A MODEL CURRICULUM FOR TEACHING PSYCHOPHARMACOLOGY TO PRIMARY CARE RESIDENTS AND CLINICIANS

Second Edition

By

The Primary Care Curriculum Committee of the American Society of Clinical Psychopharmacology

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# TABLE OF CONTENTS

**GUIDELINES AND INSTRUCTIONS** ................................................................................................................. 4  
- Objectives and Rationale .......................................................................................................................... 4  
- How to Use the Lectures ......................................................................................................................... 6  
- Getting Help ............................................................................................................................................ 7  

**OBJECTIVES, PEDAGOGY, AND EVALUATION** .................................................................................. 8  
- Overview of Educational Objectives .......................................................................................................... 8  
  - Knowledge ............................................................................................................................................ 8  
  - Skills ..................................................................................................................................................... 8  
- Tips on Content and Pedagogy .................................................................................................................... 9  
- Special Considerations Related to Lectures ................................................................................................. 10  

**ACKNOWLEDGEMENTS** ...................................................................................................................... 11  

**CONTRIBUTORS** ..................................................................................................................................... 11  

**APPENDIX A**

**READING MATERIALS** .......................................................................................................................... 12  
- Suggested Screenings for Psychiatric Disorders ......................................................................................... 12  
- Psychopharmacology Textbooks and Handbooks ....................................................................................... 14  
- Journals .................................................................................................................................................... 14  

**APPENDIX B**

**OVERVIEW ARTICLES ON PSYCHOPHARMACOLOGY PRACTICE** ............................................. 15  
- Psychopharmacology Practice Over the Long Run .................................................................................... 16.1 - 16.2  
- Teaching the Teachers of Clinical Psychopharmacology ........................................................................ 17.1 - 17.481  
- Primary Care Pitfalls for the Primary Care Psychopharmacologist ......................................................... 18.1 - 18.2
CORE LECTURES FOR PRIMARY CARE

Anxiety:
Anxiety Disorders: GAD ................................................................. 19.1 – 19.66
Daniel G. Orr, M.D.
PTSD and OCD ........................................................................... 20.1 – 20.63
Howard H. Fenn, M.D., Thomas A. Mellman, M.D. Daniel G. Orr, M.D.
Social Anxiety Disorder and Panic Disorder ................................... 21.1 – 21.76
R. Bruce Lydiard Ph.D., M.D., James Ellison, M.D., Lorrin M. Koran, M.D.

Depression .......................................................... 22.1 – 22.93
Eric Peselow, M.D., Daniel G. Orr, M.D.

Bipolar Disorders ................................................................. 23.1 – 23.69
Po W. Wang, M.D.

Treatment of Schizophrenia ........................................................... 24.1 – 24.46
Michael Jibson, M.D., Ph.D, Ira Glick, M.D.

“Psychosis” in Medical Practice ...................................................... 25.1 – 25.43
Po W. Wang, M.D.

Eating Disorders ................................................................. 26.1 – 26.53
Lawrence Cohen, B.A., Pharm. D., B.C.P.P., Matthew Macaluso, M.D.

Substance Use Disorders .............................................................. 27.1 – 27.68
Po W. Wang, M.D.

Child/Adolescent Psychopharmacology:
An Overview of Pediatric Depression ........................................... 28.1 – 28.67
Cynthia R. Pfeffer, M.D.
Treatment of Children and Adolescents with Anxiety Disorders ...... 29.1 – 29.46
John T. Walkup, M.D.

Managing Neurocognitive Behavioral Symptoms in Patients with Major Neurocognitive Disorders .................................................. 30.1 – 30.86
James Ellison, M.D.

Psychotropic Medications During Pregnancy and Postpartum .......... 31.1 – 31.67
Laura J. Miller, M.D.

Insomnia ............................................................................ 32.1 – 32.60
Lawrence Adler, M.D.
GENERAL PSYCHOPHARMACOLOGY LECTURES

Geriatric Psychopharmacology ................................................................. 33.1 – 33.25
Linda Farho, Pharm. D., Lawrence Adler, M.D.

Evaluating and Managing Side Effects of Psychiatric Medications .................. 34.1 – 34.27
Joseph F. Goldberg, M.D.

Psychopharmacology: “Warnings” and Management ........................................ 35.1 – 35.64
Daniel G. Orr, M.D.

Suicidal Behavior ...................................................................................... 36.1 – 36.23
J. John Mann, M.D.

The Art of Psychopharmacology .................................................................... 37.1 – 37.14
Ira D. Glick, M.D., Richard Balon, M.D.
GUIDELINES AND INSTRUCTIONS FOR USE OF THIS CURRICULUM

This is the second edition of the ASCP Model Psychopharmacology Curriculum for Primary Care, created for TEACHERS of medical students, residents and practicing physicians in primary care. The lectures from the first edition have been updated and additions have been made by colleagues who teach psychopharmacology to both primary care as well as psychiatry residents and physicians. We hope that you will find it both helpful and user-friendly.

Objectives and Rationale

This edition focuses on basic understandings of psychotropic medications and the conditions they treat. The ASCP Curriculum Committee members have reviewed the contents of the lectures. Each presentation covers the general background of a particular diagnostic area as an introduction to the basics of its psychopharmacologic management.

The curriculum is not a textbook nor handbook of psychopharmacology. Rather, it provides a clinically oriented overview of the field for use by TEACHERS of psychopharmacology, Directors of Primary Care Education, Department Chairs, and others with the responsibility of educating students and practitioners in primary care. Our hope is that this curriculum provides what a primary care resident/physician needs to learn to treat primary care patients with psychiatric
illness in both acute and long-term stages of their illness. We hope that it stimulates the student to continue further education in the field of clinical psychopharmacology.

Our intention is to update the curriculum every two years, incorporating ideas and updates based on new advances in the field and on feedback from users of our curriculum. This will keep the curriculum dynamic and up to date. Furthermore, we hope that this primary care version will provide a standardized, evidenced-based introduction into psychopharmacology for all primary care physicians in training, and also for primary care physicians in practice desiring continuing education.

The curriculum, depending on the target audience, can be used as a supplement to a basic course of psychopharmacology or be used in total as a basic course in psychopharmacology or as an advanced clinical course in psychopharmacology. Having received this curriculum, we know that you consider psychopharmacology an important component in your student’s education. The next step is the most critical. You must now use the curriculum. We have been pleased that the psychiatric residency version of this curriculum has in fact been widely used in the United States and globally, and we hope that this primary care version will be just as popular a teaching tool in psychopharmacology for primary care residents.
Let us reiterate, these lectures are **working teaching tools** and not a textbook or a journal article, as such, they are up to date as of September, 2015. Information underlying each topic is constantly changing, which is why periodic updates are essential.

**How to Use the Lectures**

We understand that some users will want to combine our slides with their own slides to create a personalized lecture. We fully support such use. We encourage you to add, delete, change, reorder or combine slides from different modules as you see fit. (Of course, we would like to have you mention that the ASCP curriculum was utilized in your presentation.)

