Basic psychiatry and psychotropic prescribing

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In psychiatry there are **no diagnoses**

- Diagnoses in psychiatry cannot explain (except dementias).
- Consider the question ‘What is ADHD?’ and compare with the question ‘What is diabetes?’
- Consider what happens when we argue that ‘ADHD *causes* poor hyperactivity and inattention’.
- In psychiatry we have **classification that is descriptive** not diagnosis.

Do not use screening questionnaires – use clinical judgment

PHQ designed by Pfizer to make money

Ask “what has happened to you?”

Listen to their narrative.

Tell patients that a psychiatric diagnosis does not explain their problems, its just a shorthand description

Avoid medicalised language such as symptoms
Ask about suicidal feelings
Empathic phrases while listening “That sounds really tough”

Psychiatric diagnosis explains the patients symptoms

Yes or no?

Headlines from outcome research

Key findings in outcome research: **Context and relationships**

- Research finds therapy can be helpful for mental health problems, particularly short term.
- Model or technique has a minimal impact on outcomes. BUT some models (that lead to expert/technical dependency) are worse than others long term.
- Extra-therapeutic factors such as social circumstances and motivation and expectation have biggest impact on outcomes.
- Quality of therapeutic alliance next in importance.
- Regular monitoring of progress and alliance may improve outcomes.

Key findings from research:
psychological injury causes distress

- There is no evidence for 'chemical imbalance' theory.
- Genetics may have a minor role based on twin studies, but molecular genetics have thus far identified nothing except with Intellectual Disability (ID).
- No neurological abnormalities found except for ID or as a result of anti-psychotic medication.
- Strongest associations are with psycho-social factors: Adverse Childhood Experiences (ACEs), discrimination, trauma/violence (particularly sexual), neglect, isolation, inequality.
- It seems that if bad things happen we feel bad.

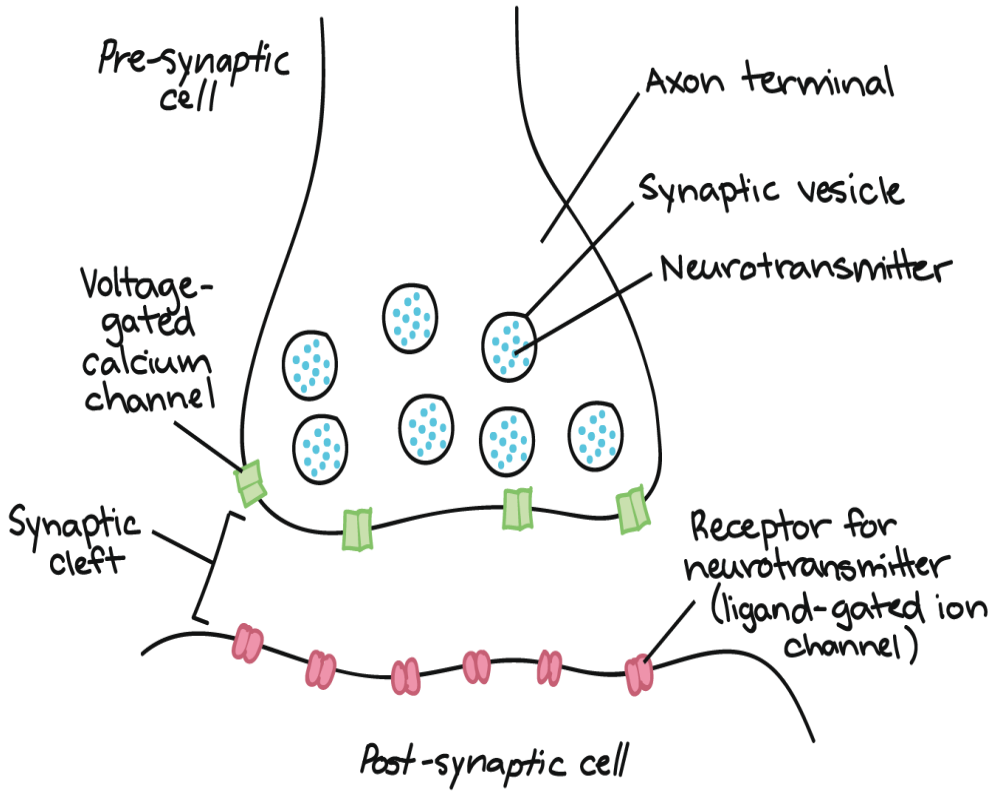
Do not tell patients they have a chemical imbalance

We often do not know the precise cause of our distress as its like pealing a never ending onion – our lives are multi-layered, but research shows the more adversity you face in social and relationships, the more likely you are to experience psychiatric and psychological problems.

