

## 7 psychopharm myths debunked

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**A**s a psychopharmacology consultant, I often encounter bits of received wisdom that do not square with results of controlled studies. Although all these “myths” contain a grain of truth, their uncritical acceptance can be a barrier to effective care.

### 1 Dual-acting antidepressants are more effective than serotonergic agents.

Although some serotonin/norepinephrine reuptake inhibitors may be modestly more effective than some selective serotonin reuptake inhibitors (SSRIs), no randomized studies show that one class of antidepressants is clearly superior to another. The overall difference in remission rates between venlafaxine and SSRIs—about 6% favoring venlafaxine—is not robust.<sup>1</sup>

### 2 Lithium is not as effective as divalproex for treating rapid-cycling bipolar disorder.

Rapid-cycling bipolar disorder can indicate reduced drug responsiveness, but lithium should not be disregarded. The relapse rate into any mood episode among rapid cyclers is not significantly different among patients maintained on lithium vs valproate,<sup>2</sup> though concomitant antidepressant treatment complicates some studies.

### 3 Psychotropics with short elimination half-lives need to be administered 2 or more times a day.

This statement may be true for some patients taking short-acting benzodiazepines for panic disorder or psychostimulants for attention-deficit/hyperactivity disorder. However, no randomized, head-to-head studies show that antidepressants or anti-

psychotics with half-lives <12 hours—such as ziprasidone—must be given several times a day.<sup>3</sup> Antipsychotic effects probably persist at dopamine-2 receptors even at trough blood levels.

### 4 Tardive dyskinesia (TD) is not a problem with atypical antipsychotics.

Atypical or second-generation antipsychotics (SGAs) are associated with TD rates approximately one-tenth to one-half that of first-generation antipsychotics. But TD can occur with atypicals, particularly in very old and very young patients. Some data indicate TD rates >10% in African-American children taking SGAs.<sup>4</sup>

### 5 Stimulants should never be combined with a monoamine oxidase inhibitor (MAOI) because a dangerous hypertensive reaction is likely.

No controlled studies or case reports show that carefully adding a psychostimulant—such as methylphenidate, 5 to 10 mg/d—to an MAOI leads to serious hypertensive or other life-threatening reactions.<sup>5</sup> Nevertheless, a careful risk-benefit assessment and close monitoring are indicated when prescribing this combination.

### 6 Antidepressants are effective and necessary in maintenance treatment of bipolar disorder.

Most recent studies find little benefit from adjunctive antidepressants in maintenance treatment of bipolar disorder.<sup>6</sup> Although most stabilized bipolar patients don't need

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an antidepressant, some may experience depressive relapse when adjunctive antidepressants are discontinued.

## 7 Co-administered mood stabilizers prevent antidepressant-induced 'switching' into bipolar mania.

It is not clear that mood stabilizers as a class provide reliable protection against antidepressant-induced switching, though lithium may offer more protection than anticonvulsants.<sup>7</sup> Even if switching is not caused by antidepressants,<sup>6</sup> irritability, insomnia, and cycle acceleration may occur in susceptible patients.

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