First Do No Harm:
Iatrogenic Harm in Mental Health

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First Do No Harm

- Following the tradition established by the ancient Greek physician Hippocrates, doctors agree to uphold a certain set of values, including the imperative to do no harm.
- Unfortunately, following our encounters with traditional psychiatric services, for many psychiatric patients and survivors, both the ideas and the practice of biomedical psychiatry have proven to be harmful to many of us.
- Misdiagnosis, compulsory treatment, adverse drug reactions, negligence, overmedicalisation, are all relatively common experiences within psychiatric services.
- Iatrogenic harm refers to the injury, either physical or psychological, caused inadvertently by the process of treatment.
- During this workshop we shall explore the phenomena of iatrogenic harm:
- What is it, how is it caused what can be done about it.

First Do No Harm

- The term iatrogenesis is from the Greek “brought forth by the healer” and refers to any effect on a person from the actions of a healthcare professional that negatively impact their patients.
- Iatrogenic harm might occur as a direct or indirect result of their treatment or as a consequence of lack of treatment.
- E.g. You go to the emergency room with a severe cough and the doctor listens intently at first and acts kindly. However, the doctor sees on your record that you have a mental health condition.
- Suddenly, the doctor begins to act differently perhaps growing curt with you or telling you nonsense such as you need to drink more water or lose weight and the cough will go away.
- According to one study, the harm that a doctor can do is not limited to the negligent use of medicine or medical procedures but may also include unjustified remarks and misinterpretations of the data. The end result, either way, is a patient who is harmed emotionally and physically and may not recover (Krishnan & Kasthuri 2005).

REPORT ON THE LOOK-BACK REVIEW INTO CHILD & ADOLESCENT MENTAL HEALTH SERVICES COUNTY MHS AREA A

STATEMENT OF FINDINGS

- 1. No extreme or catastrophic harm had occurred in the 1,332 cases considered between July 2016 and April 2021.

- 2. There were 227 children managed by NCHD1 where the diagnosis and/or treatment exposed them to the risk of significant harm by way of one or more of the following: sedation, emotional and cognitive blunting, growth disturbance and serious weight changes, metabolic and endocrine disturbance, and psychological distress. The medicalisation of ordinary emotional responses in children and their suppression by medication, risks delaying or damaging the development of skills in the self-regulation of emotions which normally happens as children mature.

- 3. 13 other children were found to have been unnecessarily exposed to a risk of harm under the care of other doctors in the service.

- 4. There was clear evidence of significant harm caused to 46 children in the files that were reviewed. This included galactorrhoea (the production of breast milk), considerable weight gain, sedation during the day, and elevated blood pressure. This figure of 46 will change as new information becomes available from meetings with the children, young adults and parents affected.

