Psychiatric Medication Demystified

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i would like to tell you a story. This was related to me by a surgeon who was treating a man for cancer. The patient became depressed, and was referred to a psychiatrist, who began psychotherapy with the patient. At some point during the treatment, the psychiatrist felt that antidepressant medication was indicated, and began prescribing it. The patient appeared to have a good response to the medication, and the psychiatrist continued to prescribe it. This went on for a couple of years, until the cancer recurred, and the man eventually died. His wife, going through his personal effects after his death, came across a folder containing every one of the prescriptions, neatly filed away in chronological order. The patient had never filled any of them, and had not been taking the medication, clearly without the knowledge of the psychiatrist!

I would like to go back to this story in a little while, but first...

today's agenda

- Psychotropic medications
  - classes
  - why to use; why to avoid
- Psychology of medications
- Use of medications: modifying sleep

this is on the agenda for today: I'd first like to talk about the handout that you received, titled "psychotropic medications in the elderly". Then I want to go back to the story and to talk about the psychology of medication prescribing and taking in the mental health setting. Finally, if we have time, we can go into some practical details about how I prescribe medication and why.

Psychotropic medications

- In general, we divide into several classes, usually on the basis of the symptom treated:
  - antipsychotics
  - antidepressants
  - anxiolytic agents
  - mood stabilisers

what is psychosis?

The handout

- It's not so simple any more:
  - antidepressants are also used to treat anxiety disorders
  - antipsychotics very effective against anxiety also
  - newer antipsychotics treat bipolar depression and stabilise mood
  - barbiturates and related meds obsolete

Why the handout? I was asked by the Mental Health 60+ team to produce a brief guide to the medications that are commonly prescribed to their clients.

Antipsychotic medications

- high potency vs low potency
- formats: po liquid, im or iv, depot
- typical vs atypical
  - atypical: clozapine, olanzapine, quetiapine, risperidone
  - risk of weight gain and diabetes
  - switch patients on typicals

low potency: compare chlorpromazine to haloperidol: the latter is 50 x more potent.
For every molecule of hal, it takes 50 molecules of cpz to get same clinical effect.
But only 1 of the 50 molecules actually needs to sit on the target receptor, so what are the other 49 molecules doing? Sitting on other receptors and causing side effects, such as drowsiness, dry mouth, blurred vision, constipation, lowered blood pressure, increased risk of seizures, etc. At McGill, low potency drugs are called “dirty drugs” because they do so many things besides what they are supposed to do.
Atypical antipsychotics have a lot less risk of extrapyramidal side effects, such as acute dystonic reactions, akathisia, parkinsonian symptoms, and tardive dyskinesia.
They do tend to cause rapid weight gain, even to the point of causing acute onset of type II diabetes. I think this is most likely in those with family histories of diabetes, and who put on weight around the middle. The answer is to decrease carbohydrates in the diet.

Anticholinergic medications

- Used to prevent or treat extrapyramidal side effects of antipsychotics
- less need with atypical antipsychotics
- most effective against acute dystonic reactions, which are more common in younger and in male patients
- can be dangerous: delirium, urinary retention, bowel obstruction

Cholinesterase inhibitors

- may improve behaviour symptoms in dementia
- may slow down deterioration
- may reduce the risk of mild cognitive impairment turning into dementia
- controversy remains over whether they are worthwhile

Benzodiazepines

- "mother's little helper" from the Rolling Stones song
- create dependence, lose effectiveness in treating insomnia, increase risk of falls and accidents, disinhibit behaviour, impair cognition, may cause delirium
- most prescribed by GPs and surgeons

Mood stabilisers

- lithium is the oldest and probably still the best
- the others are anti-epileptic drugs
- blood tests are necessary to obtain effective dosages, avoid toxicity

Antidepressants

- Among the "hottest" products being marketed by pharmaceuticals today
- large profit margins; big marketing budgets
- ever-expanding range of indications
- drug companies are "driving" the diagnostic process

Questions?

Psychotherapy and medications

I know that many of you here today see patients in psychotherapy. Could I see a show of hands, those who are doing psychotherapy with clients?

OK, those of you with your hands up, please keep your hand up only if none of your clients take psychotropic medication.

