

Letters

Questions about case study

► The case study by William P. Carter, MD (“Three weeks to mood stabilization,” February, p. 45), while certainly competent psychopharmacologically, completely ignores psychological dynamics and never considers the obvious need for psychotherapy.

*Steve Nickoloff, MD
Birmingham, Mich*

► Another diagnostic possibility not mentioned in Dr. Carter’s case study is posttraumatic stress disorder. This diagnosis could explain the 40-hour amnesic episode via a dissociative period, and could also explain the patient’s reluctance to discuss her past and the family’s policy of “self-reliance.” She may be hiding family secrets.

Treatment from a medication standpoint seemed appropriate, except why wasn’t another atypical antipsychotic tried instead of repeating olanzapine?

Why wasn’t cognitive behavioral therapy or another form of psychotherapy provided by the psychiatrist along with the medication? A carefully developed alliance should have allowed her to discuss uncomfortable issues. Even managed care companies are beginning to realize that combined medication and psychotherapy by a psychiatrist is the most cost-effective treatment strategy.

Finally, if these and other strategies still fail in the future, why not consider electroconvulsive therapy?

*Steven Moffic, MD
Professor of Psychiatry, Medical College of Wisconsin
Milwaukee, Wis*

Dr. Carter responds

Dr. Moffic’s comments enhance the case discussion in several ways. First, his reminder about a possible diagnosis of PTSD broadens the differential diagnosis to address an amnesic episode for which no definitive explanation ever emerged.

His reminder about the efficacy of combined treatment is also apt. While not addressed in the review of the patient’s pharmacologic treatment, the patient did receive concomitant psychotherapy: cognitive behavioral treatment with both the psychiatrist and a consultant, and a longer-term, exploratory psychotherapy with the psychiatrist.

Turning to Dr. Nickoloff’s concern about treatment, I would agree that the indication for psychotherapy for this patient is “obvious.” I would welcome a psychoanalytical counterargument in a future case study.

Regarding Dr. Moffic’s inquiry about the possible use of another antipsychotic, I would cite the data supporting the use of olanzapine in both mania and treatment-resistant depression. Then, specific to this case, I would highlight the striking earlier response to olanzapine and the urgency from the patient’s stated, credible timeline, which offered us little time for experimentation with novel treatments. Current speculation about the potential antidepressant properties of ziprasidone raises the possibility of an untested alternative for augmentation.

Finally, the option of ECT should certainly have been addressed.

About no-suicide contracts

► Phillip J. Resnick, MD (“Recognizing that the suicidal patient views you as an adversary,” Jan., p. 8), emphasizes when treating suicidal patients that monitoring mood, behavior, social circumstances, and communications with relatives must be done to assess suicidality. Patient reports to therapists alone are inadequate.

No-suicide contracts alone are, as Dr. Resnick says, hazardous. But when used in conjunction with his recommendations, they can offer patients another avenue for discussing their conflicts about suicide. It is not uncommon for a patient to say: “Doctor, you know that no-suicide contract I made with you? I tore it up last week.” It may be easier for some patients to say they destroyed their no-suicide contract than to proceed immediately to “I am going to kill myself.” When confronted with this situation, therapists can aggressively assess and plan accordingly.

Clinicians should not take Dr. Resnick’s comments and summarily conclude that no-suicide contracts are worthless.

*Gary Waltz, MD
Cleveland Heights, Ohio*

Dr. Resnick responds:

I agree that no-suicide contracts are not worthless. My point is to convey to therapists that they should not allow such contracts to create a false sense of security.