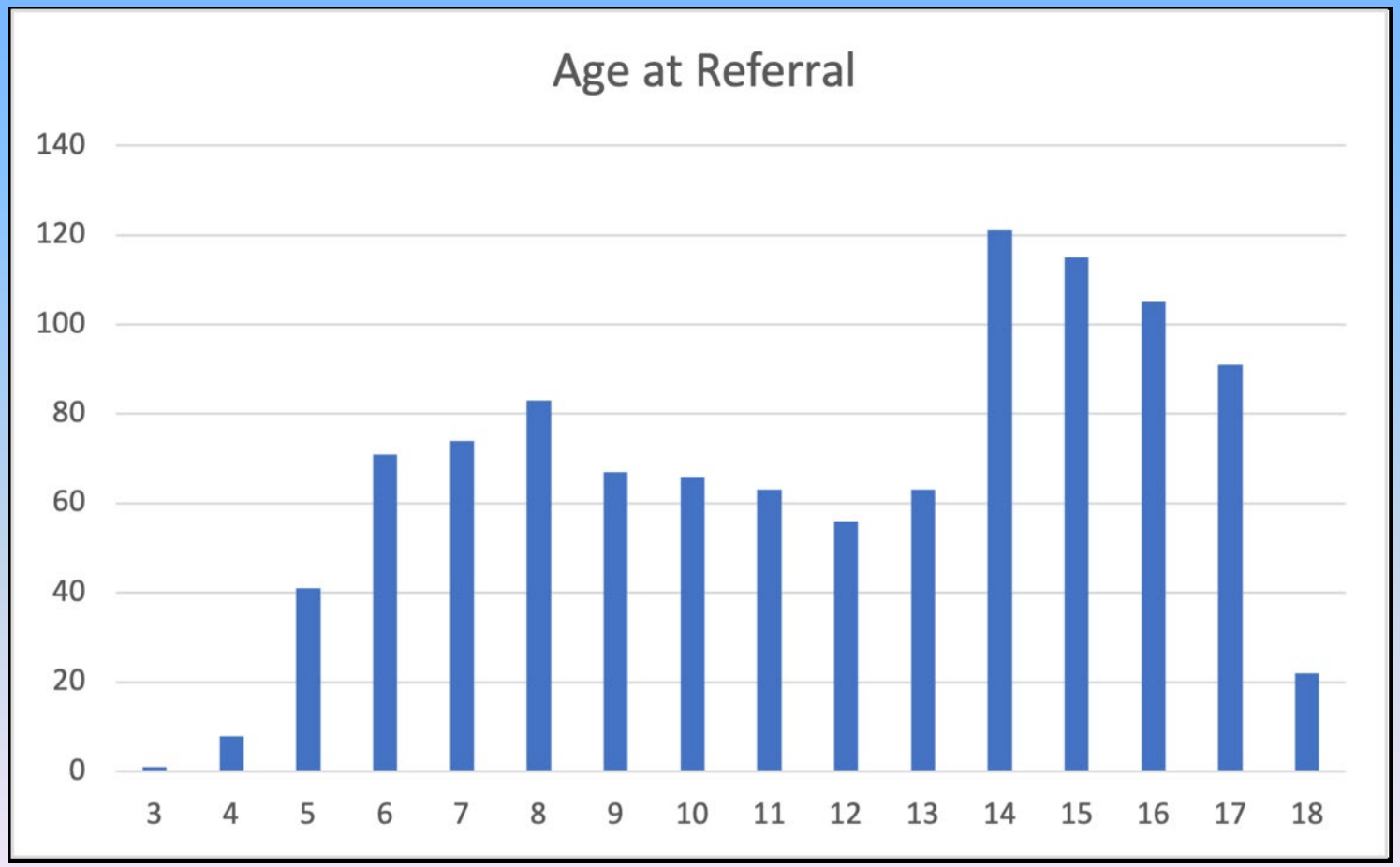
KEY CAUSAL FACTORS

- 1. The diagnoses of ADHD, particularly for secondary-school children, was frequently made without adequate evaluation and/or without the required level of information in relation to their presentation in school from their teachers.
- 2. Feedback from teachers was not requested as part of the management of treatment response for ADHD. There was evidence that this was the practice of the doctors who were prescribing for ADHD in general rather than being confined to NCHD1.
- 3. There was evidence of inconsistent and inadequate monitoring of adverse effects of medications, this included:
- a. Children started on stimulants did not routinely have a baseline pulse, blood pressure, height or weight measured and charted, to establish pre-treatment values.
- b. Children started on antipsychotics did not routinely have a baseline blood test to establish pre-treatment values.
- c. There was no expectation of checking pulse and blood pressure seven days after starting stimulant or increasing the dose.
- d. Repeated height, weight, pulse and blood pressure measurements were erratic and not plotted on developmental charts.
- e. The patient's GP was asked to do the blood tests in some but not all instances when children were started on antipsychotics. There were no results of this on file in the majority of cases. The tests were not routinely repeated at regular intervals.

