

**Psychiatry · Educational evidence summary**

Anticholinergic burden and negative symptoms

This psychiatry article focuses on anticholinergic burden and negative symptoms.

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Similar observations can have different explanations

Reduced conversation, less activity, or difficulty engaging can prompt concern about negative symptoms in schizophrenia. They can also prompt a medication review. The overlap does not mean that an anticholinergic burden category identifies the explanation. A useful assessment first describes what is observed, then considers which clinical constructs and evidence are relevant.

This explainer addresses that interpretive problem. It does not diagnose primary or secondary negative symptoms and does not recommend changing treatment. Its purpose is to prevent a medication evidence label from being mistaken for a symptom assessment.

What “secondary” adds to the question

The European Psychiatric Association’s assessment guidance distinguishes negative symptoms from similar presentations associated with other illness dimensions, depression, extrapyramidal effects, sedation, and environmental factors. The distinction requires assessment over time and attention to possible secondary causes. [EPA assessment guidance, 2021](#)

An anticholinergic review can contribute medication information to that assessment. It cannot determine that a symptom is secondary simply because a classified medication is present. The medicine may have been introduced in response to another clinical problem, and the chronology may be more complex than the current list suggests.

Cognition is a neighboring concept, not the same outcome

A study of cognitive test performance does not automatically measure motivation, emotional expression, or social engagement. These outcomes may be related in everyday life, but the measures are not interchangeable. A conclusion about a memory test should remain a conclusion about that test or domain unless the study also assessed the other outcome.

This matters when applying the psychosis literature cited below. It can justify asking whether medication exposure should be considered during cognitive assessment. It does not establish that lowering a burden category treats negative symptoms. That would require a study with an appropriate intervention, negative-symptom definition, and follow-up.



Describe the observation before assigning a mechanism

Clinical notes are more useful when they distinguish the person's experience from an observer's interpretation. "Reports wanting to participate but having difficulty staying alert" asks a different question from "reports little interest in the activity." Neither statement by itself identifies an anticholinergic mechanism.

The medication review can then capture treatment timing, actual occasional use, and recent changes. If these details are unknown, the uncertainty should remain visible. A source classification is static evidence about the medicine, whereas the clinical assessment concerns how a person is functioning over time.

Where a source table helps

UnifiedACB can identify which current medicines have published observations in a selected source and show whether sources disagree. It can also expose a coverage gap. This is useful when a complex regimen has been summarized too loosely as "the antipsychotic," even though adjunctive and nonpsychiatric medicines may also need review.

The table should be read with exact identity and formulation notes. It cannot distinguish a primary negative symptom from reduced engagement related to a treatment effect. It also cannot determine the reason an adjunct was added or whether it remains indicated. Those facts come from the clinical history and examination.

Avoid circular explanations

An explanation becomes circular when reduced activity leads to additional treatment, the additional treatment raises a burden classification, and the higher classification is then treated as proof of what caused the original reduced activity. The sequence should be reconstructed before claiming causality.

The same problem can occur in research if medication exposure and symptom severity are measured at one time point. A statistical association may be compatible with several directions of influence. Adjustment for a symptom scale can reduce some confounding while leaving unmeasured treatment-selection factors unresolved.

Follow more than one outcome

If the clinical team undertakes a justified treatment change, a useful follow-up separates the concern being addressed from the condition the medicine was treating. An improvement in alertness is not automatically an improvement in primary negative symptoms. Conversely, a stable negative-symptom measure does not mean the person experienced no worthwhile change in daily function.

Recording those outcomes separately makes the result more clinically interpretable. It also avoids defining success merely as a lower source total. The source value remains evidence about classification, not a substitute for the person's experience or a validated response measure.

Questions for a careful discussion

- What exactly is reduced: motivation, expression, attention, alertness, or ability to perform a task?



- When did the change appear relative to illness and treatment changes?
- What evidence supports a medication contribution, and what competing explanations remain?
- Which outcome would be followed if the team changed the care plan?

The wording of the observation can improve the next assessment. “Fewer spontaneous comments than at the previous visit” records a change that can be revisited. “Medication-induced negative symptoms” already embeds a causal conclusion. A descriptive record leaves room to compare the course of mood, positive symptoms, movement findings, alertness, and engagement with the person’s own account. If those features move in different directions, the explanation should accommodate that pattern rather than force them into one burden label.

Limits of attribution

The cited burden literature does not provide a diagnostic test for negative symptoms or establish that one medication mechanism explains reduced engagement. The appropriate role of the directory is to add a traceable exposure history to a broader assessment, while keeping the symptom definition and causal uncertainty intact.

References

1. Georgiou R, et al. Anticholinergic Burden and Cognitive Performance in Patients With Schizophrenia: A Systematic Literature Review. *Front Psychiatry*. 2021;12:779607. [Source](#)
2. Vennard O, Stewart C, Tolia M, Soiza RL, Myint PK. Anticholinergic Medication Burden Scales: A Systematic Review. *J Am Geriatr Soc*. 2026;74(6):1771-1784. [Source](#)
3. Mancini V, et al. Anticholinergic Burden and Cognitive Function in Psychosis: A Systematic Review and Meta-Analysis. *Am J Psychiatry*. 2025;182:349-359. [Source](#)
4. European Psychiatric Association. EPA guidance on assessment of negative symptoms in schizophrenia. 2021. PMID:33597064. [Source](#)

Explore the evidence

[Ask UnifiedACB](#) about a medication or source, browse the [Medication Library](#), or read the [methodology](#).

Disclosure

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Educational evidence summary. This content does not provide patient-specific medical advice and does not replace clinical judgment, medication reconciliation, or prescribing guidance.