

Treating Psychological Problems with Drugs: Some Thoughts

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IN THE NEW YORK TIMES ARTICLE ‘TALK DOESN’T PAY, SO PSYCHIATRY TURNS INSTEAD TO DRUG THERAPY’, GARDINER HARRIS (2011) INTERVIEWS

a disenchanted psychiatrist, Dr. Levin, who expresses frustration and disappointment about the changes forced on the practice of psychiatry by the health insurance industry and managed care. Specifically, he laments loss of job satisfaction and erosion in quality of care as a result of a fee structure that discourages treating clients with talk therapy. A 45-minute talk session only pays \$90, whereas a 15-minute medication visit pays \$50. Dr. Levin stopped doing talk therapy and he now centers his practice on brief medication-related consultations, treating some 1,200 patients—patients he barely knows.

In the US, there has been a growing trend away from talk therapy. While the percentage of the general population who use psychotherapy remained stable between 1998 and 2007, declines occurred in annual psychotherapy visits, and the total national psychotherapy expenditures were down from 10.94 to 7.17 billion dollars. An increasing proportion of mental health outpatients received psychotropic medications without psychotherapy (Offson & Marcus, 2010).

Dr. Levin raises legitimate concerns about the policy and practices of insurance providers and managed care that may not be in the best interests of the clients’ mental health. While Canada has a different health system than the US, as discussed below, the practice of using drugs to treat psychological problems has been on the rise here as well. There are some important issues at stake. Is the increased use of drug therapy to treat psychological conditions clinically justified? Are the dollars that are saved in the short run, costing us more in the long run? And, is managed care’ seeming allegiance to the medical model—a model that tends to conceptualize psychological conditions as “diseases” that need to be fixed with drugs—serving the best interests of society?

US doctors prescribed 9.9 billion dollars in antidepressant medications in 2009. Antidepressants are the third most prescribed class of drugs in the US after cholesterol lowering drugs and codeine-based pain killers (Consumer Reports, 2010). In the age range of 20 to 59, the most commonly used prescription drugs are antidepressants (Gu, Dillon, & Burt, 2010). In 2004, the total expenditures for prescribed psychotherapeutic agents (antidepressants, antipsychotics, anxiolytics, sedatives, hypnotics and CNS stimulants) were 2.5 times as high as in 1997, rising from 7.9 to 20 billion dollars. The total prescribed purchases of antidepressants increased substantially from 88.3 to 161.2 million (Stagnitti, 2007). Despite the considerable progressive increase in use of antidepressants, rates of depression have not changed since the 1950’s (Sparks, Duncan, & Miller, 2007). The prevalence rate remains at about 5%, although estimates can vary, depending on definitions, methods of data collection, and demographic factors (Pratt & Brody, 2008).

In Canada there has also been a progressive growth in the use of psychotherapeutic drugs. From 1981 to 2000, total prescriptions for antidepressants increased from 3.2 to 14.5 million. Total expenditures for antidepressants increased exponentially from 31.4 to 543.4 million dollars, adjusting for population growth (Hemels, Koren, & Einarson, 2002). In



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2007, Canadians spent 1.16 billion dollars on antidepressants (Morgan, Raymond, Mooney, & Martin, 2008).

The growing trend in treating children with psychotherapeutic drugs has become an increasing concern. The Therapeutics Initiative (2004), an evidence-based advisory group funded by the BC Ministry of Health, reported that in British Columbia, as in other jurisdictions, antidepressants are commonly prescribed to individuals under 19 years of age. Although fluoxetine is the only antidepressant approved by the FDA for treating children, prescriptions of these medications have doubled between 1998 and 2003. Up to 25% of children who are placed on various SSRIs experience adverse effects such as agitation, disinhibition, aggression, hyperkinesia, and emotional lability. Treatment with these medications also increases the risk of suicidal thinking. The Therapeutics Initiative on review of

the evidence recommended behavioral and supportive interventions as a first line approach, due to the unfavorable risk/benefit balance for treatment of children with antidepressants.

