How to Get What You Want From a Psychiatric Consultation

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The Chief Complaint

- Unvoiced agendas
  - Most patients had 5 or more agenda items
  - Doctors expect less than 3 agenda items
  - In one study, only 11% of patients voiced everything they were worried about
- Most common items addressed by the physician
  - Symptoms
  - Requests for diagnosis and prescriptions

The Chief Complaint

- Most common unvoiced agendas
  - Worries about possible diagnoses and what the future holds
  - Patient’s ideas of what is wrong
  - Side effects of treatment
  - Not wanting a prescription
Information Unknown to MD

- Patient does not mention relevant facts about medical history
- Doctor unaware of patient’s views of medicines or anxieties about treatment
- Doctor has inaccurate perception of what the patient wants
- Doctor is unaware of patient’s use of alternative or over-the-counter medications
- Doctor is unaware that patient has changed the dose or patient is confused about dosage

Information Unknown to Patient

- Patient does not understand drug action
- Patient unaware of the correct dose
- Patient wants information but doctor does not know this or thinks patient will not understand
- Disagreement about attribution of side effects
- Disagreements or misunderstandings about what kind of side effects are present
- Patient does not understand, remember, or agree with diagnosis

Why It Matters

- Better adherence to treatment
- More accurate diagnosis and treatment
- Less stress and illness for the caretaker
- More efficient use of everybody’s time
- Reduced costs and more satisfaction for everyone
Medicine vs. Illness

- The voice of medicine (The Disease)
  - medical terminology
  - objective descriptions of physical symptoms
  - classification schemes into a reductionist biomedical model

- The voice of patients (The Illness)
  - nontechnical
  - subjective experience
  - context in the patient’s personal and social life

Power

- Imbalance in knowledge about medications
- Doctors always appear to be very busy and there are always other people waiting
- Doctors have more power in this setting than patients. Patients feel their voice is not important.

Strategies

- Have the right length of appointment
- Specificity
- Brevity
- Assertiveness
- Present data in an organized way that a doctor is conditioned to hear
- Have the relevant information available
The Psychiatric Evaluation

- Identification of patient and sources of information
- Chief complaint
- History of present illness
- Past history
- Family history
- Social history
- General medical history

The Mental Status Examination

- Appearance and attitude
- Motor activity
- Mood and affect
- Thought and speech
- Orientation
- Memory
- Judgment and Insight

Information from Caregivers

- Your relationship to patient
- Precipitating event?
- History of symptoms and treatment
  - Time line!
- Allergies
- Current medications and dosages
- Any other physicians or consultants
What You Should Expect

- Case formulation
- Plan for treatment
- Explanation about medication
- How to monitor the medication

Medication

- Are there any drug interactions? Food, OTC, alcohol?
- How long does it take for the medication to work?
- How will you know if it working?
- How long will it be given?
- Follow-up and laboratory work?
- If it doesn’t work, what then?
- Outcome without medication?

Medication Monitoring

- What changes should you look for?
- Will these changes effect judgment, memory, mood, motor abilities, sleep, diet, energy, interests, relationships
Building a Relationship With Your MD

- Know what you are talking about
- Be responsible
- Be assertive and tactful
- Provide documents that help with paperwork
- Try to establish continuity with doctors
- Show appreciation

Neurotransmitters

- Neurotransmitters are the chemicals that communicate between neurons. The most common are the norepinephrine, dopamine, serotonin, GABA, and acetylcholine. Neurons may apparently have more than one transmitter. These are received by a special receptor on an adjacent nerve cell, then released and taken up again by the original sending nerve. When enough neurotransmitters are received, the nerve "fires."

Neurotransmitters

- The relationship between neurotransmitters, nerve connections, special areas of the brain, and behavior/symptoms of mental illness is very complicated and not yet understood. Beware of oversimplified explanations. They are almost certainly wrong.
Agenda

- The Placebo Effect
- Brief Medication Review

The Placebo Effect

- A placebo is a treatment with a chemically inactive substance that has an effect. Placebos have successfully treated depression, pain, asthma, arthritis, hypertension, warts, colitis, insomnia, and other conditions. Placebos can also cause negative effects (nocebo effect) including vomiting, dizziness, fatigue, numbness, hives, rashes, tremor, and death (voodoo.) 23% of people taking placebo have a nocebo effect. Sham surgery has been shown to work as well with Parkinson’s patients as neuron implants.
- The placebo effect probably accounts for most of the benefit due to acupuncture, aromatherapy, homeopathy, most other alternative treatments, and 33% of the response to antidepressants.

