Empowering narratives and psychiatric diagnosis and medication

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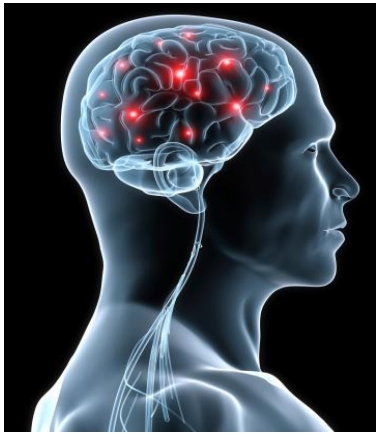
To be covered

- Basic assumptions.
- Some evidence.
- A look at ‘antidepressants’ as a working example.
- Brief discussion of antipsychotics.
- Practical models for existing ‘everyday’ practice.

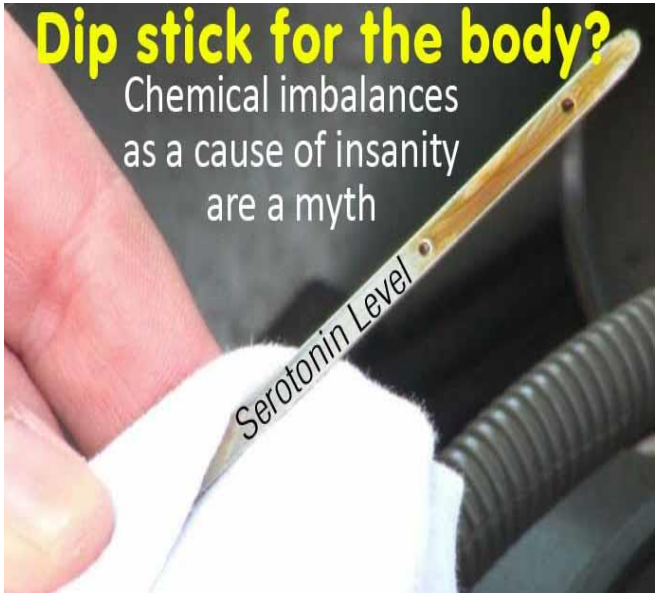
Lets consider frameworks

A patient presents as persistent low mood. She has been for CBT with IAPT, but it didn't help. Her friend thinks she needs an 'anti-depressant' as nothing else has helped. Lets assume you agree to prescribe, how will you explain this?

Medical model: Chemical imbalance.



Basic assumptions



- If your therapeutic aim is to change a mental state (psych), then its ‘psych’ o ‘therapy’.
- The framework (message/story) you use when prescribing is often more important than the chemical effect. No evidence of ‘chemical imbalance’.
- A narrow bio-medical model is probably the worst framework to use when prescribing!

Bad news : The Lab/Clinic gap

- 50-70% or more can recover or significantly improve according to research.
- 75% entering community MH treatments in US no improvement.
- 15% in UK achieve recovery (CMHT, IAPT).
- 'Defeat Depression' in UK increased treatment not outcomes.
- 'Beyond Blue' in Australia no improvement in outcomes last 2 decades– poor 'Mental Health knowledge' a protective factor!
- 24% entering community CAMHS get worse.
- Drop out rates of 40-60% in some CAMHS.
- 'Service transformation' (e.g. Fort Bragg study) no improvement in outcomes.

Long term patients

- US: Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) for ‘mental illness’ more than doubles:

  1 in 184 Americans in 1987 to 1 in 76 in 2007

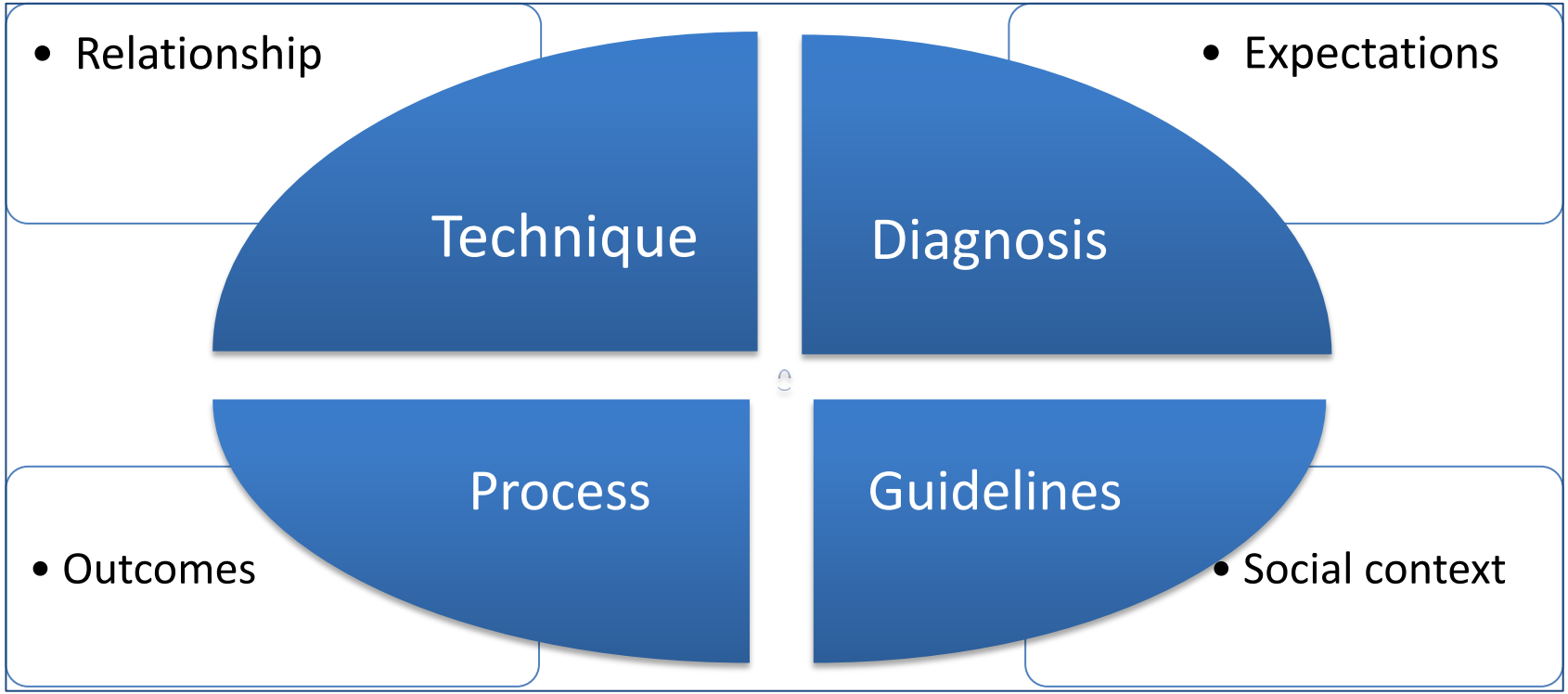
  For children a 35-fold increase in the same two decades

- UK: Mental illness became the leading reason for DLA in 2011. About 50% is for the diagnosis ‘depression’. While musculo-skeletal (the next largest) is going down, Mental Illness is going up.
- Pattern is replicated across Western countries that have been increasing their funding for mental health services.

The Vision of a psychiatric technology

- A valid classification system.
- biological and psychological causal pathways.
- Technological treatments that can be applied independently of context.

The technical model



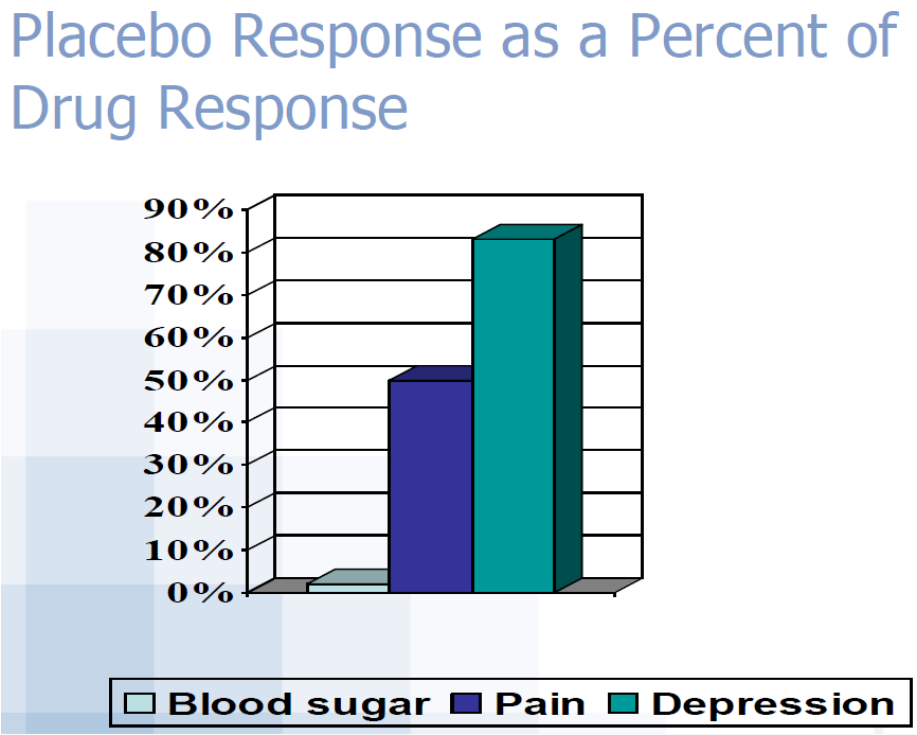
In psychiatry there are **no diagnoses**

- 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* hyperactivity and inattention’.
- In psychiatry we have **classification** not diagnosis.
- Ecosystems use multiple classifications – more appropriate for context-rich and dynamic open systems.

