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Rethinking psychotropic prescribing in primary care: a "pause before prescribing" model

Abstract

Primary care has become the principal site of psychotropic prescribing, often under conditions of limited time, diagnostic uncertainty, and constrained access to psychosocial resources. In this environment, emotional distress is frequently misinterpreted as psychiatric disorder, and medication becomes the default response to complex social, interpersonal, and structural challenges. This pattern contributes to diagnostic inflation, the medicalization of existential suffering, and exposure to iatrogenic harms, including withdrawal syndromes, polypharmacy, and long-term functional impairment. This article proposes a "Pause Before Prescribing" model to restore intentionality in primary care. Intentionality refers to the clinician's capacity to act with deliberation rather than being carried by time pressure, diagnostic habits, or institutional expectations that each visit must culminate in a concrete intervention. Reclaiming intentionality creates space for listening, contextualizing, mobilizing supports, and engaging resources—including peer specialists—before turning to medication. The model emphasizes contextual assessment, attention to social determinants, nonpharmacologic approaches, transparent risk discussions, time-limited prescribing, principles of safe reduction, and the involvement of peer support specialists. Rather than rejecting medication, it situates prescribing within a broader biopsychosocial and public health framework, promoting safer, culturally grounded, and recovery-oriented care.

Keywords: psychotropic prescribing, primary care, deprescribing, withdrawal, peer support, cultural psychiatry

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Introduction

Primary care has become the predominant setting for psychotropic prescribing in many countries, with family physicians now writing most antidepressant, anxiolytic, and antipsychotic prescriptions.[1–3] This development did not emerge from a planned redistribution of psychiatric expertise but from a long sequence of structural and historical forces. Over several decades, shorter appointment times, the expansion of diagnostic categories, and the gradual disappearance of accessible psychosocial resources have reshaped everyday practice. In the narrow span of the modern primary care visit—often too limited to explore context, meaning, or the trajectory of a person's experience—medication has become the most readily available, billable, and institutionally supported intervention.[1–6]

Epidemiologic data cited in these same sources show how deeply this shift has taken hold. Primary care physicians now initiate the majority of psychotropic prescriptions, far exceeding the prescribing volume of psychiatrists.[1–3] In many health systems, more than two-thirds of antidepressant and anxiolytic prescriptions originate in primary care, while psychiatrists account for only a small fraction of new starts. A substantial proportion of these prescriptions are written during the first encounter, often before the clinician has had the opportunity to understand the person's circumstances, the situational logic of the distress, or the broader social conditions shaping the presentation.[1–6]

These structural pressures intersect with broader cultural and clinical trends. Experiences once regarded as ordinary features of human life—grief, loneliness, insecurity, and disorientation during periods of loss or transition—are increasingly reframed through a biomedical lens.[7–12] The proliferation of diagnostic categories and the widespread use of symptom checklists have created conditions in which distress is rapidly translated into illness. Such instruments, though useful in some circumstances, can intensify this tendency by identifying "caseness" without regard for proportionality, context, or cultural meaning.[13–15]

As a result, transient reactions to adversity, normative grief, or understandable worry can be reclassified as pathology simply because they meet sufficient criteria for caseness. A positive score is often treated as equivalent to a diagnosis, and the diagnosis is then treated as an automatic indication for treatment. In this progression, the nuanced dimensions of lived experience are compressed into symptom clusters, and the complexity of psychological distress is funneled toward pharmacological solutions. Within this environment, automatic prescribing has become normalized—an almost immediate clinical move in response to distress. Yet this pattern is not benign. It contributes to diagnostic inflation, the medicalization of ordinary suffering, and exposure to a range of iatrogenic harms, including withdrawal syndromes, polypharmacy, and long-term functional impairment.[16–24,28,33,48]

Diagnostic and structural drivers of overprescribing

Psychiatric diagnoses remain descriptive categories rather than discrete disease entities with clearly established etiologies.[24–28] As diagnostic boundaries have expanded over recent decades, the threshold for classifying normal human experiences as psychiatric disorders has become increasingly porous. Several authors have shown how broadened criteria for depressive and anxiety disorders blur the line between appropriate responses to hardship and suspected mental illness.[7–10,12]

