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When the cure clouds the picture: recognizing iatrogenic psychiatric syndromes in primary care

Abstract

Psychiatric medications can be valuable tools in the management of mental health disorders, particularly during acute crises and in short-term interventions. However, it is essential to acknowledge that these same medications may paradoxically induce or worsen psychiatric symptoms in specific individuals. These iatrogenic effects can lead to complex clinical presentations that obscure accurate diagnosis and complicate treatment planning, especially in primary care settings, where access to specialized psychiatric expertise is often limited. This article explores the phenomenon of iatrogenic psychiatric syndromes, highlighting their relevance in family medicine. Through a clinical vignette and a review of common medication-induced syndromes, we underscore the importance of cautious prescribing, differential diagnosis, and structured clinical reasoning. We also emphasize the critical roles of cultural awareness and peer support in identifying and managing these syndromes. Cultural context can shape how symptoms are expressed, perceived, and treated, while Peer Support Specialists (PSS)—individuals with lived experience of mental health recovery—offer unique insights that enhance patient-centered care. Together, these perspectives enrich clinical understanding and promote safer, more compassionate treatment strategies.

Keywords: Iatrogenic psychiatric syndromes, psychopharmacology, primary care, peer support specialists, cultural competence, adverse drug reactions, diagnostic humility, integrated care, mental health equity, pharmacovigilance

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Marcello Maviglia,[1] Norman J. Cooeyate MCRP,[2] Donald Hume[3]
[1]Clinical Professor, Family and Community Medicine/ Core Faculty Member at CNAH (Center for Native American Health), University of New Mexico, USA
[2]Associate Director, Center for Native American Health (CNAH) Director, CNAH's Public Health Institute for Indigenous Knowledge and Development, Lecturer II, Department of Family & Community Medicine University of New Mexico Health Sciences, USA
[3]Senior Peer Specialist, Presbyterian Health Care Services, USA

Correspondence: Marcello Maviglia, Clinical Professor, Family and Community Medicine/ Core Faculty Member at CNAH (Center for Native American Health)/ University of New Mexico, Albuquerque, USA, Tel 505-272-1855/ 1505620628

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Introduction

As the landscape of integrated healthcare continues to evolve, primary care physicians (PCPs) and family medicine practitioners are increasingly stepping into the pivotal role of initiating and managing psychiatric treatments. This evolution arises from the growing prevalence of mental health conditions coupled with the scarcity of psychiatric specialists available to meet patient needs.[1] However, with this expanded responsibility comes a significant clinical challenge: the emergence of iatrogenic psychiatric syndromes. These adverse psychiatric effects, caused by medications intended to treat mental illnesses, are often overlooked and can either mimic the natural progression of psychiatric disorders or be interpreted as signs of unresponsiveness to treatment.[2]

Consider the case of selective serotonin reuptake inhibitors (SSRIs), frequently prescribed to alleviate symptoms of depression and anxiety. In specific individuals, these seemingly benign medications may precipitate agitation, insomnia, or even manic episodes, particularly in those who are predisposed.[3,4] Similarly, antipsychotic drugs, while offering relief to many, can induce akathisia, a profoundly unsettling state characterized by relentless inner restlessness. This can easily be misinterpreted as heightened anxiety or psychotic agitation, leading to misdirected treatment strategies.[5] Benzodiazepines, which are typically effective for acute episodes of anxiety, can paradoxically exacerbate mood disorders or instigate disinhibition in some patients.[4] Such misunderstandings can set off a troubling cascade of clinical missteps, including unwarranted medication changes, the utilization of polypharmacy, an increased burden of side effects, and prolonging the distress experienced by patients.[6]

In the realm of primary care, where time constraints and limited psychiatric training can dominate the daily experience, the risk of diagnostic overshadowing rises significantly. Therefore, cultivating a heightened index of suspicion is critical. Clinicians should remain vigilant, recognizing that the onset of new or worsening psychiatric symptoms might not always indicate disease progression, but could very well be induced by medication.[2] This realization necessitates a nuanced understanding of psychopharmacology, involving a deep familiarity with the side effect profiles of commonly prescribed agents, their potential interactions, and the timing of symptom appearance relative to any pharmacological adjustments.[2–6]

The clinical manifestations of iatrogenic syndromes can be startlingly varied. Some patients may display paradoxical reactions—like heightened anxiety when taking benzodiazepines or depressive symptoms that arise in response to stimulant medications—while others may experience subtler cognitive or affective shifts that risk being overlooked.[2]

Need for a structured clinical approach

These complexities point to the urgent need for a structured clinical approach, which may include the following elements:[7,8]

I. **Thorough medication history**: Diligently gathering a comprehensive medication history, paying close attention to any recent changes in dosage or formulation.