The Treatment of Depression Collaborative Research Project (TDCRP)

- Multi-site comparison of four treatment approaches (CBT, IPT, antidepressant, Placebo).
- No difference in outcome between approaches.
- The **patient's expectations** of treatment followed by **their rating of the alliance** at the second session were the best predictors of outcome across treatments.
- The psychotherapies (CBT, IPT) outperformed the drug conditions in long term with lower probability of relapse, and more weeks of minimal or no symptoms.

Importance of placebo



- Psychiatrist in placebo arm in TDRCP was best performing therapist.
- Placebo effects significant improvement in 50-60%.
- At least 80% of improvement is placebo/natural recovery.

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

- Research finds therapy is effective for mental health problems, mainly as a ‘catalyst’.
- Model or technique has a minimal impact on outcomes.
- Extra-therapeutic factors such as social circumstances and motivation have biggest impact on outcomes.
- Quality of therapeutic alliance important.
- Other ideas such as regular monitoring of outcomes, dialogic openness, system thinking, ‘resource activation’, all show promise.

Technique or relationship in context?

Lets re-consider frameworks

A patient presents as persistent low mood. She has been for CBT with IAPT, but it didn't help. Her friend thinks she needs an 'anti-depressant' as nothing else has helped. Lets assume you agree to prescribe, how will you explain this?

Narrative model: How do we embed change as belonging to patient?

Empowering frameworks

- If this medication works what would change? Leads to visualisation and change based goals.
- Work on motivation/expectancy.
- Getting out of a ‘loop’.
- Embed change as belonging to patient: ‘medication oils the wheels but can’t make decisions’.
- Dangers of prescription that supports desire to shut off/deny/repress.
- Prepare for ‘setbacks’ – the recover, setback, hopelessness loop.

Treatment with anti-psychotics

- **Harrow and Jobe 2007** - 145 patients with psychosis followed up for 15 years. Recovery rate for psychotic patients who came off antipsychotics was 40%, v 5% for those remaining on anti-psychotics. The divergence in outcomes between the two groups occurred between two-year and five-year follow-up assessments.
- **Wunkerink et al 2013** - 103 patients followed up for 7 years. Randomised to drug continuation v discontinuation at 6 months. At 7 years, those in the discontinuation group had a much higher recovery rate (40.4% v 17.6%) largely due to better functional outcomes. Divergence in outcomes began to appear after 18 month point, relapse rate was higher for discontinuation group prior to that.
- **The NIMH Treatment of Early Onset Schizophrenia Study (TEOSS) 2010 -** 338 under 19's - Average weight gain of 13lbs in 3 months. Only 14 remained on trial medication by 1 year due to drop out as a result of side effects and lack of efficacy. No notable improvements in symptoms after 8 weeks of treatment.

Changing your relationship to..

- Voices.
- Beliefs.
- Sense of control.
- Reduced intensity ‘feeling detached’.
- Like a plaster of Paris.

Outcome Orientated

Team	Open Effect size	Open Improved/ Recovered	Open No change	Open Deteriorated	Closed Effect size	Closed Improved/ Recovered	Closed No change	Closed Deteriorated
T2	0.7	59%	30%	10%	1.1	76%	17%	7%
N=	463	174	90	32	690	408	91	37
Boston	0.6	60%	22%	18%	0.9	75%	16%	8%
N=	167	57	21	17	343	210	45	23
SW	0.7	65%	23%	12%	1.1	76%	16%	8%
N=	446	171	62	31	1047	666	144	69
North	0.7	67%	23%	9%	1.3	73%	20%	6%
N=	915	403	139	54	1104	579	164	47

Lincolnshire CAMHS March 2016

Table 2. Proportions of CYP showing reliable change with n in parentheses.

RCADS	Social phobia		Panic		Depression		GAD		Separation anxiety		OCD	
	Child REPORT	Parent REPORT	Child REPORT	Parent REPORT	Child REPORT	Parent REPORT	Child REPORT	Parent REPORT	Child REPORT	Parent REPORT	Child REPORT	Parent REPORT
Improvement	26% (94)	20% (26)	25% (90)	13% (16)	31% (123)	8% (10)	28% (100)	13% (17)	10% (36)	6% (8)	16% (57)	8% (10)
No change	70% (249)	70% (90)	68% (243)	81% (99)	64% (249)	92% (120)	67% (237)	78% (104)	87% (304)	89% (116)	82% (292)	89% (114)
Deterioration	4% (13)	9% (12)	7% (25)	7% (8)	5% (20)	1% (1)	5% (16)	9% (12)	2% (8)	5% (6)	2% (6)	3% (4)
N	356	128	358	123	392	131	353	133	348	130	355	128

National CYP-IAPT CAMHS October 2015

In summary

- **Basic assumptions**: In mental health when prescribing the narrative, framework, and message is of greater importance to the outcome than the chemical.
- **Evidence**: Importance of placebo, expectations, natural recovery, extra-therapeutic factors, therapeutic alliance, and poor long-term outcomes in clinical services.
- **Narratives/metaphors that empower**: ‘Oiling the wheels’,, ‘A medicine can’t make a decision’, ‘like a plaster cast’, ‘help with changing the relationship with your experiences’.
- **Services that empower**: focus on the human to lead the technical.