Pharmaceuticals and paediatric psychiatry

Dr Peter Parry explains how his work as a child and adolescent psychiatrist – and particularly his interest in paediatric bipolar disorder – has inspired and driven his efforts to promote a biopsychosocial, rather than purely biomedical, approach to diagnosis and treatment.

What led you to specialise in child and adolescent psychiatry?

I graduated from Adelaide Medical School, Australia, in 1983 and worked in the Royal Australian Navy, in general practice and palliative care. That sparked an interest in psychiatry. I trained at a large asylum before subspecialising as a child and adolescent psychiatrist in 1996, and have worked in both inpatient and community clinics in South Australia; Wales, UK; and now Queensland, where I am Clinical Director for Mental Health Services within the Lady Cilento Children’s Hospital in Brisbane. I also have academic status as a senior lecturer in psychiatry at the University of Queensland, and visiting senior lecturer at Flinders University in Adelaide.

Despite warnings published in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), the conversion of the description of psychiatric disorders to discrete disease entities has become problematic. Can you expand upon the reasons for this?

The release of DSM-III in 1980 marked an upheaval in psychiatric nosology. The aim was to establish greater reliability in psychiatric diagnoses, essentially via a symptom checklist approach; theoretical underlying causes were mostly deferred to the clinician’s own inquiries. Politically, DSM-III was a coup d’étal against psychoanalysis. DSM-III passed the American Psychiatric Association’s committees by claiming ideological neutrality. Its introduction stated the Manual was ‘atheoretical’ regarding aetiology and stressed it was primarily for research; it should not be used too literally in clinical settings and was ‘not appropriate’ for insurance and legal settings.

These warnings were not heeded and by the time of DSM-IV in 1994, reification was so problematic that the introduction stated the Manual must not be used in a cookbook fashion. The descriptive psychiatry model had created a blinkered culture of, as Psychiatrist Professor David Healy noted, ‘informational reductionism’. Rather than starting points, DSM diagnoses were seen as answers. Meanwhile, the pharmaceutical industry’s massive influence created a culture of biomedical reductionism, and psychotropic drugs became over-emphasised to the detriment of non-drug approaches.

Does this trend affect your research?

I have always been a full-time clinician rather than a researcher, and it has been in my clinical work that I have seen the effects of these trends – they shape the daily reality of my work with children, adolescents, their families, schools, etc. My research interests were sparked by the topic of paediatric bipolar disorder (PBD) after hearing about it in 2006 and realising just how astray the biomedical-informational reductionist trends in my field could lead us.

You assert that there exists a stark discrepancy in PBD diagnoses between the US and other countries. Can you provide an insight into the issue?

At international child and adolescent psychiatry conferences, it is abundantly clear that PBD is a diagnosis mostly confined to the US. This has been confirmed in patient data and in opinion surveys of child psychiatrists. Colleagues and I are also currently researching the international spread of publications on PBD, and the data we have so far confirm this view.

To what extent is evidence-based medicine impacted by the pharmaceutical industry?

Since the early 1990s, there has been a commendable aim that medical practice should be based on the best evidence. The Cochrane Collaboration in particular has pioneered this. Unfortunately, it quickly became clear that commercial ownership of research data has sabotaged evidence-based medicine. Scandals relating to spun data (highlighting positive results for a sponsor’s drug, or burying or minimising poor efficacy and side-effect data), ghost authorship and high fees paid to medical ‘key opinion leaders’ have revealed we do not have the transparent research data required for real evidence-based medicine.

How does marketing-based medicine play a role in the industry?

The scandals mentioned above involved litigation of pharmaceutical companies by class-action lawsuits and governments, particularly in the US. As a result, subpoenaed internal pharmaceutical industry documents were made public. Professor Glen Spielmans, a psychologist from Minnesota, and I researched over 400 such documents referring to psychotropic drugs from several companies. The revelations, which we published in the Journal of Bioethical Inquiry in 2010 and highlighted on the Healthy Scepticism website, led to us coining the term ‘marketing-based medicine’ as more reflective of medical scientific and clinical reality than the aspired-to, evidence-based medicine.
IN 2006, THE tragic death of four-year-old Rebecca Riley due to an overdose of drugs prescribed to treat paediatric bipolar disorder (PBD) made international headlines. She had been diagnosed with the condition when she was two years old, based predominantly on how her mother described her behaviour to a psychiatrist. For many, PBD remains a controversial diagnosis – yet its incidence has risen significantly in the US over the past two decades. As a result, an ever-growing number of children and adolescents are being treated for the condition with pharmaceuticals.

Reading the coverage that followed Riley’s death initially sparked Dr Peter Parry’s interest in the subject. As a child and adolescent psychiatrist working in the Lady Cilento Children’s Hospital in Australia – a nation where rates of PBD diagnosis, particularly those that are prepubertal, remain significantly lower than in the US – Parry was struck by the state of events that had led to this so-called PBD ‘epidemic’ across the Pacific. He began to delve into the subject more deeply, soon discovering worrying holes in the literature. “Bedrock concepts of psychiatry – such as attachment theory, family dynamics and the effects of developmental trauma – are mostly absent from the PBD literature,” Parry reveals.

