

UNDERSTANDING CRITICAL PSYCHIATRY: A GUIDE TO FOUNDATION DOCTORS

PN de Silva

Abstract

This article has been specifically written for Foundation Trainees, in order to change their perceptions, and hopefully increase their interest in psychiatry by realising that major changes are being thought through to make the speciality fit for the 21st century, thereby being able to join other specialties in so called multi-specialty community hubs, where most doctors will be working in the future.

Critical Psychiatry is defined, and approaches the 3 domains of psychiatric work; how psychiatrists think, act and reflect from a Critical Psychiatry perspective. The issues of assimilating new knowledge in neuroscience, recent improvements in communication, consultation, collaborative risk management, as well as methods of objective reflections on outcome are discussed. Specific recommendations for trainees and their trainers are suggested in terms of knowledge, skills and attitudes.

Context

Of late, psychiatric services have been going through a period of introspection due to 3 factors. Firstly, the Care Quality Commission (CQC) has made suggestions to help mental health trusts gain a 'good' (satisfactory) rating (1). Secondly, along with Primary Care, Psychiatry is faced with reduced trainee applications, with increasing evidence of unfilled senior trainee and consultant posts around the country.

Furthermore, the Five Year Forward View on Mental Health (2) directs most community mental health work (about 80% of the total) be moved to primary care settings, co-localised in multi-specialty 'hubs' with District Nursing, Midwifery, Health Visiting, Social services, Pharmacy and Chronic Disease services.

A new post of a hybrid Community Consultant has been proposed (3) by the colleges of Medicine, Psychiatry and General Practice involving 18 months training in general medicine with 9 months each in Primary Care and Psychiatry. In line with this the College of Psychiatry intends to update their curriculum, which also needs revision in the rapidly developing field of neuroscience.

The key concerns of the CQC following the 2 year full inspections of all 56 mental health Trusts were inadequate joined up care with primary and acute services, poor physical health care of psychiatric patients and polypharmacy in managing challenging behaviour by Learning Disability and Old Age sub-specialties, typically involving off-label prescribing of anti-psychotic and anti-epileptic drugs.

The CQC also commented on the lack of shared decision making ('co-production') between patients, carers and clinicians on treatment and risks management. Perhaps this lack of co-production is consistent with increasing numbers of detentions under the Mental Health Act in England over the last 5 years. It is hoped that the emerging strand of critical thinking by psychiatrists themselves can help improve services. Perhaps some of the insights could also help non-psychiatrists in their work.

Critical psychiatry – what it is and is not?

The term Critical Psychiatry has been in place since the onset of the UK Critical Psychiatry Network (CPN) in 1999 (4). This is now a worldwide network of interested psychiatrists, with links to other networks such as 'Mad in America' (5). CPN is a broad church, with interests in political, philosophical and spiritual underpinnings of psychiatry, alongside critique of clinical activity including the potential implications of new technology and neuroscience. Therefore contemporary Critical Psychiatry can be defined as an **evidence based critique of how psychiatrists think, act and reflect**, with recommendations on competencies linked to these key functions.

It is perhaps useful to view critical psychiatry in the context of critical thinking in general medicine and surgery; of acute clinicians questioning the validity of treating (or remediating) lifestyle choices, for example on diet and physical exertion, encouraged by unfettered commercial advertising, and tax breaks (for example on sugar). Physicians are increasingly discussing the value of, for example, 'intermittent fasting' for preventing diabetes and managing obesity, and remediating nutritional deficiencies by supplements, for example Magnesium and Vitamin D3, both deficient in a majority of the population.

What Critical Psychiatry is not is the belief system called Anti-Psychiatry which was popularised by Thomas Szasz (6). The core belief of anti-psychiatry is that psychiatric illnesses and associated diagnostic classifications are myths, which get progressively dismantled as neuroscience finds underlying biological deficits and associated curative treatments (as opposed to palliative symptom relief and containment as offered by psychiatrists).