Nonpharmacologic Aspects of Medication

- Some meta-analyses suggest that 75-81% of drug response can be attributed to nonpharmacologic effects.
- In 2006, and NIMH study looked at outcomes by prescriber. They found 33% of psychiatrists in the study to be highly effective, 33% average, and 33% ineffective. The most effective prescribers had superior results even when they were prescribing placebos.
What do effective prescribers do?
(Mintz 2012)
• Avoid mind-body split (recognize complexity)
• Know who the patient is (lifestyle, social support, beliefs)
• Attend to ambivalence about loss of symptoms (What do you stand to lose if you get better?)
• Cultivate the therapeutic alliance
• Attend to countertherapeutic uses of medication (loss of agency, numbing to loneliness and disappointment)
• Identify, use, and contain countertransference (emotional response is often the primary impetus to write a prescription)

Using the Placebo Effect
(Brown W, 2006)
• Inspire confidence
  • Look professional
  • Display symbols of healing
  • Make notes
  • Take time, ask questions
• Provide a diagnosis
  • Perform simple diagnostic tests
• Enhance response to treatment
  • Elicit patient’s beliefs and select consistent treatment
  • Offer optimistic prognosis
  • Use a prescription pad

The Bottom Line
• Psychotherapy is actually a biological intervention and psychopharmacology is largely a social intervention.
Antidepressants

- Antidepressants are used to treat a range of disorders besides depression - anxiety disorders, bulimia, chronic pain, etc.
- All antidepressants have similar "efficacy."
- Most antidepressants have different side effects.
- Therefore, it makes sense for many clients to choose their own initial antidepressant based on what kinds of side effects are most important to them. (Am College of Physicians)

Antidepressant Side Effects

<table>
<thead>
<tr>
<th>Drug</th>
<th>Wgt Gain</th>
<th>Sexual Dys</th>
<th>Sedation</th>
<th>Nausea+</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celexa</td>
<td>no</td>
<td>yes</td>
<td>mixed</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Lexpro</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Paxil</td>
<td>yes!</td>
<td>yes!</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Prozac</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Zoloft</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>Yes!</td>
<td>no</td>
</tr>
<tr>
<td>Effexor</td>
<td>no</td>
<td>yes</td>
<td>mixed</td>
<td>Yes!</td>
<td>no</td>
</tr>
<tr>
<td>Remeron</td>
<td>Yes!</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>no</td>
<td>yes</td>
<td>?</td>
<td>yes</td>
<td>?</td>
</tr>
<tr>
<td>Wellbutrin</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
</tbody>
</table>

Side Effect Highlights

- Mirtazapine has a faster onset of action than citalopram, fluoxetine, paroxetine, or sertraline.
- Mirtazapine has the highest weight gain. Paroxetine is also high.
- Venlafaxine has the highest rates of vomiting and nausea. (This is the most common reason for stopping a medication.)
- Sertraline has the highest rate of diarrhea.
- Paroxetine and venlafaxine have the highest discontinuation rates.
- Paroxetine has the highest rate of sexual dysfunction.
- Bupropion has the lowest rate of sexual dysfunction.
Bottom Line (Carlat 2012)

- Sertraline has a very good combination efficacy, tolerability, and low expense. When escitalopram becomes generic, it will join this category.
- Bupropion is notable for its lack of sexual side effects, but it may have less efficacy for anxiety.
- Fluoxetine, paroxetine, and fluvoxamine are the antidepressants most likely to cause drug-drug interactions.

Treatment Response

- At least 50% of clients who will respond to antidepressants begin to show improvement in the first few days to a week. Remission of depression is much harder to achieve and may take 8-12 weeks.
- Achieving remission is important because clients who improve but continue to have residual symptoms are twice as likely to relapse, have greater disability and more risk of suicide.
- Clients who do not improve or who worsen on antidepressants should be re-evaluated for bipolar disorder. Antidepressants can complicate that illness.

