Bijlage 1 – visie mbt Dwangmedicatie- horend bij 2e manifest herziening BOPZ-

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Psychiatry in the age of neuroscience. The impact on clinical practice and lives of patients

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> *"During the last two decades of the twentieth century, both psychiatrists and their patients have steadily recognized that mental illnesses are diseases of the brain that can be understood and treated using established scientific tools"* (Andreasen, 2001)

Recent developments in the neurosciences are promising. Neurosciences give us not only insights in how the brain works, they also claim to produce new scientific solutions to repair the brain, as the above quote illustrates. Psychopharmaca, it is said, can eventually repair any mental disorder. Because of the claimed progress in neuroscientific research, clinical psychiatry now aims to apply the methods and results from this line of research in the assessment of diagnoses and the treatment of psychiatric diseases. In mental hospitals among psychiatrists and patients higher expectations arise from the use of medication. For instance in the context where a patient as a consequence of a mental disorder causes danger, most psychiatrists consider medication (as opposed to seclusion or the use of other physical restraints, such as bandages) as the best way to avert the danger. Even if the medication is supplied against the patient's will (Landeweer, et.al. 2007).

In this paper we want to discuss if the neurosciences and the new psychochemical solutions really support patients to deal with a psychiatric disorder. Is the progress in neurosciences a welcome development for patients who suffer from mental illnesses? To answer this question we will focus on the perspective of the patients, and their experiences with psychiatric treatments. We'll discuss the story of Jolijn, consultant and co-auteur of this article, who spent her adolescence in a mental hospital[3]. Jolijn's story implies two important issues that are relevant for recovering from or coping with a psychiatric disease. The first issue is finding the appropriate medication. This is not a simple and unambiguous process of administing drugs; it requires deliberation and dialogue between the patient, the psychiatrist, and the social surrounding of the patient. The second issue is that even when the appropriate medication is found, this in itself is not always sufficient for the process of recovery. The social context of the patient is important as well and cannot be ignored.

Jolijn's story, as well as other empirical data used in this paper, was gathered from stakeholders in clinical psychiatry (patients, family, psychiatrists and nurses) as part of an empirical-ethical evaluation of the Dutch act on coercive measures in mental hospitals (Landeweer, et.al., 2007). This study was completed in the period between February 2006 and March 2007 (14 months), and conducted by three partners (Free University of Amsterdam, Maastricht University and research institute Prismant). The Ministry of Health financed the study. A commission with experts in the field formed an advice to the Ministry on the basis of six studies. Our study focused on the use of restraints inside

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mental hospitals and consisted of 37 open interviews (12 (ex)-patients; 10 family members, 15 caregivers), 3 focus groups (2 (ex)- patients; 1 family members) and an expert meeting with psychiatrists, legal experts and representatives of patient - and family member organizations in the Netherlands. The findings from this study were published along with other evaluation studies of the Dutch Psychiatric Compulsory Admissions Act in May 2007.

The aim of this paper is to show that in daily life, issues like coping, rehabilitation and social support are of major importance for the patient in dealing with psychiatric diseases. First, we will start with explaining the biomedical model of mental illness, prevailing in the neurosciences, and the impact it has on the clinical practice. Then we'll present the story of Jolijn and her experiences of dealing with a psychiatric disorder and her recovery. Finally, we'll discuss what this story teaches us about recovery from psychiatric diseases. We will offer a suggestion on how to include the social context of the patient in addition to the approach of the neurosciences, into the recovery process. One of the leading themes is that psychiatry has two legacies: the natural sciences (neurosciences) as well as the humanities. Both legacies should be integrated in the conceptualization and treatment of psychiatric disorders.

1. The impact of the neurosciences on clinical practice

Neurosciences study the neural structures and dynamics that make perception, thought, memory, emotion and behavior possible (Bennett & Hacker, 2003). In our empirical-ethical study of the Dutch Psychiatric Compulsory Admissions Act we noticed that under influence of developments in the neurosciences clinical psychiatry uses a biomedical model to explain deviant behavior in terms of neurological dysfunctions. The biomedical model is functional within the neurosciences, and with its focus on the physiological aspects of the brain it has produced new scientific insights in the chemical causes of psychiatric disorders. Yet, the biomedical model also has consequences for diagnosis and treatment in clinical psychiatry. Psychiatric diseases are regarded as temporal disturbances of normal neuro-functioning in the brain, which, following this model can and should be repaired by using the appropriate medication. The patient is seen as a biological actor who is (temporally) restrained by chemical processes in the brain.