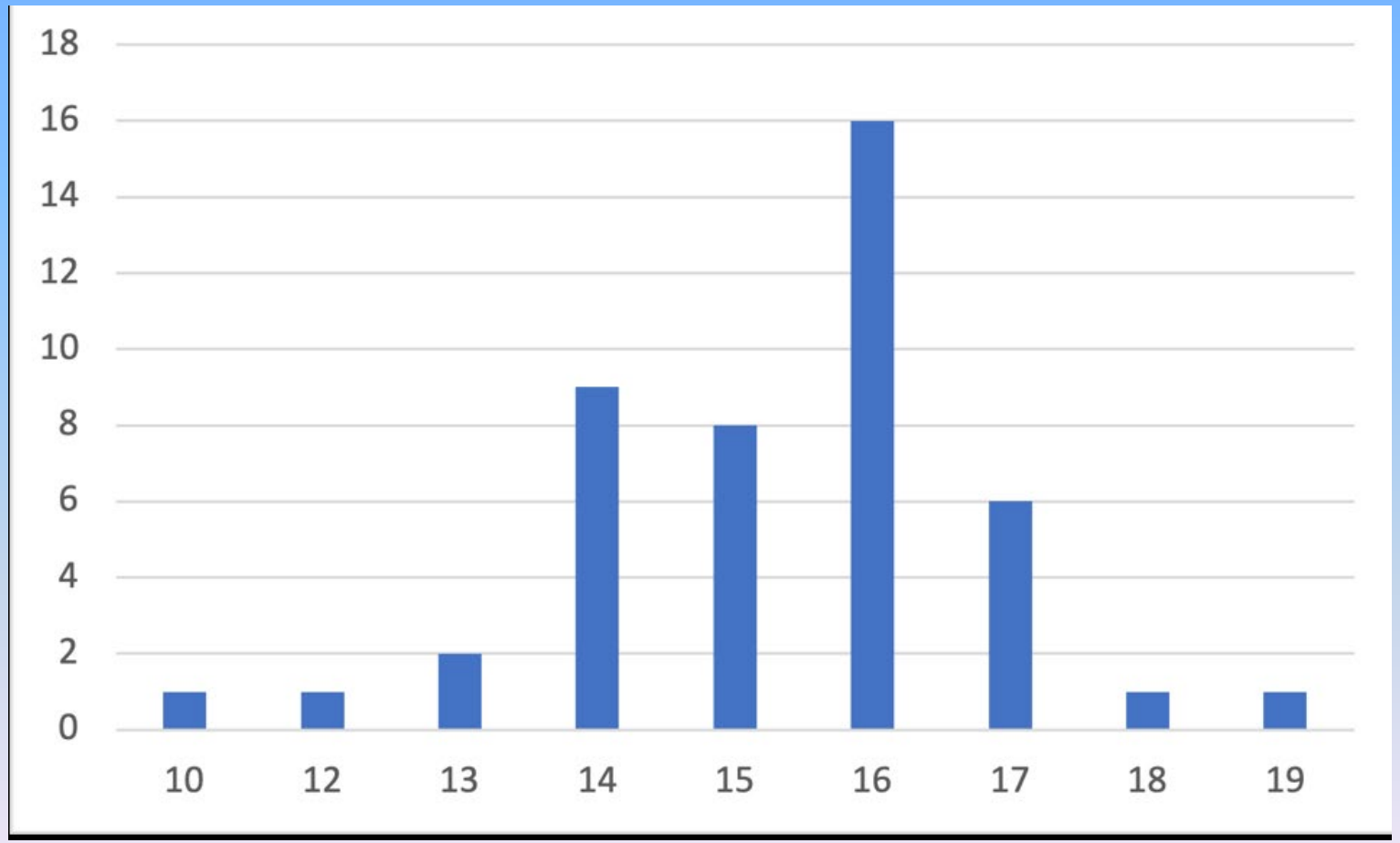
KEY CAUSAL FACTORS

- 4. It is a reasonable assumption, but cannot be confirmed because NCHD1 was not available to be interviewed by the LBR Team, **that they were intending to help, not harm**, the patients they treated and that the exposure to risk and harms occurring were as a result of a lack of knowledge about good practice. While the NCHD contract specifies involvement in education and training, these requirements are generic and could be met by any faculty registration for NCHD's on the General Division of the Irish Medical Council Register. There was no contractual requirement, or support and monitoring through supervision, to develop skills in the sub-specialty of child and adolescent psychiatry.