Treating Depression

- How you manage the treatment of depression is more important than the antidepressant that is chosen.
- There are four groups of patients
  - Placebo responders
  - Treatment non-responders
  - Poor responders
  - Drug specific responders
- We can’t predict who is which!
Treating Depression

• Clients seen weekly for six weeks show more improvement than those seen less often.
• Clients are more likely to tolerate side effects if they know they are going to see the doctor in a few days.
• Using scales to assess outcome improves care, client satisfaction, and overall treatment outcome.

Antidepressant Adherence

• 10% never fill prescription, 16% stop first week, 41% in 2 weeks, 68% by 1 month
• Risks of non-adherence
  • Side effects
  • Cost
  • Improvement
  • Lack of education about illness and treatment
  • Delayed onset of benefit
  • Fear of dependence
  • Stigma

Antidepressant Adherence

• Best messages to improve adherence
  • Take pills daily
  • The antidepressant may not work right away
  • Continue taking it even if you feel better
  • Don’t stop without talking to your doctor
  • Feel free to call
Stopping the Medication

• All antidepressants, particularly SSRI’s can cause a withdrawal syndrome. The reactions may be more common and severe with short-acting drugs like paroxetine and venlafaxine.
• Common symptoms (usually resolve in 2-3 weeks):
  • Neurosensory (vertigo, paraesthesia, shock-like, myalgia)
  • Neuromotor (tremor, myoclonus, ataxia, visual, piloerection)
  • Gastrointestinal (nausea, vomiting, diarrhea)
  • Psychiatric (anxiety, depression, suicidality, irritability)
  • Vasomotor (flushing, diaphoresis)
  • Other (anorexia, insomnia, vivid dreaming, asthenia, chills)

Types of Antidepressants

• Monoamine oxidase inhibitors (MAOI’s)
• Tricyclic antidepressants (TCA’s)
• Selective Serotonin Reuptake Inhibitors (SSRI’s)
• Serotonin Norepinephrine Reuptake Inhibitors (SNRI’s)
• Atypical/mixed antidepressants

Antidepressants

• Selective Serotonin Reuptake Inhibitors (SSRI’s) effect serotonin receptors.
  • citalopram (Celexa)
  • escitalopram (Lexapro)
  • fluoxetine (Prozac)
  • fluvoxamine (Luvox)
  • paroxetine (Paxil)
  • sertraline (Zoloft)
Our Non-Specific SSRI’s

• MDD, OCD, bulimia, panic, social phobia, PTSD, premenstrual dysphoric disorder, generalized anxiety disorder
• Off label: substance use, ADHD, autism, bipolar disorder, eating disorders, fibromyalgia, neuropathic pain, arthritis, stroke deficits, diabetic neuropathy, hot flashes, irritable bowel syndrome, migraines, fainting, premature ejaculation.

Antipsychotics

• Antipsychotics are used to treat disorganized thinking and hallucinations in people who are psychotic. Because the newer antipsychotics have less debilitating side effects than the older antipsychotics, they are being used for a wide variety of other indications, including mood disorders and behavioral disorders.

First Generation Antipsychotics

• chlorpromazine (Thorazine)
• fluphenazine (Prolixin)
• perphenazine (Trilafon)
• prochlorperazine (Compazine)
• trifluoperazine (Stelazine)
• mesoridazine (Serentil)
• thioridazine (Mellaril)
• haloperidol (Haldol)
• thiothixine (Navane)
• molindone (Moban)
Second Generation Antipsychotics

- The SGA’s cause fewer involuntary movement problems (extra-pyramidal side effects) and less tardive dyskinesia. This may account for the fact that they appear to be more effective in treating negative and cognitive symptoms in schizophrenia. Non-industry sponsored reviews of effect size have not demonstrated any robust differences in treatment effects, including cognitive benefits, between the typical and atypical drugs, except for clozapine.

- Another ongoing area of interest is whether or not SGA’s are also mood stabilizers. They probably are, but it is not clear how they are distinct from each other, or what advantages they have over lithium and the anticonvulsants.
- The main reason for using SGA’s is their side effect profile. Clients tolerate them better than FGA’s. They feel less anxious and depressed, although there does not seem to be much difference in client adherence.