If you, the lecturer want hard copies of the slides, photocopies may be made and distributed to the audience. We suggest using the power point capability of adding a place to keep notes. Currently, most teachers use the lecture in Power Point, in part or total, and also provide a handout of the slides to the audience.

In most lectures, we have not included references. Instead we refer the teacher to our recommended list of reading materials (See Appendix A). We also provide two articles – one on teaching tips by Dr. Salzman and Dr. Glick and the other on long-term psychopharmacologic management by Drs. Glick and Ellison.
Lastly, we include a piece by Dr. James Thompson specifically written for primary care psychopharmacology practice (See Appendix B).

**Getting Help**

Because we are anxious for you to get full value of this ASCP Model Curriculum through the maximization of its use, we would be delighted to answer any questions you may have and help you use it. We will respond to written queries, e-mails, or telephone calls. Please feel free to call us for help, feedback, consultations or if there is any way at all in which the committee can help you.

Your first contact should be to one of the following:

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Lastly, we would like to dedicate this second edition to Eric D. Peselow, M.D., who died in 2014. It was his initiative and hard work that gave birth to the first edition of the Primary Care Curriculum. That first edition served as an extremely valuable template with which we were able to update this second edition. Thanks, Eric.
Overview of Educational Objectives

Knowledge

The minimum objective of a clinical psychopharmacology program for Primary Care should be to make explicit the required knowledge base of psychopharmacology for educating residents and practicing physicians in an optimal and standardized fashion. The curriculum should help the participants to:

- Understand the basics of psychotropic drug use, and recognize pseudo-psychiatric symptoms that may represent medication-associated toxicity.
- Have a basic understanding of which psychopharmacological agents are the treatments of choice for particular disorders.
- Understand the limitations of pharmacotherapy and its potential dangers and pitfalls.
- Have an appreciation for when *not* to use psychotropic drugs.
- Understand basic theoretical models relating current knowledge of the biology of the disorder(s) in relation to the proper use of psychotropic drugs.

Skills

A clinical psychopharmacology program should teach specific skills so that participants will be able to:

- Understand the importance of integrating psychotherapeutic, psychoeducational, psychobiologic and psychopharmacologic aspects of care.
- Develop a systematic approach to gathering clinical data.
- Develop the ability to use psychopharmacological agents efficiently and effectively for patients often seen in primary care and other non-psychiatric medical settings.
- Develop the ability to examine critically the relevant literature via an understanding of the basic scientific principles required to test hypotheses.
- Understand when to refer patients to specialty psychiatric care.

AND BE ABLE TO DO ALL OF THIS IN THE LIMITED AMOUNT OF TIME AVAILABLE TO A PRIMARY CARE PHYSICIAN’S BUSY PRACTICE.
Tips on Content and Pedagogy

Each program will need to develop its own style and its own priorities for teaching a psychopharmacology curriculum based upon its resources, expertise, and available clinical patients. The following are suggested formats for developing an optimal teaching curriculum and program.

The didactic program, that is the psychopharmacology lecture series, includes a core series which can be tailored for use for either primary care residents or for CME. As we mentioned, these lectures focus on:

- The pharmacology of drugs used for a particular condition
- Basic information on dosing and their side effects

In addition to an introduction (which gives the rationale for the primary care physician to know psychopharmacology), we have provided what we consider the most common problems, symptoms, and disorders the primary care resident/physician encounters:

- Anxiety
- Depression
- Bipolar disorders
- ADHD
- Insomnia and sleep disorders
- Eating disorders
- Substance use disorders and abuse
- Pediatric and Geriatric psychopharmacology
- Dementia and Cognitive disorders
- Psychosis and Schizophrenia
- Pregnancy, breast feeding, and related psychiatric issues
- Side effects and drug interactions in psychiatric disorders
- Psychopharmacology warnings
• Art of psychopharmacology

We have added additional lectures to the core sequence. These are meant to augment the core lectures. They include alternate lectures on side effects, warnings, and a “pearls” lecture entitled “The Art of Psychopharmacology”. These “pearls” can be used as discussion-starters, or can be the basis of another lecture, wherein the lecturer expands on some or all of these teaching points.

Special Considerations Related to Lectures

A didactic lecture series is obviously a useful way of conveying up-to-date scientific knowledge. However, as noted above, it is important to emphasize that for psychopharmacology training, particularly for residents, didactic lectures alone are not sufficient. Issues of lack of “absorption and retention” of lecture material suggest that, whenever possible, lectures should be accompanied by seminars, relevant, clinically-oriented (or otherwise appropriate) journal articles, case examples, and textbook reading. Small-group or individual supervision and case-conference methods of teaching are necessary for adequate development of the requisite clinical skills for the physician-in-training. These lectures, or portions of them, can also be used in Problem Based Learning settings. This being said, formal didactic teaching often stimulates interest in psychopharmacology and broadens intellectual and clinical perspectives in the treatment of patients with psychiatric issues.

When seminars accompany lectures, it is strongly recommended that seminar leaders provide an opportunity for questions and answers, during and/or after a specific didactic lecture (at least 15 minutes for a one-hour lecture). A common faculty mistake is for the lecturer to talk for the full hour (i.e. attempts to make the lectures “interactive”). The purpose is to both consolidate learning and to encourage residents to ask questions in the protective setting of the seminar.

The small group method, for a group of 8-12 learners, is another useful approach. The teacher may wish to use a white board and draw learners into the process by asking their ideas, approach, etc. This is sometimes more engaging and interesting for the students, and they end up remembering more than if they passively sat and watched Power Point slides go by.
Acknowledgements

As “conflict of interest” issues are currently a major issue in the field, we wish to make clear that there was no industry support for this curriculum. All content and all lectures were developed by either members of our committee or by “expert” teachers we chose as part of their teaching responsibilities at their institutions.

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APPENDICES

Appendix A: Reading Materials

Suggested Screenings for Psychiatric Disorders

Depressive Disorders:

Patient Health Questionaire (PHQ-9)
Hamilton Rating Scale for Depression (HAM-D)
Zung Depression Scale (ZSDS)

Geriatric Depression Scale (Short or Long version)
Kutcher Adolescent Depression Scale (KADS-11)
Depression Scale for Children (CES-D)

Mood Disorders Questionnaire (MDQ) Bipolar Screen*
Young Mania Rating Scale (YMRS) Bipolar Screen*

Anxiety Disorders:

Generalized Anxiety Disorder Scale (GAD-7)
Hamilton Anxiety Rating Scale (HAM-A)
Zung Anxiety Scale (ZSAS)

Geriatric Anxiety Scale (GAI) (Short or Long version)
Spence Children's Anxiety Scale (SCAS)

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)
Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)

Screening for PTSD (Anxiety and Depression Association of America) (ADAA)
Primary Care PTSD Screen (PC-PTSD)
Young Child PTSD Screen (YCPS)
PTSD in Pre-School Aged Children (PTSD-PAC)

Screening for Social Anxiety Disorder (ADAA)

**ADD/ADHD:**

Conners Parent Rating Scale-Revised
Conners Teacher Rating Scale-Revised
Vanderbilt ADHD Diagnostic Parent Rating Scale (VADPRS)
Vanderbilt ADHD Diagnostic Teacher Rating Scale (VADTRS)

