A four pronged approach – individualization, recovery, trauma informed, and toxicity informed to prescribing, in part responding to the challenge of Robert Whittaker's "Mad in America"

A More Comprehensive Approach to Ethical and Effective Prescribing

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Like most doctors, I feel like I prescribe medications ethically and effectively. The basic foundation for that confidence is three things: 1) Knowing that my primary motivation is almost always to help my patients. I believe that my prescribing isn't substantially impacted by other motivations like my own financial gain, decreasing my own workload, or countertransference, for example. 2) I try to defend myself as best I can from being too influenced by the profit seeking motivations of the pharmaceutical industry. And 3) I try to resist responding to various self-destructive motivations of my patients (hopefully without becoming too judgmental and pejorative of their "medication abusing", "manipulative", "sabotaging" desires). Prodded by Robert Whittaker's books, I feel the need to build a more comprehensive approach to ethical and effective prescribing than I was taught or modeled or even than is expected of me. Here are four more foundations I'm building: 1) Individualized prescribing, 2) Recovery based prescribing; 3) Trauma informed prescribing, and 4) Toxicity informed prescribing.

1) Individualized Prescribing

I was first taught to prescribe based upon people's diagnoses. I was taught a rapid, highly simplified, reliable, syndromic check list method of differentiating a handful of diagnoses that have associated research driven flow charts of medications to treat them. Within this system a variety of people, for example a speed using, foster care childhood, homeless person, an emotionally labile rape victim, a person with a strong family history and clear episodes of highs and lows, and an emotionally immature teenager are all diagnosed with Bipolar disorder and treated with mood stabilizers and atypical antipsychotics. Even this system is often considered too time consuming and replaced with symptom based prescribing. I was taught to treat depression with antidepressants, anxiety with antianxiety medications, and psychosis with antipsychotics and mood instability with mood stabilizers. Chart notes are supposed to reflect targeted symptoms.

I don't find either of these approaches to be generally ethical or effective. Fortunately I have the time and support to actually get to know my patients well and to understand as well as empathize with them. We build a shared story of what their difficulties are and how they developed them. Sometimes it's a medical model, DSM story and sometimes it's not. We develop a shared treatment plan that often, but not always, includes medications as part of how their life is going to get back on track. I may or may not prescribe to help overcome family conflicts, attachment disorders, violent urges from childhood beatings, the stress of a battle between God and the Devil within them, or any of a multitude of highly individualized formulations.

I believe this method increases effectiveness both by incorporating well known "nonspecific treatment factors" and by increasing engagement and medication usage. It reduces "drop outs" and "non-compliance", arguably two of the most important mediators of ineffective treatment.

2) Recovery Based Prescribing

It has been a good deal of my life's work to develop and practice a comprehensive approach to recovery based prescribing. Key values have been embedded into key practices with every patient I see including:

- Collaborative, client-driven prescribing instead of professional driven
- Shared decision making, and shared responsibility instead of informed consent and professional responsibility
- Quality of life, goal driven prescribing instead of symptom relief prescribing
- Pursuing resilience instead of cure
- Shared journey of learning from successful and failed attempts instead of risk aversion
- Growth oriented instead of caretaking – including transitional relationships with me instead of lifelong commitments
- Basing hope on their strengths instead of mine
- Taking the long view of recovery

I have discussed each of these in detail elsewhere. In my view, developing these practices has protected the people I work with for a great deal of the damage commonly included in our prevalent medical model prescribing.

3) Trauma Informed Medications

There is a great deal of trauma and suffering associated with mental illnesses. There is also, unfortunately, a great deal of trauma associated with psychiatric treatment including medications. While consumer / survivors used to confront us with traumatic stories of involuntary hospitalizations and confinement, of being locked up and tied down and physically assaulted, today's stories far more commonly revolve around traumatic medication stories – medicated after inadequate evaluations, mis-medications, overmedication, poly pharmacy, difficulties in functioning on medications, difficulty in getting off medications, etc. While trauma informed approaches have been developed, though not nearly widely enough used, for hospital practice, I've never seen trauma informed approaches to medications articulated.