Antipsychotic Side Effects

<table>
<thead>
<tr>
<th>Drug</th>
<th>Efficacy</th>
<th>Diabetes Risk</th>
<th>Wgt Gain</th>
<th>EPSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
<td>++</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clozapine</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>-</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>++</td>
<td>+++</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Risperidone</td>
<td>+++</td>
<td>++</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>Ziprasdone</td>
<td>++</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>
### Second Generation Antipsychotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Antipsychotic Type</th>
<th>Key Features</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aripiprazole (Abilify)</strong></td>
<td>Partial agonist</td>
<td>Unique mechanism of action, few side effects, less efficacy than other SGA's</td>
</tr>
<tr>
<td><strong>Clozapine (Clozaril)</strong></td>
<td>Robustly more effective</td>
<td>Does not cause tardive dyskinesia, protective effect against suicide, weekly blood test for anemia (&lt;1%), seizures at &gt;600mg/day, strong anticholinergic side effects</td>
</tr>
<tr>
<td><strong>Olanzapine (Zyprexa)</strong></td>
<td>More efficacious than most other SGA's</td>
<td>Long acting form, shot, and rapidly dissolving pill, causes weight gain, abnormal glucose and cholesterol/lipids</td>
</tr>
<tr>
<td><strong>Quetiapine (Seroquel)</strong></td>
<td>Does not cause tardive dyskinesia or EPS's</td>
<td>Twice a day dosing, reviews have not shown quetiapine more efficacious than haloperidol</td>
</tr>
<tr>
<td><strong>Risperidone (Risperdal)</strong></td>
<td>Few side effects at low doses</td>
<td>Few side effects at low doses, but acts like a FGA at 6mg./day, available in a long acting shot, prolactin increase</td>
</tr>
<tr>
<td><strong>Ziprasidone (Geodon)</strong></td>
<td>Available as an IM injection</td>
<td>Available as an IM injection, twice a day dosing, can prolong the QTc interval, can prolong the QTc interval, agitation at lower doses</td>
</tr>
</tbody>
</table>
Second Generation Antipsychotics

- Paliperidone (Invega)
  - A metabolite of risperidone in an extended release form
  - Available in long-acting shot
  - Unclear whether there are advantages over risperidone

- Iloperidone (Fanapt)
  - Has been sold off to various companies since 1990, now marketed by Vanda
  - Lackluster efficacy combined with dizziness, headache, dry mouth, nausea, insomnia, increase in QT interval, increase in weight and blood glucose
  - Dose must be titrated over a week

Second Generation Antipsychotics

- Asenapine (Saphris)
  - Can (must) be dissolved under the tongue. Causes mouth numbness and “ chalky tongue” in some patients
  - Data from hundreds of patients in clinical trials of Saphris is missing from the literature. Only one study has been allowed to be published for schizophrenia and one for acute mania.
  - Sedation, dizziness, weight gain, akathisia

Second Generation Antipsychotics

- Lurasidone (Latuda) is the 10th SGA, approved in October 2010.
  - Average dose will cost $8,000/yr. (Generic risperidone is $1,800/yr.)
  - Lurasidone is a mixed D2/5-HT2A drug.
  - No histamine effects (weight gain), like aripiprazole, ziprasidone, and asenapine.
  - Significant sedation, you must take it with food – 350 calories (increases absorption, like ziprasidone)
  - Is it pro-cognitive? Possibly
  - Just approved in 2013 for bipolar depression. Evidence only against placebo.
Long-Acting Injections

• Haloperidol decanoate: painful, oral overlap 1-3 weeks, monthly shot, $15/month
• Fluphenazine decanoate: painful, oral overlap 0-7 days, shot every 3 weeks
• Risperdal Consta: must mix up solution immediately before injection from refrigerated powder, 3 week oral overlap, shot every 2 weeks, $900/month
• Invega Sustenna: no oral overlap, requires 2 separate loading doses one week apart, shot every 4 weeks, $1,185/month
• Zyprexa Relprevv: no oral overlap, requires caregiver registration with Patient care Program and 3 hour post-injection observation due to risk of post-injection delirium/sedation (rare – 0.07%)