Adult ADHD Self-Report Scale (ASRS-v1.1)
Wender Utah Rating Scale (WURS)

**Dementia:**

Mini-Mental State Examination (MMSE)
Self Administered Gerocognitive Examination (SAGE)

Cornell Scale for Depression in Dementia

Functional Assessment Staging Tool (Alzheimer's Disease) (Reisberg)

**Sleeping Disorders:**

Epworth Sleepiness Scale (ESS)
Insomnia Screening Questionnaire

**Addictive Disorders:**

CAGE Alcohol Abuse Screening Tool
CAGE Substance Abuse Screening Tool

**Eating Disorders:**

ACORN Eating Disorder Inventory
Eating Attitudes Test (EAT-26)

**Psychopharmacology Textbooks and Handbooks**


**Journals**

American Family Physician

Journal of Clinical Psychopharmacology

Primary Care Companion to the Journal of Clinical Psychiatry
Appendix B: Overview Articles on Psychopharmacology Practice

Overview for Following Article

By way of overview, clinicians have asked us (Drs. Glick and Ellison) to write a short introduction to the actual practice of psychopharmacology. That is, how and what to do in the initial evaluation visit and visits over the lifetime of managing patients with psychiatric illness and their significant others. We include this piece for teachers to use as they deem appropriate to their settings. Most is apropos to the psychopharmacologic visit and treatment administered to patients by the primary care physician. By way of clarification, please note:

- Assessment tools already exist to confirm clinical competency of the prescribing physician (i.e. Residency training, Board passage and Continuing Medical Education with particular focus on diagnosis and treatment of psychiatric disorders). Educational materials such as the ASCP’s core curriculum are designed to supplement this training.
- The pre visit comprehensive form to be filled out by the patient or caregiver almost always exists in Primary Care practices. Additional tools may be added such as Screens for “Depression, Anxiety, Substance Abuse, ADHD, Cognitive assessment” or others depending on the presenting problems.
- Lastly, routine medical labs for most patients are ordered at the initial visit unless they have been recently performed. Labs should also be obtained periodically depending on the medication(s) prescribed by the physician.
Improving the Practice of Clinical Psychopharmacotherapy: The Process of Long-Term Management for Patients and Caregivers

Ira D. Glick, MD, and James M. Ellison, MD, MPH

In the care of psychiatric patients, many of whom will require prolonged medication treatment and monitoring, the pharmacotherapy visit is one place where "the rubber meets the road." Complex clinical and administrative needs must be addressed, often with incomplete clinical information during encounters that are abbreviated due to packed schedules and late arrivals. Clinician engagement is undermined by growing caseloads, increasing documentation requirements, coverage limitations, and the need to keep abreast of a growing body of knowledge that defines evidence-based practices. The challenge of performing a valid diagnostic assessment, making optimal treatment decisions, answering patients' questions, and communicating with caregivers and other treatment providers is an increasingly formidable one.

Knowledge of the pharmacology of psychiatric medications is necessary but not sufficient for the delivery of appropriate, ethical, and high-quality care—to be more specific, care that is "safe, effective, patient-centered, efficient, timely, and equitable." Excellent resources are available to update clinicians on the properties of medications, but careful attention must also be paid to the framework and conduct of a pharmacotherapy visit.

Current opinion on the conduct of a pharmacotherapy visit is addressed in several texts, as well as in an ASCP Model Psychopharmacology Curriculum statement. A recent paper on "reconceptualizing medication management" includes, in addition, an assessment tool for measuring clinician competency. The present article complements those sources by describing our view of how to provide long-term medication and focused psychotherapeutic management that incorporates both patients and their caregivers, including the core pharmacotherapy visit tasks. We will discuss initial evaluation and follow-up visits, recommending a systematic approach that prompts thoroughness and reinforces the crucial pharmacotherapeutic alliance.

The Initial Consultation

Before the first meeting, we often ask patients and caregivers to complete a comprehensive form (Table 1). This information helps the evaluating clinician to complete both an individual descriptive diagnostic assessment and a biopsychosocial formulation that provides a richer context for appreciating the identified patient's concerns. In the office, a HIPAA privacy notice is signed, preliminary information is reviewed, and the patient's target symptoms are discussed. The clinician asks about past and current psychiatric medication use, including benefits, adverse reactions, and allergies. Past psychotherapy experience is noted. An objective scale for rating symptoms and drug responses will provide baseline information for later comparison. Additional questions address the medical history including the presence or absence of relevant symptoms, disorders, and treatments as well as past or present recreational substance use. The evaluator learns about the patient's understanding of his or her illness, motivation for treatment, and expectations or fears. A key issue is for patients, clinicians, and caregivers to agree on goals, including what can and cannot be achieved with medications.

The Patient-Caregiver-Prescriber Alliance

Prime objectives of the initial visit are to obtain information, move toward an agreement about goals, and formulate a treatment approach. To accomplish these goals, the clinician must build an alliance with the patient and, often, caregivers. Caregiver involvement may help promote treatment adherence and decrease risk, but it requires valid patient consent. The alliance with caregivers has special importance in the care of patients with psychotic or neurocognitive disorders, whose communication and processing difficulties, whether transient or more persistent, may undermine treatment success.

Toward the end of the initial evaluation, personalized psychoeducation is provided. The clinician elicits and responds to the patient's questions about symptoms, diagnosis, prognosis, short- and long-term goals, treatment choices, and side effects. This interaction increases adherence and strengthens the treatment alliance. When appropriate, and with valid consent, information may be shared with caregivers and their questions or concerns can be discussed. Permission is also obtained for contacting other prior and current treatment providers, to coordinate care and to learn about previous treatment successes and problems that may recur in a new treatment relationship.

Before Each Follow-Up Visit

For expedient use of time, the patient and caregivers, as well as the treating clinician, should arrive at the follow-up visit aware of the preceding visit's content and follow-up plan. The clinician should have in hand, and should have reviewed, new test results, including laboratory reports. These might include hematologic measures supporting clozapine treatment or neuropsychological tests assessing cognitive status. Relevant communications from other treatment team members such as a psychotherapist or caregiver should be available for discussion and for inclusion in further treatment planning as appropriate. Interim history includes an update on treatment adherence, benefits and adverse effects of medications, and new circumstances affecting the patient's symptoms. When appropriate, and we consider this a standard practice rather than special case, patients and their caregivers and families should know the diagnoses and treatment plans.