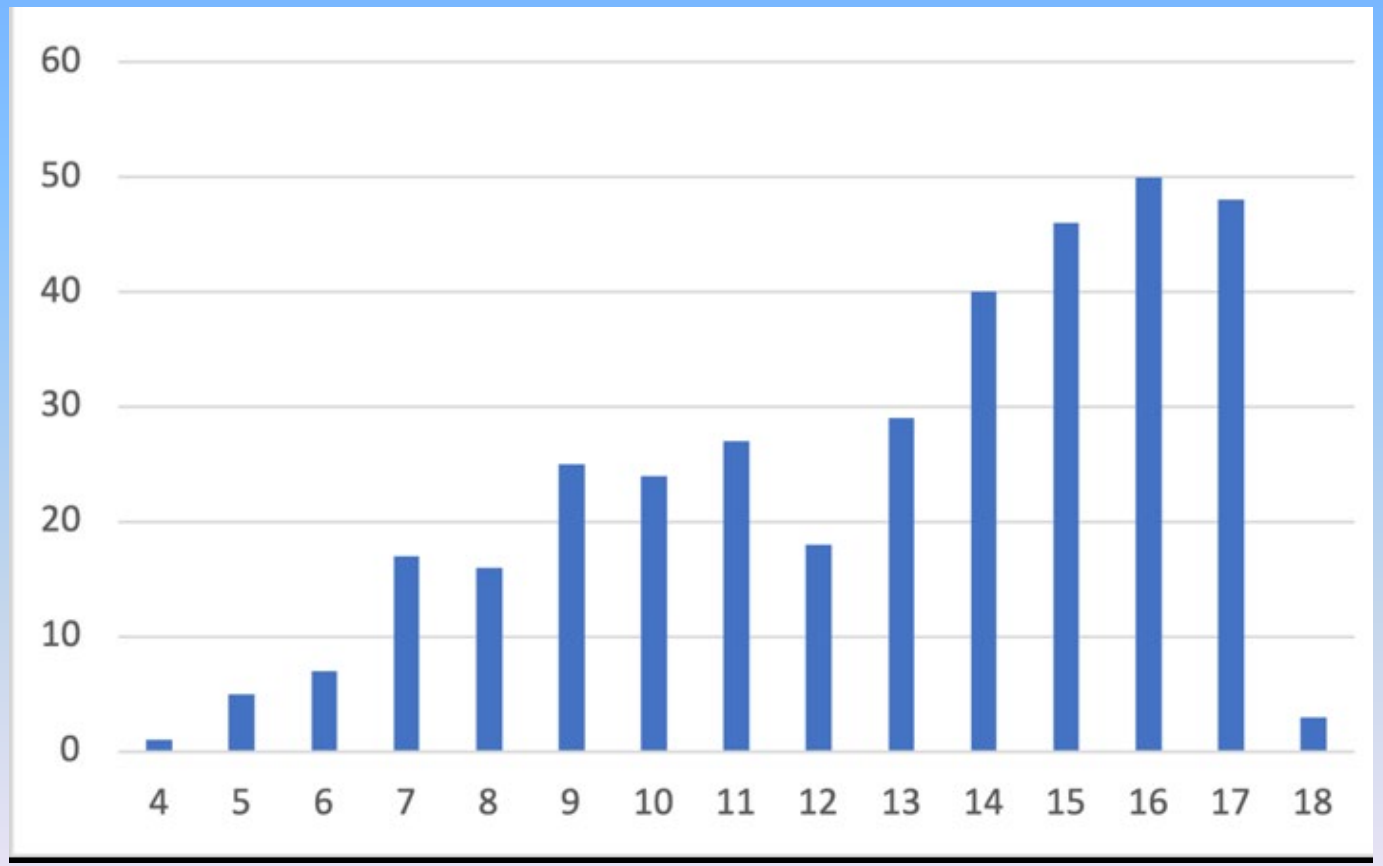
Analysis of Age on Referral



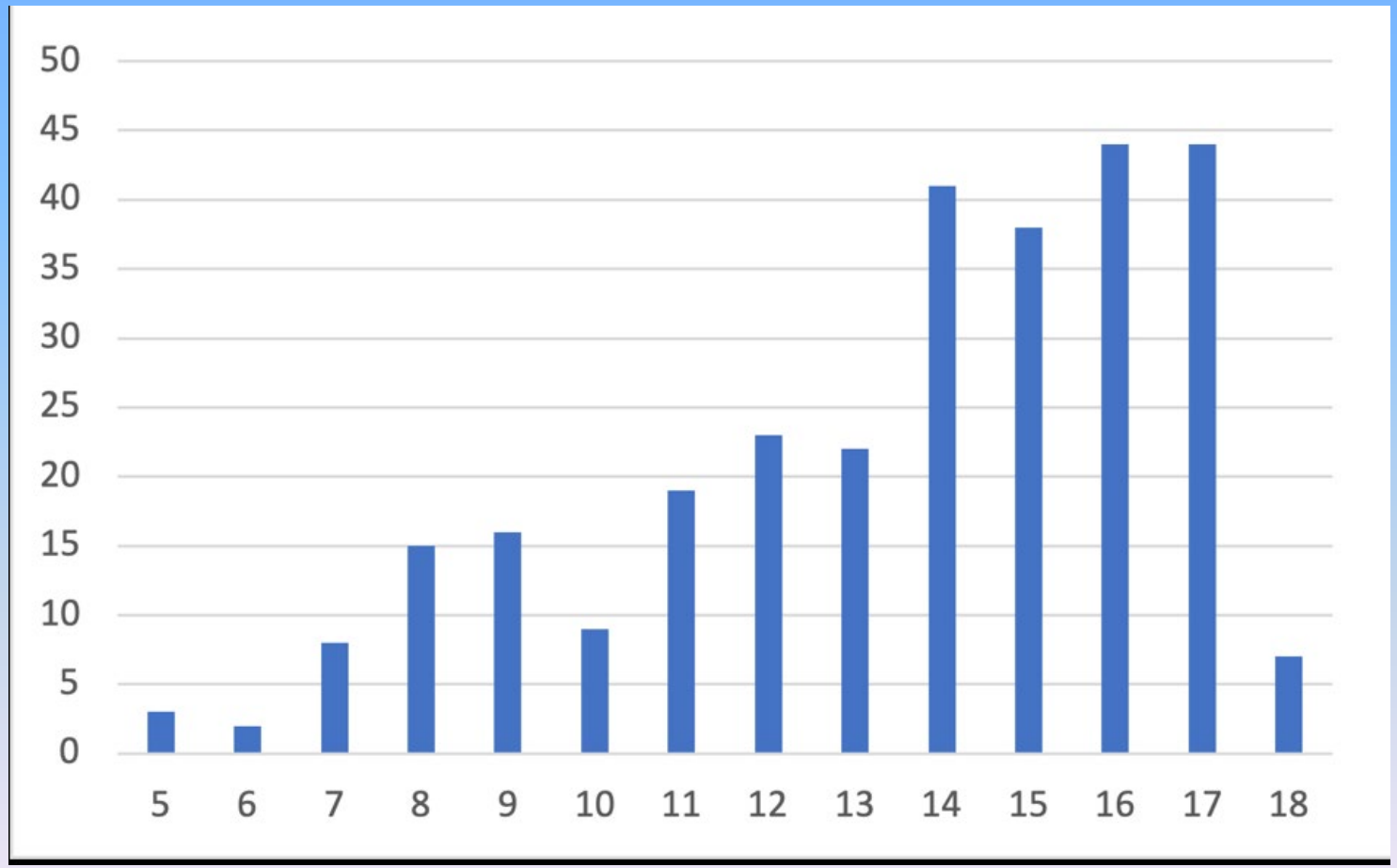
Sedatives by Age at Start



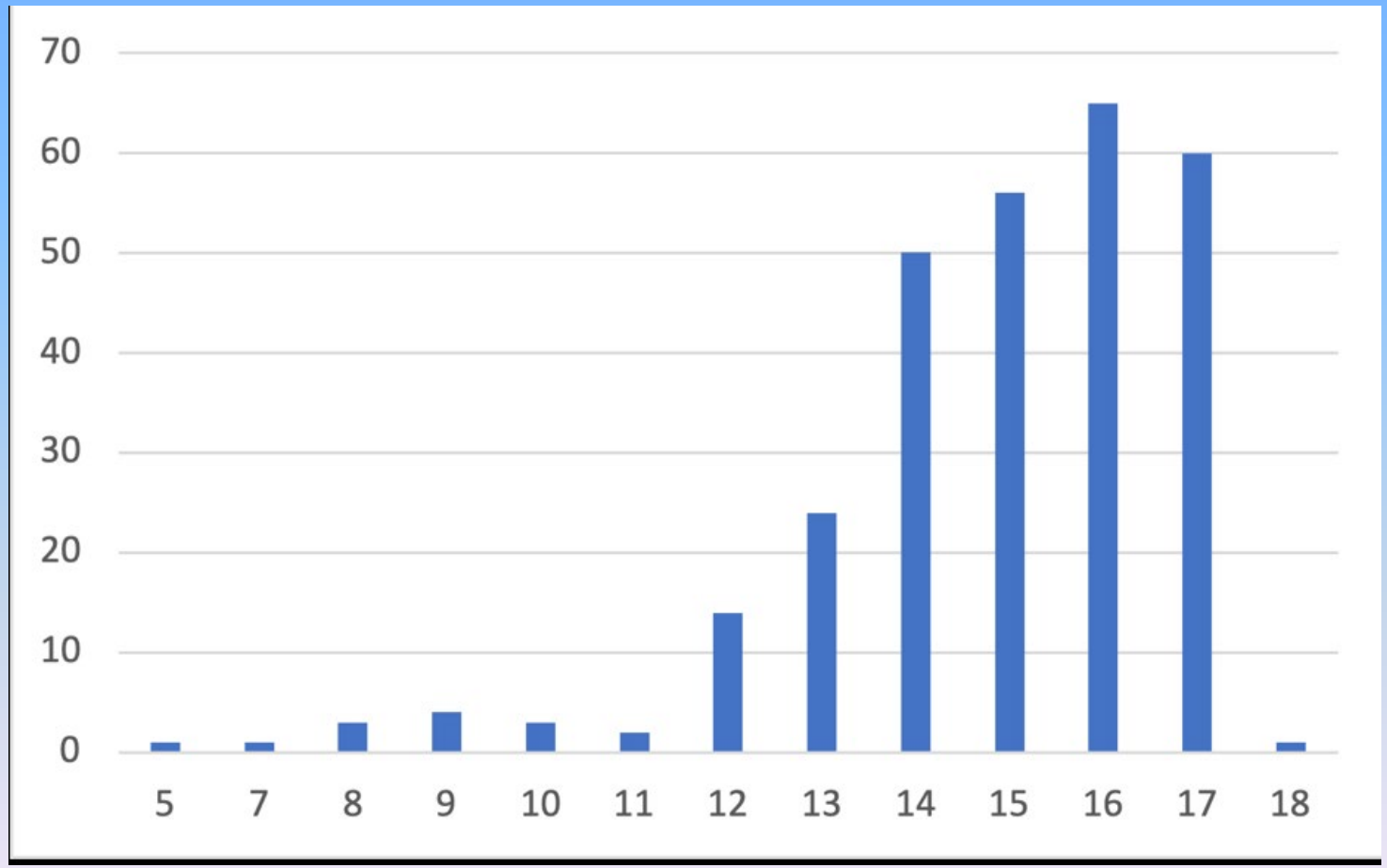
Hypnotics by Age at Start



Neuroleptics (antipsychotics) by Age at Start



Antidepressants by Age at Start



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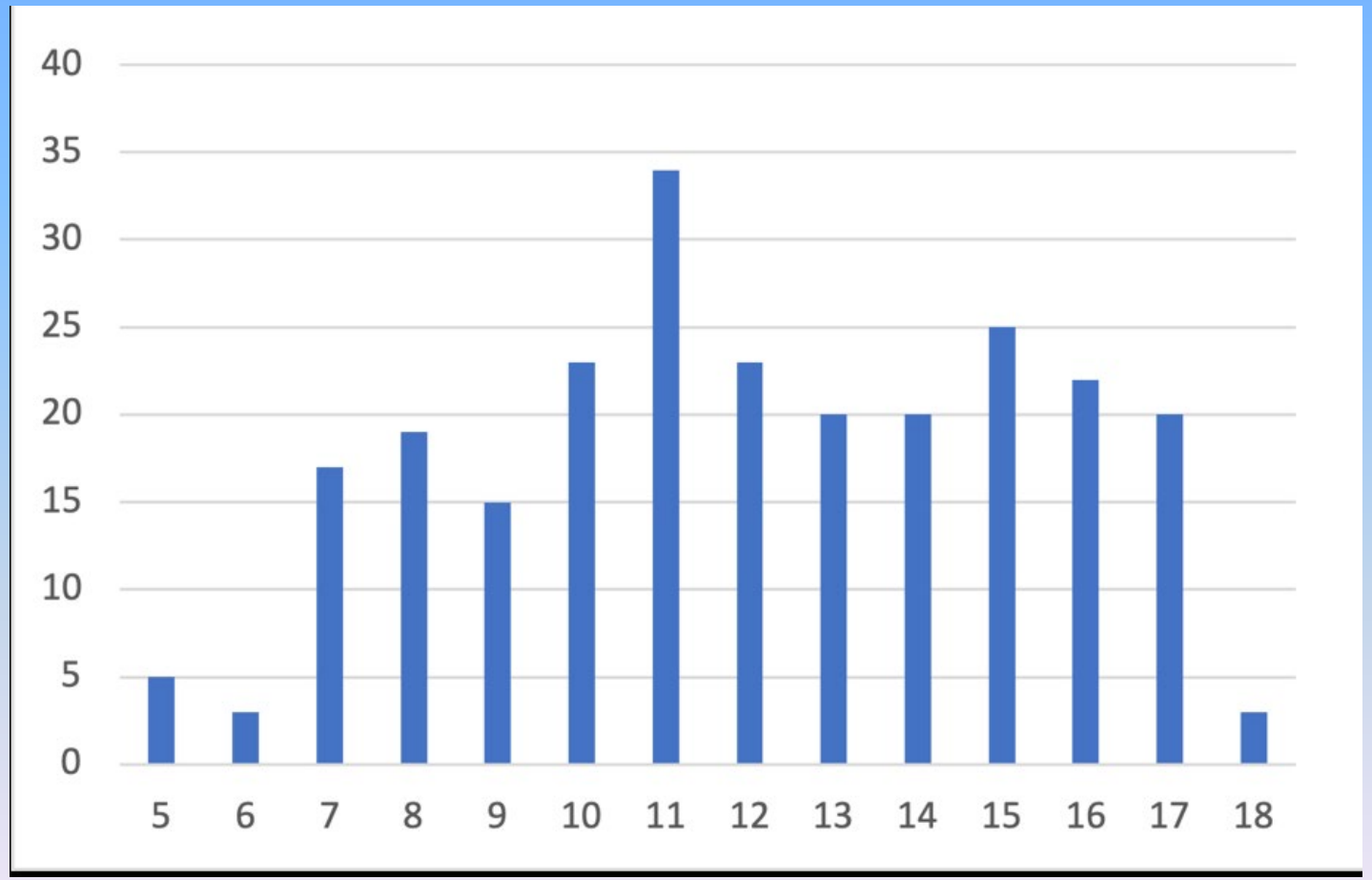
Stimulants by Age at Start



POLYPHARMACY

- The use of multiple medication types together was not warranted from the diagnosis or case formulation in around 40% of the children treated in the clinic by Team A.
- Polypharmacy greatly increases the risk of unexpected interactions and adverse effects and is a practice that should be avoided whenever possible. **The prescribing pattern seen here, one of frequent switching between different medications of the same type and switching between and also adding different types of medication simultaneously, occurs when the prescriber is anxious to contain a situation they perceive as unsafe.