Metabolic Syndrome

• Metabolically “dirty” SGA’s: determine BMI at baseline, once a month for 3 months, then every 3 months. Baseline fasting glucose, at 4 months, then yearly. Baseline lipids, at 3 months, then every 2 years
  • Olanzapine, clozapine, risperidone, quetiapine
• Metabolically “clean” SGA’s: baseline weight, at 6 months, then yearly. Baseline glucose and yearly. Fasting lipids every 2 years
  • Aripiprazole, ziprasidone

Antipsychotics and Older Adults

• Sudden cardiac death: risk in general population 1-2/1000. In Vanderbilt study of 166,324 patients on any antipsychotic, risk is 3/1000. (Risk of agranulocytosis on clozapine is 0.2/1000!)
• King’s College study of 165 older adults in nursing homes, after switching to placebo, 95% were still alive at 3 years, only 30% of those still on active drug.
• Aripiprazole does not lower glucose as well as ziprasidone after weight gain on other SGA’s.
Anti-Anxiety Medication

- Anti-anxiety medication is used to treat anxiety disorders and transient anxiety, insomnia, panic attacks, muscle spasms, seizures, side effects from antipsychotic medication, and alcohol withdrawal.
- The percentage of people who use benzodiazepines increases with age, from 2.6% (18-35) to 8.7% (65-80).
- Use is twice as prevalent in women.

Benzodiazapines

- These medications are all essentially the same. At low doses they relieve anxiety, at higher doses they relax muscles, cause sleepiness, and stop seizures.
- They are extremely safe unless mixed with alcohol or other sedatives, but because they cause euphoria and tolerance/habituation, they can trigger addictive behavior in vulnerable people.

Benzodiazepines and Substance Abuse

- Alcoholics will frequently request benzodiazepines in a way that suggests unless they can get the medication, they are likely to resume/escalate their drinking in order to relieve their anxiety. This makes the clinician feel like the burden of treatment is on them. This play must be resisted.
- Controlled drinking studies usually fail. So do attempts to control benzodiazepine use in addicts.
Benzodiazepines

- Addiction
  - Drug seeking+compulsive use+relapse
  - Past addicts are the highest risk group
  - Drug preference studies show that: alprazolam>diazepam>oxazepam
  - Most users do not abuse or become addicted to benzodiazepines.

Tapering Benzodiazepines

- Successful tapering of benzodiazepines must be done very slowly. If done slowly enough, every client can complete a taper, although everyone will feel worse each time the drug is lowered. Clients expect they are going to feel terrible when the taper is complete, but everyone feels better off the drug. They don’t feel as sedated. They don’t feel as clouded in their thought processes.

Benzodiazepines

- A recent meta-analysis concluded that BZD’s cause cognitive dysfunction during treatment, and while the cognitive function improves when the medication is discontinued, it does not return to match the level of functioning in control groups of people who did not take a BZD.
Benzodiazepines

- Speed of Onset
  - Fast: midazolam, diazepam, chlorazepate, flurazepam
  - Intermediate: chlordiazepoxide, alprazolam, lorazepam, triazolam
  - Slow: oxazepam, temazepam, clonazepam, prazepam
- Physical Dependence
  - Diazepam - 15 mg. for 90 days
  - Alprazolam - 1.5 mg. for 45 days
  - Lorazepam - 6 mg. for 60 days
- Withdrawal
  - Anxiety, poor concentration, muscle pain, perceptual disturbances, seizures

Benzodiazepines

- Alprazolam (Xanax)
- Chlordiazepoxide (Librium)
- Clonazepam (Klonopin)
- Chlorazepate (Tranxene)
- Diazepam (Valium)
- Eszazolam (ProSom)
- Flurazepam (Dalmame)
- Lorazepam (Ativan)
- Oxazepam (Serax)
- Quazepam (Doral)
- Temazepam (Restoril)
- Triazolam (Halcion)

Anti-Anxiety Medication

- Antihistamines
  - diphenhydramine (Benadryl)
  - hydroxyzine (Atarax, Vistaril)
- Other
  - buspirone (Buspar)