When there was a large conflict over whether antidepressant prescribing to depressed teenagers was causing an increase in suicidal thoughts and behavior, the discussion focused on the biological factors not the traumatic factors. I never heard the hypothesis that suicidal thoughts and behaviors increased because it was traumatizing to be diagnosed with a mental illness and give a prescription, even if you never took it.

When we do think about trauma and medications we tend to conceptualize it as internalized self stigma and then see the remedy as destigmatizing education, especially emphasizing the shame and blame reducing aspects of illness based formulations. Rarely do we linger over understanding the individualized traumatic impact of each prescription we write. Which of our patients feel degraded, dehumanized, discounted, pressured to conform, misunderstood, controlled, drugged up, physically harmed, over sedated, creatively inhibited, racially persecuted, personally devalued, etc. by their prescriptions? I've tried to develop a plausible list to explore with people as I prescribe to try to be trauma informed. Sometimes I won't prescribe as a result of the likely trauma I'll induce. Sometimes I'll help them work through the trauma to be able to use medications less painfully.

4) Toxicity Informed Prescribing

I was taught that the way to deal with toxic aspects of our medications was to learn the side effects of each medication and balance symptom relief and side effects, including attempting to share my decision making process with my patients through a discussion of risks and benefits and informed consent. I wasn't really taught that even though I was usually urged to prescribe "for the rest of your life" that all of the studies of effects and side effects were short term studies, generally 6-12 weeks. I also wasn't taught that pharmaceutical companies routinely hide the side effects to increase their profits. The Zyprexa / diabetes story was my personally traumatic lesson in "real life".

I also didn't notice that the side effects included in the FDA studies and the PDR systematically exclude "subtle" psychological and emotional side effects that are often very important to the people I work with including things like "I don't feel like I can cry anymore even when I need to", "I was able to remember more of my past and felt more alive when my medications were decreased," "I'm less creative on my medications and I just don't feel like writing poetry as much," or "I'm not as quick-witted and funny as I used to be."

Whitaker's main contribution to my thinking is his biological hypothesis that feedback responses to medication induced "positive" biochemical changes may be far more pervasive and damaging than we realized and that we often mistakenly identify them as re-emergence of underlying, still existing illnesses. I was certainly aware of this possibility with addictive medications and with tardive dyskinesia, but I'd never applied that model to "my antidepressants poop out after about 9 months and I need to change what pill I'm on" let alone to cognitive declines with schizophrenia, chronic depression and generalized anxiety, rapid cycling and mixed state bipolar, or stimulant induced chronic mood instability. On a gut level his hypothesis fits my clinical observations.

Taking this hypothesis seriously has led me to two prescribing changes. Firstly, I think I have to take the same precautions I do for medications known to create either tolerance or withdrawal based problems like benzodiazepines and stimulants and that I take with those known to cause hypersensitivity feedback syndromes like tardive dyskenesia for all medications. "If you have no side effects now, you're never going to get any. You can keep taking this medication with minimal monitoring indefinitely" is probably not an effective and ethical approach even though it's very common.

Secondly, as I read the long term studies that have gotten more recent exposure and Andreason's unique work, I've come to the conclusion that neither the pro-medication nor the anti-medication sides are correct. It isn't a question of figuring out whether untreated psychosis is damaging to your brain or long term medications are damaging to your brain. The most likely answer is that both are damaging. The prescribing recommendations of both sides of the "or" argument – aggressive preventative prescribing to people at high risk of developing psychosis and avoiding medications while pursuing holistic, interpersonal, or social interventions while the psychosis persists and grows – are both narrow minded. The "and" approach says that it's harmful both to medicate and not to medicate.

I've long suspected that "Do no harm" was a fantasy. I have to come to terms with the likelihood that I'm doing harm when I do prescribe and when I don't prescribe, regardless of my motivations. Perhaps I can apply some of the harm reduction principles I've learned to use with substance abuse. But I know how humbling and powerless and uncomfortable using harm reduction feels. I have some emotional work to do if I'm going to approach all of prescribing that way.