The Follow-Up Visit

The overriding objective of follow-up visits is to deliver quality care that includes thorough assessment of the patient's needs,
Table 2. Checklist for Follow-Up Visit

Pre-visit:
- Note primary symptoms, diagnoses, and treatments
- Note visit goals
- Review new information, e.g., laboratory results or communications/consultations

During visit:
- Review goals, progress, adherence, adverse effects
- Update psychosocial events including successes and setbacks
- Check for new medical events, diagnoses, symptoms, treatments
- Avoid irrational polypharmacy or arbitrary medication choices
- Ask about concurrent behavioral treatments such as psychotherapy by others
- Prescribe evidence-based treatment

At end of visit:
- Make treatment recommendations
- Schedule follow-up including check-in phone contact
- Address administrative needs such as prior authorizations, insurance changes, disability forms, jury participation letters, letters for return to work

Appropriate interventions, adequate risk management, and compliance with regulatory needs. Table 2 shows a checklist for use in follow-up visits. We supplement office visits as needed with phone calls that are documented in the patient’s medical records. Medication reconciliation, eliciting of new concerns or new concurrent treatments, and a review of medication effects on target symptoms are essential. As appropriate, the pharmacist may offer adjunctive psychotherapy that is focused and problem-oriented rather than exploratory. We encourage patients to call between sessions, at no additional charge, if urgent concerns arise. Various forms of asynchronous communication and data-gathering smartphone apps, providing additional data via secure forms of Internet-based messaging, are likely to enhance patient-clinician interaction in the future.

For familiar and stable patients, a visit of 20 to 30 minutes may be adequate. Those with severe or rapidly shifting symptoms should not be managed in sessions of inadequate length. When hospitalization is necessary, the clinician needs to devote adequate time for communicating treatment needs with a receiving institution. We oppose a 15-minute visit standard as excessively brief for many patients, but some individuals develop over time an ability to manage their symptoms and a strong treatment alliance that persists even during symptomatic exacerbations. Shortening visits too early in treatment, however, requires the clinician to rely on inadequate information and an impressionistic assessment, resulting possibly in misjudgment of a patient’s needs.

The allocation of time in a follow-up visit is tailored to specific needs, clinical or administrative, that may arise. In the absence of unexpected needs, one general strategy is to divide the available time (whether 5, 15, 30, 45, or 60 minutes) into 3 parts. The first, usually about one-fifth of the visit, is for inquiring about treatment adherence, response, and relevant new data. Medication reconciliation can be accomplished by asking the patient to list all the medications he or she is taking and describe any problems.8 Measurement-based care, increasingly recognized as a treatment enhancement, has become more common and can be accomplished efficiently by asking a patient to respond to paper or computerized questionnaires before the visit.9 We always inquire about use of recreational substances. We ask whether patients are actively taking their medications as prescribed and review any side effects. Patients often appreciate a frank discussion of the relative risks and benefits of pharmacotherapy, since side effects accompany most treatments.

The second portion of the visit, usually more than half the allotted time, focuses on global outcome in the context of the patient’s life in the community. This inquiry varies depending on the patient’s disorder and functional level. Areas to cover include work or school, family and other significant relationships, and quality of life. How patients appear in the office matters, but how they function and feel elsewhere is even more important. Clinicians must avoid shortcuts in treatment monitoring, even when based on a prolonged treatment relationship. Compliance or discouragement may cloud a clinician’s perception of important shifts in clinical status.

The last part of the visit, which is brief, is devoted to reviewing the visit. The treatment plan must be agreed upon. In some cases, informed consent for a treatment intervention such as an antipsychotic may be required. We often ask patients and/or caregivers to take notes on our discussion of the treatment plan. We look for further psychoeducational needs and offer appropriate encouragement. The visit ends with a specific follow-up plan and scheduling of a subsequent visit.

Summary

In our suggestions, we have focused on the process and core elements of an effective pharmacotherapy evaluation and follow-up visit in the context of the patient’s life. Implementation of evidence-based care and measurement-based outcome management, keeping up to date with new medications and their risks or benefits, adapting to insurance-related constraints on time and medication access, and incorporating new initiatives related to integration of behavioral with primary medical care are important issues beyond the scope of this discussion but worthy of attention. Providing service as we have described is not simple, but this approach covers the critical bases and improves the odds of offering effective care.

REFERENCES


ASCP Corner offerings are not peer reviewed by the Journal but are peer reviewed by ASCP. The information contained herein represents the opinion of the author.

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Teaching the Teachers of Clinical Psychopharmacology

Carl Salzman · Ira D. Glick

Abstract This commentary focuses on psychopharmacology teachers and their teaching. The authors offer broadly based pedagogic suggestions on how to deliver evidence-based and neurobiologically informed prescribing information to clinicians at all levels of experience. They argue that teaching essential psychopharmacology knowledge and practice must be up-to-date, accurate, and consistent with the reality of an individual patient’s life experience and beliefs. They stress that educators must teach that nonpsychopharmacological factors in a patient’s life may be as relevant to the treatment setting as the actual pharmacological basis of psychotropic drug therapeutics.

Keywords Psychopharmacology · Teaching techniques · Continuing medical education · Evaluation

Four years ago, we published an editorial titled The seven sins of psychopharmacology practice [1]. Using the word sins, we focused on prescribing errors that we observed that clinicians commonly made. We emphasized the importance of understanding the social, psychological, and historical context of the patient’s disorder to prescribe psychiatric medications appropriately rather than simply following a symptom checklist and prescribing algorithms. In this paper, we will attempt to address some of the problems that we have observed in teaching psychopharmacology to medical students, psychiatric residents, practicing clinicians in continuing medical education programs, and other prescribers of psychotropic medications.

Our opinions about how to improve the teaching of psychopharmacology have been the focus of numerous discussions with colleagues and at annual colloquia of the American College of Neuropsychopharmacology and the American Society of Clinical Psychopharmacology [2]. The problems that we have discussed may be divided into three broad categories: teaching basic prescribing principles, the emotional and psychological context of a patient’s disorder or symptoms that require medication, and how to teach and how to evaluate the results of the teaching process.

In addition to our own observations, this paper builds on previous literature focusing on the teaching of psychopharmacology, especially the 2005 special issue of Academic Psychiatry with the same title edited by Richard Balon [3]. We have also drawn on the writings of other authors who have focused on the need to revitalize the practice and knowledge base of psychopharmacology [4], as well as those who have written on the integration of psychopharmacology with psychodynamic principles and other therapeutic approaches (Appendix).

Teaching the Neuroscience and Clinical Practice of Psychopharmacology

Teaching psychopharmacology requires that the instructor be conversant with the latest evidence base of diagnosis and treatment and the clinically relevant pharmacogenetics and epigenetics. Some teachers’ clinical experience in prescribing psychotropic medications may be limited to only a few diagnostic categories.

Not all teachers are “expert” psychopharmacologists or academic researchers. In clinical training programs, it is not unusual to encounter faculty who base their psychopharmacology teaching and supervision predominately on their own clinical experience prescribing psychotropic medications.
Some teachers and supervisors of psychopharmacology treatment programs may not be fully up-to-date regarding the latest psychopharmacology treatment recommendations. We have also observed that some teachers with a limited range of clinical experience may primarily rely on pharmaceutical manufacturer marketing information (rather than the scientific research reports themselves) for their education. Such information may be biased and not suitable for teaching.

A teacher’s own clinical experience may be a useful starting point for teaching basic guidelines for prescribing psychotropic medication. But, in an era of modern psychiatry, we must impress upon teachers the necessity for remaining conversant with the latest data that can provide the evidence basis for medication choice, dose, comparison among therapeutic choices, and options for treating resistant patients. Table 1 shows examples of the range of information that should be taught.

