Shrinking thick charts

Consultation-liaison psychiatrists often are invited in when a patient's chart grows thick ("Thick chart syndrome: Treatment resistance is our greatest challenge," From the Editor, CURRENT PSYCHIATRY, February 2010, p. 14-16). Some hidden factors in these complex cases include the usual subjects: missed bipolarity, surreptitious substance abuse, personality disorders, and ongoing difficult life circumstances. A detailed history may reveal early trauma, abuse, or neglect or long-forgotten traumatic brain injuries.

If we leave our comfort zone, new approaches may offer considerable benefit. A large database of quantitative EEG results allows us to identify brains that are poorly wired or those with aberrant areas of fast or slow waves, which can be treated with computer-enhanced biofeedback. Stepping further away, we find that energy psychology—manipulating the body's energy systems to ease distress—could help some patients who respond poorly to various therapies. Using behavioral kinesiology,[1] we find that some people who respond slowly test weak in muscle testing where they should test strong, which can be corrected with energy techniques. Patients who change slowly often incorporate their problems into their identities, which should prompt us to address their cognitive styles to free patients from this trap.

It is tough sledding with the thick charts, but we have hopeful alternatives to traditional therapies.

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1. Diamond J. Your body doesn't lie. New York, NY: Grand Central Publishing; 1989.

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Who makes the diagnosis?

Dr. Nasrallah's question, "Are some treatment-resistant patients victims of misdiagnosis?" is timely in view of the request for comments on proposed revisions for DSM-V ("Thick chart syndrome: Treatment resistance is our greatest challenge," From the Editor, CURRENT PSYCHIATRY, February 2010, p. 14-16). In DSM-III and DSM-IV, the clinician could decide if he or she was expert enough to make a diagnosis. This means that non-physician clinicians could miss medical problems, such as the ones Dr. Nasrallah mentions. Of course, psychiatrists can miss medical conditions as well, but I feel it is more appropriate for psychiatrists to be responsible for diagnosis, whether by examining the patient, signing off on the diagnosis, and/or monitoring the case. I hope DSM-V will clarify who the diagnostician should be. I'd say it should be psychiatrists, even if it means we sell fewer copies of DSM-V.

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Dr. Nasrallah responds

I agree with Dr. Moffic that a strong argument can be made that psychiatric physicians should perform the initial assessment, differential diagnosis, and workup. DSM-IV-TR mandates that signs and symptoms that may be due to a general medical condition or substance use must be eliminated before a psychiatric diagnosis can be made. Among mental health professionals, only psychiatric physicians are trained to recognize medical disorders that can masquerade as a psychiatric illness. Many articles demonstrate psychiatrists' skills in distinguishing psychiatric symptoms generated by medical illnesses.[1-3]

I have seen many patients referred by therapists because their psychiatric illness was not improving or getting worse after a year or more of psychotherapy and a medical workup found an underlying medical problem. I believe every psychotherapist should consider collaborating with a psychiatrist consultant who would conduct a diagnostic evaluation before beginning psychotherapy or counseling. This view may not be well received by some mental health professionals, but it is the best way to ensure good health care and to avoid delaying appropriate medical treatment.

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3. Popkin MK, Mackenzie TB, Callies AL, et al. Yield of psychiatric consultants' recommendations for diagnostic action. Arch Gen Psychiatry. 1982;39: 843-845.

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