Under the influence of the neurosciences, clinical psychiatry is tempted to classify itself as part of an independent faculty within the medical sciences. In the interviews we conducted in mental hospitals, most of the psychiatrists regard their profession as medical. Like physical diseases, which can be seen as harmful physical dysfunctions and cured by medication, psychiatric diseases can also be regarded as a dysfunction of the physical system and treated using advanced psychopharmaca. The primary responsibility of the psychiatrist is to assess the right diagnosis and to determine what kind of medication is necessary for recovery. Mental disorders are understood as biomedical disorders that can be cured (as opposed to chronic conditions that entail a capricious process of recovery and rehabilitation).

The biomedical model of psychiatric diseases has an impact on the clinical practice of psychiatrists, nurses and patients. Psychiatrists consider themselves more and more as physicians that can fix a psychiatric disorder like a doctor repairing a broken leg. In one of the interviews, a psychiatrist compared himself with a surgeon, who applies treatments on patients in emergency situations without consent. The citation below illustrates this.

"As a medical practitioner I'm not any different from a surgeon. They don't have to wait for consent in case they arrive at an accident by helicopter. They start immediately with giving the treatments that are necessary to save lives".

The idea is that psychiatry, as a profession should focus on repairing the dysfunctions of the brain. In clinical practice this means finding the right medication for disorders (Double, 2002). Although this focus is important the question remains whether and to what extend this strategy is experienced as beneficial by patients having to cope and deal with chronic mental disorders. Is medication alone sufficient to handle one's illness and accompanying uncertainties and feelings, and to find a new perspective in life? Is recovering from a psychiatric disease only a matter of taking the appropriate medication and restoring the chemical imbalances in the brain to normal functioning? We'll argue that in daily life having a psychiatric disease and coping with it is a much more complex process. Even repairing a broken leg, does not automatically mean that the patient can immediately walk again. The patient has to attend physiotherapy to strengthen the muscles, has to cope with uncertainties (Will I be able to walk again?) and physical and other limitations (for instance difficulties in mobility) and needs encouragement of the social surrounding to rehabilitate. Likewise, one can question whether in psychiatry taking the appropriate medication is enough to restore normal functions.

The biomedical model creates an identity problem in theory as well as in practice. In theory there is discussion about the mind-body problem in the context of neuroscience and psychiatry. For example, Bennett and Hacker in their work 'Philosophical Foundations of Neuroscience' (2003) draw attention to the conceptual confusions in the neurosciences by pointing at a mereological fallacy in the reductionist framework for neuroscience; the primary focus on the brain as the part that locates psychological attributes (of the mind) is meaningless because the whole human being can only be the proper subject matter. The mind and her psychological attributes have to be conceived as a process and not as an object-like entity. In clinical practice, psychiatrists experience a dualistic position. On the one hand they use a naturalistic perspective in diagnosing and subscribing medication ('erklären') and want to develop a more naturalistic identity, like somatic physicians. On the other hand they have to interpret and give meaning to the stories of the patients who are suffering from psychiatric diseases ('verstehen'). But this second characteristic of clinical practice seems less scientifically valid (Nieweg, 2005).

We claim that both perspectives are necessary to conduct good clinical care in a process of recovering. Which perspective should be leading, depends on the person and his or her circumstances and features. As we feel that the humanistic approach of psychiatry nowadays has become undervalued, in the next paragraph we will give voice to an ex-patient by presenting Jolijn's story, a woman who suffered a major depression in her adolescence. In this story it will become clear that patients do not experience recovery as a linear (physical) process as the biomedical model supposes. In spite of the developments in the neurosciences, recovery of a mental illness is still not always possible. Most of the time recovery is about accepting limitations that spring from the illness, as well as discovering what you (still) can. Patricia Deegan (1988) describes the process of recovery as an urge, a wrestle and a resurrection. Patients have to find ways to cope with a mental disorder, and develop new values in accepting a different life perspective. This perspective on recovery differs from the perspective of the biomedical model. To improve clinical practice, psychiatrists have to listen to the stories of patients in order to develop a mutually acceptable treatment strategy. Accepting and overcoming the mental illness is a broader paradigm than on repairing dysfunctions by administering the appropriate medication.