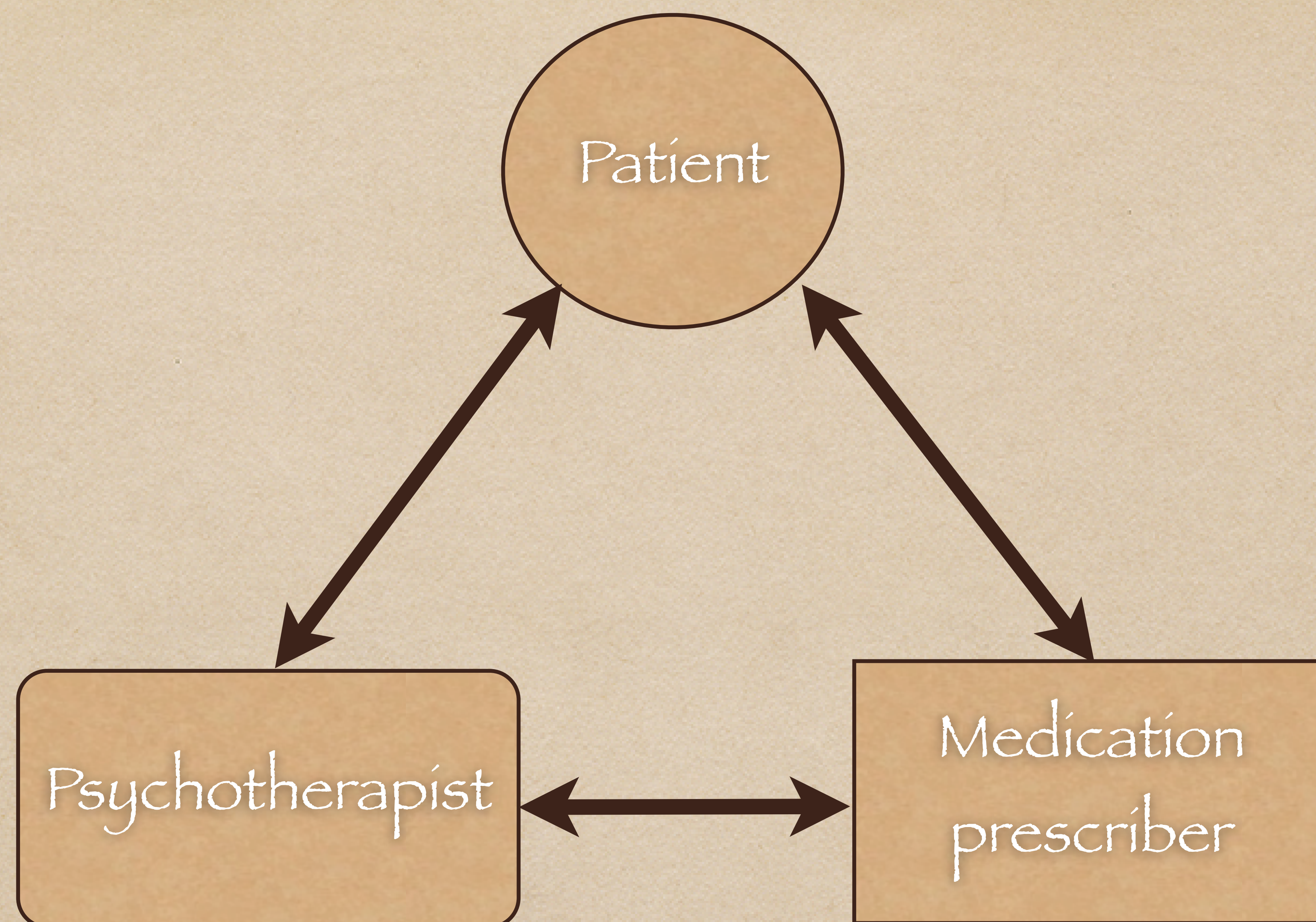
Now, put your hand down if your clients are refusing to take medication.

It seems clear that there are many clients who are on medication, or who might do better if they were taking medication.

A few years ago, I took part in a panel discussion in front of a group of psychoanalysts, on the relationship between drugs and psychotherapy.