The persistence of the chemical imbalance narrative further accelerates this diagnostic drift. Although repeatedly criticized as scientifically unsupported and overly reductionistic, the idea that

depression stems from a serotonin deficit—and that medication corrects this imbalance—remains deeply embedded in public consciousness.[14–17,28,29] Lacasse and Leo demonstrated the disconnect between pharmaceutical advertising and scientific evidence.[14] Moncrieff, Whitaker, Davies, and others argue that this narrative functions more as a cultural metaphor than an empirical explanation—one that simplifies suffering into a biochemical failure requiring pharmacologic correction.[16–18,28,33,34]

Social determinants—including poverty, discrimination, violence, and unstable housing—are among the most significant contributors to emotional distress.[21,22,35] When these structural forces are reframed as individual problems, the clinical response shifts from social or public health interventions to pharmaceutical solutions.[7–12,35] Summerfield, Farmer, Patel, and Marmot have shown how global mental health initiatives can unintentionally medicalize normal reactions to adversity.[21,22,35] Instruments designed to identify potential cases can reinforce this trend by detecting "caseness" without regard for context, duration, or proportionality.[13–15] A positive score is often treated as equivalent to a diagnosis, and the diagnosis becomes an automatic indication for treatment.

Iatrogenic risks of automatic prescribing

When distress is rapidly labeled as disease, and disease is assumed to require medication, a cascade of iatrogenic risks is set in motion—risks that become increasingly evident over months and years.[5,7–18,33,34] A central driver of these harms is the enduring belief that psychotropic medications correct underlying biological abnormalities. Many patients—and clinicians—continue to view antidepressants, anxiolytics, and antipsychotics as disease-modifying agents.[3,14–17,28,29] Yet evidence points to a different reality: psychotropics induce significant changes in mental and physical states but do not correct a specific defect.[14–17,28,29,33,34] Withdrawal from antidepressants and other psychotropics is common, often severe, and frequently mistaken for relapse.[16–18,30–34] Symptoms such as insomnia, agitation, sensory disturbances, emotional volatility, and autonomic instability reflect neuroadaptive processes rather than the return of an underlying condition.[17,18,30–34] Yet these symptoms are often interpreted as evidence that the patient "needs" the medication, leading to reinstatement, dose escalation, or the addition of new drugs.[5,12,16–18,30–35]

Polypharmacy frequently emerges from this diagnostic uncertainty and misinterpreted withdrawal. Clinicians often add medications in an attempt to stabilize fluctuating symptoms.[5,12,3,33–35,48] Long-term studies show that such polypharmacy is associated with worse functional outcomes, greater disability, and reduced chances of recovery.[16,17,33–35] Iatrogenic chronicity may be the most profound consequence of automatic prescribing. Long-term psychotropic use can produce physiological adaptations—receptor downregulation, neurochemical sensitization, autonomic dysregulation—that make discontinuation difficult.[16–18,30–34] Several authors argue that this shift represents a transformation in psychiatric morbidity: from episodic and self-limiting to chronic and treatment-dependent.[16,17,33-35] Psychotropic prescribing also carries cultural and social risks. These medications can reinforce narratives of fragility, undermine traditional healing practices, and obscure the social determinants that contribute to distress.[5,12,10–12,19,35–37]

The pause before prescribing model

These pressures are substantial. Severe time constraints, productivity metrics, and the billing architecture of medicine create an environment in which prescribing becomes the most accessible and institutionally reinforced intervention.[1–9,35–37,49,50] This article proposes a "Pause Before Prescribing" model to restore intentionality in primary care. Intentionality refers to the clinician's capacity to act with deliberation rather than being carried by time pressure, diagnostic habits, or institutional expectations that each visit must culminate in a concrete intervention. Reclaiming intentionality creates space for listening, contextualizing, mobilizing supports, and engaging resources—including peer specialists—before turning to medication. The model emphasizes contextual assessment, attention to social determinants, nonpharmacologic approaches, transparent risk discussions, time-limited prescribing, principles of safe reduction, and the involvement of peer support specialists.

The need for such a model arises precisely because intentionality is routinely eroded by structural realities. These forces do not merely shape workflow; they shape clinical thought, accelerating encounters and narrowing interpretive frames. Acknowledging these pressures is essential, yet it does not absolve clinicians of responsibility. The Pause model insists that clinicians must continually assert their intentionality—reclaiming the clinical pause as an ethical act that protects judgment from being overtaken by institutional momentum.

