Human Givens

PROMOTING EMOTIONAL HEALTH AND CLEAR THINKING

This biannual journal explores the relevance of the very latest knowledge about human psychology to the way we live today.

The needs and resources that are built into our biology make up what we term the human givens. These basic emotional needs – such as for security, control, connection to other people, attention, intimacy, status, and to be stretched in what we do – have to be met in balance if we are to be mentally and socially healthy. Our innate resources – including memory, imagination, problem-solving abilities, self-awareness, dreaming and a range of complementary thinking styles to employ in different situations – are designed to help us do this.

Ensuring that people's emotional needs are better met, and that they are using their innate resources effectively, is known as the human givens approach. This way of looking at behaviour and mental health is not only being successfully applied to the counselling of distressed people but is also influencing fields as diverse as parenting, politics, education, work, law, psychology, philosophy and communication – wherever, in fact, there is a need to understand and nurture people or make best use of valuable human resources.

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IN BRIEF

ADOLESCENTS in stepfamilies use different labels when describing their stepfather, such as 'stepfather' or 'mother's husband'. A study of nearly 2,000 adolescents living with their mother and 'stepfather' husband suggests that closeness with non-resident fathers increases the likelihood that teens will avoid the stepfather label, while closeness with mothers increases the likelihood that they adopt the label. Closeness with their stepfather was not associated with how they label him. Other characteristics of the step-family are also important predictors of stepfather labelling, add researchers. (*Journal of Social and Personal Relationships*, 2015, doi: 10.1177/0265407515599677)

BENZODIAZEPINES are frequently prescribed for people with Alzheimer's disease before diagnosis and are three times more likely to be prescribed to those with Alzheimer's after diagnosis than to non-sufferers, to aid with sleep and reduce anxiety. This is according to findings from the Finnish Medication Use and Alzheimer's Disease Study. While Finnish care guidelines permit benzodiazepine use short term to treat behavioural problems associated with Alzheimer's, the drugs are known to increase the risk of falls and cause cognitive impairment. (*Journal of Alzheimer's Disease*, 2015, doi: http://dx.doi.org/10.1016/S1878-7649(15)30063-2)

NOW researchers are recommending the antipsychotic drug aripiprazole for older people with treatment-resistant major depression. A greater proportion of those who received the drug achieved remission of symptoms compared with those given placebo. However, the price seems high: akathisia, a common side effect, in which a person feels extremely restless and unable to sit still, and more Parkinsonism. (*The Lancet*, 2015. doi: 10.1016/S0140-6736(15)00308-6.)

Professionals and patients clash over drug withdrawal problems

THERE are sharp discrepancies between the understandings of patients (and patient support charities) and medical professionals about dependence and withdrawal problems with particular psychiatric drugs.

This is revealed in a recently published report by the British Medical Association's Board of Science, which "aims to provide a platform for action to improve the prevention, identification and management of dependence and withdrawal associated with prescribed drugs". It focuses particularly on the prescribed use of benzodiazepines, z-drugs (drugs similar to benzodiazepines), opioids and antidepressants.

Professor Sheila Hollins, chair of the Board of Science, writes: "In undertaking this project, it was clear from the outset that this subject was contentious and emotive. It is characterised by a mistrust of the medical profession, government and policy makers by those affected, who describe meeting a denial of the problem and too little help from their doctors. It was also apparent that any constructive dialogue on how best to address this problem was being prevented by a wide spectrum of differing views. That is why we took the approach of a call for evidence, to allow us to hear all viewpoints, however conflicting they may be. Despite this, some individuals and organisations declined to participate."

Among the more concerning clashes of opinion, the Royal College of General Practitioners (RCGP) is quoted as saying it is not aware of good research to guide the most effective method of withdrawal from benzodiazepines. "In contrast," according to the report, "submissions from withdrawal charities and support groups reported that there are existing guidelines available that can, and should, be used more frequently by GPs when supporting patients to withdraw. These guidelines included the Ashton Manual, BNF (British National Formulary) and NICE CKS (clinical knowledge summary)."

Many GPs do not realise that, while it can be helpful for users to stop illicit drugs cold turkey, it is dangerous to do so with benzodiazepines and certain other prescribed drugs.

