Current PSYCHIATRY

From the editor

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Our mission: To meet your needs

Many of you know me from my published research and books, national presentations, or CME broadcasts. What you might not know is how much I enjoy the clinical practice of psychiatry and helping seriously ill patients regain their wellness and return to social and vocational functioning.

Over the years, my patients have been my best teachers about disease burden, effective treatment strategies, coping with illness, and recovery. I never cease to be amazed at how vital a strong physician-patient alliance is to achieving successful clinical outcomes. My patients also have been my best source of research questions about the causes and treatment of psychiatric brain disorders. The more I learn, the more I am humbled by how much remains to be discovered in our field.

The mission of clinically focused journals such as CURRENT PSYCHIATRY is to inform readers about practical applications of the latest medical advances. That's why many of you read CURRENT PSYCHIATRY from cover to cover. Psychiatry is a vibrant, rapidly growing medical specialty with a solid neuroscience foundation and a promising future, but we face many unmet needs in daily practice. Most relate to the diagnosis and treatment of common psychiatric disorders.

NEEDED: DIAGNOSTIC CLARITY

The schema of psychiatric diagnosis needs to become anchored in scientific evidence, for example. DSM-IV-TR's clusters of inclusion and exclusion symptom-focused criteria are unsatisfactory and not validated by empiric biomedical findings. Many patients have multiple comorbidities, which raises questions about:

- which illness is primary or secondary
- what is the shared neurobiology
- why does a class of drugs approved for one diagnosis—such as selective serotonin reuptake inhibitors, atypical antipsychotics, or anticonvulsants—help many other symptoms or diagnoses?

DSM's symptom-focused criteria are unsatisfactory, especially for patients with multiple comorbidities

When it comes to personality disorders, why do axis II symptoms emerge during an acute axis I onset and disappear when the axis I episode remits? Why, on the other hand, do the features of "real" axis II disorders endure for a lifetime? Why the distinction between axis I and II anyway?

Why do addictive disorders such as substance abuse plague so many of our patients? Why do symptoms such as insomnia, anxiety, dysphoria, or aggression occur in disparate psychiatric disorders such as anxiety, mood, psychotic, or personality disorders?

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Every day these nosologic questions challenge us and influence our management decisions and prognostic formulations. Much research is needed because specific, effective treatment requires diagnostic clarity and validity.

NEEDED: MORE EFFECTIVE TREATMENTS

This brings us to a perennial unmet need: more effective treatments. Psychiatry is experiencing a relative drought of innovative biological and psychological treatments. Pharmacologic agents are approved for a limited number of DSM-IV-TR diagnoses, which has created an extensive "black market psychopharmacology." Approved psychotropics are used for unapproved indications, in unapproved doses, and in unapproved combinations—particularly in child and adolescent psychiatry with its serious dearth of controlled studies. We urgently need:

- nondopaminergic approaches to schizophrenia (where so many clues point to glutamate pathways) that can effectively treat cognitive deficits and negative symptoms
- antidepressants with rapid onset of action, especially for patients with suicidal intent
- an unambiguously effective mood stabilizer which, as monotherapy, restores balance to all phases of bipolar disorder
- effective treatment for alcoholism and drug dependencies.

We also await breakthrough medications for brain disorders with no known treatments, such as antisocial behavior, hypochondriasis, autism, pedophilia, and dissociative disorders, to name a few. Finally, we need drugs designed to avoid metabolic complications and other serious illnesses that can disrupt quality of life and lead to premature death.

A drought in innovative treatments has led to extensive 'black market psychopharmacology'

NEEDED: MEDICAL CARE FOR THE MENTALLY ILL

Speaking of early mortality—and its association with chronic psychosis, mood, and anxiety disorders—another unmet need is the integration of primary care and psychiatric care for public-sector patients whose nonpsychiatric medical needs are woefully neglected. The mental health system is widely described as "broken," and to fix it we need to advocate tirelessly for a more rational system of comprehensive medical care for our seriously mentally ill patients.

We also need to advocate for parity in reimbursement for treating psychiatric brain disorders, to eliminate the stigma of having an emotional or behavioral ailment, and to end the shameful incarceration of the criminally mentally ill in lieu of proper and humane treatment in a medical setting.

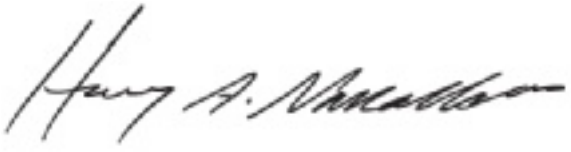
WHAT DO *YOU* NEED?

CURRENT PSYCHIATRY will continue to bring you the latest advances regarding the causes and treatments of psychiatric illness. Please contact me by:

- e-mail (henry.nasrallah@currentpsychiatry.com)
- or fax (201-391-2778)

about your major unmet clinical needs. Besides publishing your letters, I pledge that we will listen to you and meet your needs. That, ultimately, is CURRENT PSYCHIATRY'S mission.

I look forward to hearing from you.



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