

# Recovery is a core goal of psychiatrists

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We write in response to Wand's paper 'Recovery is about a focus on resilience and wellness, not a fixation with risk and illness' (Wand, 2015). The author had an opportunity to provide a balanced and positive contribution to this important topic. Instead, he adopts a rather simplistic approach to social determinants of recovery and iatrogenic mediators of mental health problems, despite overturning the role of genetics and biology in mental health and wellbeing. We note that Wand's paper has already generated debate in the Journal, and wish to take this forward by arguing, *inter alia*, that recovery has been and remains at the very heart of the true practice of psychiatry. We also wish to challenge a number of Wand's premises and correct some of his interpretations of the literature.

Wand (2015) raises the important issue of the adverse impacts of restrictive interventions in psychiatry, but does not acknowledge the fact that mental health clinicians hardly enjoy or wish to use such interventions and that there have been a plethora of governmental and health service initiatives to reduce such use without compromising the immediate safety of all concerned.

Wand (2015) maligns mental health services for their concerns regarding risk assessment. Puzzlingly, he ignores the overrepresentation of suicide in people experiencing mental illness and the necessity for healthcare service and population health approaches to assess such risk. This is beyond a purported counter-therapeutic 'fixation'

with risk within mental health services and an espousal regarding 'therapeutic risk taking and dignity of risk'. This fails to take into account the reasonable expectations of consumers, their families and their advocates, that consumers in mental health services receive safe and effective care.

Wand (2015) provides a selective (and highly biased) overview of the evidence base for biological treatments in psychiatry. Regarding antidepressants, for example, there is no reference to recent evidence about the clinical superiority of selective serotonin reuptake inhibitors (SSRIs) over placebo in most of the 32 studies encompassing approximately 7000 individuals with major depressive disorder, when depressed mood rather than the global Hamilton Depression Rating Scale was utilized (Hieronymus *et al.*, 2016). There is also no consideration of the massive alleviation of suffering that can accrue with judicious use of antidepressants. There is simply a spurious statement that clinicians need to 'reflect on the number of individuals they see on antidepressants who remain depressed'. Well, yes, some patients on antidepressants remain depressed, just as some people with epilepsy continue to have seizures despite anticonvulsants, and some people undertaking psychological treatments for depression remain very unwell indeed. This does not eschew the utility of these approaches for many individuals.

Wand (2015) dismisses the utility of electroconvulsive therapy (ECT), ignoring, *inter alia*, a systematic review of six studies that shows improved

relapse prevention and a reduction in recurrence in major depressive disorder (Brown *et al.*, 2014), and recent randomized controlled trial (RCT) evidence of the utility of ECT in augmenting clozapine response in people with treatment refractory schizophrenia (Petrides *et al.*, 2015). Any experienced clinician will testify to the life-saving benefits of ECT in patients with psychotic depression who are not eating or drinking and would otherwise die.

Wand (2015) details the potential side effects associated with antipsychotic treatments without a balanced appraisal of their undoubted benefits in terms of reducing psychotic symptoms and the robust population health benefits for relapse prevention in schizophrenia (Leucht *et al.*, 2012). Neither does he acknowledge the concerted efforts of mental health services to try to deal as effectively as

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possible with medication side effects, notably the metabolic syndrome. As it happens, strong epidemiological evidence shows that mortality in schizophrenia is highest in patients who are not taking antipsychotic medication, while greatest reduction in mortality is noted in patients taking clozapine long-term, despite its metabolic problems. Wand (2015) also makes a bold assertion that antipsychotics result in 'irreversible changes in brain structure and function', quoting a paper of his own and not discussing any of the methodological problems associated with studies in this domain.

In regard to classification, Wand (2015) glosses over any useful discussion about the utility of psychiatric diagnoses and fails to enunciate that the National Institute of Mental Health (NIMH) in the United States has endeavoured to address the atheoretical approach of syndromal classification systems such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) by setting out a Research Domain Criteria (RDoC) framework to unite symptoms (positive valence, negative valence, cognitive systems, systems for social processes, arousal regulatory system) with a matrix of the underlying neurobiology such as genetics and neurocircuitry.

Although we concur that recovery is about a focus on resilience and wellness, it is also about instilling hope via raising awareness of existing and emerging evidence-based biopsychosocial treatment options within collaborative therapeutic relationships. Beyond the inherent individualized approach to 'recovery', there are continuing research endeavours to refine extant understandings of mental 'illness' and to reduce the use of restrictive interventions while concurrently considering risk at the level of the individual, healthcare service and broader community. The latter is incompatible with a purported paternalistic, dogmatic 'fixation' on risk and skewed depictions of hegemonic, ossified treatment approaches.

Wand's (2015) contribution, to our minds, lacks any nuanced appraisal of the contribution psychiatrists play in the holistic care of the mentally ill and as such is divisive. Recovery is a core goal of psychiatrists and is most likely to be achieved by use of biopsychosocial treatments delivered in a manner that supports the recovery principles and is supported by scientific evidence, rather than antipsychiatry doctrine.

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