Current PSYCHIATRY

Busting my own myth

I enjoyed the article "From Persephone to psychiatry: Busting psychopharmacology myths" (Pearls, Current Psychiatry, September 2010, p. 40-41) because I think we all have biases, and I wanted to look at my practices. After learning about the use of multiple antipsychotics for schizophrenia despite little evidence it helps, and the fact that most panic disorder patients are not taking a selective serotonin reuptake inhibitor, I began to change what I do.

I recall a recent trial where I tried to follow algorithms until the patient reached remission. In my opinion, these types of algorithms, which are used routinely in the United Kingdom and other government-run health care systems such as the VA, take the guesswork out of our profession and allow us to trust the evidence and give our patients realistic and positive expectations for full remission or recovery regardless of the extent of their disorder. When enacted on a large scale, I also believe that following algorithms and taking out your personal biases leads to improved results by simply making people make almost automated decisions. I also agree that checking evidence and recent articles doesn't take a lot of time.

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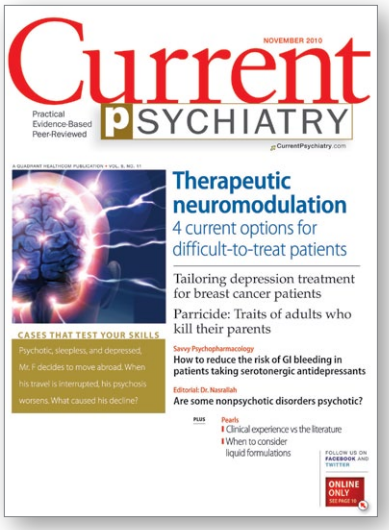
'Shoebox' diagnoses

I have always been a strong advocate of antipsychotic treatment, not only for major depressive disorder but also many anxiety disorders, such as posttraumatic stress disorder while in combat and obsessive–compulsive disorder, as well as hypochondriasis and some personality disorders ("Are some nonpsychotic psychiatric disorders actually psychotic?" From the Editor, Current Psychiatry, November 2010, p. 16-19).



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Above all, do no harm, but our patients are suffering from severe, disturbing, restrictive, and hurtful illnesses that require any approach we have at hand. I have to admit, it's not something I do comfortably regardless of the benefit to my patients. There is always a lawyer ready to knock at my door.

When I was practicing as a physician in New Zealand, a patient's well being was never compromised by fear of being sued, yet I was able to obtain some much-needed relief for many of my patients.

I would like to share with you my thoughts about not forcing patients into a "shoebox" diagnosis that limits a specific treatment, as the DSM tends to do. Keep the government from dictating to doctors and keep doctors from being limited to only FDA-approved indications, when clinically we know which treatment is best, but may be subjected to legal risk. Finally, society as well as lawyers needs to stop expecting perfection, especially with illnesses where remission is not the rule and recurrence is part of the natural history of the disease.

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Accepting opposite beliefs

I would like to add to Dr. Henry A. Nasrallah's editorial ("Are some nonpsychotic psychiatric disorders actually psychotic?" From the Editor, Current Psychiatry, November 2010, p. 16-19) that if we go by his definition of "delusional" then most of us are psychotic, considering that some individuals are atheists, some believe in God or gods, and all of us cannot be right. Politically, some have fixed beliefs and others have exactly the opposite fixed beliefs. Some are right, some are wrong, and some are psychotic. It is true that psychiatric conditions such as depression and anxiety can be considered psychotic and an antipsychotic can help the patient. However, what do we do with those who have fixed beliefs that do not fit into our beliefs? It happened not too long ago in totalitarian regimes where psychiatric treatment was a tool of the oppressors.

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