Also, there was "a large consensus among responses" that illicit drug treatment services are not appropriate for the management of prescription drug dependence – the sole dissenter being the RCGP.

"Charity and support groups reported that the harm associated with antidepressants – including severe mood disturbances, suicidal intention and dependence potential – is not generally recognised, or is underestimated, by GPs and psychiatrists. In contrast, the RCGP reported that there is "evidence of the long-term benefits of antidepressants and the relative safety of their use. Most side effects and problems occur earlier in treatment and there is generally a delay in therapeutic response. Compared to the other medications considered [opioids and benzodiazepines] there appears to be a very low prevalence of misuse and addiction. The Royal College of Psychiatrists did note that antidepressants carry the risk of a discontinuation syndrome that can be unpleasant for the individual, but added that this is not prolonged."

The Council for Evidence-based Psychiatry commented that increasing antidepressant prescribing rates reflect the fact that patients find themselves unable to discontinue their use because of the onset of withdrawal symptoms. The report quotes their view that, for a proportion of patients, BNF prescribing guidelines [of at least six months or more, and for at least two years for patients with a history of recurrent depression] are leading to involuntary dependence upon these drugs.

Charities and support groups asserted that antidepressants were similar to benzodiazepines in terms of severity of side effects and withdrawal, whereas the RCGP and the Royal College of Psychiatrists claimed that antidepressants were safe, relative to benzodiazepines and opioids.

There is no professional consensus over how to handle withdrawal: "The BNF advises that the dose should be reduced gradually over about four weeks, or longer (up to six months) for patients on long-

term maintenance treatment; while NICE advise that antidepressant use can be stopped over a four-week period." Conversely, the Council for Evidence-based Psychiatry stated that, according to the experience of charities supporting people through withdrawal, antidepressants should be tapered very slowly at a rate of no more than 10 per cent of the previous dose every four to six weeks, at a pace guided by the patient. "A four-week taper is therefore much too fast, and this guidance should be changed," it concluded.

The BMA report concludes, "A clear view emerged that some prescribing guidelines, as well as the views and understanding of medical professionals, do not correlate well with the lived experience of patients", and calls for a more collaborative approach. ■

BMA Board of Science (2015). Prescribed drugs associated with dependence and withdrawal – building a consensus for action: analysis report.

Reversing negative symptoms in schizophrenia

DIFFICULTY in anticipating or experiencing pleasure (anhedonia) is one of the symptoms of schizophrenia, commonly associated with lack of emotional expressiveness and social withdrawal. When people suffer these so-called 'negative' symptoms that 'take away' from a person (as opposed to 'positive' symptoms, such as hallucinations and delusions, which add something on), their prognosis is less good and their quality of life much lower. Now researchers have published a preliminary report of their Positive Emotions Programme for Schizophrenia (PEPS), devised by the first two authors, which specifically targets negative symptoms.

Twenty-four men and 13 women, aged between 18 and 65 and recruited from three social and nursing homes in Switzerland, agreed to take part in the programme, which teaches skills to help overcome defeatism and to increase anticipation and maintenance of positive emotions through eight one-hour group sessions. The average duration of illness among participants was 19 years. Most were single and lived in sheltered housing, and none was working.

Twenty-eight completed the eight sessions, which all began with a relaxation exercise and an exercise in challenging defeatist thoughts, such as "I can't relax" or "I'm useless", presented through two characters, Jack and Jill. In each of the sessions, participants learned a particular skill, linked with increasing ability to experience enjoyment. They learned how to: savour a present or past pleasant experience (for instance, by looking at a picture of attractive countryside or listening to soothing music, and becoming aware of, and appreciating, how pleasant this could be); increase behavioural expression of positive emotions (participants were asked to imitate pictures of actors expressing positive emotions and to become aware of the sensations this produced); make the most of positive moments (by communicating and celebrating certain positive events with each other); anticipate pleasant moments (by being guided through the different positive feelings and emotions that could be produced by a positive future event, whether that was eating an apple or taking part in an enjoyable social activity). Homework tasks were given for between sessions.