The evidence for anti-psychiatry rests on management of epilepsy, moving from the Psychiatry to Neurology (7). Unlike Anti Psychiatrists, critical psychiatrists hope to rejuvenate the speciality in order to make it relevant to the 21st century, and acceptable to the general public.

How psychiatrists think?

Psychiatric conditions rarely have specific and sensitive biomarkers. Even in Dementia sub typing, the sensitivity afforded by modern scanning is around the 80% mark (8). The best fail safe for over-diagnoses is research based operational criteria, but practicing psychiatrists rarely use these due to limitations in time (9).

Psychiatrists are considered to have expertise in predicting another's motivations and future behaviour; the so called 'theory of mind' competency (10). This skill appears to be related to the ability to 'see ourselves as others see us'. In general, this skill appears to be more accurate when predictions are made using an abstract rather than an emotional mind set (11); relevant for example in risk assessment.

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All humans have thinking errors, both in individual and group settings. These can result in incorrect assumptions unless due diligence is practiced. For example, doctors tend to look for evidence to support a diagnosis, rather than evidence which would contradict it. This is called 'confirmation bias' (12). Furthermore, 'misuse of heuristics' (13) occurs when a doctor applies treatment guidelines to patients who do not fit inclusion criteria of trials used to formulate these.

This bias is compounded by the doctor not disclosing this limitation of evidence to the patient because of losing face - which is known as 'affective' bias (14). National guidelines on treatment are often arrived at by comparing effect sizes between different trials under differing conditions including control groups. This leads to a bias called 'overconfidence' (15). Slavishly following such guidelines due to fear of peer disapproval leads once again to affective bias.

Group biases can originate in Multi-Disciplinary Teams (MDT's). The best known of these is 'groupthink' (16) when there is unquestioned agreement on a judgement or decision due to various influences of group members. The other main group bias is 'escalation of commitment' (17), where a treatment plan is continued despite evidence of ineffectiveness due to fear of consequences if the direction is changed or reversed.

New knowledge

On the emerging field of Neuroscience, there is evidence of excess activity of immune responses in the brain as part of common psychiatric conditions such as Major Depressive Disorder and Schizophrenia. This involves excess synaptic pruning due to activation of microglia, especially in frontal areas of the cortex. This process is added to by activation of the complement system.

Furthermore, it is now recognised that around 6% of acute psychoses are accounted for by 'limbic encephalitis' typically resistant to antipsychotics, caused by excess anti NMDA receptor and Potassium channel antibodies. Consequently, trials have commenced on using microglial deactivators such as Minocycline, and routine checks on auto-autoantibodies in acute psychoses to decide on the use of steroids and immunophoresis in limbic encephalitis.

It is also being increasingly recognised that there is a 'toxic triad' of depression (associated with persistent excess cortisol production), central obesity (Insulin resistance, hypertension, dyslipidaemia and reduced growth hormone production) and cognitive impairments in attention, memory retrieval and executive function (associated with microglial activation, reduced brain tropic factors such as BDNF). As yet the various clinical departments dealing with these previously disparate conditions have not teamed up to work collaboratively, despite existence of liaison psychiatry services in most general hospitals.

Regarding trainee competencies, knowledge about biases needs to be in the Part 1 MRCPsych curriculum. The RCPsych eCPD portfolio has 2 modules dealing with bias, with the latter focussing on how these can compromise effective leadership in teams. In terms of clinical practice, clinical leaders and supervisors need to be conscious of bias when making diagnoses and decisions. Furthermore, Case Based Discussions (CBDs) need to examine potential biases, and how these were safeguarded against.

Knowledge of Neuroscience developments entails a steep learning curve for both trainees and trainers, aligned to CQC requirements to upskill psychiatrists knowledge and competency in identifying and managing common medical conditions, such as those involved in the 'toxic triad' mentioned above. The expectation of the 'parity of esteem' agenda is to eliminate the morbidity and mortality gap between the general public and mental health patients, this needs focussed training and possibly continuing assessment of career psychiatrists as well as trainees.