BIG PHARMA AND BIOMEDICAL REDUCTIONISM
To Parry, the PBD controversy is emblematic of a more widespread problem: over recent decades the trend from traditional to evidence-based medicine has been side tracked by ‘marketing-based medicine’. He argues that it is in the interest of drug companies to promote pharmaceutical interventions while simultaneously widening the definitions of what constitutes a condition that requires such treatment – a process that has been termed ‘disease-mongering’. Indeed, through the analysis of internal industry documents released following legal proceedings, Parry and others have found evidence of a number of shady practices. These are aimed at promoting pharmaceutical solutions rather than pursuing evidence-based best practice, and include the suppression and spinning of negative data and the employment of ghost writers and ‘key opinion leaders’.

The extent to which pharmaceutical companies have been able to influence healthcare, however, has been facilitated by a more widespread climate of biomedical reductionism that Parry asserts has been the result of the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM) from the third edition in 1980 onwards. DSM-III was the first version to define psychiatric conditions using a symptom checklist, making little reference to aetiology. The result was the growth of a psychiatric culture in which conditions are understood in terms of symptoms rather than underlying causes.

A BIOPSYCHOSOCIAL ALTERNATIVE
In cases of potential PBD – in which DSM-style symptom checklists appear to support this diagnosis – Parry believes that a biopsychosocial approach must be adopted to avoid distracting families and clinicians from looking for deeper causes. This looks for explanations for a young person’s behaviour from a range of angles – including social, psychological and environmental – rather than just biomedical. This ensures that cases are not misdiagnosed based on superficial assessment of symptoms alone.

Parry illustrated the harm that can occur when this approach is not employed in a paper entitled ‘Biologism in Psychiatry: A Young Man’s Experience of Being Diagnosed with “Pediatric Bipolar Disorder”’ that was published in the Journal of Clinical Medicine last year. The paper told the story of a young American referred to using the pseudonym...
COUGH DISORDER AND SUPPRESSALIN: AN ALPHABET DIAGNOSIS ALLEGORY

In a 2009 article in the Medical Journal of Australia entitled ‘Cough disorder: an allegory on the DSM-IV’, Parry put forward a fictional representation to convey the DSM’s impact on psychiatric nosology. In this story, a mother believes her son to have ‘cough disorder’ – a condition she has read about on the internet. She is equally certain that the co-advertised medication ‘Suppressalin’ is the required treatment.

“The story unfolds with my persuading both parents that their son’s cough could have many different causes and the diagnostic label of ‘cough disorder’, while being descriptively correct, is only a starting point,” Parry expands. “I advocate the importance of a biopsychosocial diagnostic formulation reflecting all contributing factors, which naturally points to appropriate interventions.” In the end, the cause of the boy’s cough is identified as mild asthma, which is improved when his parents cease smoking around him, and treatment with Suppressalin is not required.

According to Parry, ‘cough disorder’ can symbolise any number of conditions, from attention-deficit hyperactivity (ADHD) or oppositional-defiant disorder (ODD), to autism-spectrum (ASD) or generalised anxiety disorder (GAD) etc. Of course, this allegory can also be applied to paediatric bipolar disorder (PBD). Rather than only listing ‘alphabet diagnoses’, a biopsychosocial formulation gives an accurate real life picture of the likely causes of the problem.

‘Adam’, who received a PBD diagnosis at the age of 12 followed by eight years of pharmaceutical intervention. In the paper, Adam describes how these experiences have negatively impacted him and also explains how he is now off the medication, benefiting from seeing a psychotherapist, and believes the psychiatrist should have asked if he was ever so inclined”. Whereas a biopsychosocial approach would have examined these factors alongside the possibility of PBD, the patient reports that a biomedical approach was used from the very start, leading to years of massive over-medication and untreated physical and psychological trauma.

IMPROVING DIAGNOSES

If a biopsychosocial perspective is to continue as a guiding philosophy in child and adolescent psychiatry, several fundamental changes are required. First, a change in psychiatric education is needed, particularly in the US, to move psychiatrists away from what Parry refers to as ‘DSM fundamentalism’. “I feel fortunate having learnt psychiatry in Australia,” he enthuses. “The capacity to make a biopsychosocial diagnostic formulation was more important for gaining one’s Fellowship of the Royal Australian and New Zealand College of Psychiatrists membership than making DSM checklist-based diagnoses.”

Second, infrastructures that may be contributing to the over-diagnosis of PBD must be recognised and righted. For example, health insurance companies in the US are often more likely to fund psychiatric treatment following a DSM diagnosis such as bipolar disorder, than they are for other ‘less biological’ DSM diagnoses, such as a parent-child relational problem. The US is also the only country with a large psychotropic market in which direct advertising to consumers is legal.

Third, further research is required on non-pharmaceutical therapies for common psychiatric disorders, particularly around lifestyle interventions such as exercise, sleep and diet. Although links between such lifestyle factors and common psychiatric conditions like depression have been identified by studies, the results are often relegated to lower impact journals.

Addressing these systemic issues would allow for better quality clinical care in psychiatry. Parry also notes that adopting the policies of the ‘AllTrials campaign’ [www.alltrials.net] – which seeks independent scientific access to clinical drug trial data – would set the scene for the promotion of truly transparent and evidence-based medicine.