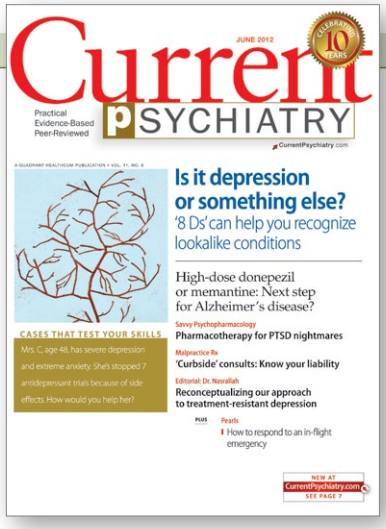

June 2012

Biopsychosocial psychiatry

With all of the discussion about a truly comprehensive and inclusive psychiatry, it was sad to see the emptiness and one-sidedness of Dr. Nasrallah's June editorial ("Innovative approaches to treatment-resistant depression," From the Editor, Current Psychiatry, June 2012, p. 4-5; http://bit.ly/MaDoH0). Depression certainly is not a unified diagnosis such as measles or appendicitis. In the face of so-called treatment-resistance, the first step is to review the psychological and biologic formulation of the patient and the reasons for his or her depression. Dr. Nasrallah does not mention the need for a review of all aspects of the patient's life. The approaches he suggests are dreary, dull, ineffective, and unchanging. It proves that patients are best cared for by psychiatrists who practice biopsychosocial psychiatry and not merely to pay lip service to it.

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Dr. Nasrallah responds

I thank Dr. Robbins for his letter. As someone trained by the father of biopsychosocial psychiatry—George Engel, MD, at the University of Rochester—I agree that it is the optimal practice of psychiatry and I practice that approach with all my patients. However, I was describing innovative interventions and paradigm shifts for truly end-of-the-road refractory depression, where all psychosocial and pharmacotherapy treatments have failed and the patient is desperate, disabled, and at high risk for suicide. None of the available interventions work with such individuals and that's why I regard the innovative breakthroughs I described in my editorial as a promise of hope, thanks to dedicated psychiatric neuroscientists. I hope psychotherapy researchers can achieve breakthroughs for these patients as well.

Henry A. Nasrallah, MD
Editor-in-Chief

Psychotherapy for GAD

I appreciated Dr. Barry's in-depth review of current diagnostic criteria and therapy for generalized anxiety disorder (GAD) ("Generalized anxiety disorder: Helping patients overcome worry," Current Psychiatry, May 2012, p. 40-44; http://bit.ly/Jn1nTz). However, I want to point out an error under the "Evidence-based treatments" section labeled "Psychotherapy." Dr. Barry states that cognitive-behavioral therapy (CBT) is the preferred form of psychotherapy for GAD. In my 40 years of practice, I have found a combination of medication—preferably selective serotonin reuptake inhibitors—and psychodynamic psychotherapy is the most effective treatment for GAD and provides more enduring relief.

Jonathan Shedler, PhD, of the University of Colorado Denver School of Medicine reported on the efficacy of psychodynamic psychotherapy vs behavioral therapy.[1] He compiled the results of meta-analyses of psychotherapy efficacy by 18 investigators covering 792 studies. The findings show a superior result for psychodynamic psychotherapy over behavioral therapy and the effects are more lasting.

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The author responds

I appreciate Dr. Parsons' comments and his valuable contribution to the dialogue on GAD. Dr. Parsons reemphasizes the importance of psychotherapy in this chronic condition. As demonstrated by the meta-analyses reviewed by Dr. Shedler, there is sufficient evidence in the medical literature to support either psychodynamic psychotherapy or CBT. The specific therapeutic recommendation should consider unique patient variables, such as therapist availability and expertise, the presence of co-occurring conditions or dynamics that would better align with a specific modality, and patient preference and psychological mindedness, to name a few. Regardless, psychotherapy is indicated in the treatment of GAD, and both CBT and psychodynamic psychotherapy are well-supported interventions.

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Caution with prazosin

We welcome the article discussing the use of prazosin and antipsychotics for posttraumatic stress disorder (PTSD)-related nightmares (Graham RL, Leckband SG, Endow-Eyer RA. "PTSD nightmares: Prazosin and

atypical antipsychotics," Current Psychiatry, June 2012, p. 59-62; http://bit.ly/LVAlSo). The favorable outcomes associated with prazosin use combined with its low cost and general tolerability give it considerable potential. Prazosin may be particularly valuable given the unfavorable cardiometabolic risks associated with antipsychotic use, especially because evidence suggests individuals with PTSD have higher rates of cardiovascular disease.[1]

We believe the occurrence of adverse cardiovascular effects when starting prazosin requires further attention. As an α1-adrenergic receptor antagonist, it has been linked to orthostatic hypotension and syncope.[2,3] Its cardiovascular effects may be further complicated by concomitant use of other antihypertensive medications. Therefore, we suggest a low initiation dose and gradual titration of prazosin. In individuals who initially were normotensive but then experienced hypotension following prazosin administration, we successfully used short-term sodium chloride tablets, 4 g/d. We discontinued sodium chloride after titration was completed and no postural hypotension was evident.

To minimize polypharmacy, individuals on multiple agents for hypertension may benefit from substituting prazosin for 1 of their regular antihypertensives. Despite the mounting evidence supporting prazosin use, it is not indicated for PTSD.

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The authors respond

We agree with the comments by Drs. Vahabzadeh and Duncan regarding the cardiovascular adverse effects of prazosin. It is important to assess the hemodynamic status of the patient before initiating prazosin therapy, and usually, initiation is attempted only if a patient is normotensive or hypertensive because of potential orthostatic hypotension and syncope, which can occur in up to 4% of patients.[1] As noted by Drs. Vahabzadeh and Duncan, prazosin often is viewed as a dual treatment for both nightmares and blood pressure in individuals who are hypertensive prior to initiation. Prazosin therapy usually is initiated at 1 mg at bedtime and titrated by 1 to 2 mg every 3 to 5 days.[2] The average dose was approximately 3 mg in studies evaluating prazosin for treating PTSD-associated nightmares (dose range: 1 to 10 mg).[2] Until the patient is stabilized on a prazosin dose, blood pressure should be monitored daily for inpatients. Outpatients should be educated regarding the signs and symptoms of hypotension, especially dizziness and light-headedness upon standing, along with monitoring blood pressure at his or her next clinic appointment.

Prazosin does not carry an FDA indication for PTSD. Although this is important to consider, the level of evidence in terms of treatment of nightmares also is key. Aurora et al found prazosin was the only medication with a level A rating for treating PTSD-associated nightmares, indicating it as a recommended therapy option.[2] Because we do not have any medications indicated for PTSD-associated nightmares, it is crucial to practice evidence-based medicine and base therapy choices on available literature supporting the most effective and safe options.

Safety is an issue in many clinicians' minds, especially when treating geriatric patients with PTSD because of the risk of hypotensive effects with prazosin leading to negative outcomes, such as falls. In Peskind et al's open-label study of 9 older patients (mean age: 76) with intractable PTSD-associated nightmares treated with prazosin (mean dose: 2.3 mg; increased by 1 mg per week to a maximum dose of 4 mg), 8 patients experienced >50% reduction in nightmares after 8 weeks of treatment, and 1 patient experienced transient orthostasis when starting prazosin that resolved spontaneously with only mild decreases in blood pressure noted otherwise (<20 mm Hg decrease in systolic blood pressure upon standing).[3] Although this study was small, it provides evidence that prazosin can be an effective and safe treatment option in geriatric patients and is devoid of the highly sedating side effects of some other treatment options.

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