USING MEDICATION WISELY

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Dialectical views of the potential of pharmacology:
Medication, in the wrong hands, as thief of the self;
Medication, in the right hands, as restorer of the self.
Peter Kramer *Listening to Prozac*

Neuroleptic drugs – now commonly known as "antipsychotic" medications – have played a decisive role in the evolution of the psychiatric treatment of psychosis and will doubtless continue to do so well into the foreseeable future. Many people feel modern psychotropic medications are a godsend. Antipsychotic drugs certainly provide some people with very welcome relief from tormenting symptoms such as hostile "voices" and anxiety-provoking thoughts (e.g. "persecutory delusions") while mood-stabilising drugs, either on their own or in tandem with neuroleptics, can help limit the disruption of extreme mood swings. The prophylactic action of both classes of medication is now widely relied upon to reduce the likelihood of people having further psychotic episodes: so-called "relapse prevention".[*]

Nevertheless, the fact that these potent medications have become the dominant treatment modality is a cause of concern to many thoughtful people. These drugs and the mind-set which accompanies them have come to govern everyday clinical practice so completely the many contentious issues that attend their use are often overlooked. However, questions regarding how best to use these drugs – and indeed, whether to use them at all – are far too important to be ignored, despite their often daunting complexity.

While conventional treatment is sometimes beneficial, widespread misuse has led to the role of these drugs becoming one of the most hotly debated topics in contemporary mental health care. Psychiatric medications are sometimes prescribed inappropriately and are often given in excessive doses or continued longer than necessary, practices that only exacerbate their deleterious effects. *There are many legitimate grounds for concern about the way these drugs are often now used*. In an unusually candid statement in 2005, the then president of American Psychiatric Association acknowledged the "widespread concern of the over-medicalization of mental disorders and over-use of medications" before belatedly admitting "many patients are being

[*] ***Important Note****:* The term "schizophrenia" appears herein in deference to the fact that this clinical diagnostic label is still widely used and accepted. However the author, along with many others, has come to feel the schizophrenia concept is outmoded, scientifically invalid, and unhelpful.

prescribed the wrong drugs or drugs they don't need. These charges are true … a 'pill and an appointment' has dominated treatment."[1]

Spurious Invention of the "Atypicals"

Since neuroleptic drugs were introduced to psychiatry in the early 1950s their usefulness has been bedevilled by their numerous physical, mental, and social side effects. Advent of clozapine in the early 1990s promised a new era of the so-called "second generation" or "atypical" neuroleptics. However – despite what many still believe – with the possible exception of clozapine atypical neuroleptics as a group have *not* proven to be more therapeutically effective than the older medications.[2] Independent research (i.e. not sponsored by the pharmaceutical industry) comparing efficacy and side effect profiles of the two groups has revealed that heavily publicised claims regarding the unparalleled superiority of the newer drugs are erroneous.[3] In January 2009 a scathing editorial in the prestigious medical journal, *The Lancet*, included these remarks:

> What was seen as an advance 20 years ago – when a new generation of antipsychotic drugs with additional benefits and fewer adverse effects was introduced – is now, and only now, seen as a chimera that has passed spectacularly before our eyes before disappearing and leaving puzzlement and many questions in its wake ... Antipsychotic drugs differ in their potencies and have a wide range of adverse-effect profiles, with nothing that clearly distinguishes the two major groups. Importantly, the second-generation drugs have no special atypical characteristics that separate them from the typical, or first-generation, antipsychotics. As a group they are no more efficacious, do not improve specific symptoms, have no clearly different side-effect profiles than first-generation antipsychotics, and are less cost effective. The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed. But how is it that for nearly two decades we have, as some have put it, "been beguiled" into thinking they were superior?[4]