II. **Temporal mapping of symptom onset**: Meticulously analyzing the timeline of symptoms regarding pharmacologic interventions to find potential correlations.

III. **Focus on differential diagnosis**: Distinguishing between primary psychiatric conditions and those induced by medications.

IV. **Trial discontinuation or dose adjustment**: Considering whether to discontinue or adjust the doses of "problematic medications" to observe any resultant changes in symptoms.

V. **Interdisciplinary collaboration**: Fostering collaboration with psychiatric specialists for cases where uncertainty regarding

diagnosis and treatment persists, ensuring a more comprehensive understanding of the patient's condition.

As PCPs navigate these complex tasks, it becomes increasingly clear that a thoughtful and systematic approach is essential to safeguard patient well-being while effectively addressing their mental health needs.

Clinical vignette

To protect patient confidentiality, the following case is presented in a simplified and illustrative form. The location of care is a clinic in the Southwestern United States; other identifying details have been deliberately omitted. A 45-year-old female patient with a long-standing history of Major Depressive Disorder (MDD) sought routine follow-up care after being treated with a selective serotonin reuptake inhibitor (SSRI). Several months prior, she had been prescribed an SSRI to manage her persistent depressive symptoms, which included low mood, lack of interest in activities, and difficulty concentrating. Initially, she reported a marked improvement in her mood and overall functioning during the first few weeks of treatment.

However, approximately three weeks after starting the medication, the patient began to experience troubling side effects. She noted significant increases in anxiety, characterized by excessive worry, restlessness, and an inability to relax. Additionally, she struggled with insomnia, finding it difficult to fall asleep and stay asleep throughout the night. These new symptoms left her feeling unsettled and led her to suspect that her depression was worsening.

During a routine follow-up appointment, the patient openly discussed these developments with her primary care provider. Unfortunately, the provider, unaware of the potential adverse effects of SSRIs—such as anxiety and insomnia—increased the dosage of the medication, believing that the initial dose might not be sufficient to manage her depressive symptoms effectively. This decision was made without a thorough review of the patient's presenting symptoms or consideration of the potential for medication-induced side effects.[2,4]

Following the dosage adjustment, the patient reported no improvement; in fact, her levels of anxiety soared, and her insomnia worsened significantly. Her emotional distress led to increased irritability and difficulties in her personal relationships and work performance. Concerned about the escalating symptoms and their impact on her day-to-day life, the patient returned for another appointment, where further changes to her medication regimen were considered.

It was at this critical juncture that the patient's case was reviewed in a collaborative consultation with a psychiatrist specializing in psychopharmacology. The psychiatrist conducted an in-depth assessment, considering the timeline of symptom onset and the initiation of the SSRI. Through careful evaluation, the psychiatrist established a clear link between the medication and the patient's new symptoms, identifying her condition as an iatrogenic response rather than a simple progression of her depressive disorder.[2]

The psychiatrist recommended a gradual tapering of the SSRI, followed by an alternative treatment strategy that involved psychotherapy and lifestyle modification to address her mental health concerns without the adverse effects of medication.[7,8] Upon discontinuation of the SSRI, the patient noted an immediate reduction in her anxiety levels and regained the ability to sleep more soundly. Over several weeks, her condition gradually improved, and she reported feeling like herself again, with better coping mechanisms and strategies in place.