Matching treatment model to diagnosis is best predictor of positive outcomes

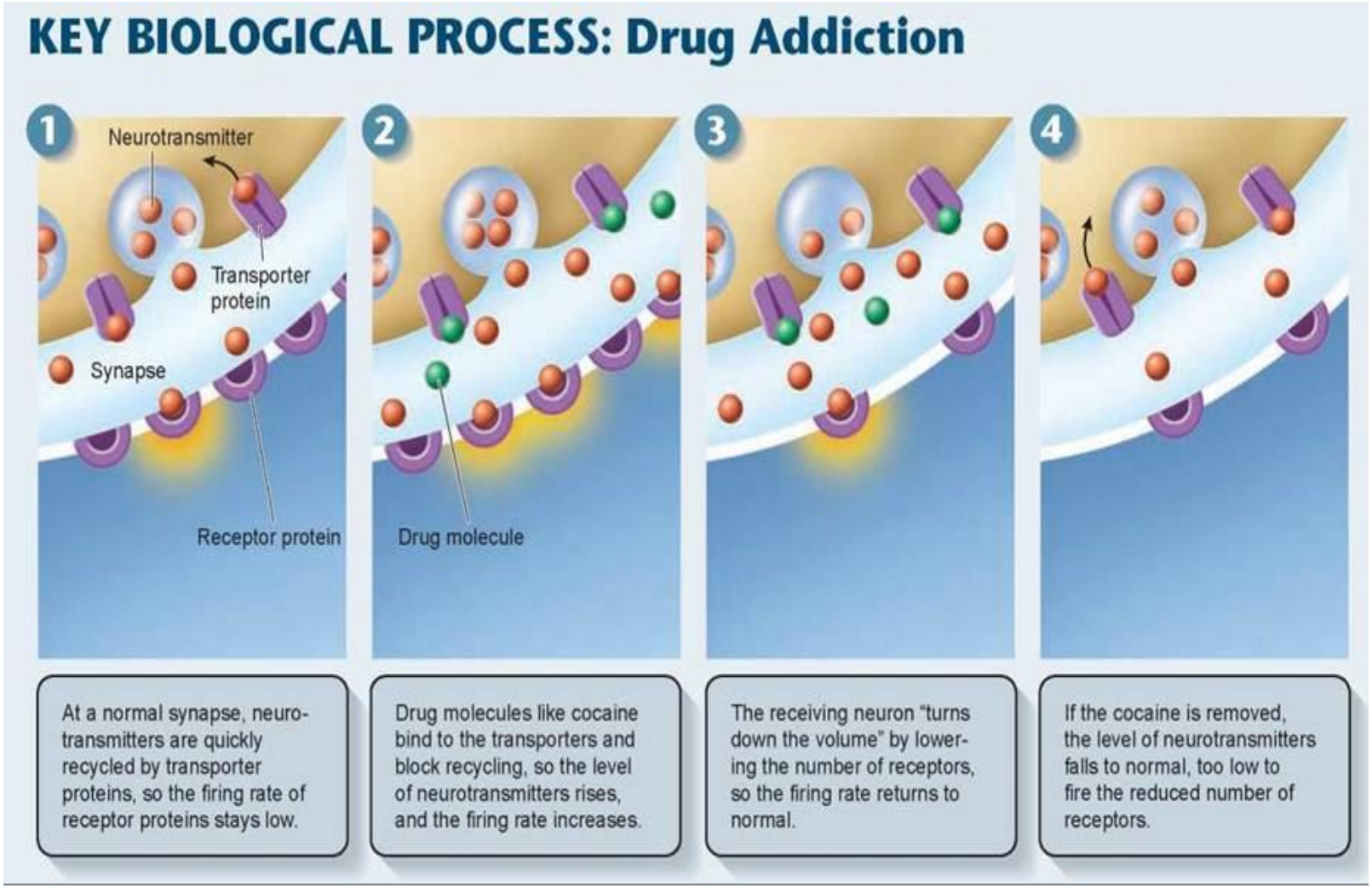
Yes or no?

