The issue of (maybe) treating too much

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Recent editorials in the British Medical Journal (BMJ) about “too much medicine and too little caring”1-3 caught my attention and led me to contemplate how often psychiatrists treat patients “too much.” The BMJ editorials focus mostly on overtreatment due to overdiagnosis,1 the culture of “more is better,”1 changing the disease definition, and shifting the dividing line between normal and abnormal.2 They point out that, “we are now so busy managing the proliferation of risk factors, ‘incidentalomas,’ and the worried well that we lack the time to care properly for those who are seriously ill.”2 One editorial3 focuses solely on psychiatry and the DSM system with its continuous increase in the number of diagnoses and “medicalization of ordinary experience.” That may be true, but there are many other ways of treating our patients “too much.”

I often am amazed at how imprecise we are in our diagnoses and their treatment implications. At times, this is due to insurance pressure or our own “worry” about reimbursement. I recall a colleague telling residents to avoid the diagnosis of adjustment disorder because there is little (or no) reimbursement for it. I have seen many patients diagnosed with bipolar disorder and treated with mood stabilizers because they had “mood swings.” A careful discussion of their symptomatology revealed no signs of mania, only getting angry and upset easily.

We often use medications deliberately, without sound justification. Is there a good reason for some of our patients being on 6 or 7 psychotropic medications? Is there a good reason to routinely add anticholinergic medication when we start antipsychotics? Did we forget that this combination worsens tardive dyskinesia? Yet I often see the routine addition of benztrapine to antipsychotics. Similarly, is there a good reason to treat some patients suffering from schizophrenia with extreme dosages (eg, hundreds of milligrams of haloperidol decanoate and oral haloperidol)? There is lack of evidence of long-term (>3 years) treatment with antipsychotics being effective and reducing or eliminating psychosis. The 20-year data from a recently published study4 suggest that after the first few years,
antipsychotics do not eliminate or reduce the frequency of psychosis in schizophrenia. As the authors suggest, many patients with schizophrenia, based on their psychotic activity and disruption of functioning, are not truly in remission. Perhaps the medications cease to have a positive effect for some patients? Considering the long-term negative effects of antipsychotics, we need to ponder whether schizophrenia treatment should be intermittent with focus on exacerbation, or continuous. (There is evidence that long-term outcome for schizophrenia in the modern era has not improved much from the pre-antipsychotic era.)

Using medication “too much” is not the only type of treatment being used “too much.” How many times have we seen patients engaged in what appears to be permanent treatment without any improvement? How many times do we see a therapist—or psychiatrist—saying “you do not need to be in therapy anymore” or “you do not need any treatment,” or even, “we do not have treatment available for your condition?” Could we say, similar to our approach to ineffective medication, “this psychotherapy (cognitive-behavioral therapy, interpersonal therapy, dialectical behavior therapy) does not work, let’s try another one,” and leave our theoretical or other bias behind us?

Many times we avoid simple interventions and use much more complex or complicated ones. For example, we would rather prescribe a hypnotic and an antidepressant than use medical leave of absence or adjustment of work duties for an exhausted patient who feels down and has difficulty sleeping.

Whom do we serve? Ourselves, insurance companies, pharmaceutical industry, or our patients? We need to start considering our treatments and their continuation more wisely, more carefully, and with continuous checking and rechecking the indications and necessity for continuation to avoid treating patients “too much.” That would be a true service to our patients.

### REFERENCES


