Current PSYCHIATRY

Considerations for CAM use

I thoroughly enjoyed the article on complementary and alternative medicine (CAM) for depression ("CAM for your depressed patient: 6 recommended options," CURRENT PSYCHIATRY, October 2009, p. 38-47) and have seen patients benefit from these treatments. I wish the authors had included information about the use of valerian root for anxiety, as this is common among some CAM users.

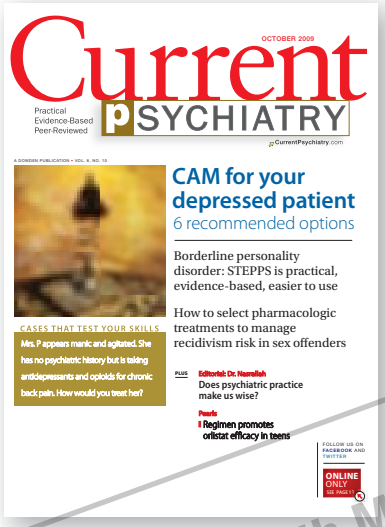
I think our use or discussion of CAM can show our patients we are flexible and will consider various treatments. I believe if you dismiss all CAM treatments as not as effective as prescription medications—which may be true—you will lose patients. We know how popular CAM is with the American public, despite lack of evidence and poor oversight.

In depression treatment, exercise is as effective as sertraline in some studies,[1,2] but I would think the high dropout rate for exercise would make sertraline more likely to be effective in the long run. In 1 study, participants received a phone call if they missed an exercise session. This doesn't mimic real life at all. Also St. John's wort is administered 300 mg tid, while many antidepressants are once a day. Efficacy aside, we can guess that compliance with a medication taken 3 times a day will be less than 1 taken once daily.

I believe we need to examine our patients' thoughts about CAM vs traditional treatment. Do they feel CAM is safer because it is natural? Do they feel less stigma if they use CAM? What are their "automatic thoughts" about this?

I disagree with the conclusion that bibliotherapy can't hurt. Bibliotherapy does have a cost: the cost of the book, the time spent reading it, and minimal benefit. There are people making millions of dollars on self-help books that may be having little, if any, impact on our patients' lives.

Corey Yilmaz, MD
Southwest Behavioral Health Rural Services
Tolleson, AZ



October 2009

References

1. Blumenthal JA, Babyak MA, Moore KA, et al. Effects of exercise training on older patients with major depression. Arch Intern Med. 1999;159(19):2349-2356.
2. Babyak M, Blumenthal JA, Herman S, et al. Exercise treatment for major depression: maintenance of therapeutic benefit at 10 months. Psychosom Med. 2000;62(5):633-638.

Dr. Saeed responds

Despite the common belief that valerian root is effective in reducing stress and anxiety, it has not been tested for depressive disorders and is not supported by studies on anxiety disorders. Our paper did not review CAM treatments for anxiety disorders, so we did not point out that a recent Cochrane review[1] of valerian for anxiety disorders included only 1 randomized controlled trial[2] and found no differences between valerian and placebo.

We also agree that treatment discontinuation is a serious problem, but this is a universal concern for treating many chronic disorders. There is evidence that patient reports of treatment adherence can be unreliable. Research has shown that periodic monitoring,[3] even by automated systems, can maintain compliance longer.

We disagree with Dr. Yilmaz' comments about bibliotherapy. A meta-analysis of 29 bibliotherapy studies found bibliotherapy using cognitive and behavioral techniques superior to wait-list comparison groups.[4] We feel there is ample evidence supporting bibliotherapy as a low-risk, low-cost alternative or complementary treatment for mild-to-moderate depressive disorder.

Sy Atezaz Saeed, MD
Department of psychiatric medicine
Brody School of Medicine at
East Carolina University

References

1. Miyasaka LS, Atallah AN, Soares BG. Valerian for anxiety disorders. Cochrane Database Syst Rev. 2006;(4):CD004515.
2. Andreatini R, Sartori VA, Seabra ML, et al. Effect of valepotriates (valerian extract) in generalized anxiety disorder: a randomized placebo-controlled pilot study. Phytother Res. 2002;16(7):650-654.
3. Gensichen J, von Korff M, Peitz M, et al. Case management for depression by health care assistants in small primary care practices: a cluster randomized trial. Ann Intern Med. 2009;151(6):369-378.
4. Gregory RJ, Schwer Canning S, Lee TW, et al. Cognitive bibliotherapy for depression: a meta-analysis. Professional Psychology: Research and Practice. 2004;35(3):275-280.

Exploring irony in psychiatry

Dr. Nasrallah should make us all proud. In his editorial, "Does psychiatric practice make us wise?" (From the Editor, CURRENT PSYCHIATRY, October 2009, p. 12-14) he presents how

continued on page 19

ONLINE ONLY

Visit this article at CurrentPsychiatry.com to view letters from readers debating the dissociative identity disorder controversy

To comment on articles in this issue or other topics, send letters in care of Erica Vonderheid, CURRENT PSYCHIATRY, 110 Summit Avenue, Montvale, NJ 07645, erica.vonderheid@dowdenhealth.com or visit CurrentPsychiatry.com and click on the "Send Letters" link.

continued from page 5

deep, complex, and relevant our work as psychiatrists can be and how it can enhance our personal development and wisdom. I think this article should be required reading for every medical student. Dr. Nasrallah even provides suggestions on ways to research how our brains may change. However, this must be tempered with some irony.