Of very grave concern is the extent to which the pharmaceutical industry now employs powerful and sophisticated advertising strategies to

influence the beliefs and prescribing practices of psychiatrists and other mental health clinicians. Worryingly, these efforts are increasingly intended to shape the beliefs and expectations of those who take medications as well as those of their families and helpers. These ethically dubious practices make it extremely difficult for anyone – professional or layperson – to discover the truth about psychiatric medications. In view of these facts Dr David Healy, an internationally-renowned authority on psychotherapeutic medications, has offered the following sage advice:

> An increasing proportion of the so-called scientific literature in therapeutics is ghost-written and, in scientific terms, is ornamental rather than substantive. It has the appearance of science, but is increasingly a set of infomercials aimed to sell drugs rather than inform science ... In this new situation … takers of medications [are encouraged] to pay heed to their own experiences on treatment, and not to be cowed by professional statements of what the drugs do, which are typically little more than crude bio-mythology.[5]

Hypersensitivity and the "Neuroleptic Shield"

If it is accepted that anti-psychotic medications are *sometimes* helpful, the question arises as to why this should be so. The conventional – misleadingly simplistic – explanation is that such drugs help by rectifying the "chemical imbalance" in the brain that is supposedly responsible for causing psychotic symptoms. A rather different, and less stigmatising, view relates to certain characteristics long noted in individuals diagnosed with schizophrenia. A distinguishing trait of such persons is that they often seem to be endowed with an *exquisitely sensitive nervous system*. From a very early age many seem to possess what could be described as a "hypersensitivity" to sensory and emotional stimulation. This may be partly genetically determined, as suggested in this statement from *Comprehensive Textbook of Psychiatry*:

> All schizophrenics are, at least originally, more sensitive than the average person. It is likely that increased sensitivity and heightened responsiveness to sensory and emotional stimulation is present in schizophrenics from an early age, possibly from birth. Schizophrenia may be characterised by a genetic hypersensitivity that leaves the patient vulnerable to an overwhelming onslaught of stimuli from without and within.[6]

One of the principal effects of neuroleptic drugs, Professor Manfred Bleuler notes, is to induce a state of calmness by dampening the intensity of the brain's responses to inner (psychodynamic) and outer (environmental) stimuli:

> Neuroleptics act by changing the activity or the sensitivity of definite neurological systems. The therapeutic consequence consists mainly in *calming agitation* and *diminishing the sensitivity to stimulation* both by psychodynamic experience and by experience from the outer world. For these reasons, neuroleptics are of great value in many schizophrenic conditions.[7]

Neuroleptics reduce the activity of specific receptors in the brain, especially those involving the neurotransmitter dopamine (so-called D_2 receptors). In David Healy's view, possible beneficial consequences of this may include the following:[8]

- Induction of a feeling of detachment, of being less bothered by what had formerly been bothering (a "who cares" feeling).
- When working properly takers report beneficial effects on ability to focus or concentrate on things. Subjects feel more mentally alert, more able to focus on tasks, less in a daydream, less distracted by internal dialogues, strange thoughts, or intrusive imagery.
- Voices, thoughts or obsessions may still be present but have receded from centre stage.
- At least part of person's mind is left free to get on with other thoughts.

Psychiatric Medication: Part of the Solution or Part of the Problem?

Extensive experience, both clinical and first-hand, lends considerable support to Healy's contentions regarding these effects of neuroleptic medications. In practice, *possible benefits* – to the treated person and others, such as family and friends – of skilful treatment include the following:

- Alleviation of distressing symptoms (therapeutic effect)
- Reduced likelihood of "relapse" (prophylactic effect)
- Enhanced sense of stability, groundedness, and self-control
- Reduced distractability and disorganised thinking and/or behaviour

- Facilitation of participation in social, occupational and/or therapeutic activities (e.g. work, counselling, psychosocial rehabilitation)
- Reduction of innate "hypersensitivity" to a more readily manageable level

Abundant experience has shown that obtaining optimal benefit from neuroleptic treatment in any given case is easier to hope for than achieve. The potency and great variety of possible adverse affects of these drugs guarantees that unless they are employed with great wisdom and skill, their detrimental effects can easily outweigh any beneficial effects. The following are among the *potential risks* of such treatment:

- Excessive de-sensitisation ("psychic indifference")
- Numbing of emotions, blunting of personality and creativity ("not the real me")
- Tiredness, sluggishness, loss of energy and vitality
- Shame, embarrassment, guilt, stigmatisation
- Loss of control, autonomy, self-determination
- Adverse effects ("side effects") – physical, mental and social (both immediate and longer-term)

A Neuroleptic Dilemma

As their catalogue of possible adverse effects has grown it has become clear that the atypical neuroleptics are far from the harmless "wonder drugs" they are sometimes made out to be. Indeed, the generally lower incidence of extrapyramidal side effects (EPS) such as tremor, muscular stiffness, restlessness, and tardive dyskinesia (TD) with these drugs as compared to first-generation neuroleptics may be counteracted by their *greater* propensity to cause other serious side effects. Some psychiatric authorities warn that metabolic and other physical side effects of atypicals are at least as great a cause for concern as were the extrapyramidal side effects of the older drugs:

> Atypical antipsychotics can compound a patient's risk for developing metabolic, endocrine, and cardiac complications that may be comparable, if not worse, than risks associated with extrapyramidal side effects and tardive dyskinesia … This reminder becomes especially pertinent today as we stand only one decade after the introduction of atypicals and begin to

> realise that these medications carry their own adverse effects, the long-term consequences of which are only just emerging. The key question to be considered is whether atypicals are in fact safer and better or whether they are merely different in their side-effect profiles, compared with the older, typical neuroleptics.[9]

Neuroleptic-Induced Dopamine Receptor Supersensitivity

Even if it is accepted that some people may benefit from skilful neuroleptic treatment, unanswered questions remain regarding the possible consequences of long-term exposure to these potent drugs. Of increasing concern to many people is the prospect of a phenomenon referred to as "neuroleptic-induced dopamine receptor supersensitivity". As journalist and outspoken critic of psychiatry Robert Whitaker explains, the consequences of such medication induced brain changes would be serious indeed:

> The brain responds to neuroleptics – the blocking of dopamine transmission – as though it were a pathological insult. To compensate, dopaminergic brain cells sprout more D2 receptors. The density of such receptors may increase by more than 50 per cent. The brain is now 'supersensitive' to dopamine, and this neurotransmitter is thought to be a mediator of psychosis. The person has become *more* biologically vulnerable to psychosis and is at particularly high risk of severe relapse should he or she abruptly quit taking the drugs.[10]

What are the implications of this phenomenon, should it occur? One is that the effectiveness of neuroleptic medication could decrease over time so that ever-increasing doses are needed to maintain control of symptoms. There is good evidence to suggest that such a tolerance effect can occur. Of even greater concern is the possibility that some people may become more prone to relapse – and, if relapse occurs, for it to be more severe – than would have been the case if they had never received neuroleptics in the first place. Such an increased predisposition to relapse is most likely to become evident if a person's neuroleptic dosage is reduced relatively rapidly.

Neuroleptic-induced dopamine receptor supersensitivity is not widely acknowledged by mainstream mental health clinicians. Indeed, it is not hard to form the impression there has been a deliberate effort in certain quarters to

ignore this phenomenon, so serious are its implications for conventional psychiatry.

Until key questions regarding the scientific status of supersensitivity have been satisfactorily answered this will remain a cause of great concern to many people. In the meanwhile it is worth considering recent comments on this contentious subject by Joanna Moncrieff, co-founder of the Critical Psychiatry Network and author of *The Myth of the Chemical Cure*. Moncrieff makes the following comments in a review published in *Acta Psychiatrica Scandinavica* in 2006:[11]

