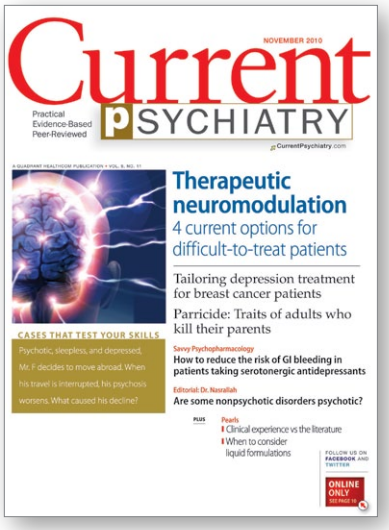
Current PSYCHIATRY

Breaking the box

I agree with Dr. Henry A. Nasrallah's commentary, "Are some nonpsychotic psychiatric disorders actually psychotic?" (From the Editor, CURRENT PSYCHIATRY, November 2010, p. 16-19), but I believe the issue is bigger than he states. Let's start with the fact that psychiatry mostly operates with diagnoses that do not have any tangible biologic underpinning and remain phenomenological descriptions. No one in general medicine would accept a diagnosis of headache or nausea, but we are quite comfortable with anxiety disorder, not otherwise specified (NOS) or intermittent explosive disorder. The list could go on.

Psychiatry is not considered a true medical discipline and we are paying the price. The "old school" of clinical psychiatry operated within a dichotomy of major categories—neurosis or psychosis—and the latter one recognized only 3 diagnostic entities: schizophrenia, manic-depressive disease, and organic disorder. It was a medical classification based on the putative biologic underpinnings of the disease, as in other medical specialties. Since then our psychiatric language became inundated with multiple NOS and descriptive labels in lieu of medical diagnoses.

True, in psychiatry we cannot use ultrasound to diagnose schizoaffective disorder, and we have to use the same method of careful medical interview and history-taking as did many generations of psychiatrists before us. We lack objectivity of the diagnosis but still—hopefully—possess our mental capacity and ability to analyze data and use our clinical experience. We are making some headway



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in using medical tests such as genetic testing or MRI, but they remain supplemental to our clinical thinking. The analytical part of a psychiatric brain does not seem to be too much in demand or relied upon. DSM classification gives us many choices to pick a label for the occasion regardless of the essence of the disease. The Texas Medication Algorithm Project is supposed to help streamline treatment modules, but it also eliminates the need to think because the perfect recipe is ready at every step. If patients are not getting better—oh well—we followed the protocol.

About Dr. Nasrallah's article: how much could traditionally nonpsychotic conditions be psychotic? We know that multiple neurotransmitters in the brain are engaged in psychiatric diseases. We do not know all of them and have only a partial understanding of their role in pathogenesis, but any psychiatric condition has a list of usual participants—neurotransmitters. Imagine a piano keyboard where one can play a popular song or jazz or Bach using the same keys, depending on the taste and skills of the performer. Our brain probably has the same "keyboard" of neurotransmitters playing different tunes.

The diagnosis of treatment-resistant depression—recently so fashionable and investigated—does not make clinical sense, but responds well to olanzapine and other second-generation antipsychotics (SGAs), which the bravest of us use off-label. Before the SGA era we used haloperidol intravenous drip to treat "resistant depression" and it helped! But before we hooked our patients to a bolus of haloperidol, we talked about the clinical diagnosis and at least tried to outline what we were attempting to treat. Sadly, the art of clinical interview and refining analysis is steadily moving toward extinction.

Our residents are brought up on a combination of traffic rules and basic cookbooks—not even gourmet ones—learning how to use a cookie cutter for any occasion. Residents are taught how to fit patients into a familiar pattern, not how to see in what ways patients are different. During my supervision with recent graduates I heard questions that follow the pattern they were taught—finding the correct and quick recipe and mold by association, not by analysis.

I would to thank Dr. Nasrallah for breaking the box psychiatry was corralled to and provoking our peers to think rather than live in the one-dimensional world of a cookbook.

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