This case highlights the critical importance of recognizing and understanding iatrogenic syndromes associated with psychiatric medications. It emphasizes the need for vigilant and thorough medication management, particularly when patients present with new or worsening symptoms following the initiation of treatment. The necessity for ongoing communication between primary care providers and specialists is paramount, ensuring that patients receive holistic and informed care during their treatment journey.[2,7,8]

Discussion

Recognizing iatrogenic psychiatric syndromes is a critical aspect of clinical care, requiring a nuanced understanding of pharmacological effects, patient-specific vulnerabilities, and the broader psychosocial context in which treatment occurs. These syndromes encompass a wide range of unintended psychiatric and psychological effects—such as depression, anxiety, mania, psychosis, cognitive impairment, emotional blunting, agitation, insomnia, and suicidal ideation—that may result from both psychiatric and non-psychiatric medications. These effects are frequently underrecognized, misattributed to primary psychiatric illness, and may lead to inappropriate treatment escalation or stigmatization.[9,10]

Among psychiatric medications, SSRIs and SNRIs are known to induce agitation, insomnia, hypomania, or suicidal ideation, particularly in younger individuals or those with undiagnosed bipolar disorder.[9] Second-generation antipsychotics, such as risperidone and olanzapine, are associated with akathisia, emotional flattening, and cognitive dulling, which can mimic negative symptoms or contribute to functional decline.[10] Benzodiazepines, while effective for acute anxiety, may paradoxically cause disinhibition, depressive symptoms, or dependence, especially in older adults.[10]

Equally important is the recognition of psychiatric side effects from non-psychiatric medications. Corticosteroids are well-documented to cause mania, psychosis, mood lability, and cognitive disturbances, often in a dose-dependent manner.[11] Beta-blockers, particularly lipophilic agents like propranolol, have been associated with depressive symptoms, fatigue, and vivid dreams. At the same time, calcium channel blockers and ACE inhibitors have been linked to mood changes and confusion, especially in elderly populations.[11] Even antibiotics, such as fluoroquinolones and isoniazid, have been implicated in causing acute psychosis, anxiety, and insomnia, particularly in vulnerable individuals.[11]

The clinical vignette presented in this paper illustrates the importance of acknowledging the iatrogenic syndrome not only as a pharmacological phenomenon but as a crucial diagnostic consideration. Failure to recognize medication-induced psychiatric symptoms can lead to significant clinical confusion—where adverse drug effects are mistaken for worsening of the underlying psychiatric condition or emergence of a new disorder. This misattribution often results in unnecessary polypharmacy, increased patient distress, and poor clinical outcomes. Moreover, it may obscure the true trajectory of recovery, delay appropriate interventions, and reinforce stigmatizing narratives about chronic mental illness.

By highlighting the iatrogenic syndrome, the vignette serves as a reminder that careful medication review, longitudinal observation, and contextual understanding are essential to avoid diagnostic overshadowing and therapeutic missteps. It underscores the need for clinicians to maintain a high index of suspicion for drug-induced symptoms, especially in complex cases involving multiple medications or vulnerable populations. Ultimately, acknowledging iatrogenesis is not merely a technical exercise—it is a safeguard

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against harm and a cornerstone of ethical, person-centered psychiatric care.

To adequately address these challenges, **continuous education** on medication side effects—including emerging research and clinical guidelines—is essential for PCPs. Regular training sessions, workshops, and access to updated literature can enhance their ability to recognize the signs of iatrogenic syndromes early.[12] Active monitoring of patient responses post-medication initiation or dosage change is vital. This process may involve the use of standardized assessment tools, routine follow-ups, and encouraging patients to maintain a journal of their mood, behaviors, and any side effects they experience.[13]

The increasing complexity of psychotropic medication regimens adds another layer of difficulty in managing patient care. PCPs must develop robust systems for assessing and documenting changes in mental health symptoms in conjunction with pharmacological interventions. This could include integrating patient feedback into **electronic health records (EHRs)** for better tracking of medication effects over time. Regular **interdisciplinary meetings** between PCPs and mental health professionals can also foster a more cohesive understanding of individual patient cases, promoting refined treatment plans tailored to the patient's evolving needs.[14]

Collaboration between primary care and psychiatric specialists not only enhances the treatment process but also ensures that patients receive comprehensive and nuanced care. This approach can be facilitated through **shared care models**, where PCPs and psychiatrists work closely together, perhaps through co-located services or coordinated care plans. **Telemedicine** can further enhance communication between specialists and primary care providers, enabling timely consultations when complex issues arise.[15]