- The term "rapid onset psychosis" is preferable to "supersensitivity psychosis" because the former is neutral about possible mechanisms
- There is currently no consensus about the existence or possible mechanisms of supersensitivity psychosis
- Psychotic deterioration following withdrawal of antipsychotic drugs is usually taken as evidence of the chronicity of the underlying condition though evidence suggests *some* recurrent episodes of psychosis may be iatrogenic
- Clinicians may want to re-evaluate the benefits of long-term treatment in some patients
- There is urgent need for further research to clarify the possible risks associated with long-term neuroleptic treatment
- Strategies to manage conditions related to medication withdrawal that attempt to avoid automatic resumption of long-term treatment should be developed, both to facilitate patient choice and reduce unnecessary exposure to drugs

Neuroleptic Medication and Long-Term Improvement

It is often assumed the main reason many people do better in the long-term than was once thought possible is because neuroleptic medication has helped them achieve and maintain stability. However, while it is true that short-term neuroleptic treatment is sometimes helpful during acute psychotic crises (as acknowledged above), research shows prolonged "maintenance" medication plays a rather more equivocal role.

Because he spent his entire professional life working closely with, learning from, and treating people diagnosed with schizophrenia, the views of Professor Manfred Bleuler on this issue deserve special consideration. Bleuler's impressions were based on 23 years continuous observation of 208 individuals he treated personally and whose progress he monitored and

assessed at first-hand. This unique perspective led Bleuler to conclusions quite different to conventional beliefs regarding the long-term treatment of schizophrenia:

> Of all my numerous patients who had long-standing remissions or who had even reached a stable recovery lasting throughout the observation period, not a single one has been on long-standing neuroleptic medication. Many of them were given neuroleptics during active phases of the psychosis, but not for longer than a few weeks after they had recovered. This should be remembered when we consider the value of continuing neuroleptic medication after recovery.[12]

Many others have subsequently confirmed the general validity of Bleuler's findings. It is vital to point out, however, that while he challenged conventional ideas about the necessity of long-term medication for everyone, Bleuler nevertheless noted there were exceptions to his general conclusions regarding the role of "maintenance" treatment:

> We can dispense with permanent administration of drugs more frequently than usual. However, there are some patients in whom new acute attacks [psychotic episodes] can only be prevented by medication lasting many years. In other instances, a chronic psychosis can only be kept under a certain control with permanent medication.[13]

An Holistic Approach is Vital

Excessive reliance on psychotropic medications is fostered by exaggerated and misleading claims regarding their therapeutic effectiveness. Wise use, by contrast, is predicated on a clear understanding of what such drugs can and cannot do.

It has been conclusively shown that favourable social circumstances – especially those helping to alleviate stress and anxiety – can exert a powerful beneficial influence. Professor Luc Ciompi's research, like that of many others, has made it quite clear that less medication tends to be needed when adequate psychosocial support is provided:

> As for medication, and the neuroleptics in particular, the view developed here does not question their potential usefulness,

> either in acute conditions or as preventive measures against relapses. Their ability to reduce sensitivity to stress and the vehemence of emotions, and thus to act as an effective "brake" in cases of psychotic "runaway", suggests their main function is as general buffers. Although this function may certainly be advantageous in some situations, it may be superfluous or even harmful in others ... Medication represents a potentially useful tool that is best employed only when a patient's total social and personal situation is taken into account. The results from the Soteria Project indicate that drug therapy can become unnecessary even for acute schizophrenics if other conditions for therapy are particularly favourable.[14]

In order to maximise the potential beneficial effects of neuroleptic treatment, while simultaneously reducing possible risks, it is imperative these drugs are used in the context of a *holistic approach*. Although the validity of this basic principle is supported by an abundance of scientific and clinical evidence, it is still common for medication to be used excessively or aggressively in pursuit of a quick fix. Comments made by the president of the American Psychiatric Association in 2005 will come as no surprise to anyone familiar with the conventional psychiatric milieu:

> The U.S. pharmaceutical industry is one of the most profitable industries in the history of the world, averaging a return of 17% on revenue over the last quarter century ... Antipsychotic medications generated $6.5 billion in revenue [last year alone] ... The interests of Big Pharma and psychiatry, however, are often not aligned … One of the charges against psychiatry [is that] many patients are being prescribed the wrong drugs or drugs they don't need. These charges are true, but it is not psychiatry's fault … As we address Big Pharma issues, we must examine the fact that as a profession we have allowed the biopsychosocial model to become the bio-bio-bio model.[15]

Focussing on relevant social, psychological and spiritual issues would help redress this unfortunate cultural and professional myopia.