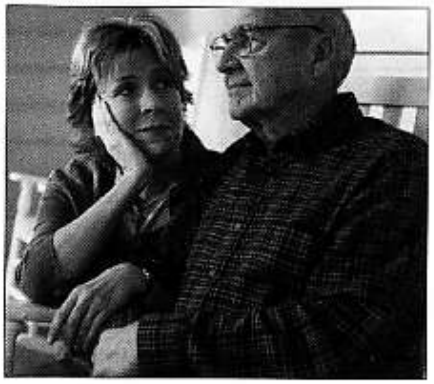
The programme was highly successful in reducing anhedonia, apathy and depression, with all patients expressing very positive views about it. The researchers comment, in addition, that "Several participants spontaneously declared their appreciation of the fact that the group leaders also participated in the exercises, sharing their personal experiences and even carrying out the homework tasks. A few participants even stated that the very fact that some group leaders reported experiencing less pleasure in certain exercises than the patients did themselves demonstrated to them that pleasure might be independent of their illness. Thus the collaborative approach alone, used as a part of the programme's psychoeducational format, may have had an impact on participants." ■

Favrod, J, Nguyen, A et al (2015). Positive Emotions Program for Schizophrenia (PEPS): a pilot intervention to reduce anhedonia and apathy. BMC Psychiatry, *15, 231, doi:10.1186/s12888-015-0610-y*

The pain of a breaking heart: caring for loved ones with Alzheimer's

A HIGH proportion of caregivers for patients with Alzheimer's disease report pain complaints and use over-the-counter painkillers to dull pain that largely arises from a sense of loss, Polish researchers have found.

Their study involved 127 people caring for someone with Alzheimer's. Nearly half had at least one chronic disease; nearly 88 per cent reported pain in the week before the study, most commonly backache or headache. Ninety-three per cent used analgesics at least once a week and eight per cent daily.



The researchers gave questionnaires to the carers, 82 of whom were adult children and 39 were spouses of the patients, to elicit experiences of physical and emotional pain. They found that "the higher the intensity of physical pain perceived, the higher the assessment of painfulness of loss, and the more acute the sense of loss. The sense of loss and painfulness of loss turned out to be the strongest predictors not only of pain intensity but also of using analgesics."

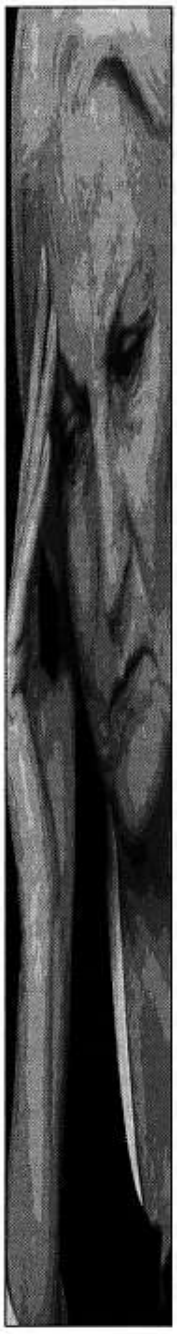
Although the pain reported by participants could also be a symptom of depression, which exacerbates the experience of pain, 87 per cent reported the presence of pain whereas only 35 per cent had significant symptoms of depression. ■

Wojtyna, E and Papiolek, K (2015). The pain of a heart being broken: pain experience and use of analgesics by caregivers of patients with Alzheimer's disease. BMC Psychiatry, *15, 176, doi:10.1186/s12888-015-0571-1*

Psychiatric drugs may do more harm than good and take away people's humanity. ***Denise Winn*** *went to a conference which pulled the alarming facts together.*

Better to be human

"DSM-III gave us a false idea of what it is to be human. We need to come up with a new philosophy of being that recognises the extraordinary resilience in people – not a disease model." So said award-winning science journalist Robert Whitaker at a packed one-day conference held in the autumn by the Council for Evidence-based Psychiatry (CEP). Its theme was in its name: "More Harm than Good: confronting the psychiatric medication epidemic".



When *DSM-III* (the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*) was published in 1980, it was the first to include explicit diagnostic criteria. Hardly light reading, its 494 pages covered 265 diagnoses. Yet mental health doctors, nurses, lawyers, psychotherapists and social workers rushed to buy it, and it sold out immediately. As Dr James Davies, psychologist and co-founder of CEP, pointed out, its publication fundamentally changed the course of treatment and research in psychiatry. Yet it represented the viewpoint of only about nine people, as its chief architect Dr Robert Spitzer admitted to Davies for his book, *Cracked*.[1] "We took over," Spitzer said, "because we had the power."

