Unbalanced appraisal of psychosocial versus antipsychotic literature

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We would like to highlight several limitations of Jauhar and Lawrie's appraisal of evidence for antipsychotics and psychosocial interventions for people with psychosis.[1]

First, there is more evidence for antipsychotics of ostensibly higher quality because drug studies are typically paid for by manufacturers, whilst fewer resources are allocated to studies of non-pharmacological interventions.

Second, antipsychotics may reduce acute symptoms more than a placebo or than some other sedatives, but they likely do so by inducing a particular type of mental suppression which is unpleasant and may cause social impairment in the long-term.[2]

Third, Jauhar and Lawrie's presentation of the evidence for relapse-reduction properties of antipsychotics, based on discontinuation studies, neglects to recognise the adverse effects of medication withdrawal that will inevitably depress outcomes in placebo groups, especially since discontinuation is usually abrupt.[3] Antipsychotic withdrawal effects, including anxiety, agitation, and insomnia, may be mistakenly classified as relapse, especially since definitions of relapse are mostly broad and inclusive.[3] Moreover, there is evidence that medication withdrawal may, in itself, give rise to psychotic symptoms and precipitate relapse of the underlying condition.[3]

Fourth, regarding a recent CBT trial in adolescents with first episode psychosis, the authors neglect to mention that antipsychotic treatment alone reduced PANSS scores by half as much as psychological intervention (6.2 vs 13.1 points) at 6 months.[4] Even if the study was not adequately powered, it is important as it represents one of only two modern RCTs that

compare antipsychotics directly to not giving antipsychotics in the context of psychosocial intervention . The other trial found no difference at 6, 12 or 24 months in symptoms or social functioning between patients with first-episode psychosis receiving case management and antipsychotics or placebo.[5] Further, while the authors highlight allegiance bias, expectancy and nocebo effects with respect to non-pharmacological treatments, these biases are also relevant, perhaps moreso, to antipsychotic trials.

Taken together, the evidence for antipsychotics is less strong than presented and early evidence for equal or greater effectiveness of non-pharmacological treatments (with fewer adverse effects) suggests a promising direction for future research and an option that should be more readily provided in clinical practice.

Conflict of interests

KM and MAH declare no conflicts of interest. JM is Chief investigator of an NIHR-funded trial of gradual antipsychotic reduction (RADAR), and receives royalties for books about psychiatric drugs.

Authors' contributions

MAH wrote the initial draft of the letter. JM and KM substantially revised and edited the letter.

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Ethics committee approval

No ethics approval was needed for this letter as patients were not directly involved.

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