Current PSYCHIATRY

Ask more questions

The list of interview questions Dr. Henry Nasrallah suggested in "The hallucination portrait of psychosis: Probing the voices within" (From the Editor, CURRENT PSYCHIATRY, May 2009, p. 10-12) is a much-needed reminder of the clinical importance of patients' verbal auditory hallucinations. In 15 years of practice—much of that inpatient psychiatry—I have cared for many patients with hallucinations, and until recently I confess my interview was not as thorough as Dr. Nasrallah advises. Then after attending a workshop in January 2009, I modified my usual clinical interview when a patient reported religious, paranoid, persecutory, and/or command verbal auditory hallucinations. The results have been startling.

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May 2009

'What do the voices tell you?'

I would like to thank Dr. Nasrallah for his wonderful editorial about assessing auditory hallucinations ("The hallucination portrait of psychosis: Probing the voices within," From the Editor, CURRENT PSYCHIATRY, May 2009, p. 10-12). He has eloquently addressed many of the concerns I have had regarding how psychiatrists respond when a patient says "I am hearing voices." In my experience many psychiatrists simply leave it at that and don't even attempt the briefest characterization of these hallucinations, let alone the rigorous elucidation that Dr. Nasrallah suggests.

We are doing a disservice to our patients by not performing a thorough evaluation of what a patient means when he says "I am hearing voices." How can we really understand what our patient is experiencing if we don't attempt to grasp the specifics of something as remarkable as a hallucination?

Unfortunately, there are patients who use statements such as "I am hearing voices telling me to kill myself and others" in order to be admitted to hospitals or for secondary gain. Getting or attempting to get details about these "voices" and documenting what we are told can be an invaluable part of a patient's records. Inconsistencies arise that can be taken into consideration during subsequent encounters.

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Workplace mobbing is real

I found Dr. James Randolph Hillard's article on workplace mobbing timely and extremely interesting ("Workplace mobbing: Are they really out to get your patient?" CURRENT PSYCHIATRY, April 2009, p. 45-51). As clinical director of a consultation service for corporations, I am asked to assess employees suspected to be at risk for workplace violence and for fitness for duty. Mobbing seems to be more prevalent and the consequences more dire for a victim who is feeling pressured to leave his or her job when there is little hope of getting another one or is taking on responsibilities previously held by others who have been laid off.

This brings to the forefront a very important consideration for individuals who confront such assessment challenges. Gathering collateral information is critical for diagnostic accuracy and well-articulated interventions that may be recommended. Evaluators who do such assessments at the behest of corporate clients should insist that they have access to employee files investigative reports, and—if appropriate—permission to interview supervisors, employee assistance program representatives, and human resources personnel familiar with the case. Mobbing is real and deserves much greater attention by researchers and clinicians in the United States.

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Don't 'teach to the test'

I was disappointed to read Dr. Henry Nasrallah's editorial calling for the use of clinician measurement tools in the management of psychiatric illness ("Long overdue: Measurement-based psychiatric practice," From the Editor, CURRENT PSYCHIATRY, April 2009, p. 14-16). I agree that general and vague comments such as "doing better" are of limited value. I would further argue

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that such documentation is the psychiatric equivalent of "WNL"—which stands for "we never looked"—in a medical review of systems. But I do not believe the answer is to further dumb down the practice of psychiatry by generating quantifiable, 1-dimensional scores that purport to measure how well our patient is doing.

In the past, when these psychometric tools were developed (approximately from 1960 to 1987), 2 primary concerns were voiced.

First, there was limited data to support their validity and reliability, although that concern is somewhat less now, at least with some of the tests Dr. Nasrallah recommended. These tests still lack criterion-related validity. For example, IQ as measured by an IQ test predicts performance on an IQ test, so it's reliable. But to use that number to predict fitness for a job or even academic success ends up discriminating against some individuals or groups who are more than just a number.

Second, there was the concern that, similar to schoolteachers who end up teaching to a normative test, we could end up treating a patient's test score rather than the discomfort with his or her life. I believe this also remains true. Unlike diabetes mellitus, which is defined by increased blood sugars, psychiatric diagnoses are purely syndromal and require "clinically significant distress or impairment" or they are not a disease according to DSM-IV-TR. It's the distress and the impairment that we treat.

Today, I see 2 positive trends in our field: to find increasingly efficient methods to appropriately tailor and effectively deliver care and to be recovery-focused. It seems to me that routine and indiscriminate use of psychometrics obstructs both of these. Each test takes 30 to 40 minutes to administer and requires skilled and trained clinicians, if not psychiatrists themselves. That at least doubles the length of the visit with no evidence-based benefit. A recovery focus requires that we—as does the DSM—focus on our patients' perceived impairments, not their test scores.

Lyle B. Forehand, Jr, MD
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Dr. Nasrallah responds

I thank Dr. Forehand for his comments. I agree that psychiatric diagnoses at this time are purely syndromal and require "clinically significant distress or impairment." What I am calling for is to quantify the various signs and symptoms of the distress and impairment before and after treatment with a standard scale widely used by all researchers and some clinicians.

The definition of remission, which is the phase that precedes recovery, actually is based on standard rating scales' severity score for a given psychiatric illness. Therefore, clinicians must rate their patients on the scale corresponding to that illness to recognize when their patients have met the official criteria for remission.

Practitioners do not have to use a scale to rate the patient's symptoms separate from the standard interviewing process. Rather, once clinicians become familiar with these scales, they could conduct their usual interview and then take a moment when writing their note in the chart to circle the score of each symptom they assessed during their clinical interaction, and cite the total score in the admission or progress note. A copy of the scale can be included as a supplement to the progress note and will ensure that all signs and symptoms related to an illness are assessed, rather than just some of them.

To summarize, until scientific research leads to actual lab tests for psychiatric disorders—and I believe that day will come—psychiatrists should quantify their patients' clinical distress and impairment with the same objective measures used in evidence-based FDA trials, even if the scales' reliability and validity are not perfect.

Henry A. Nasrallah, MD
Editor-In-Chief

Scales are worth the time

Thank you for bringing the issue of measurement-based psychiatric practice to light ("Long overdue: Measurement-based psychiatric practice," From the Editor, Current Psychiatry, April 2009, p. 14-16). As nurse practitioners, we were strictly taught to elaborate on psychiatric symptoms and progress, which is why the notes are called "progress notes" and not "shorthand notes." I use blank forms of various modified scales—such as the Hamilton Rating Scale for Depression and Positive and Negative Syndrome Scale—and I checkmark and write all 4 axis and global assessment of functioning scores. These objective findings include a short version of the mental status exam. On the top of the chart, I note subjective symptoms. I never use general syntax such as "Pt. is improving, doing well." Also, I utilize a 0-to-10 scale for overall improvement, with 0 being the worst and 10 being no symptoms.

In my treatment plan, I state which symptoms have resolved and which have not. My psychiatrist friends object to that because it is time-consuming. The fact is it takes only approximately 5 minutes.

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