Millions of people now live with the results of this unethical wielding of power. There are 370 different disorders in the current edition, *DSM-5*, and psychiatrists still, in the main, treat its approach as gospel. Yet, as most readers of this journal will be aware, no biological markers have ever been identified for any mental disorders, bar organic ones such as Alzheimer's and Huntington's disease. Far from being evidence based, *DSM* represented an approach where, if a consensus couldn't be reached, Taskforce members, as they were known, would take a vote on the inclusion of a disorder or symptom. As Davies commented, "When was voting ever a scientific activity?" He discovered that, at one Taskforce meeting to discuss inclusion of symptoms for a particular condition, a psychiatrist protested, "Oh no, we can't include *that* as a symptom, because I do it."

Professor Allen Frances, who led the *DSM-IV* revisions, later became a critic of what he saw as the medicalisation of ordinary problems. Yet, as Davies told the conference, Frances still managed to preside over the addition of 100 new mental disorders to *DSM-IV*, including bipolar 2 and attention-deficit hyperactivity disorder (ADHD). Bipolar disorder diagnoses doubled in the next 15 years, and ADHD diagnoses tripled. When Davies asked why other dubious disorders such as female orgasmic disorder, caffeine-related disorder and oppositional defiance disorder had been allowed to remain in *DSM-IV*, Francis said gravely, "There had to be substantial scientific evidence to add or remove". Despite the fact that substantial scientific evidence had been astoundingly lacking when including disorders in the first place, he insisted that his role had been to "stabilise the system, not change it arbitrarily".

Robert Whitaker, author of ground-breaking *Mad in America*,[2] moved on from the myth of meaningful psychiatric classifications to the myth of meaningful psychiatric drug treatments: "The terms 'antipsychotic' and 'antidepressant' sound like treatments targeted at a specific illness. The introduction of chlorpromazine (Largactil) was claimed to be as important for mental health as penicillin had been in medicine. Then came the idea of the 'chemical imbalance', which psychiatric drugs could 'fix', just as insulin 'fixed' diabetes. But, whereas, penicillin stopped people dying from bacterial infections, the number of people in America disabled by mental illness has since quadrupled", as disability payments for people off work with stress and depression show. In New Zealand and in Australia, over the past 20 years, the figure has also quadrupled; dipping into Europe, in Iceland and Denmark, it has tripled and in Sweden quadrupled.

The chemical imbalance story

The idea of chemical imbalance was based on the observation that psychiatric drugs acted on certain neurotransmitters – for instance, raising serotonin levels in depression and lowering dopamine levels in schizophrenia. The conclusion was jumped to that low serotonin and high dopamine must, therefore, be the cause of depression and schizophrenia, respectively. This was roundly disproved – no biological markers of any kind have ever been found, even by biological researchers keen to find them. However, what is now known to happen (although perhaps not by most psychiatrists) is that when serotonin is added to the brain via antidepressants, the brain decreases its own receptors, thus decreasing sensitivity to serotonin; and when dopamine is blocked by antipsychotics, the brain becomes extra-sensitive to dopamine. While the effects of this are kept in check to some degree while on the medication, it is clear to see what will happen on stopping it. So, with a horrible irony, the situation comes about where, off drugs, a person becomes low in

serotonin or high in dopamine – inducing the very situation which the drugs were wrongly thought to correct. As Whitaker put it, "You may not have had higher dopamine before, but now you certainly do." The added risk is that people may become more biologically prone to symptoms, and of greater severity. The dreadful condition of tardive dyskinesia, slow onset of repetitive involuntary movements, has an association with increased dopamine receptors.

Coming off the drugs

But antipsychotics were the drugs that emptied the asylums. So-called relapse studies, which found that relapse was higher in those who stopped taking the drugs, are still cited as reasons to stay on them. "However, in these studies, withdrawal was abrupt – and show only that abrupt withdrawal is bad," said Whitaker. As we have just seen, someone who stops taking the drug becomes more vulnerable to relapse. There are few studies into the effects of tapering off gradually – although such evidence as exists shows better outcomes after one, two and three years for those who were tapered off their medication. Countries where antipsychotics are used only to deal with psychosis in the acute stage of psychosis have best outcomes.

