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MINIMALISM IN MEDICINE: LEADING EFFORTS

Medical Science

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KEYWORDS

Starting in the 1970s, the profession of psychiatry and behavioral health was accused of being 'completely unconcerned' about new evidence on the association between antipsychotic use and brain damage called 'tardive dyskinesia'. In the realm of psychiatry, it is presumed that the distress, despair and pessimism that have come to be called depression could be eradicated, as if they were a medical case of pneumonia.

There is no doubt that psychotropic medications lead to significant adverse effects and sometimes psychological dependence. One who has experienced the full force of the psychiatrist's pharmacopeia knows that they come with a heavy price and goes on to develop akathisia (an internal unrest that makes it necessary for constantly pacing about), tardive dyskinesia, tremors, obesity, hyperlipidemia, and finds it hard to get up in the morning. Unfortunately, many prominent psychiatric problems including schizophrenia, bipolar disorder, schizoaffective disorder, psychosis not otherwise specified, major depressive disorder, post-traumatic stress disorder, schizotypal personality disorder and so on do not have a recognizable solid base or evidence to confirm or a typical lab test. At times patients are on several different neuroleptic medications. They also find it hard to imagine a life without being on psychiatric drugs.

A lot is known about psychotropic drugs: the putative mechanisms of action, the evidence background, the indications, cautions and contraindications, interactions, side effects, toxicity, and monitoring. We learn how to start different agents. We learn how to prescribe different combinations of psychotropic drugs, what is called 'rational polypharmacy' and also learn how to switch from one drug to another, which is called 'cross-tapering'. What we do not learn and not know is how to stop these drugs. There is no guidance on how to stop these drugs. What there is no evidence on is how to stop these drugs. We never seem to stop these drugs, for the sheer fear of precipitating original illness or uncontrollable withdrawal symptoms! Recent pioneering work by Dr. Gaurav Jain, a triple boarded psychiatrist, internist and pain medicine specialist at the Berkshires Medical Center in Massachusetts is leading us into these novel directions. In a significant study, Dr. Jain demonstrated the feasibility of deintensifying antidepressants, without the primary disease symptoms reappearing.[1]

Earlier, a study reported the seven year follow up results of the Dutch antipsychotic discontinuation study. This study, conducted with people who had recovered from a first episode of psychosis, found that people randomized to a flexible and gradual antipsychotic discontinuation strategy were twice as likely to show a full social recovery than those who were allocated to continuous (maintenance) antipsychotic treatment. Moreover, relapses, which had been higher in the discontinuation group at 18 month follow up, had equalized. It is well-known that antipsychotics are bad for the brain and can reduce people's social functioning when used continuously over long periods. Dr. Jain's paradigm shifting findings lays open the foundation for performing further clinical trials, not only in deprescribing antidepressants, but in also weaning off other classes of medications including opioids and benzodiazepines.

Every now and then, 'blockbuster drugs' are advertised by pharmaceuticals. Psychiatrists have long marketed themselves as 'psychopharmacologists'. However, these, often-times unthoughtful prescriptions, have led to iatrogenic misery and financial black-hole. In continuing to mindlessly advocate psychotropic medications, we contribute to erosion of a sense of personal agency, like resilience and autonomy, and instead create a dependency and helplessness. Dr. Jain is showing us the way that one of the keys to coming off psychiatric drugs is for the individual to have their own coherent narrative of their experiences, and to see these experiences as within their control, and to encourage them to think in that direction.

Long-term treatment with antipsychotic drugs has adverse effects on the brain and may impair rather than improve chances of recovery for many. In 2012, Nancy Andreasen's research group, the former editor of the American Journal of Psychiatry, published results of a brain scanning study of people diagnosed with schizophrenia or psychosis.[2] The study found that people's brains shrank over time in proportion to the amount of antipsychotic drugs they had been exposed to. The report concluded that "antipsychotics have a subtle but measurable influence on brain tissue loss over time". The study confirmed that the brain shrinkage that were seen in animals also occurs in humans. We don't know whether these observed effects of antipsychotic treatment are temporary or permanent, and we don't know whether they have any functional implications. In other words we do not have rigorous evidence whether the brain shrinkage is associated with intellectual decline or other brain-based abnormalities. The evidence is conflicting, with some studies suggesting there is no impact on mental ability, but worryingly, other studies, including Andreasen's study, indicate that there may be an association between reduced brain volume and some cognitive or mental deterioration. A recent finding suggests that in an average week, nursing facilities in the United States administer antipsychotic drugs to over 179,000 people who do not have diagnoses for which the drugs are approved. The drugs' sedative effect, rather than any anticipated medical benefit, too often drives the high prevalence of use in people with dementia.[3] It is obviously a worrying trend and warrants further studies. On the practical clinical front to challenge medication misuse, the courageous recommendations of Dr. Jain is taking the field by storm. The prophesy of "less is more" is being increasingly adapted by conscientious physicians.