In contemporary psychiatric practice, clinicians and students are often faced with the influence of managed care, insurer-based time pressures for treating psychiatric patients [4]. The pressure for rapid therapeutic response to a medication may lead to doses that are too high, unnecessary polypharmacy, or premature medication switching. We should also teach that time pressures and resulting partial therapeutic response may lead to the use of unproven therapeutic techniques (e.g., unusual augmenting agents and off-label prescribing).

### How to Improve Teaching and Stimulate Students

Psychopharmacology teachers may encounter problems with the students themselves and must be prepared to adapt to them. Like many of our teaching colleagues, we have been perplexed by the seeming lack of curiosity among some students regarding the breadth and depth of psychopharmacology treatment and clinical response. Some students seem to want to learn only the minimum psychopharmacology information: which medication and dose, for which diagnostic category of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Others appear to be dissatisfied with the dominance of biological theories of illnesses and treatment that seems to characterize many psychopharmacology teaching programs. Despite great efforts to improve teaching techniques and stimulate more interest in psychopharmacology, many teachers ruefully note that some students do not read the psychopharmacology literature at all (many students confirm this perception anecdotally) or read without a critical understanding. Consequently, we all have seen students acquire incorrect, incomplete, or dated information.

Lectures are a standard and primary means of teaching psychopharmacology. Professional meetings and continuing education symposia depend on lectures and their use of visual aids, usually electronic slide presentations. Like most of our teaching psychopharmacology colleagues, we spend long hours creating and updating lecture materials, and we depend on the scientific literature to help guide us. But, educators have increasingly realized that the lecture format encourages “passive” learning, and though efficient in reaching large numbers of students, passively acquired information may not result in true learning of the material, as evidenced by incorrect prescribing in a clinical setting. Newer teaching techniques advise supplementing lectures and slides with clinical case conferences that illustrate the use (or misuse) of psychotropic medications. We strongly suggest that teachers.

Table 1  Teaching basic principles of psychopharmacology

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<thead>
<tr>
<th>• Selection of appropriate medications depends on diagnosis, history, medical status, family history, and previous response:</th>
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<tr>
<td>• Therapeutic differences among medications of the same therapeutic class are often similar, although side effects may differ.</td>
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<tr>
<td>• Heterogeneity of treatment response:</td>
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<tr>
<td>• Some patients respond better to one medication in a therapeutic class than others. Differences in response may depend on genetic sensitivity (receptors, enzymes), other medications or illness, and/or sensitivity to side effects.</td>
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<tr>
<td>• The importance of dose:</td>
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<tr>
<td>• Some patients respond to low (or very low doses) whereas others require standard or even higher-than-usual doses. Differences in response may depend on genetic sensitivity (receptors, enzymes), other medications or illness, and/or sensitivity to side effects.</td>
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<tr>
<td>• Medication interactions, enzyme function, and basic pharmacokinetics:</td>
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<tr>
<td>• Increasing information is available regarding genetic polymorphisms that may affect medication metabolism, pharmacokinetics, and receptor sensitivity.</td>
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<tr>
<td>• The necessary duration of treatment:</td>
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<td>• Many, if not most, psychiatric disorders are chronic and require ongoing maintenance treatment to prevent relapse or recurrence.</td>
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<td>• Some patients need encouragement and support in continuing maintenance medication, especially if it is to be lifelong.</td>
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<td>• As patients age and take other medications, doses may need to be adjusted.</td>
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<tr>
<td>• Medication side effects and differences among medications:</td>
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<td>• There may be similarities in the experience of medication side effects among patients, but medications themselves may cause different degrees of side effects, and medication selection is often (if not usually) based on side effects that need to be avoided (e.g., metabolic syndrome).</td>
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<tr>
<td>• Some side effects can be used therapeutically (e.g., sedating effects can promote sleep).</td>
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<tr>
<td>• Acute vs. maintenance treatment:</td>
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<td>• Acute treatment may require use of unusual doses or combinations of medications, but these should not necessarily continue throughout treatment.</td>
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<td>• Maintenance doses may need to be the same as therapeutic doses in the acute setting, but not always. Doses should be based on individual response and toleration of side effects.</td>
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<tr>
<td>• Nonadherence to or inappropriate discontinuation (or reducing doses) of medications may lead to relapse.</td>
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should be “active,” with Socratic-style interaction with trainees: asking the students questions and engaging in a dialogue with students about the genesis of a patient’s disorder and symptoms, as well as the choice and use of a medication to be prescribed. Experienced teachers also know that learning is enhanced when they actively add case examples for discussion or use a specific patient as a teaching example.

Other problems are evident. Students correctly complain that too much information is presented (e.g., too many facts on an electronic slide) or that teaching material is presented too rapidly and without direct clinical relevance. These are reasonable concerns; teachers should simplify their materials, slow down the presentation, and leave space for questions and comments. Other problems may arise with the use of newer electronic devices. Much psychopharmacology information is now available in handheld electronic tools. Students no longer have to memorize psychopharmacology facts, because they are readily available at a moment’s notice. If the available data are accurate and up-to-date, this new technology can provide immediate information to be used in the clinical setting. Whether it improves learning is unclear; we have observed that some students show little interest in mastering basic psychopharmacological concepts because they rely on readily available electronic resources. Electronic information may augment, but not substitute for, personal teaching.

How then can teachers of psychopharmacology instruct their students in a more interactive manner using the currently available techniques: lecture, seminar, printed word, and electronic databases? Teachers can teach by setting a good example! They should discuss their literature reading, recommend articles and books, discuss their own clinical prescribing experience, and share their own appraisal of psychopharmacology as a useful treatment modality. Like many other teachers, we suggest that teachers also learn to use electronic devices themselves to appreciate their usefulness and their limitations. We should also encourage teachers to develop creative teaching methods of their own. For example, some innovative teachers have developed computerized interactive case presentations that guide students toward correct treatment of a patient, with alternative treatment options and outcomes. Some universities are experimenting with online teaching in which students at many centers can interact and discuss treatment strategies. Some centers have developed games that pique the students’ interest and are fun to play while learning.

But, traditional learning resources (psychopharmacology books, journals, lectures) are not outmoded and are still necessary components of an adequate teaching program. We recommend that teachers may also wish to use the latest American Society of Clinical Psychopharmacology (ASCP) model curricula [5]—targeted to teachers—which discusses teaching strategies and includes 86 lectures with electronic slides, teaching objectives, and pre/post questions as a resource for up-to-date psychopharmacology information. Because the psychopharmacology literature is the basis of clinical work at our institutions, we use the appendices of the model curriculum that provide a list of classic psychopharmacology articles and book chapters and more up-to-date clinically important publications.

In addition to newer teaching techniques, we must emphasize that careful reading of psychopharmacology literature is an essential and irreplaceable component of psychopharmacology education. Whenever time and interest permit, teachers and students should be encouraged to learn to read the methods and results sections of research papers, not just abstracts and summaries. Teaching how to evaluate clinical trial data, including basic statistical and research methodology (e.g., sample size, outcome measures, doses and duration of treatments, use of adequate controls, and effect size), as well as the important difference between statistical significance and clinical significance, is essential to learning psychopharmacology [6] (Table 2).

