

Medication: Informed Choices

Patrick Bracken and Philip Thomas

Professors of Philosophy, Diversity & Mental Health

Institute for Philosophy, Diversity & Mental Health

Centre for Ethnicity & Health

University of Central Lancashire

Preston PR1 2HE

Lancashire

England

Drug treatment: 3 axioms

- Brain states do not necessarily cause mental states
- Brain disorders do not necessarily cause mental disorders
- In reality, the relationships between brain, mind, society and culture is dynamic, plastic and rich beyond the abilities of science to know.

‘...given the current state of technological limitations, the field is years, and possibly decades, away from having a fully explicated etiology- and pathophysiology-based classification system for psychiatry. Although the past two decades have produced a great deal of progress in neurobiological investigations, the field has thus far *failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacological treatment.*’

First, M (2004) A research agenda for DSM-V: Summary of the DSM-V preplanning white papers published in May 2002. On <http://www.dsm5.org/whitepapers.cfm> accessed on 26th October 2006.

Medication: recent developments

‘Antidepressants are assumed to work on the specific neurobiology of depressive disorders according to a “disease-centred” model of drug action. However, little evidence supports this idea. An alternative, “drug-centred,” model suggests that psychotropic drugs create abnormal states that may coincidentally relieve symptoms. Drug induced effects of antidepressants vary widely according to their chemical class—from sedation and cognitive impairment to mild stimulation and occasionally frank agitation. Results of clinical trials may be explained by drug-induced effects and placebo amplification. No evidence shows that antidepressants or any other drugs produce long-term elevation of mood or other effects that are particularly useful in treating depression.’

**Do Antidepressants Cure or Create Abnormal
Brain States? Joanna Moncrieff*, David Cohen**

PLoS Medicine

July 2006 | Volume 3 | Issue 7 | e240

Evidence for a rapid onset psychosis (supersensitivity psychosis) following clozapine withdrawal was found and weaker evidence that this might occur with some other antipsychotic drugs. Some cases were reported in people without a psychiatric history. It appears that the psychosis may be a feature of drug withdrawal rather than the re-emergence of an underlying illness, at least in some patients. Meta-analyses of withdrawal studies have suggested that antipsychotic discontinuation may also increase the risk of relapse over and above the risk because of the underlying disorder, but not all individual studies show this effect. Mechanisms may relate to brain adaptations to long-term drug use but data are sparse.

Conclusion: These effects require further urgent research. Interventions to reduce morbidity after drug withdrawal need to be developed.

(Does antipsychotic withdrawal provoke psychosis? Review of the literature on rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse

J. Moncrieff, *Acta Psychiatrica Scandinavica*; 2006: 1–11)

Adverse effects induced by discontinuation of psychiatric medication include:

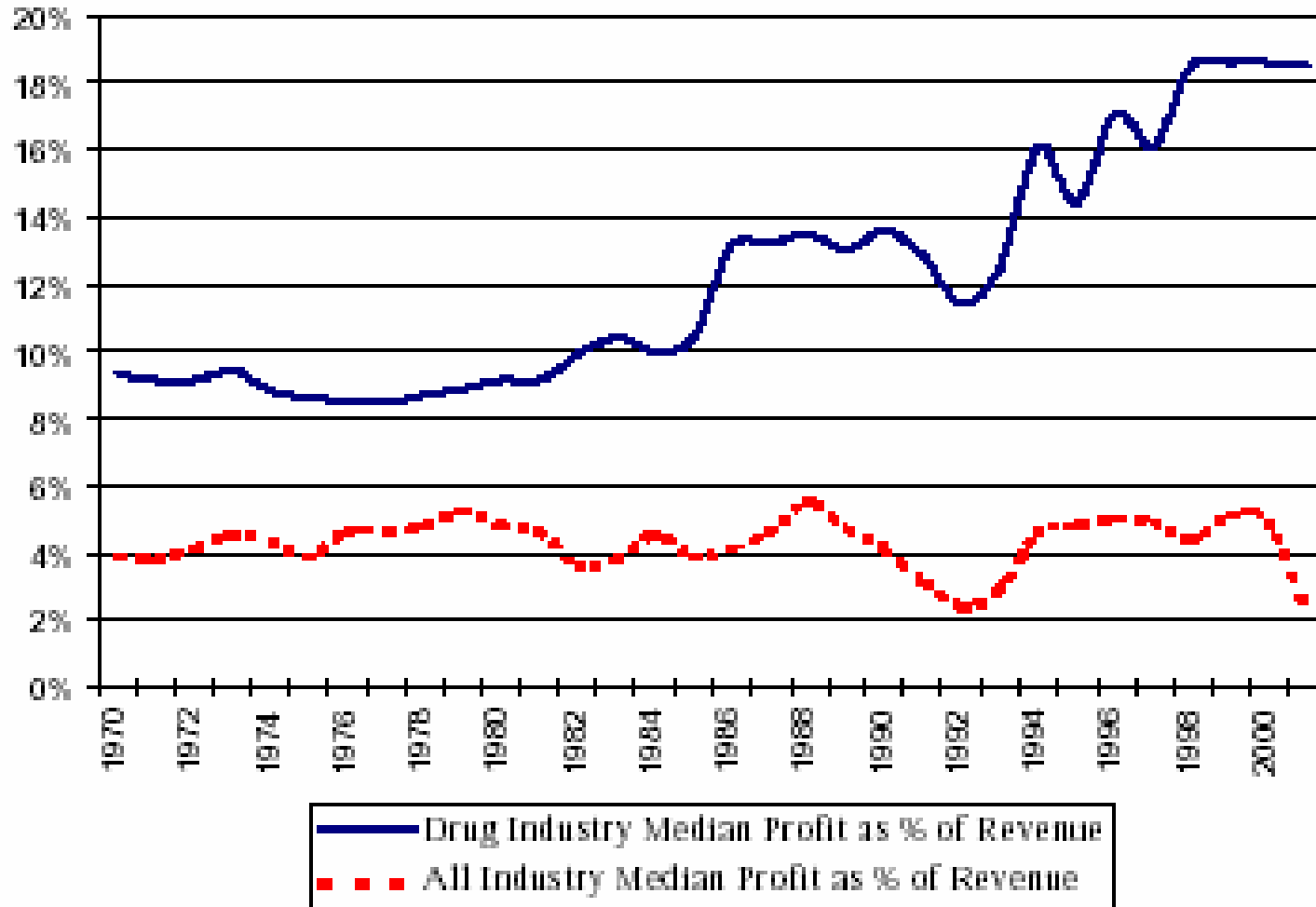
- (1) a somatic discontinuation syndrome that includes psychological symptoms which may be mistaken for relapse,
- (2) a rapid onset psychotic reaction after withdrawal of both conventional neuroleptic drugs and some atypicals, notably clozapine (sometimes referred to as supersensitivity psychosis),
- (3) a psychological reaction to withdrawal, which may be mistaken for relapse or may itself precipitate relapse,
- (4) a genuine relapse of the underlying condition precipitated by the process of withdrawal.

The implications of these effects include the possibility that much of the research on maintenance treatment is flawed and that the recurrent nature of psychiatric conditions may sometimes be iatrogenic. If withdrawal induced adverse effects could be effectively managed, the success of drug discontinuation might be much greater than usually assumed and might outweigh the disadvantages of continued treatment.

Why is it so difficult to stop psychiatric drug treatment? It may be nothing to do with the original problem. Joanna Moncrieff (2006) In press *Medical Hypotheses*

So, how come we have all been
led to believe that psychiatric
medication is safe, scientific and
effective?

Profitability of Fortune 500 Drug Industry and All Fortune 500 Industries 1970 to 2001



Pharmaceutical Company Influence

- Clinical practice guidelines
- Multi-publications of the same results
- Publication bias
- ‘Ghost’ writing
- Authors’ covert interests

<http://www.nofreelunch.org/>



Medication: Informed Choices?

Conclusions: 1

- Disclosure of ‘interest’
- Scepticism about claims for new drugs
- Negotiated medication
 - Full and honest discussion of risks before benefits (which are few anyway)
 - Find out what has made things worse
 - Find out what has helped
 - Allow the person (*expert by experience*) to experiment with doses

Medication: Informed Choices?

Conclusions: 2

- Consider using short-term benzodiazepines in preference to neuroleptics
- In neuroleptically naïve subjects never use any medication for more than 2 months. If it ain't working in 6-8 weeks, it ain't gonna work so try something else!
- Always reduce the dose at the earliest opportunity
- Maxim: it takes as long to come off long-term medication as the person was on it before the reduction commenced