Furthermore, fostering a culture of **open communication with patients** is crucial to ensuring they feel comfortable voicing concerns about their medications and any adverse reactions. PCPs should create an environment that encourages patients to express their feelings and questions regarding treatment. Initiating conversations about possible side effects and providing clear information about what to expect can enhance treatment adherence and satisfaction. Empowering patients with knowledge about their medications helps them take an active role in their treatment, facilitating timely interventions when issues are identified.[16]

The role of peer support specialists and cultural awareness

In addressing iatrogenic psychiatric syndromes, it is essential to recognize the unique contributions of Peer Support Specialists (PSS) and the importance of cultural awareness in clinical practice. Peer Support Specialists—individuals with lived experience of mental health challenges and recovery—offer a robust, person-centered complement to traditional medical approaches. Their involvement can be particularly impactful in identifying and addressing iatrogenic effects, as they are often attuned to subtle psychological changes that may be overlooked in clinical settings.[17,18]

PSS can help individuals articulate their experiences with medication side effects, validate their concerns, and support them through the often complex and emotionally charged process of psychiatric medication withdrawal. Their role is especially valuable in fostering trust, reducing stigma, and promoting shared decision-making. Moreover, they can bridge communication gaps between patients and providers, ensuring that experiential knowledge informs clinical care.

Cultural awareness further enhances the effectiveness of peer support. In communities such as Native American populations, culturally grounded peer support programs have shown promise in addressing the historical, social, and spiritual dimensions of mental health. Tailoring peer support to reflect cultural values and practices not only improves engagement but also supports holistic healing and resilience.

Recent work on the subject underscores the importance of integrating peer support into withdrawal planning. It highlights the supervision and structural challenges that must be addressed to fully realize its potential.[17,18] This line of research advocates for culturally sensitive, community-informed models that empower individuals and respect diverse pathways to recovery.

Conclusion

Recognizing and managing iatrogenic psychiatric syndromes is not only a matter of clinical precision but also a profound ethical obligation. Misdiagnoses in this domain can lead to avoidable suffering, increased stigma, and a breakdown in trust between patients and the healthcare system. These consequences extend beyond individual cases, influencing public health outcomes and shaping societal attitudes toward mental health care.

To address these challenges, it is imperative to enhance the training of primary care physicians (PCPs) in psychopharmacology, the identification of adverse drug reactions, and the principles of interdisciplinary collaboration. Medical education should integrate focused modules on iatrogenic psychiatric conditions, while continuing medical education (CME) programs must prioritize this critical area.[12,13] Furthermore, healthcare systems should equip PCPs with timely access to psychiatric consultation, evidence-based decision-support tools, and integrated care frameworks.[14,15]

Promoting pharmacovigilance, cultivating diagnostic humility, and fostering collaborative care are essential strategies to ensure that treatment interventions do not inadvertently cause harm. Equally important is the inclusion of **Peer Support Specialists (PSS)** and the integration of **cultural awareness** into clinical practice. PSS—individuals with lived experience of mental health challenges and recovery—offer a unique, person-centered perspective that complements traditional medical approaches. Their insights can be instrumental in detecting subtle psychological shifts that may signal iatrogenic effects, often before they are clinically recognized.[17,18]

Finally, cultural humility plays a crucial role in enhancing the efficacy of peer support services, particularly within various health care contexts. The importance of appropriate culturally sensitive supervision in peer support programs, particularly in Native American communities, has long been identified as a necessary factor to improve patient health outcomes. This perspective is validated by a substantial body of literature, which also stresses that cultural humility training enhances awareness of cultural dynamics and supports the development of positive therapeutic relationships among individuals of diverse backgrounds.[18,19]

Additionally, the integration of cultural humility within the realm of clinical pharmacology is imperative for providing equitable and effective patient care, especially in increasingly diverse healthcare settings. Cultural humility is defined as a lifelong commitment to self-evaluation and self-critique that recognizes and addresses power imbalances within the clinician-patient relationship and has significant implications for clinical practice and research in pharmacology. Hence, culturally informed care enhances the relevance and effectiveness of interventions, ensuring that diverse patient experiences are respected

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and understood. Together, peer support and cultural humility represent vital components in a holistic approach to preventing and managing iatrogenic psychiatric syndromes—one that centers empathy, equity, and shared understanding at the heart of mental health care.

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Conflicts of interest

The author declares there is no conflict of interest.

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