Teaching the Nonpharmacological Basis of Clinical Psychopharmacology

Shared concern among some of our colleagues suggests that the rapidly emerging neurobiological basis of psychiatric disorders and their treatment may have relegated more than 100 years of clinical experience and knowledge of human psychology as a less important component of patient evaluation and psychopharmacological treatment. We worry that in many training programs, students are taught that psychiatric disorders are only a consequence of dysfunctional genes and neurotransmission; treatment is primarily or only medication.

We, like many others, suggest that students learning psychopharmacology must be taught to see the patient’s symptoms or disorder as part of an integrated understanding of the patient’s life experiences, past and present. Simply prescribing a psychotropic medication on the basis of a list of symptoms and/or DSM criteria may miss an essential understanding of the patient’s life experience and illness. We should remind our students that not all psychiatric symptoms indicate psychopathology that requires medication treatment. For example, we need to teach that not all “unhappiness” is clinical depression; not all “worry” is anxiety; not all “enthusiasm” or “high energy” (or “short sleep”) is mania; not all ruminations are obsessive-compulsive disorder; not all odd thoughts or suspiciousness are evidence of psychosis; and not all distraction, forgetfulness, or poor concentration is attention-deficit/hyperactivity disorder or dementia. Students learning psychopharmacology need to be taught that some patients who complain of “depression,” “anxiety,” or poor cognition may actually be demoralized, their hopelessness, frustration, and low self-
or controlling figures, like their parents or other previously
advice, including prescription medications. Some female
issues such as the doctor
of the treatment, and powerful transference-countertransference
prescription process (Table 3). Here, the teacher needs to empha-
well as the medication itself, is also an essential part of the
prescribing medications and the potentially biased media-
size that students must be aware of such issues as the
pharmacology also focuses on the psychodynamic meanings
esteem reflecting a deep sense of shame, a long-standing poor
quality of life, and an uncertain future.
Patients’ attitudes toward taking medications (especially psy-
chiatric medications) may vary widely, depending on individual
beliefs, fears, and preferences. These nonpharmacological factors
may influence the outcome of medication treatment (Table 3).
We should teach students of psychopharmacology to recognize
differing belief systems and biases that may vary from patient to
patient. Some individuals want only medication to alleviate their
suffering, no matter how mild; others are reluctant to take any
medication except as a last resort. Differing beliefs in the role of
medication to alleviate suffering that are based on family back-
ground, parental opinions, religious beliefs, and personal experi-
ence may affect the therapeutic alliance and possibly influence
medication adherence and therapeutic outcome.
Electronic media are another source of patient opinions
about psychiatric medications. As the risks and benefits of
psychiatric medications become more widely known, patients
may already have formed an opinion about which type of
medication (if any), which individual medication, and even
which dose they want and expect. Some of the media-based
information may be incorrect, biased, or out of date. Teachers
should alert students to the nonpharmacological factors of
prescribing medications and the potentially biased media-
based information, because ignoring each or both can lead to
lack of improvement or worsening of a disorder.
How the individual patient sees the role of the prescriber, as
well as the medication itself, is also an essential part of the
prescription process (Table 3). Here, the teacher needs to empha-
size that students must be aware of such issues as the “parental”/
authority power of the prescriber, the medical (not social) setting
of the treatment, and powerful transference-countertransference
issues such as the doctor’s “approval” or “disapproval” of the
patient [7–9]. Some patients see prescribers as authoritarian and/
or controlling figures, like their parents or other previously
important adult figures, and almost automatically reject treatment
advice, including prescription medications. Some female
patients, speaking with a male prescriber, may feel “controlled”
or “dominated” by a man, who they believe does not understand
problems that women experience emotionally or physically [10].
Some health-conscious patients believe that introducing an arti-
ficially constructed chemical into their body is tantamount to self-
poisoning; only “natural” treatments are acceptable. For some
psychotic patients, certain medications carry a specific series of
delusional beliefs that either facilitate or inhibit their use. For an
increasing number of patients, psychiatric medications are too
expensive or the side effects are too limiting to follow prescrip-
tive advice [4]. We need to do a better job of teaching these
nonpharmacological factors in the prescribing of psychotropic
medications. The astute clinician learns to understand unspoken
wishes of the patient, and the skillful teacher imparts the impor-
tance of the actual beliefs and wishes of the patient as part of a
psychopharmacology evaluation.
In our opinion, there is also insufficient teaching of different
ethnic, cultural, societal, and religious beliefs that may influ-
ence a patient’s understanding or wish to receive or not receive
a psychiatric medication. We should teach that the causes of
psychiatric disorders are often multiple and may have personal
meaning for an individual that must be deciphered in order to
understand and formulate an appropriate treatment program.
Teachers of psychopharmacology need to alert their students to
these hidden factors in seemingly traditional psychopathology
and adjusting their medication treatment strategies
accordingly.
Many nonpharmacological aspects of prescribing psycho-
tropic medications are in a large body of literature regarding
the nonpharmacological aspects of prescribing medications
(see Appendix). Embedded in this literature that discusses
the integration of psychodynamic psychotherapy with psycho-
pharmacology also focuses on the psychodynamic meanings

<table>
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<th>Table 2</th>
<th>Teaching techniques</th>
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<tr>
<td>• Use fewer slides</td>
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<td>• Limit teaching points on each slide (two or three)</td>
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<td>• Slow down the pace of slide presentations</td>
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<td>• Ask if there are questions</td>
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<td>• Provide slide handouts for reference after the lecture</td>
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<td>• Augment lectures with new techniques:</td>
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</table>
  - Multimedia, patient vignettes, and live interviews |
  - Model curricula, associated reading materials |
  - Electronic resources |
  - Games that cover diagnosis, medication, side effects, etc. |
  - Flipped classrooms—residents do the teaching with lecturers at their side |

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Social and psychological contexts of psychiatric disorders, their impact on treatment, and the nonpharmacology of psychopharmacology</th>
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<tbody>
<tr>
<td>• Effect of the patient’s relationship to the prescriber on individual variation in medication response, e.g., the impact of transference and the therapeutic alliance</td>
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<td>• Impact of countertransference of the prescriber on individual variation in medication response</td>
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<td>• Role of psychology in pharmacological treatment “resistance”</td>
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<tr>
<td>• Role of psychology in individual variation in response to psychotropic medication</td>
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<tr>
<td>• The necessity of a therapeutic alliance for adequate drug treatment</td>
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<td>• Importance of cultures and especially family/significant others on symptoms</td>
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<tr>
<td>• Distinguishing symptoms from normal human experience</td>
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<tr>
<td>• Understanding the wide range of human experience and symptoms</td>
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<tr>
<td>• Understanding the role of age, gender, and ethnicity in medication treatment and response</td>
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<tr>
<td>• The importance of treatments other than medications</td>
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of medication. The books and articles are especially rich in their discussion of the relevance of psychological transference and therapeutic alliance, to the prescriber, problems of “treatment resistance arising from past and present psychological conflicts, the variety of meaning of medicine depending on an individual’s personal beliefs and experience, and understanding the patient in a broad psychosocial context.

