

The art of psychopharmacology: Avoiding medication changes and slowing down

Willa Xiong, MD



Dr. Xiong is a PGY-4 Psychiatry Resident, Department of Psychiatry, Washington University, St. Louis, Missouri.

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As physicians, we are cognizant of the importance of patient-centered care, active listening, empathy, and patience—the so-called “hidden curriculum of medicine.”¹ However, our attempts to centralize these concepts may be overshadowed by the deeply rooted drive to treat and fix. At times, we are simply treating uncertainty, whether it be diagnostic uncertainty or the uncertainty arising from clinical responses and outcomes that are far from binary. Definitive actions, such as adding medications or altering dosages, may appear to both patients and physicians to be a step closer to a “cure.” However, watchful waiting, re-evaluation, and accepting uncertainty are the true skills of effective care.

Be savvy about psychopharmacology

Psychotropics can take weeks to months to reach their full potential, and have varying responses and adverse effects. Beware of changing regimens prematurely, and keep in mind basic, yet crucial, pharmacokinetic concepts (eg, 4 to 5 half-lives to reach steady state, variations in metabolism). Receptor binding and dosing heuristics are notably common in psychiatry. Although such concepts are important to grasp, there is no one-size-fits-all rule. The brain simply does not possess the heart's machine-like, linear functioning. Therefore, targeting individual parts (ie, receptors) will not equate to fixing the whole organ systematically or predictably.

Is the patient truly treatment-resistant?

Even the best treatment regimen has no clinical benefit if the patient cannot afford the prescription or does not take the medication. If cost is an impediment, switch from brand name drugs to generic formulations or to older medications in the same class. Before declaring the patient “treatment-resistant” and making medication changes, assess for compliance. This may require assistance from collateral informants. Ask family members to count the number of pills remaining in the bottle, and call the pharmacy to find out the last refill dates. If the patient exhibits a partial response to what should be a therapeutic dose, consider obtaining drug plasma levels to rule out rapid metabolism before deeming the medication trial a failure.²

Medications as liabilities

Overreliance on medications can result in the medications becoming liabilities. The polypharmacy problem is not unique to psychiatry.³ However, psychiatric patients may be more likely to inadvertently use medications in a maladaptive manner and disrupt the fundamental goals of long-term care. Avoid making medication adjustments



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in response to a patient's life stressors and normative situational reactions. Doing so is a disservice to patients, because we are robbing them of chances to develop necessary coping skills and defenses. This can be overtly damaging in certain patient populations, such as those with borderline personality disorder, who may use medication adjustments as a crutch during crises.⁴

Treat the patient, not yourself

We physicians mean well in prescribing evidence-based treatments; however, if the symptoms or adverse effects are not bothersome or cause functional impairment, we risk losing sight of the patient's goals in treatment and imposing our own instead. Displacing the treatment focus can alienate the patient, harm the therapeutic alliance, and result in "pill fatigue." For example, we may be tempted to treat antipsychotic-induced tardive dyskinesia, even if the patient is not concerned about abnormal movements. Although we see this adverse effect as a secondary problem that necessitates treatment, from the patient's perspective, taking additional medication may be a far greater burden. The patient's perception of direct beneficial effects from medications is crucial not only for patient-oriented care but also for adherence.⁵

Change does not happen overnight

Picking a treatment option out of a lineup of choices, à la UWorld questions, does not always translate into patients agreeing with the suggested treatment, let alone the idea of receiving treatment at all. Motivational interviewing is our chance to shine in such situations and the reason why we are physicians, rather than answer-picking bots. Patients cannot change if they are not ready. However, we should be ready to roll with resistance while looking for signs of readiness to change. We must accept that it may take a week, a month, a year, or even longer for patients to align with our plan of action. The only futile decision is deeming our efforts as futile while discounting the benefits of incremental care.

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Clinical Point

The patient's perception of direct beneficial effects from medications is crucial not only for patient-oriented care but also adherence