There is certainly evidence that people do better long term *off* the drugs. Trials have shown that, while outcomes were better at one year for people treated for psychosis in 1967, when antipsychotics were available, than outcomes for those treated in 1947, when they weren't, in the long term the latter did better than the former. Even when people decided to stop their medication abruptly, because they couldn't stand the side effects, although they were still psychotic after two years, few were still psychotic after 20 years – unlike those who remained on the drugs. "I conclude that patients with schizophrenia not on antipsychotic medication for a long period of time have significantly better global functioning than those on antipsychotics,"[4] lead researcher Professor Martin Harrow, psychologist and expert on schizophrenia and bipolar disorder, told the American Psychiatric Association annual meeting in 2008.

Summing up, Whitaker (a warm, calmly spoken and unassuming man, who was once likened by a newspaper to an AIDS denier) said that no cross-cultural study, animal study, MRI study, prospective longitudinal study, randomised controlled trial or drug-compliance study carried out since 1980 has demonstrated a case for use of antipsychotics. On hearing this from Whitaker at another conference, a psychiatrist wedded to the *DSM* model could think of nothing other to say than, "I'm so sick of evidence-based medicine!"

A simple alternative to antidepressants

Professor Peter Gøtzsche, a professor in clinical research design and analysis as well as co-founder of the Cochrane Collaboration (an international body that assesses medical research) had more concerns to express about antidepressants. "People think antidepressants work because they forget about spontaneous healing. It is all attributed to the drug." He described studies which show that benefits of antidepressants over placebo might be as minor as two days longer to recover, and mentioned Spanish research, which found that 59 per cent of 1,022 people who had had a normal sex drive became sexually disturbed after being put on antidepressants. When he mentioned this at a talk in Australia, one psychiatrist told him of three teenage patients on antidepressants who tried to kill themselves when they couldn't get an erection the first time they tried to have sex. "They didn't think it was the drug. They thought there was something wrong with them." One of Gøtzsche's PhD students has found that withdrawal symptoms are as severe for SSRI antidepressants as they are known to be for benzodiazepines. But that is termed dependence only in the case of benzodiazepines. "If people get better in a day if they restart their drugs, it is a fake depression caused by the drug itself," said Gøtzsche, author of newly published *Deadly Psychiatry and Organised Denial*.[3] Meanwhile, the age up till which antidepressants are thought to increase risk of suicidal behaviour keeps increasing – it has risen now from 25 to 40.

"People ask me," said Gøtzsche, " 'What is the alternative to antidepressant drugs?' Simple! No antidepressant drugs. That's the answer, even leaving psychotherapy and whether it is good or bad out of the question." While adamant that there is no place whatsoever for antidepressant drugs, he acknowledged a place for acute use of antipsychotics in some cases – although he then went on to say that very short-term use of benzodiazepines calms people down faster than antipsychotics. "So I don't think we need antipsychotics either. What we do need is detox clinics everywhere, to help people come off them safely."

Sociologist Professor John Abraham turned to the misadventures of pharmaceutical regulation. Until 1989, the process was entirely secret, with unauthorised sharing of 'medical' information a contravention of the Official Secrets Act. We didn't even know that our expert advisers had shares in and consultancies with drug companies until conflicts of interest started to be published in 1989. Between 1971 and 1989, the regulator, which was the Medicines Division at the Department of Health, was half funded by drug companies, and clinicians working within it tended to come from those, and go back to them. The US Food and Drugs Administration, on the other hand, was completely state-funded. In the 1990s, it was argued that regulators should have a lighter touch to stimulate innovation within drug companies. So, in the UK and Europe, regulation became completely funded by pharmaceutical companies and the time for considering new drugs cut down. Since then, innovation has fallen, and more unsafe

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5 The MTA Cooperative Group (1999). A 14-month randomised clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. Archives of General Psychiatry, 56, 1073–86; Jensen, P S, Arnold, L E et al (2007) A 3-year follow-up of the NIMH MTA study. Journal of the American Academy of Child & Adolescent Psychiatry, 46, 989–1002; Molina, B S G (2009). MTA at 8 years. Journal of American Academy of Child & Adolescent Psychiatry, 48, 484–500.

drugs have been approved (as measured by the percentage subsequently having to be withdrawn from market).