2. The impact of neurosciences on the lives of patients: a patient's story

In the context of our empirical-ethical research on coercive measures in mental hospitals, we spoke with Jolijn about her experiences with coercion. In an open, conversational interview we asked her about her experiences and opinions of coercive treatments in psychiatry. During the interview she told us her life story. She related how she was involuntary admitted in a mental hospital and how she eventually got out again. The interview lasted 1,5 hours, was tape-recorded, completely transcribed, analyzed using a narrative framework (Lieblich, et.al., 1998) . Later on in the process the respondent was again consulted to give feedback on our presentation of her story in this paper. Jolijn approved of our description, and her responses have been included in this version.

Jolijn was 16 years old when she felt her life was not worth living anymore. She feels lonely and miserable because of all the changes that happened in her life. Her parents broke up, her mother had a nervous breakdown, and she couldn't get along with her father. At that stage in her life she decides to take an overdosis of medication to commit suicide. After a hospital admission where she tried to cut her wrists she was involuntary admitted in a mental hospital.

Her experiences with the first mental hospital where she stayed were not well. She didn't trust the staff and the staff didn't trust her. She kept trying to commit suicide, which brought her for long periods in the seclusion room against her will. She was convinced that the staff of the mental hospital could and would not help her. She refused medication, but was forced to use it. The coercive measures made her think there was no way out of her misery. The medication made her drowsy and she experienced only negative effects. She distrusted her body, felt poisoned and even compared this with being raped. Things got really out of hand between Jolijn and the staff of the hospital. Trust between them was on such a low level, that when she accidentally cut her Achilles tendon right in front of the eyes of the staff, they didn't believe the symptoms of this irregular injury and it took weeks before she could get the medical treatment she needed. Eventually this led to her transfer to another hospital. By that time she had just reached the age of 18 years. In this second hospital Jolijn's experiences with the staff were much better. Jolijn described her impressions on how they treated her.

"Then I got transferred to another hospital. The staff said to me; 'You have been traumatized by the staff of the previous ward. We want to make you feel safe again'. And that division was actually really nice. There was some sort of match between the staff and me. You could really laugh with them. We went to the movies or just for a drink. I felt recognized as a person, like I was allowed to participate in the normal life, where before I was not".

Although her experiences with this hospital were much better, after a while she decided she wanted to get out. As the staff didn't think she was ready for leaving, she ran away and started living on the streets. It took her some time to find a place of her own to live, but when she found it, she picked up normal life, went to school and got her degree. Later on she became politically active in the patient movement. At this moment Jolijn is successfully leading an action group against seclusion rooms and pleads for better treatment of (young) people in mental hospitals. She gets regular invitations of international congresses for telling her story and helping to improve psychiatric practice.

When we look at her recovery it gives us a good perspective on the aspects that are important according to Jolijn to recover from the major depression she suffered. In the following section we will attend to her experiences of getting medication against her will and how that eventually led to using marihuana which she considers as an effective form of self-medication. After that we will discuss the fact that although this self-medication was part of her recovery, this alone was not enough to find meaning in life. Support and recognition by friends and family, and being allowed to participate in society were important aspects according to her to be able to recover.

3. Experiences with medication

In the story of Jolijn self-medication proved important for her recovery. But during her admission in the first hospital, a lack of trust prevented her from finding the appropriate and the right dosis of medication. The medication she received against her will didn't help her at all she said. It made her frightened and insecure. She didn't trust her own thoughts anymore, she felt poisoned. It made her distress even worse. Since she already received severe medication, starting to smoke marihuana proved to be a small step when some other patients offered this to her. She described her first experiences with smoking marihuana as follows:

"Before my admission, I actually was very sportive. I didn't smoke and was swimming for competitions all the time. So I wasn't interested in using drugs or anything. But as I already received so many chemicals, it wasn't so difficult anymore to start with smoking marihuana. Well, aren't illegal drugs just medicines that can't be bought in a drugstore?"

Jolijn describes her first experience with using marihuana as a moment of change. For the first time in a long period she felt a sense of happiness. She lively recalls this unforgettable moment in her recovery trajectory:

"When I first used marihuana, it was the first time in two years that I felt some happiness inside. I just sat against the wall, feeling so amazed I could feel this well. I just forgot about all the shit. It remains drugs of course, but it really had an impact on me. For me, this was the moment that changed everything. Feeling good seemed possible all of a sudden".

