandling – hva mener pasientene? Tidsskr Nor Legeforen 2019; 139. doi: 10.4045/tidsskr.18.0912. [PubMed][CrossRef]

Publisert: 10 February 2022. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.21.0895
Received 15.12.2021, accepted 12.1.2022.
© Tidsskrift for Den norske legeforening 2023. Downloaded from tidsskriftet.no 4 June 2023.