A teacher’s knowledge of psychopharmacology may be primarily based on the teacher’s own clinical experience rather than reflect the latest data from published reports or recently published texts. A teacher who treats severely ill and treatment-refractory patients may not have the same view of a particular medication (or group of medications) as a teacher who primarily treats outpatients with less severe illnesses. It is not unusual for some teachers to describe the therapeutic response to a medication on the basis of a single patient whom they had once treated. Teaching psychopharmacology on the basis of a single case experience may be misleading to students who are just beginning to learn to use psychotropic medications. Teachers need to stay conversant with current psychopharmacology literature. We recommend that clinicians who teach psychopharmacology need their own continuing education regarding updated psychopharmacology information to expand their own clinical experience. Recommended journals for up-to-date psychopharmacology and neuroscience are listed in the Appendix.

**Evaluating Students’ Learning and Teachers’ Teaching**

The teaching of psychopharmacology (like many subjects) needs to be continually evaluated and adapted to the needs of the student. Asch and Weinstein [11] point out that valid and feasible measures of training success need to be defined. Teachers, under the stress of multiple demands on their academic teaching time, may find it difficult to evaluate and give corrective feedback to their students. In many programs, there is not traditional one-to-one supervision in psychopharmacology as there is for psychotherapy. We have observed that students may finish a training program without documenting basic competence in psychopharmacology.

In order to evaluate the success of psychopharmacology education, we need systems for routinely measuring our teaching on the quality, distribution, and course of care delivered by our students and by graduates of our schools and training programs. Some residency training centers use standardized psychopharmacology tests (e.g., the Psychiatry Resident-In-Training Examination (PRITE) from the American College of Psychiatrists or the American Board of Psychiatry and Neurology’s Part I exam); other centers create basic questions to be administered before and after a course has been taught. Continuing education courses often use computerized question/answer push-button technology to assess whether or not the audience has learned certain basic principles. These methods of student evaluation should be part of all psychopharmacology teaching programs. We also find mock board examinations very useful, in which the teacher evaluates the trainees as they diagnose and treat a patient.

We also believe that there is a need evaluate ourselves, the teachers. Someone should watch us teach and provide feedback. At some medical schools where teaching excellence may be a basis for academic promotion, educators are observed during their teaching sessions, and their competence is directly evaluated. Students’ opinions of teachers and feedback to the teachers are also essential. Continuing medical education programs commonly gather participants’ evaluations of teachers and the materials that are presented. Simple rating forms are useful for students in training programs to evaluate their psychopharmacology teachers. The ASCP curriculum has examples of such forms [5].

**Conclusion**

Modern psychopharmacology is complex, with ever-changing practice recommendations based on new research and clinical observations. The knowledge base for psychopharmacology is expanding so rapidly that it is nearly impossible to read and absorb all the new information. It is not easy for teachers, who are busy in their own professional lives, to stay current and teach students of varying backgrounds, interests, knowledge bases, and ultimate careers. In addition, nonpsychopharmacological factors in an individual patient’s life may be as relevant to the treatment setting as the actual pharmacological basis of psychotropic medication therapeutics. Evaluation of students and teachers is essential: students’ learning psychopharmacology that is up-to-date, accurate, and consistent with the reality of an individual patient’s life experience and beliefs and educators’ ability to teach essential psychopharmacology knowledge and practice that is also relevant in today’s changing psychiatric environment.

**Disclosures**

Dr. Glick is the editor/chairman of a committee that has developed the American Society of Clinical Psychopharmacology’s model psychopharmacology curriculum. There was no funding source for this paper.

**Appendix**

**Literature on Integrating Psychodynamic Principles with Psychotropic Drug Treatment:**

The Importance of Non-Pharmacological Factors in Treatment and Recommended Journals for Psychopharmacology Teachers


Ostow M. Psychotherapy and psychopharmacology. New York: Basic Books; 1962


Sandler L. On the prescribing psychoanalyst. Psychoanalytic Quart. 2014; 83:97–120.


Recommended Journals for Psychopharmacology Teachers

- Journal of Clinical Psychopharmacology
- American Journal of Psychiatry
- Neuropsychopharmacology
- Biological Psychiatry
- International Journal of Neuropsychopharmacology
- Schizophrenia Research
- JAMA Psychiatry
- Journal of Clinical Psychiatry
- British Journal of Psychiatry
- Journal of the American Medical Association

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2. Glick ID. Special educational session: Improving the teaching-learning process in psychopharmacology: A demonstration of new teaching formats from the ASCP Psychopharmacology Curriculum, presented at the 2012 NCDEU-ASCP Annual Meeting, Phoenix, June 2012
Primary Care Pitfalls for the Psychiatrist Psychopharmacologist

James W. Thompson, M.D., M.P.H.

Much has been written about the interface between general psychiatry and general medicine,1 and indeed a new subspecialty of psychosomatic medicine has been spawned to address clinical issues and doctor-to-doctor problems at this interface. It is often assumed that the psychiatrist psychopharmacologist is less susceptible than the general psychiatrist to such interspecialty problems. After all, general physicians are biologically oriented and so are we. There are, however, a number of primary care pitfalls for the psychiatrist psychopharmacologist (hereafter, simply “psychopharmacologist”). It is the purpose of this column to discuss several of these pitfalls and suggest ways to avoid them.

We Think Alike—Or Do We?

The basic assumption noted above (that we share a biological view of medicine with primary care physicians [PCPs]) does have its validity. We do tend to stick to biology, and (rightly or wrongly) seldom bring psychodynamics or psychosocial considerations into a discussion of psychopharmacologic treatment. Nevertheless, medical conceptualization and decision making in primary care medicine differs in a number of ways from that of psychiatry, including psychopharmacology. First, although psychiatrists in consult-liaison psychiatry do tend to see the psychiatric world as a part of the larger medical world, we still have a specialist’s view. The brain is still “our” organ, and we focus on it, try as we might to not do so. The general physician, on the other hand, sees psychiatric problems as a relatively small part of the larger picture. Even when general physicians see a psychiatric problem as a key factor in the patient’s illness, they do so in a way that very much integrates that problem with the larger clinical picture. Indeed, the psychiatric problem may be seen as something to deal with first, in order to get to more “major” problems in a particular patient.

“Lumpers” and Splitters

Psychiatrists, in large part because of DSM-IV, are splitters. That is, we have separated syndromes into small pieces and often apply treatment modalities on the basis of relatively small distinctions. All specialists tend to do this, of course, but PCPs cannot afford this luxury. Their diagnostic process involves a very broad range of pathophysiology, and to obsessionately subdivide each of the areas of disease would be confusing and overwhelming. Specialists have the first step in medical decision making already done for us—we know what organ we’re going to focus on. Even if we decide that the primary problem is elsewhere, the focus is still on the brain. In the pathology of that complex organ, we find a myriad of minute distinctions. However, the first step for PCPs in diagnosis is to choose the offending organ system, and the continuing diagnostic task involves keeping all organ systems in mind. They cannot afford to subdivide each of these too much, as this would interfere with decision making.