** Unsurprisingly when several things are being altered at the same time, it is not possible to know which changes (for better or worse) are caused by which medication. In the hope of getting the situation under control, more medications are added, but because the behaviour of the patient is considered unsafe or dangerous, the clinician does not feel safe in reducing any of the medications that are in place.
- Despite these finding the report defensively states: “While it is important not to draw too precise a conclusion from a small sample (in Team A’s population) it is clear the proportion of ADHD medication used in Team A is far lower than that in Scandinavian countries or Catalonia. In contrast, use of antipsychotic medication falls between that in the two regions and it is around one quarter of the neuroleptic use”.
- The whistle-blower "resigned from the HSE because he received no support, and was side-lined after raising concerns.“ He has said the issues identified in South Kerry are not confined to that area and that there were serious problems in several other units in which he worked as a locum.

Iatrogenic Harm – Caused by Ideas

- Biological imperialism
- Imposition of unscientific and unevidenced ideas
- Privileging of biological explanations over other legitimate frameworks
- Important to note that biological explanations actually **decrease empathy** & **significantly** reduce clinicians' empathy.
- Focuses on deficit and chronicity.
- Overly concerned with what is wrong with the individuals brains, cognitions & neurobiology
- Vulnerability – Stress Hypothesis –
- F*irmly maintains the primacy of biology…by making it look as if the 'stress' of the model consists of ordinary stresses which most of us would cope with, but which overwhelm only 'vulnerable' people. We are thus excused from examining too closely either the events themselves or their meaning to the "vulnerable" person.' (*Boyle M. 2002)

Iatrogenic Stigma of "mental illness" (Norman Sartorius)

"Psychiatrists and other mental health staff also stigmatise patients in other ways. Until recently psychiatrists in some European countries and elsewhere were requesting longer holidays and a higher salary than other doctors because they had to work with mentally ill patients who are dangerous, while arguing, at the same time, that mental illness is no different from other illnesses".

(Norman Sartorius. BMJ v.324(7352); 2002 Jun 22).

