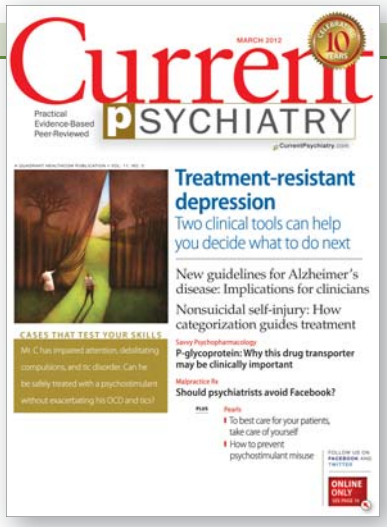

March 2012

Treating resistant depression

We read "Personalizing depression treatment: 2 clinical tools" (Current Psychiatry, March 2012, p. 26-33; http://bit.ly/Mle7KW) with interest. With lack of response or partial response to major depressive disorder (MDD) treatment, the authors' reminder to not assume treatment resistance without systematic review of the patient's clinical status—using the SAFER Interview—and adequacy of medication trials—using the Antidepressant Treatment Response Questionnaire (ATRQ)—is well taken.

The authors noted that the ATRQ considers only pharmacotherapy and electroconvulsive therapy (ECT), and that comprehensive assessment of treatment-resistant depression (TRD) requires asking about depression-specific, evidence-based psychotherapies. We would add that assessment should consider transcranial magnetic stimulation (TMS), which is FDA-approved for TRD and is included in the American Psychiatric Association's treatment guidelines for MDD. The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality characterizes TMS as having "high strength of evidence" for efficacy from well-controlled randomized controlled trials.[1] The New England Comparative Effectiveness Public Advisory Council noted that TMS provides a net health benefit that is equivalent or superior to ECT.[2]

Current Psychiatry's December 2010 supplement, "Transcranial magnetic stimulation for major depressive disorder," noted "The disappointing remission rates (approximately 25% to 30%) achieved in both the first and second phases of STAR*D [Sequenced Treatment Alternatives to Relieve Depression], coupled with the substantial drop off in both the subsequent chances of remission and attenuated durability of effect, argue for an earlier consideration of SGA [second-generation antipsychotics] augmentation or TMS."[3]

Given the deleterious effects of prolonged depression, consideration of TMS should occur early when treating patients who initially do not respond to pharmacologic and psychotherapeutic interventions.

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The authors respond

We thank Drs. Baumbacher, Mulder, Bermudes, and Beck for their insightful comments. TMS is an interesting neuromodulation technique that needs to be considered when assessing treatment resistance. In the same vein, vagus nerve stimulation[1] and deep brain stimulation[2] also could be added to a thorough evaluation of treatment resistance, because these techniques may be used increasingly in the future. We have added these techniques to a revision of the ATRQ specifically designed to assess augmentation trials.

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More on 'creative destruction'

Although other medical specialties focus on observable lesions of the body, psychiatry focuses on the patient's internal experience, something that cannot be objectively or directly observed or measured. Leaving aside the question of how to distinguish an abnormal internal experience from a normal one, no clinically useful, consistent, and individual-specific biologic correlate of abnormal internal experience has been discovered. Despite the reported neuroscience breakthroughs Dr. Henry A. Nasrallah writes about in his April editorial ("Is psychiatry ripe for creative destruction?" From the Editor, Current Psychiatry, April 2012, p. 20-21; http://bit.ly/KsXAE3), psychiatrists make diagnoses by speaking with and listening to their patients, the same way we have done for decades.

Dr. Nasrallah writes, "Numerous lab data have been developed for psychiatric disorders, but extensive heterogeneity has prevented diagnostic or commercial use of those tests…" This is another way of saying that these tests essentially are useless for the practicing clinician. Diagnosis aside, any clinically based psychiatrist knows that our medications work unpredictably and inconsistently, practical psychopharmacology is a matter of trial and error, and the "gold standard" of current knowledge, the randomized placebo-controlled study, has limited applications when treating an individual patient. The sort of "creative destruction" that Dr. Nasrallah writes about cannot correct the shortcomings of current psychiatric practice.

It is wishful thinking that giving the specialty a new name or pretending to have knowledge we do not possess would "lead to a quantum leap toward a brilliant future anchored in cutting-edge neuroscience." Until new, clinically relevant knowledge is acquired, the call for creative destruction is premature.

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Consider market forces

I found Dr. Nasrallah's April editorial interesting because I think morphing our profession is exciting. However, the reasons for the need for transformation were not laid out concretely.

We are always interested in the development of new diagnostic models and novel treatments; however, how can the mental health delivery system be changed? It is huge, poorly funded, and generally not run on the medical model. Community mental health programs tend to be lead by nonpsychiatrists at non-university hospitals. Insurance companies and private payees are reluctant to pay psychiatrists and reimbursements are comparatively lower than other medical specialties, so why would they pay for double-boarded psychiatrists? It doesn't appear that the market would support further psychiatric education when more lucrative medical professions exist.