Starting to use marihuana "changed everything," according to Jolijn. It gave her control again, and made her aware of her capabilities and forgotten possibilities in life. She experienced positive feelings, which before seemed impossible. Problems with her parents at home, concerns over her physical well-being and struggles with the staff, it all moved to the background, and new perspectives emerged. The start of her recovery story was triggered by the chemical influences of her neurological state. The marihuana helped her to feel more self-confident and in control. But we cannot say that her recovery solely depended on her using (self-)medication. The use of marihuana started after getting in contact with other patients in the hospital. They offered her marihuana, and implicitly stimulated her to actively take responsibility for the direction of her own life. Her fellow patients did not force her to take the marihuana like the doctors forced her the medication, but invited her to choose to either take or to refuse the drugs. Jolijn experienced she had a choice (accepting or refusing the drugs), and rediscovered her own agency and responsibility. Responsibility not only for herself, but also for others, since her fellow patients trusted

her in keeping the secret of smoking in the hospital. Still another aspect that eventually fostered the process of Jolijn's recovery was the psychiatrist who approved that using marihuana was a better option than cutting herself. Jolijn experienced his approval as another important stimulus to continue her newly, unconventional but creative and effective way of dealing with her illness, as the following quote shows:

"I started smoking marihuana, and then I didn't cut myself anymore. I was not depressed all the time anymore. The psychiatrist acknowledged that using marihuana was a better option than cutting myself."

The story of Jolijn illustrates that the use of this self- medication contributed to her recovery, but that recovery is not about (self-)medication alone. For Jolijn the fact that the use of marihuana was her own choice, made her feel in control. The decision offered to her by her fellow patients triggered a process of empowerment. Jolijn became a subject (versus an object), and a moral agent who took responsibility for her life again.

Jolijn's story also demonstrates that recovery through medication is a dynamic process of intensive social interactions with others, including fellow patients and professional experts. Finding the appropriate medication for an individual is a process of searching and experimenting (versus the linear and standard application of scientific knowledge in terms of this diagnosis requires that medication) requiring a close co-operation between psychiatrist and patient. There should be a basis of trust between patients and psychiatrists so that patients will not feel out of control. Trust is an important condition to discuss and deliberate on symptoms and side effects. There should be attention to the fears and prejudices that exist (Widdershoven & Abma, 2007). From the story of Jolijn we conclude that recovery is not only about finding the right medication for a particular psychiatric disease, it is also about finding the right medication for the particular person who is suffering from a certain psychiatric disease. The medication should match with personal values and individual circumstances of the patient. For Jolijn the use of marihuana was a starting point. It gave her hope and it addressed her ability to fight instead of addressing her self-destructive behavior. The story shows that chemical substances can be important in recovering, but only as one step in the process and in a context wherein the person feels safe and can trust the medication and the person administrating it.

With this preliminary conclusion we can assert that the work of a psychiatrist should not only be about administering medication. It is also about creating trust, consensus, motivation and empowerment. Through this approach, patients become partners and co-owners of their medication treatment, will accept and trust medication more, find better solutions fitting their situation and hence may experience the beneficial aspects of pharmacotherapy. In the next paragraph we will discuss which other steps are important in the process of recovering.

4. Coping and Rehabilitation

If we look at the social context in the story of Jolijn, we find that for her, recovery meant finding meaning in her life again. The medication she received against her will did not make her feel better. Instead, it was her self-medication that gave her strength and confidence. The social support from others to cope with life was of major importance as well. Jolijn experienced a caring, supportive attitude in the second hospital where the staff made her responsible for her own life. For example, instead of the punishment she was expecting, because she acted against the rules by going out for a day, she received a compliment when she returned. The staff did not rigidly stick to the hospital rules, but was able to view

the situation from a positive side. Jolijn was able to take on her own responsibilities. Giving positive feedback fostered a trusting working relationship between Jolijn and staff (as opposed to the tensed struggle with the staff in the first hospital). Jolijn remembers how surprised she was:

"After I spent a day outside the hospital against regulations, I was prepared for a major punishment. But then they said; 'you have come back without any problems, so you have proven that you are able to handle more freedom'. So instead of a punishment, I got a compliment! That was really nice".

For Jolijn rehabilitation meant being treated as a person and a moral agent with capabilities to direct her own life, and not primary as a patient. Getting her own responsibilities meant that the staff trusted her. This recognition made her trust the staff in return, despite her previous experiences in the first hospital. It became possible for her to identify with them. This basic recognition of being a person and a moral agent served as the beginning of opening up to other persons and developing new perspectives. The staff asked Jolijn what she wanted in her life. They made her reconsider such questions which motivated her not to become what they called a 'chrono', a person who's not leaving the hospital anymore.