Iatrogenic Harm – Caused by Ideas

- Minimising or ignoring deleterious environments and/or collusion with perpetrators
- Reactions to abuse are often reframed as symptoms of mental illness, especially borderline personality disorder.
- The harmful effects of psychiatry are especially concerning given the increasing evidence of links between childhood abuse and mental health problems (Varese et al. 2012), (see Spandler & Mckeown. 2017).
- Additionally, there is evidence that patients have been sexually and physically abused within services, especially in-patient settings (Henderson & Reveley 1996); with patients reporting abuse disbelieved, pathologized and silenced (Jennings 2016, Masson 1988). (see Spandler & Mckeown. 2017).
- Even when disclosure occurs, and is believed, proportionately low numbers of service users receive appropriately formulated or compassionate care (Read et al 2016; Sweeney et al. 2016). (see Spandler & Mckeown. 2017).
- Mind–body separation – outdated ideas and practices
- Reputational damage, stigma and discrimination – lifelong, social and legal implication's

Epistemic Injustice

- Epistemic injustice is the idea that **we can be unfairly discriminated against in our capacity as a knower based on prejudices about the speaker**, such as gender, social background, ethnicity, race, sexuality, tone of voice, accent, and so on.
- **Testimonial injustice** is unfairness related to trusting someone's word. An injustice of this kind can occur when someone is ignored, or not believed, because of their sex, sexuality, gender presentation, race, disability, or, broadly, because of their identity.
- **Hermeneutical injustice** occurs when someone's experiences are not well understood — by themselves or by others — because these experiences do not fit any concepts known to them (or known to others), due to the historic exclusion of some groups of people from activities, such as scholarship and journalism, that shape the language people use to make sense of their experiences.(Fricker, 2007).
- Arguably, systematic refusal to attend to users and survivors experiential knowledge - ‘’ - might be a specific form of psychiatric harm and epistemic injustice (Crichton et al 2016: Liegghio 2013). (see Spandler & Mckeown, 2017).

Iatrogenic Harm – Caused by Practice

- The language of diagnosis and disorder – impacts the way that we think about people - & leads to oppressive & coercive practice
- Ideas and practises that are not conducive to healing & recovery.
- Dangers of traumatisation, retraumatisation & iatrogenic harm – via drugs, seclusion, coercion, compulsion, denial, stigmatising labelling…
- Mental health services can be traumatising and re-traumatising, even being referred to as 'trauma-organised systems' (Bloom & Farragher, 2010; Sweeney et al 2016). (see Spandler & Mckeown. 2017).
- Over-reliance on medication which has a disputed evidence base and can cause serious, long-term detriments (Whitaker 2002; Moncrieff 2013).

Iatrogenic Harm – Caused by Practice

- There are a litany of harms experienced by users of psychiatric services.
- Examples include: “lobotomies, incarceration, seclusion, and restraint, harmful drugging and electroshock, and stigmatising diagnoses meted out to people of particular ‘race’, gender and sexuality” (Wallcaft & Shulkes: 2012: 12).
- Such practices continue within contemporary psychiatric services in one form or another. If anything, the relative dominance of a singular bio-psychiatry has been consolidated, despite rhetorical commitments to biopsychosocial approaches (Read 2005).
- Widespread practices including physical restraint, seclusion and forced medication are most obviously implicated (Freuh et al., 2005), but more subtle coercions occur which inflict or revisit experiences of powerlessness, such as restrictions on liberties or discursive pressure to comply with treatment (Bloom & Farragher, 2010).
- (see Spandler & Mckeown. 2017).

Iatrogenic Psychological Harm (Rees.)

"Inattention to iatrogenic psychological harm is a striking anomaly of a climate determined by considerations of safety in a risk-averse world. It can, however, be of greater and more sustained importance and less reversible than physical harm…"

"Prevention of psychological harm should be as great a priority as that of physical harm…"

- Parallels between parental emotional abuse and psychological iatrogenic harm

(Rees, 2011).

Iatrogenic harm from psychological therapies – time to move on

(Glenys D. Parry, Mike J. Crawford and Conor Duggan).

- As a range of evidence-based psychological therapies have become routine in mainstream health services, interest has grown in the potential for these treatments to cause harm; in the same way that effective medical treatments carry risks and toxicity, it is becoming clear that psychological treatments cannot be at once psychoactive and harmless.
- Part of the difficulty in accumulating knowledge is the plethora of different terms used in research reports, with confusion between them and no systematic way to describe adverse effects of treatment.
- In a recent scoping review as part of a research programme on this topic, we needed over 14 search terms to address the issue, including negative effects, adverse effects, adverse events, harm, symptom exacerbation, treatment failure, clinical deterioration, negative outcome, harmful effects, patient safety, negative therapeutic reaction, negative results.
- Failure to agree the most appropriate terms and definitions to describe harm associated with psychological treatments may help explain the striking disparity between the large amount of testimony on the internet from patients describing their experience of harm from therapy, compared with little or no reference to the risk of harm in the major textbooks in the field.
- It is difficult to report the proportion of therapy patients who experience negative results from therapy as there are few systematic studies of prevalence.
- The estimate of 5% is typical. This is consistent with results from a survey of psychological therapy service users in England, where 1 in 20 respondents reported that they had experienced lasting bad effects from therapy.