- Study at Columbia University Center for Psychoanalytic Training and Research:
    - 27 psychoanalytic candidates, 56 training cases
    - 29% were on psychotropic medication
    - the training analysts themselves had 18% of their patients on medication

This slide shows the results of a study on the use of psychotropic medication by psychoanalytic patients. So, even in the cathedrals of the psychoanalytic religion, many patients still get medication for their condition. I don't want to get into a debate about the relative merits of medication or psychotherapy, but I do want to point out that medication, psychotherapy, or any other treatment can have four kinds of effects, direct therapeutic effects; placebo therapeutic effects; direct side effects, and placebo side effects.
And in the same way that psychotherapy influences not only the patient, but also the therapist through the mechanisms of transference and countertransference, projection, projective identification, and so on, so also does prescribing medication influence the prescriber. When the medication prescriber and the psychotherapist are different persons, then the possible effects multiply.



Each arrow in this diagram represents four different influences acting in each of two directions: direct effects, direct side effects, placebo effects, and placebo side effects. That's a lot of different things going on! Of course, if the psychotherapist is also the person prescribing the medication, it simplifies things, but only a little.

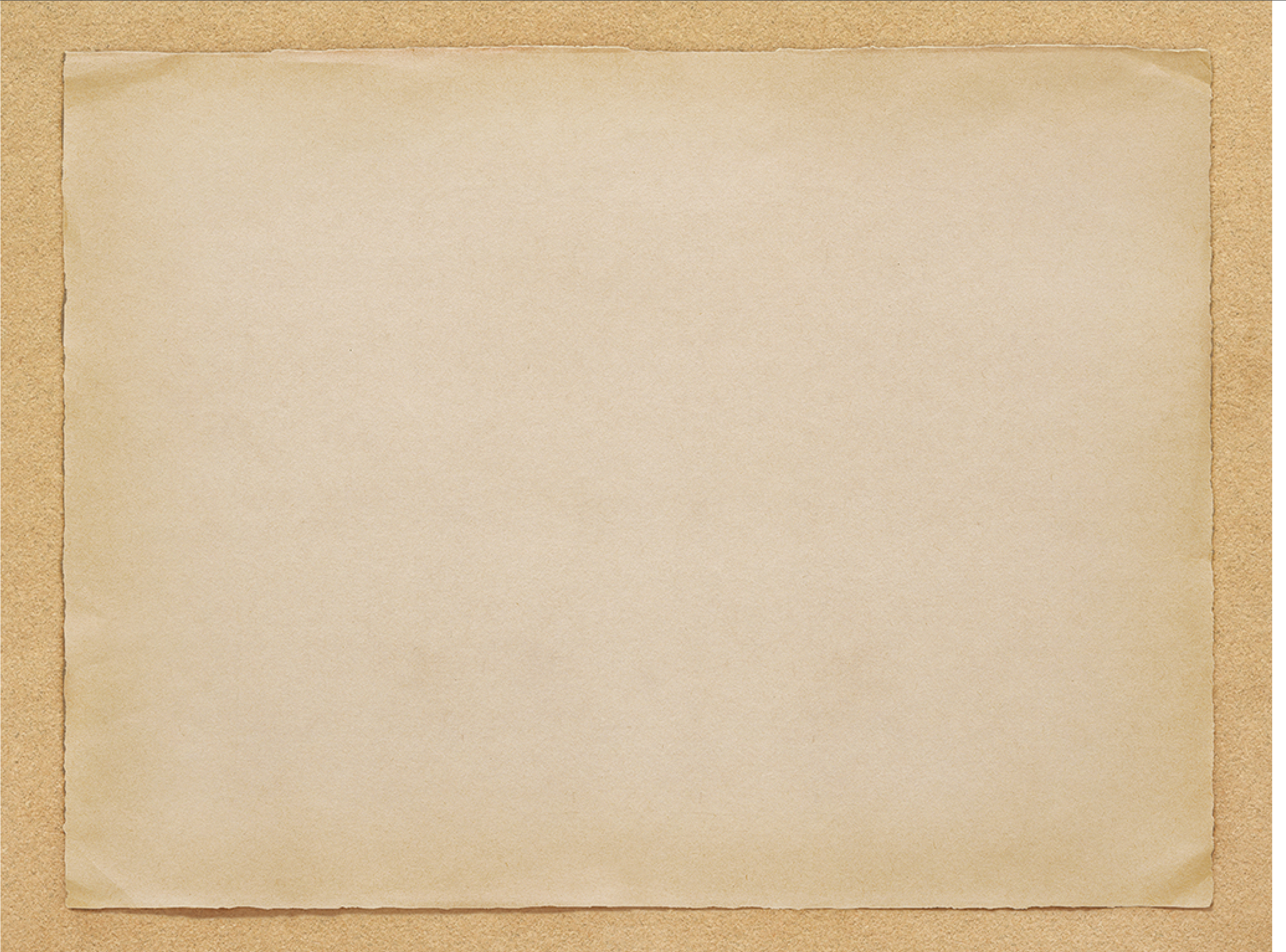
Let's look at some of them of the possible effects. In the psychoanalytic setting, it was usually the analyst who referred the patient to a psychopharmacologist for medications. The effects on the patient might differ, depending on whether the referral was made at the beginning of the psychotherapy, during it, or when the therapy was being terminated.