"They gave me a lot of respect and pointed at my own responsibilities and wishes in life. They said: 'If you could choose a kind of hobby or sport, what would you choose?' Well, I hadn't thought about what I wanted for two years, I was only thinking about how could I kill myself. At first I was dazed, I didn't know what to want. But it brought humanity back to me".

So according to Jolijn, her recovery was also about belonging to a group of peers, enjoying and participating in life and being recognized as a person. Taking over responsibilities (again), making contact, developing friendships and trusting others were important aspects for her recovery. Recovery is more than explaining and repairing psychiatric diseases. For persons suffering from a psychiatric disorder, it is also important to cope with the illness and to find new meaning in life with a chronic disorder.

In the following paragraph we will further reflect on the implications of Jolijn's story for the biomedical model of the neurosciences, and for clinical practice.

5. Recognition and trust

The biomedical model has certainly benefits for persons with psychiatric diseases. It explains what is happening when a person experiences a mental illness by referring to dysfunctions of the brain. Because of that, the solution is to take the appropriate medication and restore the malfunctions. But this explanatory story does not fully relate to the actual stories of patients like the story of Jolijn. As she pointed out in her story, some significant aspects are neglected if clinical psychiatry only addresses to this model. Clinical psychiatry aims at healing the patient and focuses on their wellbeing. What exactly is in the interests of the patient, is not objectively given, but determined and constructed by (inter)personal factors. Firstly, one of the consequences is that finding the proper medication is a difficult process and cannot be simplified. Every person has different physical features and this complicates finding the right match of medication. Standard solutions are furthermore problematic because of severe side effects (Helmchen, 2005). As the story of Jolijn shows it is also important that patients trust the medication. You

need dialogue and deliberation to come to a constructive pathway to recovery. Coercive medication will be less effective because of the stress and distrust it causes. Secondly, for Jolijn being recognized as a person and a moral agent, having her own responsibilities, developing friendships and trusting others, appeared just as important as finding the right medication. Those were the conditions, which had to be met, in order to make her recovery possible.

The way the biomedical model looks at persons with psychiatric diseases does not fully do justice to the experiences from patients in daily life. Patients hardly explain their disabilities in medical terms of the neurosciences. Jolijn refers mainly to aspects in the social context. Other patients as well experience their disabilities not primary as biological, but mainly as social (Deegan, 1988). The focus on wellbeing and recovery of clinical psychiatry demands a broader model to include these relevant factors. People need to find hope (that bad times will pass), empowerment (trust in their own power to change and to direct their lives), taking own responsibilities in the process of recovering and developing a social role in society.

In mental hospitals most of the professionals consider (coercive) medical treatment as the best option in order to avert dangerous behavior. Yet, it is important to realize that clinical psychiatry is more complex than that. Trust and recognition seem to be important features for clinical practice aiming at and working on recovery (in terms of coping with the illness, instead of repairment) of psychiatric disorders. From the perspective of patients, medication alone is not enough to help them in their recovery. As the story of Jolijn shows, coercive medication can worsen things. This means that even in the context of a crisis, professionals should try to balance medical treatment with the narratives involved. They should strive for dialogue and deliberation with the patient to come to a joint perspective of what is in the best interest of the patient. This implies a shift from a paternalistic to a deliberative relationship in which patients become partners and co-owners of their own treatment. Active engagement of patients in their process of recovery means that patients are recognized as persons with unique capabilities and possibilities to growth.

Axel Honneth defends the importance of recognition for the wellbeing of persons in The Struggle for Recognition (1995). Recognition is seen as a vital human need. Inspired by Hegel, Honneth defends the claim that full human flourishing depends on the existence of well-established 'ethical' relations of mutual recognition. He identifies intersubjective conditions based on the establishment of relationships of mutual recognition for individual growth and development, which makes sense considering Jolijn's story. Based on modern social theory he distinguishes personal development in three modes; the development of self-confidence, self-respect and self-esteem, which can only be acquired and maintained intersubjectively. These modes are developed by mutual recognition as a person in relationships of love and friendship (self-confidence), through recognition as an autonomous person (self-respect) and as a particular, unique person (self-esteem). In the story of Jolijn we see that the vital human need of mutual recognition was of major importance for her recovery. Being recognized as a person (as opposed to being treated solely as a patient), at first by fellow patients and later by the staff in the second hospital helped her to regain confidence about her own strength. Because Jolijn was being treated nicely in the second hospital (and even could have a laugh with the staff), she felt invited and allowed to participate in normal life again. This paved the way to create new perspectives on life, and to see how she could live a meaningful life with a psychiatric disorder. Jolijn became less self-destructive and developed hope for the future. She identified with the staff and they mutually trusted each other more and more.