The disgrace of ADHD

Then came the appalling story of ADHD and its 'treatment' with stimulants like Ritalin. Harvard professor Joseph Biederman, who sat on the *DSM-IV* committee, did much to promote the diagnosis and get it included, claiming that between six and nine per cent of American children suffer from ADHD. It later emerged that, between 1996 and 2011, Biederman received fees from more than 24 pharmaceutical companies and worked for every single one that manufactured stimulants. Janssen alone gave him over one million dollars. But, said Robert Whitaker, there is no biological basis for ADHD. Neuroimaging has shown normal brains and neurochemical imbalance has not been found.

Ritalin, Whitaker said, ups dopamine activity, just like cocaine – but cocaine clears the body more quickly. Ritalin also works on serotonin and noradrenalin, causing compensatory changes in these pathways. It is not known if this normalises after stopping. Studies have shown that Ritalin can enhance performance on routine, repetitive tasks but not improve vocabulary, reading, spelling or maths. Meanwhile psychologists noticed that children on Ritalin played on their own more, initiated contact with other children less, had reduced curiosity and became passive and socially withdrawn. By 1994, after 20 years of use, the American Psychiatric Association's own *Textbook of Psychiatry* was stating that there was no improvement in terms of aggression, educational achievement and criminality with its use. But perhaps studies showing these negative effects were too short? The American National Institute of Mental Health embarked on a study to assess long-term outcomes. At 14 months, researchers concluded that "carefully crafted medication management was superior to behavioural treatment". (Whitaker pointed out that those on the medicine arm of the trial received far more contact with a clinician – thus far more attention – than those receiving the behaviour therapy.) However, by 36 months, those taking the medication had deteriorated (this wasn't publicised) and the children were found to be smaller. Six years on, medication was associated with worse ADHD symptoms and overall functional impairment. At the study's conclusion, investigator William Pelham of the University of Buffalo said, "We had thought that children medicated longer would have better outcomes. That didn't happen to be the case. There were no beneficial effects, none. In the short term, [medication] will help the child behave better; in the long run it won't. And that information should be made very clear to parents."[5] It hasn't been and, as we know, Ritalin is still widely used.

A review of 2,287 studies by researchers in Oregon, published in 2005, found no good outcomes.[6] A long-term study of ADHD drugs carried out in Western Australia found that "medicated ADHD children were 10 times more likely than unmedicated ADHD children to be identified by teachers as performing below age level".[7] To cap it all, stimulants can induce mania and psychosis, said Whitaker, so children originally diagnosed with ADHD may end up diagnosed with bipolar disorder and on antipsychotic medication for life.

Psychiatrist Dr Peter Breggin, often called "the conscience of psychiatry" for his many decades of working to reform the mental health field, spoke via Skype from his home in America. Since starting his career 61 years ago, he has never once prescribed a psychiatric drug. He didn't mince his words. "All drugs disable the brain. No drugs improve brain function. It's too complicated in there. Pouring poisons in is not going to be helpful. All psychoactive substances eventually burn the brain with lethargy and apathy. Blocking [dopamine] is a frontal lobotomy." He advised that anyone wanting to come off antipsychotics should do it slowly and make sure they have support around them.

Asked whether it is possible to restore brain function fully, he said, "The more treatment you've had, the less likely a full recovery. It is case by case and not predictable. But we are more than our brains. I've had patients with substantial brain damage induced by psychiatric drugs yet, although the brain doesn't recover, they are leading better lives than before – because they can love. They love their children, their families, and nature, and have a much more positive influence. So there is enormous hope for every human being, however damaged."

The best hope, however, for preventing such damage, is in changing the culture of psychiatry. As a variety of speakers said at the end of the conference, we need to identify and address the problems that people face, whether social, environmental or psychological, rather than diagnose illness. And people need to be helped to change their own expectations of a pill to magic it all better (perhaps through the powerful media of the popular press and threads in soap operas), which drug companies have both insidiously and assiduously promoted, with their false claims and false raising of hopes. ■

***Denise Winn** is editor of* Human Givens, *a tutor for Human Givens College, and a human givens therapist.*

6 McDonagh, M S and Peterson, K (2006). Drug class review on pharmacologic treatment for ADHD. See www.ohsu.edu/drugeffectiveness

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