Psychopharmacology

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KEYWORDS

• Psychopharmacology • Antidepressant • Mood stabilizer • Antipsychotic
• Primary care • Depression • Anxiety • Bipolar

KEY POINTS

- Primary care providers (PCPs) are prescribing more psychotropic medications.
- Medication side effects are a major barrier to adherence and successful treatment. When PCPs understand both class and individual drug effects, they can better tailor medication recommendations for individual patients.
- Psychotropic medications have significant medication interactions with commonly prescribed medications, such as antibiotics, antihypertensives, and other psychotropic medications.

INTRODUCTION

The use of medications to treat psychiatric conditions is a mainstay of treatment in primary care practices. This article reviews the major classes of antidepressants, anxiolytics, mood stabilizers, and antipsychotic agents and focuses mainly on issues pertinent to the adult ambulatory population.

GENERAL APPROACH TO TREATMENT

- Pharmacotherapy (with or without psychotherapy) is effective for a range of psychiatric conditions and, in general, confers a moderate treatment effect size.
- Nonpsychiatrists are increasingly responsible for the initiation and management of pharmacotherapy in the ambulatory setting.
- Primary care providers (PCPs) must familiarize themselves with the indications, risks, and benefits of medications used to treat common mental health conditions.

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Psychiatric conditions that cause functional impairment or reduction in quality of life can be approached by several modalities. Nonpharmacologic treatment is conventionally used as monotherapy for less severe manifestations of psychiatric disease and is combined with pharmacotherapy to treat more severe disease. Nonpharmacologic therapy includes behavioral interventions; self-care, such as exercise and dietary interventions; and, importantly, psychotherapy in its many forms. Pharmacotherapy is typically reserved for moderate to severe manifestations of psychiatric disease.[1] In practice, many clinicians use pharmacotherapy monotherapy because access to psychotherapy and other supported nonpharmacologic approaches may not be readily available.

The efficacy of psychotherapy and pharmacotherapy for various psychiatric conditions has been questioned and continues to be a source of controversy. A 2014 large and well-done meta-analysis found that for most psychiatric conditions, pharmacotherapy and psychotherapy had a moderate beneficial effect size (0.5 confidence interval, 0.41–0.59) in comparison with placebo.[2] The study's analysis of head-to-head trials showed psychotherapy and pharmacotherapy were similar in efficacy across conditions, though pharmacotherapy was a superior treatment of dysthymia and schizophrenia, and psychotherapy was superior for the treatment of bulimia and major depression relapse. The meta-analysis supported the use of combination therapy, showing an improved efficacy of treatment with a combination of psychotherapy and pharmacotherapy (vs either alone) for most psychiatric conditions with the exceptions of schizophrenia and posttraumatic stress disorder (PTSD).

Increasingly, PCPs are responsible for initiation and titration of pharmacotherapy. A 2014 study that looked at trends in US mental health care between 1995 and 2010 found that nonpsychiatrist providers diagnosed mental health disorders and prescribed psychotropic medications more commonly than psychiatrists for children (72% nonpsychiatrist), adolescents (52%), and adults (64%).[3] The study, based on the National Ambulatory Medical Care Survey, found the prevalence of mental health–related visits was higher for adults than children, and the number of visits for psychotropic medication management increased equally for those older and younger than 21 years. However, the study found a near doubling of the diagnosis of mental health disorders and referrals to psychiatrists in people younger than 21 years, whereas those older than 21 years had minimal increases. Largely, the increased diagnosis and pharmacologic management of attention-deficit/hyperactivity disorder and other behavioral disorders in children and adolescents drove the trend. Similar trends have been seen in Canadian and European populations (**Box 1**).

Before initiating pharmacotherapy, providers should make a concerted effort to determine the accurate psychiatric diagnosis and exclude common mimics of psychiatric disease that may present with similar symptoms. Failure to identify bipolar depression as the cause of depressive symptoms can lead to inadvertent triggering of a manic event with the initiation of an antidepressant instead of a mood stabilizer.[4,5] Failure to recognize Lewy body dementia as the cause of visual hallucinations can lead to empirical treatment with a neuroleptic agent, resulting in confusion, worsening movement disorder, autonomic dysfunction, and an increased risk for mortality.[6]

Disease-Specific Considerations

Antidepressants

PCPs who manage mood disorders should have a working understanding of 2 to 3 antidepressants per class. Side effects are the number one reason for discontinuation of anxiety and depression medications.[1] Hence, providers must be aware of common