Medication and Soteria

A number of carefully conducted studies lend support to the claim that providing adequate support to people experiencing acute psychosis can have marked beneficial effects. A frequently-cited example, the *Soteria Project*, ran from 1971 to 1983 in San Jose, California in a small (6 bed) community-based residential facility providing a home-like sanctuary for young people experiencing acute psychosis of recent onset. (Retrospective analysis shows residents during this period would have been diagnosed with schizophrenia (42%) or schizophreniform disorder (58%) according to *DSM-IV* criteria.)

Soteria's clinical director, psychiatrist Loren Mosher, was Chief of the Centre for Studies of Schizophrenia at the US National Institute of Mental Health and editor-in-chief of the *Schizophrenia Bulletin*. A fundamental aspect of the Soteria philosophy was that acute psychosis was considered a "crisis in development" rather than an incurable mental illness. In keeping with this philosophy, residents received support and guidance from a team of specially selected staff (none of whom were mental health clinicians) who tried to engender a simple, home-like, safe, warm, supportive, tolerant, non-intrusive social environment.

The Soteria project undoubtedly has many valuable lessons to teach – particularly the fact that some acute psychotic episodes abate spontaneously in low-stress, supportive environments. However, with increasingly strident calls for widespread establishment of Soteria-style facilities as an alternative to conventional hospital treatment it is vital to guard against the seduction of utopianism. In particular, many people appear to have formed the *erroneous* impression that Soteria was anti-medication, or even anti-psychiatric, in its orientation. Careful examination of the available evidence challenges these notions. In his 2010 review of the Soteria findings, Robert Whitaker states that while 42% of the residents were never exposed to medication, 39% had used it on a temporary basis, and 19% needed medication continuously during the two-year follow-up period.[16] In his own account of this research Loren Mosher describes the Soteria approach as *restricting or minimising* use of medication rather than outlawing it altogether:

> The findings reported here indicate that, contrary to popular views, minimal use of antipsychotic medications combined with specially designed psychosocial intervention for patients newly identified with schizophrenia spectrum disorders is not harmful but appears advantageous.[17]

Research conducted by Professor Luc Ciompi and his colleagues in Switzerland led to conclusions similar to Mosher's. In Ciompi's programme residents were helped to grow through the "severe developmental crisis" of acute psychosis in a small (6-8 beds) home-like environment. Significantly, in contrast to the original Soteria, Ciompi's community provided formal therapies including psychotherapy and sociotherapy.

Anti-psychotic medication was not routinely administered in Ciompi's community. Rather, these drugs were used only when a situation arose that involved serious danger to a resident or others, if no improvement occurred within the first 3 to 4 weeks of admission, or if a resident seemed on the verge of an impending relapse that could not be prevented by other means. The majority of people remained in the programme between one and four months. Analysis of data obtained from 51 residents (DSM-III-R diagnoses were 39 acute schizophrenia, 14 schizophreniform psychosis, 3 uncertain) revealed that 20 had received no neuroleptic drugs while in the programme and the other 31 had received neuroleptic treatment approximately 2/3 of the time. Average daily dosages for the drug-treated residents were estimated to be about 1/3 of the usual European dosage and between 1/5-1/10 of the usual American dosage.