(Glenys D. Parry, Mike J. Crawford and Conor Duggan, The British Journal of Psychiatry, March 2016).

Iatrogenic harm from psychological therapies – time to move on

- **Three ways to move the field forward:**
- First, greater standardisation of terms is required. As a starting point, they suggest the following definitions for a range of adverse effects of therapy.

1. (a)Adverse events refer to significant episodes during or shortly after treatment (e.g. suicide, suicide attempts, mental health-related hospital admissions), which if related to or directly caused by treatment amount to harm or severe harm.
2. (b)Clinically significant deterioration refers to a worsened mental state after therapy is complete, which can include the emergence of new symptoms. In this context, harm refers to sustained, statistically reliable deterioration having been caused by therapy but consensus on what is a statistically reliable and clinically significant degree of deterioration has not yet emerged.
3. (c)Finally, but crucially, the patient may have a very negative experience of therapy, with lasting bad effects, despite this not being picked up either in adverse event monitoring or observed clinical deterioration. This could be described as patient-experienced harm. Those close to the patient can also experience harm from the treatment.

(Glenys D. Parry, Mike J. Crawford and Conor Duggan, The British Journal of Psychiatry, March 2016).

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Iatrogenic Harm and Medication

- Psychiatric iatrogenesis typically manifests as complications of psychotropic drug treatment such as:
- tardive dyskinesia,
- insulin resistance,
- cardiac/metabolic disturbances,
- and result from direct toxicity, intoxication, withdrawal, or drug interaction.

Iatrogenic Harm and Medication

- The authors, Giovanni Fava, a psychiatrist and professor at the University at Buffalo, and Chiara Rafanelli, a psychiatrist and professor at the University of Bologna, write:

- “Current classification systems in psychiatry fail to consider the iatrogenic components of psychopathology related to behavioural toxicity…Such neglect is serious since manifestations of toxicity are unlikely to respond to standard psychiatric treatments and may be responsible for the wide spectrum of disturbances subsumed under the generic rubric of treatment resistance.”
- “[T]he ill-defined concept of treatment resistance is based on the untested assumption that treatment was right in the first place and failure to respond is entirely shifted (and implicitly blamed) upon patient characteristics,”.
- “Withdrawal symptoms can easily be misinterpreted as signs of relapse”.

Fava, G. A., & Rafanelli, C., (2019). Iatrogenic Factors in Psychopathology. Psychotherapy and Psychosomatics, 14, 1-12. doi: 10.1159/000500151

What can be done?

- Raise awareness
- Campaign for and create alternatives
- The following are some thoughts…

[Withdrawal from Psychiatric Drugs Tickets, Fri 6 May 2022 at 15:00 | Eventbrite]

The “100 patient stories” Qualitative Study

- Retrospective qualitative study based on 100 semi-structured, in depth interviews with patients and family members.
- To investigate patients’ and family members’ perceptions and experiences of disclosure of healthcare incidents and to derive principles of effective disclosure.
- 39 patients and 80 family members who were involved in high severity healthcare incidents (leading to death, permanent disability, or long term harm) and incident disclosure.
- Disclosure of error is a patient right
- The apology or expression of regret should include – “I'm sorry/we are sorry” (not linguistic gymnastics – “Sorry that you felt that your care was insufficient”...)
- Include a factual explanation of what happened
- Discuss the consequences of the adverse event/s
- Describe what is being done to manage the adverse event and prevent reoccurrence
- The victim/survivor of harm is given an opportunity to relate their own experiences of harm, in detail.

(**Patients’ and family members’ views on how clinicians enact and how they should enact incident disclosure: the “100 patient stories” qualitative study.** *Rick Iedema, Suellen Allen, Kate Britton et al. 2011. BMJ* 2011;343:d4423).

Exploring the case for truth and reconciliation in mental health services

(Spandler & Mckeown)

“The authors describe an innovative Truth & Reconciliation process as an important transitional step towards accomplishing reparation and justice by acknowledging the breadth and depth of service user and survivor grievances. This may be a precondition for effective alliances between workers and service users/survivors. As a result, new forms of dialogic communication and horizontal democracy might emerge that could sustain future alliances and prefigure the social relations necessary for more humane mental health services”.

(Helen Spandler, Mick Mckeown in Mental Health Review Journal. 12 June 2017).

Can psychiatry apologise for crimes against humanity?

(Wallcraft & Shulkes)

"The first step is to identify the wrongs through gathering the testimonials of service users, survivors and their friends, families and allies. Justice must include the reform of all laws and practices so that they can recognise our full human rights on an equal level with others. This means especially ending forced treatment, ensuring support is always informed choice and involvement, and ultimately compensation, in forms to be negotiated with users/survivors at national and international level."

Can psychiatry apologise for crimes against humanity? Jan Wallcraft and Debra Shulkes. Published in Open Mind, 2012.

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