When the idea that selective serotonin re-uptake inhibitors (SSRIs) might make people feel suicidal first started to be discussed by Dr. David Healy, many people were skeptical. Since that time, however, the evidence has accumulated, and moreover, the suicidal thoughts and behaviors usually occur in the context of a state of intense tension and agitation that is so unpleasant as to make people impulsively harm themselves, and some evidence suggests it may lead to aggressive behavior. Some large meta-analyses, which combined results from different trials, started to find an association between the use of modern antidepressants and suicidal thoughts and actions, especially in children.

In 1989, Joe Wesbecker shot dead eight people and injured 12 others before killing himself at his place of work in Kentucky. Wesbecker had been taking the selective serotonin reuptake inhibitor (SSRI) antidepressant fluoxetine for four weeks before these homicides, and this led to a legal action against the makers of fluoxetine, Eli Lilly. The United States labels for all antidepressants as of August 2004 note that "anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric". Currently, substantial evidence from SSRI clinical trials show that these drugs can trigger agitation. Approximately five percent of patients on SSRIs in randomized trials drop out for agitation against 0.5% on placebo. The current data sheets for SSRI antidepressants specify that the drugs can cause akathisia and agitation

and warn about developing suicidality in the early phase of treatment, on treatment discontinuation, and in the wake of a dosage increase during treatment. These medications can also cause emotional blunting, detachment, or an amotivational syndrome, described in one report as the equivalent to a "chemical lobotomy". Some of these medicines can cause sleep-walking (somnambulism). Several reports have been published of an association of paroxetine with sleepwalking in people not previously known to have sleepwalked; somnambulism has also been reported for other SSRIs. Somnambulism can provide an absolute defense against murder, in that the defendant in such a case does not have the capacity to form intent.

It seems that there is conspiracy by drug companies to suppress evidence of the dangers of their products. There is also evidence of a more systemic failing. The advice from leading psychiatrists is to not take too much notice and to carry on prescribing. With a few exceptions, psychopharmacology researchers have shown no interest in studying the way these drugs alter normal mental functions and emotions. We know very little therefore about the state of agitation that SSRIs can induce, how often it happens, in what circumstances and what sort of thoughts and behaviors it can give rise to.

Why the reluctance to investigate this matter properly? Financial conflicts of interest is one answer, of course. Other factors include psychiatrists' professional insecurity, and doctors' perceived need to have something to offer the people who queue up daily in the hope of a remedy for their distress. Dr. Jain takes the field to an all-new level, where conscious balanced care is the only motivation to identify the behavioral condition with the prime philosophy of *primum non nocere*. In the field of pain management, Dr. Jain is a vociferous advocate of alternate pain management methods, including physiotherapy, acupuncture, osteopathy and cognitive therapy, so as not to initiate or minimize any dependence on the addictive classes of pain medications.

Ivan Illich's book *Limits to Medicine: Medical Nemesis- the Expropriation of Health* gives us courage to rethink about diagnosis in psychological medicine, when to prescribe, how much to prescribe, how long to prescribe, and ultimately, when to sincerely endeavor to take the patient off the medication, and encourage to move on with life. The current Pharma-driven mental health industry epitomizes Illich's ever-expanding, technocratic monster. The idea that our discontents are a manifestation of faulty brains that can be abolished with sophisticated medical treatment is just the sort of illusion that Illich is responding to. Medicine's promise of a quick fix diminishes the capacity of individuals and communities to deal with the difficulties and differences that are labeled as mental health problems. Dr. Jain has intense background training in Internal Medicine, which gives him a unique aspect of the behavioral and mental health care. This fresh perspective is increasingly being adapted not only by psychiatrists, but also lends precedence to many aspects of chronic care. For example, elderly patients on multiple diabetes medications have very high risk of developing hypoglycemia and loss of consciousness and falls. An effort to impact deintensification of prescriptions is crucial to increase the quality of life across all age groups, including weaning off patients of opioid based pain medications.[4] In a very interesting case with neuropsychiatric presentations in a patient with abdominal pain, Dr. Jain diagnosed the cause as porphyria, a blood disorder which can be treated.[5] These levels of clinical finesse demonstrated by Dr. Jain portrays the laudable wide-angle perspective that he brings to behavioral healthcare.

There are no medical tests that prove one has a mental illness: no blood work, saliva, urine specimens – nothing. There are people who have done well with the psychiatric medications and their lives perhaps even saved by them, but prescription practices must include full disclosure of the risks, and potential for dependence and severe withdrawal without minimization. Fish oil and magnesium can be supplemented during withdrawal of psychiatric medications. In addition, folic acid derivatives and other natural remedies may also help getting off these psychiatric medications, about whom we still know very little. With a little bit of courage and cooperativity, the pioneering efforts of Dr. Jain is letting off these dangerous psychomedications and still have a fruitful, productive life. Dr. Jain is encouraging appropriate deintensification strategies to get to the sweet spot for treatment. Dr. Jain's recommendations are in sync with national campaigns like *Choosing Wisely* (an American Board of Internal Medicine Initiative, and guidelines adapted internationally) and National Institute of Health and Care Excellence (NICE) guidelines, which robustly voice and educate the public about care that may not be needed.[6]

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