How psychiatrists act

The key aspect of psychiatry is communication. However, a common theme based on general practitioner (18) and hospital doctor (19) feedback is that written communication by psychiatrists tends to be disorganised, unnecessarily lengthy and inadequately headlined with 'key items' such as diagnosis, risk management, treatment and follow up.

On interviewing, service users often describe 'passive listening' by trainees, who ignore repeated questions (20). In some instances, trainees appear to respond to direct questions with a further question. This might be due to anxiety to achieve a diagnosis.

Similar findings have been elicited with qualified psychiatrists (21) with younger and female doctors performing better in handling patient questions. Care Planning (CPA) meetings have also had mixed feedback from service users (22), with concerns about being interrogated, not having specific questions addressed, not knowing staff in attendance, not seeing the consultant beforehand, and being expected to wait without a set appointment.

Full disclosure of benefits and side effects of treatments leading to shared decision-making is stipulated in national guidance for major psychoses (23). Evidence of this actually taking place consistently is lacking (24). Particular concern has been expressed about psychiatrists not discussing metabolic, cognitive and stroke risks associated with antipsychotic medication (25).

Furthermore, appropriate discussion leading to shared decisions respecting a patient's right to take risks in order to maintain their privacy and family life (article 8 of the European Convention of Human Rights) is recommended (26), but not always achieved.

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A specific example of where ‘co-production’ could be helpful is in the field of risk remediation. There is no evidence that clinician generated risk assessment (including the use of structured risk scales) is effective in predicting actual suicidal behaviour (27). Recently, co-production; jointly writing a suicide safety plan for all service users in receipt of mental health services has been devised (28). This includes documenting resilience factors, harm reduction strategies and agreeing reliable points of contact if suicidal thoughts arise.

On trainee competencies, demonstrating sensitivity and flexibility when taking a history or giving information is a valuable competency. There is a role for ‘experts by experience’ (patient and carers) to teach and assess consultation skills (29). Furthermore, the recent adoption of ‘Open Dialogue’ (30) in admission prevention provides trainees with consultation skills aimed at helping patients and families to formulate their understanding of the current problem, leading to their own solutions. Furthermore, learning how to complete a suicide safety plan with a patient and carer should perhaps be a competency for all trainees, independent of speciality.

Learning to use a template such as SBARD (31), in handovers, CPA meetings, routine documentation and letters will help in improving salience and brevity. Templates are used increasingly in other specialities, for example in Radiology and Geriatric Medicine. The SBARD format will also facilitate efficient telephone triage of new assessments, and in skype consultations with patients either accompanied by carers, GPs or nurses (32).

Competencies in knowledge include understanding cardiovascular protection via medication, exercise and nutrition, so an informed discussion on health promotion can take place with patients, for example using ‘Q Risk’. Understanding sleep disorders (33) should perhaps be mandatory for psychiatric trainees, as it is for trainee neurologists. Regarding medical topics, knowledge on metabolic syndromes, as well as ‘neuroinflammation’; the relevance of activated microglia and changes in the complement cascade in major depression and non-affective psychoses could be potential sources of examination questions for the MRCPsych part 1 exam.

How psychiatrists reflect

Objective reflection, using outcome data is difficult to collect due to ‘new ways of working’ leading to prompt discharge, and follow up by a separate team (34). Furthermore, publication of outcomes of Consultant led teams is often lacking, so analysis of ‘outliers’ cannot take place. This is despite all provider organisations collecting information on time to be diagnosed, medication errors, complaints, ratio of new assessments to discharges, friends and family test results etc.

The usual method of reflection, the Case Based Discussion (CBD), is a snapshot of process rather than outcome, with no feedback from patients (35). However, it provides a framework to review the logic leading to a diagnosis, and the rationale for treatment selection and follow up arrangements. Defensibility of documentation can be examined although checking validity of contents, although examining documentation of other professionals is rare. The process of selecting cases for a CBD varies, but often a case is selected by the psychiatrist rather than a random selection by another person.

All doctors are subject to 360 degree feedback on personal qualities, involving anonymised input from colleagues, patients and managers. However, feedback provided can simply reflect an isolated contact, and might not reflect a longer term experience of the doctor, as provided in a reference. There is also the potential for false assessments by respondents associated with affective bias (36).