Within this frame, several core considerations help clinicians maintain deliberation. One concerns whether the patient has a clear understanding of the risks associated with long-term psychotropic use. Many individuals are unaware of the full range of potential harms—including withdrawal syndromes, dependence potential, emotional blunting, metabolic and neurological effects, and the possibility of iatrogenic chronicity.[9,14–18,28–37] Transparent discussions about benefits, risks, and uncertainties are essential components of informed consent.[16,17,28,29,33,35–37] Another consideration involves establishing plans for review and deprescribing. Time-limited prescribing and regular reassessment reduce the risk of chronicity.[16–18,30–37] A further consideration is the evaluation of reversible medical contributors, as several medical conditions can present with symptoms resembling anxiety, depression and psychosis.[12–15,35]

These elements are not simply procedural steps; they function as practices of resistance against the automaticity that structural forces promote. They help clinicians maintain a stance of deliberation and relational presence—qualities that are easily eroded in high-pressure environments.

Principles of safe tapering

Before turning to the practical elements of dose reduction, it is important to state that deprescribing is part of the Pause Before Prescribing model. The same structural pressures that accelerate prescribing—compressed visits, productivity demands, and institutional expectations—also shape how clinicians approach medication reduction. Restoring intentionality therefore requires attention not only at the moment of initiating a medication but throughout the entire course of treatment, including the process of tapering and discontinuation. With this continuity in mind, the following principles outline the clinical foundations of safe and context-aware deprescribing.

Safe deprescribing requires personalized, context-aware, harm-reduction-oriented care.[16–18,30–35,37] Dose reductions must be paced to match the body's capacity for neurobiological adaptation. When reductions are too rapid, they frequently exceed this adaptive capacity and can trigger withdrawal syndromes.[16–18,30–35] Hyperbolic tapering helps prevent this mismatch by reducing the dose in progressively smaller steps as the total dose becomes lower, aligning

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dose changes with receptor-level neuroadaptation and minimizing destabilization.[16–18,30–34] In addition to tapering slowly, it is important to avoid rapid switches or cross-tapers, as abrupt transitions between medications can amplify withdrawal effects and increase the risk of destabilization.[3,12,33–35,49]

Close monitoring is essential throughout the process, as withdrawal is both physiological and relational. Patients often need support not only for emerging symptoms but also for the uncertainty and vulnerability that can accompany dose reductions.[6–9,30–34,49–54] Psychosocial, cultural, and relational supports—including peer support—play a central role in maintaining stability and reinforcing safety during tapering.[10–12,35–37,46,49–54]

Taken together, these principles underscore that tapering is not a technical afterthought but an integral expression of the same intentional, context-sensitive practice that the Pause Before Prescribing model seeks to cultivate.

Peer support and cultural grounding

Peer support specialists play a distinctive and increasingly vital role in contemporary mental health care.[49–56] Their experiential knowledge allows them to bridge communication gaps and help patients articulate concerns that may feel unsafe in traditional clinical settings.[49–56] Peer specialists help restore a more human and contextual understanding of suffering, offering guidance rooted in shared experience rather than diagnostic authority.[49–56] They also bring cultural fluency essential in communities shaped by historical trauma, structural inequities, and cultural disruption.[35–37,55,56] Peer support can help re-establish connections to cultural narratives of resilience and community-rooted identity.[10–12,35–37,55,56]

Conclusion

Psychotropic prescribing in primary care cannot be separated from the social, cultural, and historical contexts in which distress arises. When symptoms are interpreted without reference to these contexts, ordinary human experiences—grief, exhaustion, fear, the effects of trauma, or the physiological consequences of medication—are easily reframed as psychiatric disorders.[7–12,35–37] This tendency is reinforced by structural pressures, diagnostic conventions, and biomedical narratives that privilege symptom clusters over meaning, and efficiency over understanding. The "Pause Before Prescribing" model offers a different orientation—one that insists on contextual understanding, transparent risk discussions, time-limited prescribing, and careful consideration of deprescribing when appropriate. Peer support specialists, with their experiential knowledge and cultural grounding, play a central role in this shift. Taken together, these elements point toward a primary care practice that is slower, more attentive, and more deeply rooted in the lived realities of patients and communities. By restoring context, meaning, and cultural grounding to clinical encounters, the model opens the possibility of care that is thoughtful rather than automatic, contextual rather than categorical, and aligned with the dignity and resilience of the people we serve.

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Conflicts of interest

The author declares there is no conflict of interest.

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