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Suicide and anxiety

I found Dr. Scott Freeman's article on suicide prevention ("Suicide assessment: Targeting acute risk factors," Current Psychiatry, January 2012, p. 52-57) to be bold and courageous. Two of the 6 suicide risk factors he described are related to anxiety symptomatology: panic attacks and psychic anxiety. In the case study, Mr. L was prescribed clonazepam, a benzodiazepine, despite his history of comorbid alcohol abuse. Often, patients with substance abuse have related anxiety disorders—including posttraumatic stress disorder—and management with selective serotonin reuptake inhibitors (SSRIs) is not sufficient.

Because clinicians are hesitant to prescribe benzodiazepines to patients with a substance abuse history, patients often are forced to purchase these medications on the street or feel compelled to relapse to substance abuse in a frantic, albeit misguided, effort to contain their crippling symptoms. Even in inpatient drug rehabilitation settings, benzodiazepines often are not an option because they are not allowed. The "safer" SSRIs may be more dangerous when given to substance abusers in whom a comorbid mood disorder often is missed.

Current Psychiatry has never been shy in addressing the truth or uncomfortable issues in our complex field. Do we have the courage to open this up for dialogue and conversation?

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Patients unaware of TMS?

Recently, when *The Dr. Oz Show*'s Dr. Mehmet Oz turned to his television audience to ask if anyone had heard of transcranial magnetic stimulation (TMS) after a demonstration of its effectiveness in treatment-resistant depression (TRD), no one in the audience raised their hands.

I wonder why Drs. Desseilles, Fava, Mischoulon, and Freeman did not discuss TMS as an important choice for TRD in their article ("Personalizing depression treatment: 2 clinical tools," Current Psychiatry, March 2012, p. 26-33). Harvard Medical School has done trials of TMS and McLean Hospital has created a positive video on TMS.

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More on 'antipsychiatry'

In reference to the "antipsychiatry" editorial by Dr. Henry A. Nasrallah ("The antipsychiatry movement: Who and why," From the Editor, Current Psychiatry, December 2011, p. 4-6, 53): many years ago, when I was working at Chestnut Lodge, the family of a hospitalized patient asked Dr. Thomas Szasz to evaluate—as a consultant and "antipsychiatrist"—what should be done for this patient. Contrary to the family's expectations, Dr. Szasz's opinion was that the patient needed psychiatric treatment and hospitalization.

As a resident at Yale University, I knew Dr. Theodore Lidz very well. It is true that at a time of limited biological knowledge, he emphasized family dynamics as contributing to severe psychopathology, but he did not—to my knowledge—object to electroconvulsive therapy for a particular catatonic patient. His being demonized as an "antipsychiatrist" offends me because it misrepresents him.

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