In a summary report published in the *British Journal of Psychiatry* these researchers stated their research "confirm findings by Mosher et al" and demonstrated that, in a setting providing adequate and continuous emotional support combined with sociotherapy and psychotherapy, a low-dose or drug-free approach is a feasible alternative to standard treatment for many people experiencing acute psychosis. "It is particularly interesting", they note, that for certain patients "remission of symptoms can occur without neuroleptic medication."[18]

The above evidence suggests that, while it is certainly worthwhile advocating for alternatives to conventional medication-centred approaches, we should beware not to allow ourselves to be beguiled by a utopian fantasy – as were many who gullibly accepted greatly exaggerated claims regarding the "second-generation" neuroleptics. Mosher's Soteria and Ciompi's Soteria Berne programmes both used medication, and found it helpful, in certain circumstances, the vital difference being that its role was marginalised, so that it was very much seen as a secondary rather than the primary treatment modality.

The Varieties of Psychotic Experience

When discussing the role of anti-psychotic medication it is vital to pay careful attention to the nature of the condition being treated as this is a crucial variable in determining what kind of help is required and whether drug treatment is likely to help or hinder recovery. In particular, it must be understood that the clinical term "psychosis" encompasses a wide range of extreme mental states and conditions which, while involving overtly similar behaviours, can vary greatly in form, cause, and personal significance. Even if they receive a similar DSM diagnosis, individuals displaying typical psychotic symptoms (hallucinations, delusions, loss of contact with reality) may be *having radically different inner experiences* and *grappling with very different personal predicaments*. Many of the problems that befall affected individuals and their helpers are a direct result of a widespread failure to appreciate these critical differences and respond to them in adequate and appropriate ways.[19]

Some acute psychotic episodes are inherently transient (e.g. DSM Brief Psychotic Disorder) and affected individuals can be expected to recover relatively quickly and not ordinarily require prolonged treatment. While anti-psychotic medication may sometimes be helpful temporarily in such cases, it could hinder recovery if used excessively or continued longer than necessary. By contrast, it is in the nature of some psychoses to be much longer-lasting (e.g. DSM schizophrenia) and to often require more intensive and protracted treatment. Having said this it is good to recall Manfred Bleuler's finding that in time even these persons recover far more often than is usually considered possible (though he did note that *some* may need long-term "maintenance" medication to enable them to remain stable).

Using Medication Wisely: Ten Key Principles

Learning to use medication wisely is both an art and a science and, as with any complex undertaking, experience is surely the best teacher. Finding ways to maximise potential benefits of neuroleptic and other psychiatric drugs while minimising possible detrimental effects calls for genuine collaboration between prescribers and those receiving treatment and creative application of their combined knowledge and experience. Experimentation is the only way to discover whether medication is necessary and, if it is, of finding which particular drug or combination of drugs will prove most beneficial. With this aim in mind, all concerned must work together toward the goal of learning

what part medication might play in helping to promote recovery, enhance wellbeing, and improve overall quality of life.

In order to use medication wisely it is essential that everyone involved have a clear understanding of what psychiatric drugs can realistically be expected to do and what they will not and cannot do. Everyone must realise that, while these drugs may be beneficial at certain times and in certain ways, there are very real limits to what they are capable of. It is particularly important they not be looked on as some kind of magical cure-all that will provide an easy solution to any problem or difficulty the person being treated happens to experience. These facts are easily forgotten in an aggressively commercial culture in which medications are promoted in ways that tend to foster unrealistic expectations on the part of doctors, patients, and families.

Another key point is that all treatments involve various kinds and degrees of risk that cannot be avoided entirely. While stopping neuroleptic medication may result in increased risk of "relapse" for some, remaining on medication entails risk of immediate and long-term side effects, especially if treatment involves prolonged high dosages. Rather than endeavouring to eliminate risk entirely, the art of using medication wisely involves finding ways to maximise its potential benefits, while always working to reduce the possibility of harm as much as possible.