Finally, our government and patients want more access to medical care and lower costs. Would our patients and government support and reimburse us for more specialization?

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Changing terminology

I applaud Dr. Nasrallah's visionary April editorial. One of the biggest obstacles to lifting stigma is the mental-physical categorization. "Mental" is the last slur still commonly used, instantly bringing to mind its synonyms: "crazy," "looney," and "nuts." This term should be extinguished from the psychiatric nomenclature. I suggest the label "neuriatry" in place of psychiatry because "neuro" gets us away from the stigmatizing term "psyche" while creating a linkage with our sister specialty, neurology.

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The larger mosaic

Dr. Nasrallah paints a frightening vision in his April editorial. There are many schools of thought in psychiatry, including biological, psychodynamic, cognitive behavioral, relational, and humanistic approaches. All of these reflect a piece of the larger mosaic that makes us human and contributes to our mental health. Psychiatry is the only medical specialty where well and broadly trained clinicians can treat patients on any or all of these levels in an integrated fashion.

The desire to redefine psychiatry as the treatment of strictly neurologically based conditions may work well for illness such as schizophrenia or bipolar I disorder, but it does a disservice to patients with anxiety, depression, trauma, etc., who can benefit from an integrative approach that may include medication and a neuroscience perspective but does not deny the healing power of approaches that work with the subjective side of mental life.

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See this article at
CurrentPsychiatry.com
for more letters on
Dr. Nasrallah's April 2012 editorial
and his response

Same goal, different method

I agree with Dr. Nasrallah that psychiatry is ready for creative destruction. We differ in the best way to achieve that goal. It is not enough to revolutionize current diagnostic schemes or the disastrously dysfunctional mental health bureaucracy. My suggestion is to get psychiatry out of the pocket of pharmaceutical manufacturers who support academic psychiatry and its publications. The April 2012 issue of Current Psychiatry has 78 pages; one-half are drug advertising. If we want to revolutionize our profession I suggest we wean ourselves from our dependency on pharmaceutical manufacturers' support, and advocate for the elimination of direct-to-consumer advertising.

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Dr. Nasrallah responds

I thank my colleagues for their comments on my editorial, whether supportive or dismissive. Editorials represent my opinion, sometimes critical, sometimes aspirational, but always intended to provoke healthy discourse with Current Psychiatry's readers. My intent in this editorial was to urge psychiatrists to continuously question what we do and whether we can practice our art differently, better, or in a more scientifically valid manner.

Regarding the issue of laboratory testing to confirm a clinical diagnosis—which many were hoping would be part of DSM-5—I have no doubt that this will become a reality in the not-too-distant future. Testing will include a mix of blood, cerebrospinal fluid, neurophysiological, or neuroimaging tests—structural, functional, spectroscopic, and diffusion tensor imaging MRI. If this sounds unlikely right now, that's what most people thought about our ability to land on the moon a mere decade before it happened.

When it comes to the future of psychiatry, I uphold 1 mantra: yes we can and yes we will!

Henry A. Nasrallah, MD
Editor-in-Chief

Facebook and boundaries

Drs. Douglas Mossman and Helen M. Farrell's article on the social networking Web site Facebook ("Facebook: Social networking meets professional duty," Malpractice Rx, Current Psychiatry, March 2012, p. 34-37; http://bit.ly/LcawQ4) deserves some expansion.

We shouldn't give Facebook more credit than it deserves, nor our patients less just because they are mentally ill. Even severely mentally disturbed patients often possess a fair degree of knowledge when it comes to social media. Most patients can and often do obtain information about us from Internet searches without ever having to "friend" us on Facebook. What psychiatrist hasn't seen patients who say they "found us on the Internet"?

Drs. Mossman and Farrell are correct that there are Web sites that provide our academic, personal, family, legal, and military information with the click of a mouse; patients don't have to go to Facebook. Because Facebook has a number of security and privacy settings, anyone who does not take the time to learn about these settings shouldn't be on Facebook.

Handling a Facebook friend request can be a tool to educate or exploit. A psychiatrist might have a Facebook presence that has nothing to do with mental health, but devoted to his or her hobby. A patient may have the same hobby; however, a friend request such as this cannot be honored because it is a personal/boundary issue.

We've all seen patients at gas stations, supermarkets, post offices, banks, movie theaters, and libraries. We don't change banks, gas stations, or supermarkets just because a patient patronizes the same business we do. We don't refuse to be interviewed for newspaper or magazine articles, radio programs, or television shows just because a patient might read, listen, or watch. We treat these unintended encounters as a natural by-product of our chosen discipline with respect and integrity that maintains the therapeutic relationship without crossing professional boundaries, or having to completely alter one's lifestyle. Should we react differently if a patient is on Facebook or Twitter? Until the American Psychiatric Association makes a definitive ruling on this issue, it is an individual matter of cautious judgment.

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