The Therapeutics Initiative (2009) also reported that antipsychotics have been increasingly used to treat children, although in Canada these medications are only licensed to treat adults. For example, in BC between 1997 and 2007 there was a tenfold increase in the percentage of children under the age of 14 treated with the newer antipsychotics (olanzapine, quetiapine, and risperidone). In addition to treating dubious diagnoses of schizophrenia in children, these drugs have been used to treat ADHD, despite a lack of evidence supporting their effectiveness. The Therapeutics Initiative concluded that the long-term effectiveness of these drugs remains to be established, and the use of these drugs in children presents

significant safety concerns in terms of weight gain and metabolic problems. The multibillion dollar pharmaceutical industry, through its marketing campaigns, lobbying and pervasive influence on the practice of medicine, has made the pharmacological management of psychological conditions a highly appealing choice for many. This growing practice of treating psychological problems with drugs is difficult to justify based on recent research evidence. The effectiveness of psychotherapeutic drugs, and the risks of side effects and withdrawal, have not been accurately presented (Antonuccio, Danton, & McClanahan, 2003). An accumulation of research has shown that psychotherapy is as effective as drug therapy in treating depression, but without the risks that drugs pose (Brown, Dreis, & Nace, 1999). The commonly accepted notion that a combination of psychotherapy and drug therapy produces better outcomes for depression has received scant empirical support (Sparks, Duncan, Cohen, & Antonuccio, 2009).

There is good evidence that antidepressant effects are largely placebo-related. Meta-analyses of studies in which patients were treated for depression have found small to insignificant benefits of antidepressant medications over placebos for low to moderate levels of depression. Only for very severe levels of depression was there a clinically significant difference in benefit for antidepressants. Yet, even at those severe levels, there was a substantial placebo effect (Kirsch, Deacon, Huedo-Medina, Scoboria, Moore & Johnson, 2008). Kirsch and colleagues concluded that “there seems to be little evidence to support the prescription of antidepressant medication to any but the most severely depressed patients, unless alternative treatments have failed to provide benefit” (p. 266).

Taking a pill to feel better, or to improve one’s depressed mood or anxiety, is an appealing notion, but medications are not without risks, some that can be serious. Medications often have side effects, including agitation, sleep disruption,

gastrointestinal complications, sexual difficulties, and weight gain.

A common practice in medicine is the off-label prescribing of medications; that is, prescribing medications for conditions for which they have not been approved. Anticonvulsants are often prescribed for off-label treatment of depression and other disorders, although the research evidence supporting this practice is often weak (Sweet, 2003). Various newer so-called atypical antipsychotic medications approved to treat schizophrenia and bipolar disorder are being prescribed to millions of patients in North America for depression, dementia, and other psychiatric disorders. There is, however, a lack of evidence that these off-label uses are effective, according to a new analysis by the Department of Health & Human Services’ Agency for Healthcare Research and Quality (2007). Although these newer antipsychotics are regarded as safer than earlier generation antipsychotics, and in some studies have shown some benefit for conditions such as Obsessive-Compulsive Disorder and combat-related PTSD in men, there is the potential for serious problems, such as stroke and neurological complications.

Depression is often tied to situational stresses, impaired self-esteem, ineffective interpersonal skills, and unresolved attachment issues. Hence, a medication approach in many instances will fail to adequately address the core issue. While psychotherapeutic medications have their place in the treatment of psychological conditions, in face of the research cited, one should question their appropriateness as a routine first-line approach for depression and anxiety, when a safer approach (one that may have more enduring results) is available. There is a hidden cost to the health system when patients on psychotherapeutic agents end up with serious side effects or other complications. In my experience, when clients are asked about their medications, they are often unclear about what their pills are for, and rarely know that they have been prescribed antipsychotics or anticonvulsants

for off-label use. In the informed consent process, if the client is provided with a clear understanding of the risks and benefits of the treatment options, he or she may decide to first try the safer approach—psychotherapy.

When the client is unreceptive to talk therapy, or is disposed to believe that his or her problems have a biological source that requires a medical approach, then drug therapy may be the better choice. Having a shared view of the problem may facilitate change, since the client is more likely to come into treatment with hope and expectation for improvement, and an effective alliance or working relationship with the treatment provider is more likely to be formed. On this point, a positive working alliance has been repeatedly shown to be one of the best predictors of outcome (Duncan & Miller, 2005).

While it is argued here that in most cases talk therapy is the better first choice for treatment of depression (and also for anxiety conditions), the reality is that practical constraints such as limited mental health resources in the community, the high cost of private psychotherapy, and the exigencies of a general practitioner's busy practice, which allow little time for involved discussions of psychological problems, will serve to perpetuate the modus operandi of trying to fix psychological conditions with pills. ☞

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