All substances that effect the brain

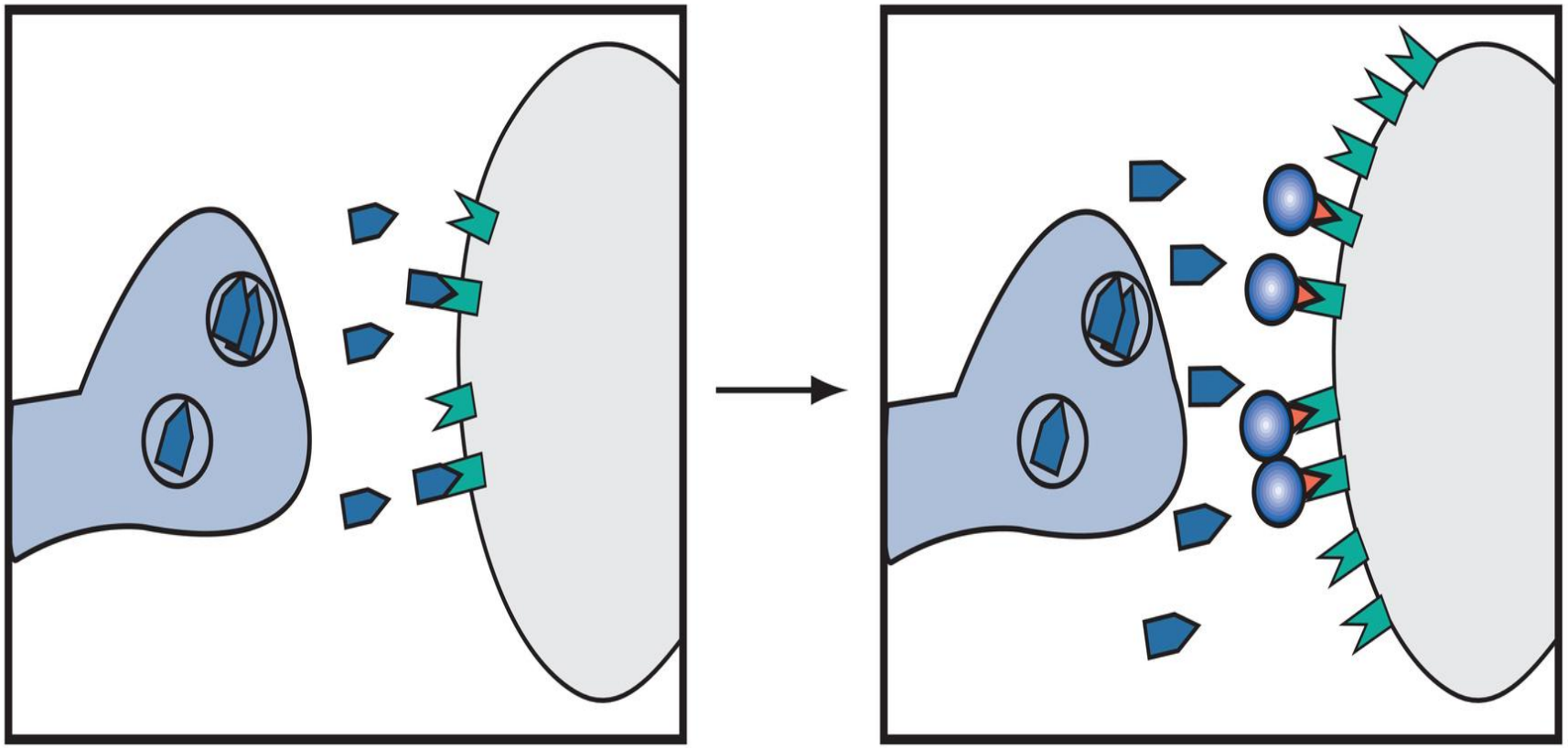


- Increase neurotransmitter (stimulant)
- Decrease neurotransmitter (depressant)
- Some short term benefits – little long term, but exposure to long term adversities.

Long term effects of neurotransmitter stimulation



Long term effects of neurotransmitter depression



Uppers and downers

Uppers (⇩ receptors)

Amphetamines
Methylphenidate

Downers (⇧ receptors)

SSRI
SNRIs
Major tranquilisers
Benzodiazepines
Anti-epileptics
Lithium

All substances that act on neurotransmitters can produce tolerance/withdrawal effects

Yes or no?

Treatment with Psychotropics

- **Antidepressants:** No clinical advantage above placebo in young, minimal in older. Star D trial only 3% got well and stayed well over 1 year naturalistic follow up. Long term use associated with more relapse and worse outcomes.
- **Stimulants**: sustained improvements beyond 1 year not demonstrated. Long term naturalistic studies - no difference between medicated/unmedicated, or worse for medicated.
- **Antipsychotics**: Harrow, Wunderkind and other long term studies (e.g. WHO) poorer functioning in those on long term anti-psychotics.
- **Some short term gains, little evidence of sustained improvements or better 'life' outcomes.**

All Psychiatric drugs can cause tolerance (addiction)

You may well experience physical and/or psychological symptoms when it comes to withdrawing from this medication