Recently, I attended a lecture on "Irony" by University of Chicago professor Jonathan Lear. He asked profound questions of irony, such as: "Among all the pious, is there a pious person?" and "Among all the doctors, is there a doctor?" He explained his point by wondering how often we fall short of what we can be as doctors. Extending that idea to Dr. Nasrallah's column, in our days of 15-minute med checks, we might ask, "Among all psychiatrists, how many are Nasrallah psychiatrists?" As the saying goes, it takes one to know one.

H. Steven Moffic, MD
Professor of psychiatry
Medical College of Wisconsin
Milwaukee, WI

Single payer is not a solution

As a former Canadian with many contacts still there, I would strongly advise against a single-payer system ("Health care debate: Do psychiatrists support the public option?" From the Editor, Current Psychiatry, November 2009, p. 16-18). It will not solve our health care problems; in fact, many of our patients will be worse off than now.

The lack of choices for both the patient and doctor when the government makes therapeutic choices can lead to a situation where psychotherapy almost disappears from psychiatry. In the United States we are struggling with managed care and its disincentives for psychotherapy in psychiatry, but at least patients can choose a psychiatrist who uses a combined approach.

Norman Straker, MD
Clinical professor of psychiatry
Weil Cornell Medical College
New York, NY

Refer more patients for medical evaluations

We read with interest Drs. Carroll and Rado's article, "Is a medical illness causing your patient's depression?" (Current Psychiatry, August 2009, p. 43-54) and commend the authors for focusing attention upon the role medical illnesses can play in causing or contributing to depressive disorders. However, we believe the authors missed the opportunity

continued on page 74

continued from page 19

to strongly urge behavioral health providers to routinely refer their patients for medical evaluations to better identify illnesses masquerading as psychiatric disorders.

Conservative estimates suggest that at least 10% of presenting psychological disorders are driven by medical or somatic conditions, yet many mental health providers—medically and non-medically trained clinicians alike—mistakenly believe psychological symptoms rarely are caused by a "hidden" medical etiology.[1,2] In fact, a recent sampling from a psychiatric inpatient setting found high rates of medical illnesses that were "missed" by mental health clinicians.[3] We feel that these studies support a recommendation that persons diagnosed with new-onset or treatment-refractory psychiatric disorders be routinely referred for a medical evaluation.[4]

Although one might argue that it is more prudent to refer only individuals who are suspected of having a medical illness underlying their presenting symptoms, this approach ignores the reality of our behavioral health system. In most public behavioral health systems (eg, community mental health centers, crisis units, safety net clinics, etc.), the person who makes the initial diagnosis and develops a treatment plan is a behavioral health specialist with no formal medical training. Consequently, many of these frontline clinicians understandably are unable to recognize signs and symptoms of the most common medical illnesses that cause psychological symptoms.[5] To ensure patient safety, behavioral health clinicians without medical training should strictly adhere to this recommendation.

August 2009

After weighing the costs and benefits, medically trained mental health care providers should allow patient safety concerns to guide their decision to refer. We believe that in situations of new-onset or treatment-refractory mental illnesses, referring patients for a medical evaluation will lead to a treatment model that is efficacious, integrated, and comprehensive. Our patients who suffer the effects of comorbid conditions have a right to nothing less from those of us responsible for overseeing their care and healing.

Richard C. Christensen, MD, MA
Professor and chief division of public psychiatry
University of Florida College of Medicine

Glenn D. Grace, PhD, MS
Staff psychologist
North Florida/South Georgia Veterans Health System

James C. Byrd, MD
Assistant professor of psychiatry
University of Florida College of Medicine
Gainesville, FL

References

1. Morrison J. When psychological problems mask medical disorders: a guide for psychotherapists. New York, NY: Guilford Press; 1997.
2. Koran LM, Sox HC, Marton KI, et al. Medical evaluation of psychiatric patients: I. Results in a state mental health system. Arch Gen Psychiatry. 1989;46:733-740.
3. Rothbard AB, Blank MB, Staab JP, et al. Previously undetected metabolic syndromes and infectious diseases among psychiatric inpatients. Psychiatr Serv. 2009;60:534-537.
4. Grace GD, Christensen RC. Medical evaluations for patients with psychiatric disorders. Psychiatr Serv. 2009;60:849.
5. Grace GD, Christensen RC. Recognizing psychologically masked illnesses: the need for collaborative relationships in mental health care. Prim Care Companion J Clin Psychiatry. 2007;9:433-436.

Drs. Carroll and Rado respond

We thank Dr. Christensen and colleagues for their comments regarding promoting medical care in patients with mental illness. As physicians trained in internal medicine and psychiatry, we frequently are confronted with the lack of adequate medical care for psychiatrically ill patients. Our primary goal with this article was to educate and assist behavioral health providers in distinguishing depressive symptoms that might have an underlying medical cause.

Although we agree that patients with depression—and mental illness as a whole—are medically underserved, referring all patients with treatment-refractory or new-onset depression might not be fiscally responsible or always necessary. However, we wholeheartedly support encouraging regular follow-up with a primary care provider. Psychiatrists can order laboratory tests that might indicate medical diagnoses—for example, thyroid stimulating hormone or parathyroid hormone—and refer their patients if needed.

The discussion of public behavioral mental health systems is a different topic and outside the scope of our article. Our sentiments are not in disagreement with Dr. Christensen et al, and we are glad to see that our article prompted this discussion.

Virginia K. Carroll, MD
Fifth-year resident

Jeffrey T. Rado, MD
Assistant professor
Departments of psychiatry and internal medicine
Rush University Medical Center, Chicago, IL