Psychopharmacologists share the specialist’s predilection for splitting syndromes but also are splitters when it comes to the drugs utilized. We have a great deal of experience with our pharmacologic agents and tend to know which ones work best in particular situations and for particular subsets of disease. In fact, this knowledge is often the very reason we’re consulted by a general medical physician. The goal is to convey our reasoning for choosing a particular drug for a certain condition without overwhelming the physician with detail. Avoiding this mistake is important because often the PCP will be following the patient over time, and needs to understand the basic reasoning behind the use of a particular drug.

Better, but Not Well

To borrow the recent Madison Avenue slogan, psychopharmacologists want to see the patient get “well,” i.e., completely free of symptoms and back to optimal functioning. Philosophically, of course, so do PCPs. However, in actual practice, many PCPs are quite satisfied with “better” in psychiatric illness. This point of view has several roots, including not having the time to really assess the finer points of improvement in psychopathology. The PCP generally has a patient who is delighted to be 65% less depressed or anxious, and the physician may not have seen enough 90% to 100% “cures” to appreciate that the job is not finished. Of course, a small minority of PCPs continue to believe that getting better from mental disorders is largely based on placebo effect, and given that assumption, 65% better is good.

Descartes Lives

As much as we would like to think otherwise, there remains a mind-body dualism in medicine, and the use of psychopharmacologic agents is no exception. Primary care physicians, even though they really know better, may see psychotropics as largely acting on brain disorders, separate from other disorders and pharmacologic effects going on in the patient’s body. In all fairness, primary care training has addressed this dualism of late, and the situation is far better than it used to be, but old paradigms die hard. The result is that PCPs may not fully appreciate the effects that psychotropic drugs have on the body below the tentorium, or they may appreciate this fact but not think about how the drugs they are giving might interact with these psychotropics. Likewise, they may not consider how general medical and substance abuse comorbidity might influence the effects of drugs given to treat mental disorders.

Avoiding the Pitfalls

Psychopharmacology and psychopharmacologists today usually are recognized as valuable members of the medical team, as PCPs confront a caseload filled with mood and anxiety disorders, substance abuse, and geriatric behavioral issues among others. However, there remain many slips at the interface. Many of these, however, can be avoided.

Walk a mile in the PCP’s shoes. Psychopharmacologists have to appreciate the situation of PCPs and put our recommendations into their framework. They call us because they have a patient problem that goes beyond simple depression that quickly responds to fluoxetine. We are often there precisely because of the complexity of the situation. On the other hand, when we make our assessment and propose a therapeutic approach, PCPs want to have an understanding about what we have done, whether this is because they will continue to follow the patient’s psychotropic or because what we do psychopharmacologically impacts the rest of what they do with the patient.

One approach is to provide the PCP with a 2-part report. The first part is a brief summary of the problem, the assessment, and the approach we are suggesting, with a few key facts such as drug interactions, side effects, and possible untoward physiologic effects. This allows the PCP to quickly get an overview of the situation and the suggested solution. The second part of the report is a more detailed explanation of the thinking behind our as-
Assessment and treatment plan. This gives the physician a more in-depth reference, should this be desired.

References from the literature are also helpful in conveying the underlying reasons for our therapeutic approach and can accompany the consultation report. Specialty review articles can be useful but often are lengthy and assume knowledge of the psychiatric literature. Articles on psychiatric issues from a primary care journal or other general medical journals often fit better with the worldview of primary care. Also, abstracts from Medline (available at: http://www.nlm.nih.gov/portsals/healthcare.html) are a brief read, and give physicians a start toward reading more on the topic, should they desire.

Finally, most PCPs have little time to educate patients. The psychopharmacologist can help by providing the PCP with patient education handouts or websites the patient can consult.

Do more “lumping.” We are generally more effective in our communications when we refer to larger categories, such as “depression,” rather than “major depressive disorder versus dysthymia.” One way to do this is to become familiar with one of the primary care psychiatric diagnostic manuals, such as DSM-IV–PC (primary care version), which generally take a much broader view of our diagnostic entities. There are, of course, distinctions that must be made because of differential therapeutics, such as bipolar II disorder, depressed, versus unipolar depression; however, if there is a common treatment for related categories, it is better to refer to the overarching category. Similarly, it is usually preferable to refer to a class of drugs, unless there are differences that are important in the specific clinical situation. Few PCPs are concerned about the more subtle differences among fluoxetine, sertraline, and paroxetine, for example.

Achieving 90% to 100%. Remission, that is, the point at which a patient arrives at an optimal therapeutic result, is often not clear. Psychopharmacologists, as specialists, may rely on comparisons with a myriad of similar patients to say whether or not the patient is “well.” Generalists often will not be able to rely on such evaluation methods. Instead, they and we must adopt an approach that goes back to basic diagnostic criteria: Which target symptoms are better and which are not? What are the implications of the residual symptoms on the patient’s ability to function and achieve a good quality of life? How will residual symptomatology interact with comorbid conditions? Relating degree of remission in these ways will give the general physician a better understanding of where the patient is and provide ways to measure further improvement.

A simple way to help the physician assess the degree of remission is through the use of rating scales. Such instruments initially help with diagnosis, but they can also be used to follow the progress of patients. If the scale is self-administered by the patient and placed on the chart by the nurse, the physician has a welcome tool to assess and follow patients with psychiatric disorders.

Differing with Descartes. Finally, the psychopharmacologist must deal with mind-body dualism. Some of the above suggestions have addressed this issue, in part, by subtly pointing out that psychiatric illness and treatment often interact with nonpsychiatric illness and treatment. In addition, however, it is also necessary to be overt in undermining dualism. Psychopharmacologists have several routes they can take to accomplish this task. In their consult reports, they can point out the interactions between psychiatric and nonpsychiatric medications, using one of several handbooks on the market. They can also point out the somatic side effects that often accompany psychiatric medications. Recruiting other specialists in addressing a complex diagnostic or therapeutic situation can also be very helpful in bridging the mind-body gap. For example, a rehabilitation physician, neurologist, and psychiatrist together can arrive at a formulation and approach that will tend to be nondualistic.

Conclusion

It is sometimes assumed that psychiatrist psychopharmacologists do not really know a great deal about general medicine, and that primary care physicians do not really know a great deal about psychiatry and psychopharmacology. In fact, most of those in each group have a workable understanding of the other. The problem often is not in knowledge, but rather in medical worldview and therapeutic approach. Often these differences are born of a pragmatic need to address patient needs and clinical situations in different ways. It is up to both the psychopharmacologist and the primary care physician to address these differences. Doing so will lead to better relationships between specialties and better patient care.

Dr. Thompson began his career as a primary care physician and has long been involved with psychiatry in primary care settings through teaching, research, and clinical work. He is Administrative Director of the American Society of Clinical Psychopharmacology.

Dr. Thompson reports no financial affiliations or other relationships relevant to the subject of this column.

REFERENCES


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