Wise use of psychotropic medications is guided by these ten principles:[20]

- Adopting an holistic approach
- Initial medication-free assessment
- Individualised treatment (e.g. low dose, intermittent)
- Emphasis on non-drug coping strategies
- Minimal effective dose ("start low, go slow")
- Early medication-reduction trial
- "Relapse" or Withdrawal Syndrome? Re-emergence?
- Regular review of long-term "maintenance" regimes
- Judicious use of benzodiazepines (short term only)
- Risk minimisation strategies (minimal cumulative exposure, attention to lifestyle and nutritional factors)

The power of psychiatric drugs to alleviate distress can be a boon if it is harnessed to help people move forward in their lives. On the other hand, the same drugs can be used as a means of avoidance or escape. It is far easier to take a few pills than it is to face and deal with difficult personal problems! Medication can be used in ways that help facilitate growth and personal

development – but it can also become a substitute for constructive action and personal responsibility. While acknowledging the possible therapeutic value of medication those who adopt a holistic approach to mental health know that true healing cannot occur unless adequate attention is also paid to the social, psychological, and spiritual aspects of a person's life.

Guidelines For Reducing and/or Stopping Neuroleptic Medication

There are a range of legitimate reasons for people to reduce their medication, among which are the following:

1) To establish the lowest effective neuroleptic dosage
2) To minimise problematic adverse effects ("side effects")
3) Prior to switching to a different neuroleptic medication
4) Prior to commencing an intermittent treatment regime
5) In the process of discontinuing neuroleptic therapy

Just as there are risks associated with prolonged neuroleptic treatment (e.g. short and long-term side effects), so too are there possible risks associated with reducing or stopping it, e.g. the possibility of symptom exacerbation or increased likelihood of relapse. Experience teaches that medication reduction can be undertaken in a cautious way or a more risky way. Anybody who tries to reduce or stop their medication without taking appropriate precautions could experience untoward consequences ranging from severe withdrawal symptoms to another psychotic episode. Sadly, people who are impatient to get off medication sometimes act in ways which could actually increase their likelihood of finding themselves back on it! Failure to approach this matter with due care could even result in imposition of involuntary treatment, e.g. supervised depot medication or other restrictive measures. On the other hand, by observing a few simple precautions, it is possible for anyone to greatly reduce the likelihood of finding themselves back at square one. Guidelines listed below are based on the principle of risk-minimisation and have been validated by extensive clinical experience.

- Legitimate reasons for reducing and/or stopping?
- Devise and follow a plan (systematic approach)
- Seek and accept appropriate guidance and support
- Be well prepared (physical, mental, social, spiritual)
- Learn to recognise personal "warning signals"
- Prepare contingency plans in case of difficulties
- Reduce medication dosages very gradually

- Only change one medication at a time
- Be prepared to increase dosage if necessary
- Accept more personal responsibility
- Don't make medication the centre of your life

The Most Powerful Drug There Is

Psychiatric treatment does not occur in a social vacuum but in the context of relationships of various kinds. An interpersonal dimension is *always* involved even when medication is the central focus since a person (or, more likely, a number of people) has to prescribe, supply, and supervise the drugs. While it is often assumed the relationship a person has with those providing treatment is irrelevant to a drug's therapeutic effects, there are good reasons to question this belief.

The clinician's behaviour and the status of the therapeutic alliance can exert a powerful influence for better or worse in a number of ways. On a psychological level a treated person's willingness to comply with medication regimes is likely to be influenced by the relationship he or she has with the prescriber and others (such as case managers) responsible for monitoring their responses. Furthermore, the confidence, skill and understanding of those providing treatment can instil hope and positive expectations. Researchers have found that, for people being treated for psychosis, a positive therapeutic alliance is associated with better clinical outcomes and significantly reduced neuroleptic dosages.[21] Dr Edward Podvoll is not alone in emphasising the unique healing potential of human relationships:

> Recovery from psychosis is possible and is much more likely to come about through the catalyst of human intimacy. There is no medicine that can ever substitute for it.[22]

At a time when mainstream mental health care is becoming ever-more industrialised, impersonal, outcome-driven and biological, such sentiments are a sorely needed reminder of ancient commonsense wisdom.

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