Reflection on effectiveness of various treatments rests on awareness of relevant research findings. There is limited understanding ‘publication’ bias (37) - especially awareness that publication rests on financial and academic interests of the authors, journal editors and pharmaceutical companies. Trainees might not appreciate the constraints of discussion led by paid speakers and chairs at meetings sponsored by the pharmaceutical companies due to ‘commercially sensitive’ issues.

Reflecting on history and ethics of psychiatric practice is rare, largely due to its neglect in the curriculum. Previous psychiatric involvement in Eugenics and Social Darwinism are not considered by most trainees (38), and not part of the current curriculum. Ethics of enforced treatment is taught mainly on the basis of legal requirements - i.e. how restriction can be carried out - rather than if restriction is in the best interest of the person. Furthermore, the social and governmental expectations of psychiatrists are rarely discussed due to the fear of appearing overtly political.

Trainee competencies for reflection include being able to critically appraise a research paper. Trainees can join a team carrying out a systematic review via the Cochrane Collaboration, which will provide the necessary training and mentoring needed. History of Psychiatry lends itself to MCQ type questions for the part 1 exam, and will help inculcate an appropriate ethical framework.

A further competency is the ability to be aware of the various influences restricting independent thought, including requirements of the training curricula and peer expectations. Being able to balance powers afforded by the Mental Health Act with human rights of individual patients, including the right to take risks in order to return home is a key competency for senior trainees. Independent thinking requires support; perhaps group reflection - the equivalent of Balint groups in General Practice (39) could also be helpful.

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Conclusions

Critical Psychiatry often elicits a combination of fear and irritation amongst some psychiatrists; hopefully this article can dispel some of the accompanying myths about the approach, and encourage critical thinking by all psychiatrists.

Dualistic thinking remains a problem in all branches of medicine, including psychiatry, despite evidence to the contrary (for example between Schizophrenia and Bipolar disorder, Vascular and Alzheimer's dementia, physical 'disease' and 'medically unexplained' symptoms). There needs to be an attitudinal shift which could be inculcated via teaching rounds involving sub specialities. Joint working to target the so called toxic triad described above would be a good place to start.

Perhaps another attitudinal shift is to 'think outside the box' about psychotropics; moving away from seeing these drugs as 'treatment' for diseases, towards methods of temporarily relieving specific symptoms independent of diagnoses.

Moncrieff (40) has described psychotropics as legal mind altering chemicals, capable of changing a person's mental state for the better or worse (sometimes a bit of both). Impartially summarising the effects of a drug to service users using layman's language is a key general competency for psychiatrists and other doctors alike, going back to the essence of the Hippocratic Oath 'primum non nocere'.

MCQs – Best out of 5 answers

1. Critical Psychiatry

- Is a belief system*
- Critiques how doctors think (Best)*
- Is against biological approaches*
- Hopes psychiatry will implode*
- Is against use of antipsychotics*

2. Common thinking errors include

- Delayed gratification*
- Need for classification*
- Confirmation bias (Best)*
- Use of feelings*
- Use of heuristics*

3. Recent neuroscience findings include

- Autonomous circuits*
- Stress responses causing depression*
- Hypercortisolaemia*
- Synaptic overgrowth in depression*
- Synaptic pruning by microglial activation (Best)*

4. Research on interviewing skills of psychiatrists

- Recommends more structuring*
- Suggests older psychiatrists do better*
- Younger psychiatrist are more responsive (Best)*
- Female psychiatrists no better than male*
- Feedback from users unhelpful*

5. Study of history and ethics of psychiatry

- Includes study of eugenics (Best)*
- Excludes human rights*
- Is associated with anti-psychiatry*
- Teaches when not to declare side effects*
- Is part of the current psychiatric curriculum*

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Author

Dr Prasanna N de Silva

Consultant Psychiatrist
Monkwearmouth Hospital
Newcastle Road
Sunderland, SR5 1NB
prasanna.desilva@ntw.nhs.uk

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