What sort of reactions might a patient have, if his therapist refers him to a medication specialist during the therapy?

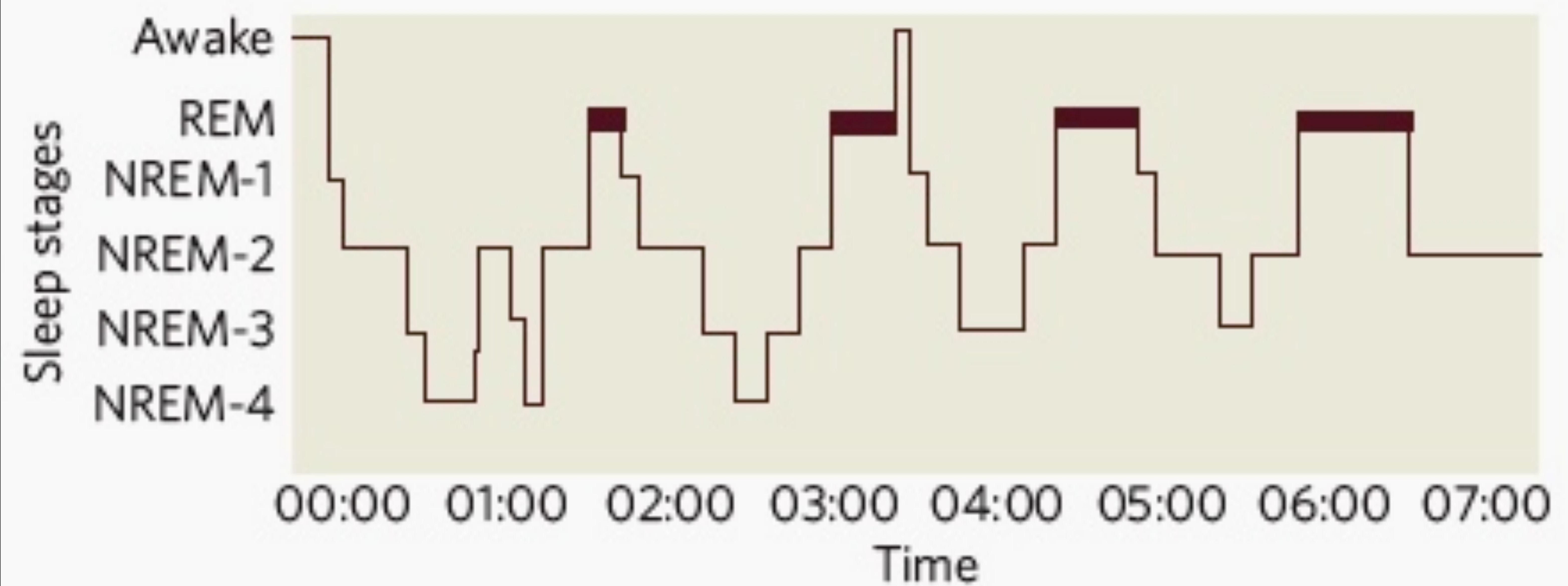
One possibility is that the patient might think that the therapist has given up on him or her, that their problem is too tough. Some patients might begin to believe that there is something wrong with their therapist.