Mutual recognition cannot develop without a basis of mutual trust. Annette Baier (1994) acknowledges that trust is a basic condition for every good that can exist and develop within mutual

relationships between persons. Trusting each other is a complex and vulnerable process, but also inevitable. In all sort of ways we depend on each other for which we have to trust each other. Especially in the clinical setting of psychiatry, patients are in a vulnerable position. They depend on the physicians to leave the hospital and to recover from a mental illness. Trust means giving some discretionary power and control to another person over you, which makes you vulnerable. If we get betrayed or disappointed it is difficult to rebuild a trusting relationship. In the first hospital the staff and Jolijn distrusted each other. The professional-patient relationship was characterized by strive, conflict, struggle and ignorance instead of mutual engagement, co-operation and agreement. The staff distrusted Jolijn so bad that eventually they didn't believe her when she said she injured her Achilles tension. Likewise Jolijn distrusted the staff. They had admissioned her against her will in the hospital. She hadn't any reasons to trust them. They did not convince her they were looking after her best interest. In the second hospital a trusting relationship did develop. Jolijn came to trust the staff of that hospital, because the staff acknowledged (recognized) her as a person and moral actor (and not primary as a patient) and trusted her to handle own responsibilities.

Although mutual recognition and trust are difficult processes, the story of Jolijn shows that these are vital ingredients for recovery. Patients should become partners and co-workers of their own recovery. Some critical psychiatrists might object to this, by referring to the fact that developing a trust-relationship with mutual recognition is not always possible, because of a psychiatric disorder, for instance a psychosis. Sometimes distrust can be part of the psychopathology. We don't want to deny that building on trust is a difficult process. The clinical practice of psychiatry can be frustrating and complex, and most of the time very hard to reach any success. But despite the fact that clinical practice is confronted with frustrations and inabilities, we claim that trust and recognition are vital ingredients to eventually create a perspective on recovery for persons with psychiatric disorders. The primary focus should always be on restoring and building trust. Mutual trust and recognition eventually create the necessary context for repairing any dysfunctionings of the brain. Within that context psychopharmaca can be of assistance in the recovery process.

6. Conclusions

In this paper we pleaded for a patients perspective on recovery as an important extension and correction of the biomedical model of the neurosciences. We illustrated this with Jolijn's story which offers a perspective of an ex-patient who has been admissioned involuntary to a mental hospital. This story shows us that involuntary medication did not have a beneficial effect on the patient's wellbeing and recovery. Finding medication that the patient can trust is a deliberative process wherein recognition as a person, personal growth and taking responsibilities are important instead of primary being seen as a patient. We concluded that for recovery medication alone is not enough. Medication should match with the wishes and values of the person who suffers a mental illness. Another aspect that the story of Jolijn made clear was that for her recovery other things were as important as using medication. Being recognized as a person, belonging, taking own responsibilities, developing friendships and trusting others determined her recovery. These findings lead to the conclusion that dealing with psychiatric diseases is more complex than the biomedical model presupposes and that one should include the social context of the patient into the recovery process. Mutual trust and recognition are vital ingredients for the success of clinical psychiatric practice. To create a mutual and overall recovery story

professionals have to strive for dialogue and deliberation with the patient and aim to come to a joint perspective of what is necessary in psychiatry as a practice of healing persons.

To develop a beneficial recovery model in clinical psychiatry, professionals should acknowledge that their role and identity are more complex than a naturalistic perspective in diagnosing and subscribing medication ('erklären') supposes. The perspective of the patients shows us that understanding and relating to the stories of patients ('verstehen') cannot be ignored if one wants recovery and coping to succeed. As Jolijn put it in the following words;

"It is not that the healthcare workers don't want to develop good care, but traditions are difficult to change. Psychiatry deals with specific problems. People need education and guidance to eventually get on with their lives. That's what the main goal of psychiatry should be".

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