What about the psychotherapist? He or she also may consider the therapy a failure, most likely because they have somehow failed as therapists.

And the medication prescriber? This person may be regarded as the saviour by both patient and therapist. If the prescriber harbours rescue fantasies, what might the outcome be?



My recommendation? Refer to a psychopharmacologist at the beginning of psychotherapy, to avoid too many transference and countertransference issues.



Now I'd like to move to some practical issues about the use of these medications. My research interest is the connection between sleep patterns and affective disorders, including depression, bipolar disorder, and anxiety disorders. When I was working at the Jewish General, I also saw many people who were referred for their insomnia.

This slide shows what is called a polysomnogram. On the vertical axis you see the five stages of sleep, which are based on particular characteristics of the electro-encephalogram during sleep. On the horizontal axis is the time of night during which sleep occurs.

Sommeil et dépression

- Une privation de sommeil paradoxale peut stimuler un état de manie
- Trop de sommeil paradoxale peut déclencher un état dépressif
  - ou quelques symptômes de dépression, eg la fatigue, manque de motivation, manque d'énergie
- Une instabilité de quantité de sommeil paradoxale donne une dépression agitée (avec qq symptômes de manie)

Les personnes le plus sensible aux effets de sommeil sur leur humeur, sont les personnes atteintes de “bipolar spectrum disorder”.

Sommeil et douleur

- Diminution de sommeil delta augmente le douleur
- Mauvais qualité de sommeil delta stimule le douleur fibromyalgique

Sommeil et insomnie

- Le plupart des cas d'insomnie arrivent quand on essaie de dormir plus qu'on a besoin
- Un legère privation de sommeil est le meilleur façon d'avoir un bon qualité de sommeil

Nos buts pour le sommeil

- Si l'insomnie:
  - hygiène de sommeil
  - plus tard au lit, levez plus tôt
  - le but serait une légère privation de sommeil
  - pour somnolence: courtes sièstes (> 10 min)
  - diminuer graduellement les somnifères

Qu'est-ce que sont les aspects d'hygiène de sommeil?
Comment on juge si on a un quantité de sommeil adéquat? Trop de sommeil? Pas assez de sommeil?

Comment modifier le sommeil

- Si une dépression avec rétardation:
  - Se lever tôt
  - Ne retourner pas au lit pendant la journée
  - Si on se reveille trop tôt, se lever

Evitez en particulier le sommeil le matin.

Comment modifier le sommeil

- Pour un état de manie :
  - Plus de sommeil, et ça plus tard
  - Donnez les somnifères plus tard, disons minuit
  - Augmentez le dosage afin d'obtenir 5-6 hres de sommeil
  - Reveillez et faites lever le patient à bonne heure

Comment reconnaître un état de manie ?

Dépression avec agitation

- Le plus important: se lever au même heure chaque jour
- Ne que les courtes siestes après l'heure de reveil
- Aller au lit afin de donner un quantité de sommeil approprié à l'âge

Quand il y a de douleur

- Améliorer le qualité de sommeil delta:
  - Moins de temps au lit
  - Eviter les sièstes
  - Voir à la temperature, bruit, lumière dans la chambre
- Maximiser le quantité de sommeil delta:
  - être éveillé le plus longtemps possible

Médicaments pour le sommeil

- somnifères: benzodiazepines, zopiclone augmentent stage 2, diminuent delta, peuvent augmenter sommeil paradoxale
  - peuvent déclencher une depression
- certains antipsychotiques sédatifs (eg zyprexa) augmentent delta, diminuent sommeil paradoxale
  - peuvent améliorer une depression
  - stabilisent l'humeur

Médicaments contre le sommeil

- ritalin (methylphenidate) garde quelqu'un éveillé, reduit le sommeil paradoxale
- donnez ritalin 5 mg @ 6h ou 7h pour les patients qui refusent ou ne peuvent pas se lever à bonne heure
- donnez un deuxième dose vers midi ou même un troisième afin de garder éveillé quelqu'un avec hypersomnie (eg, ASO)

Médicaments pour le douleur

- Certains médications augmentent le sommeil delta:
  - antidépresseurs: remeron, elavil, trazodone
  - anticonvulsivants: neurontin, pregabalin