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Comorbid MDD and AUDs

In "Pharmacotherapy for comorbid depression and alcohol dependence" (Current Psychiatry, January 2013, p. 24-32; http://bit.ly/TWJssZ), Drs. Gianoli and Petrakis report that the potential benefits of mixing antidepressants and alcohol dependence medications is extremely limited. Their article confirms the general wisdom in addiction psychiatry and is distressing in the short shrift given to the primary avenue physicians have for treating this dual condition—encouraging abstinence.

McLellan et al[1] found that treating alcohol addiction produces outcomes comparable to treating hypertension and diabetes. However, if psychiatry were to bring its current overemphasis on pharmacology and underappreciation of psychotherapy to treating alcohol addiction, it would not produce the effectiveness of current multimodal, multidisciplinary approaches. Under the Affordable Care Act, primary care physicians will be expected to identify high-risk alcohol consumption and encourage reduction of risk, including treatment and recovery. What the authors allude to as "encouraging abstinence" is a complex art and craft that all physicians will need to attend to more than in the past. Drs. Gianoli and Petrakis' work tells us why this is so: pharmacology does not rule in the treatment of mixed depression and alcohol dependence.

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Reference

1. McLellan AT, Lewis DC, O'Brien CP, et al. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000;284(13):1689-1695.

The authors respond

We thank Dr. Cermak for his comments on our article. We wrote a review of the literature on the efficacy of various pharmacologic treatments to treat patients with comorbid depression and alcohol dependence. The purpose of our review was to remind practitioners that efficacy of antidepressants or medications to treat alcohol use disorders may be different in individuals with a comorbid disorder. Studies determining efficacy have been conducted primarily in noncomorbid groups and the results may not be generalizable. Emerging literature is trying to address this shortcoming. This is an important point that we hope we adequately conveyed to Current Psychiatry's readers.

Our article was not a comprehensive review of all possible treatment options; we mentioned that a review of nonpharmacologic treatments was beyond the scope of our review. This does not mean that psychosocial treatments are not valued or important; they are an important part of any comprehensive treatment plan.

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Depression in pregnancy

I would like to thank Drs. Hatters Friedman and Hall for their excellent article, "Antidepressant use during pregnancy: How to avoid clinical and legal pitfalls" (Current Psychiatry, February 2013, p. 10-17; http://bit.ly/WJmwgc). Their emphasis on the risks of untreated depression was much appreciated and resonated deeply with me because of my own experiences.

During the second year of my residency, I treated a 31-year-old woman who experienced depressive symptoms starting in her first trimester of pregnancy. She was suffering from major depressive disorder, single episode, mild type, and was referred to me for psychotherapy. As the therapy and her pregnancy progressed, her depression worsened and I faced the difficult decision of starting a pregnant woman on psychotropics.

Despite her worsening symptoms, I was hesitant to offer her medication

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Correction

"Drug interactions with tobacco smoke: Implications for patient care" (Current Psychiatry, January 2013, p. 12-16; http://bit.ly/13Es2oy) contained incorrect information. In ***Table 1***, mirtazapine should have been listed as an α-2 antagonist. The article has been corrected online.

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because she was pregnant. My discussion with my psychotherapy supervisor was the first in a series of events that made me aware of the stigma regarding prescribing psychotropics to pregnant women. I was amazed when he expressed his views of "not exposing pregnant women to medications" without a reasonable discussion of benefits. While discussing the risks, my patient replied bitterly: "You doctors won't even say Tylenol is safe… everybody only thinks about the baby. What about me? I stopped being a person the day I became pregnant."

After a careful risk-benefit discussion, and with guidance from my psychopharmacology supervisor, we started my patient on sertraline. More than 6 years later, I still recall my patient's description of her attempt to fill her prescription. She said the pharmacist refused to fill the prescription and told her that a pregnant woman should not be taking that medication, implying she was being a "bad mother." She said to me, "I did not have the strength to walk across the road to the other pharmacy. This incident again confirmed that I don't exist; I am just a body for the baby." I was horrified. Are we not taught to discuss the risks and the benefits of a treatment, and then help patients make the best decision for themselves? I am amazed at how often we let our personal views bias the way we look at objective evidence and how little we think of what a patient wants or needs.

After a few weeks, my patient started sertraline and responded well. She continued to attend therapy regularly. For months after her symptoms remitted, she described how disconnected she had felt from herself and how she later grieved for the time lost. Although she never blamed me, I always felt guilty for adding a few weeks to her suffering by not starting her on medication earlier.

This experience had a lasting personal impact. I am committed to ensuring that my residents and I are up-to-date about prescribing psychotropics for pregnant patients. However, the need for these well balanced and well written articles is ongoing, because I continue to see patients whose psychosis or depression worsens dramatically because their psychiatrist abruptly stopped maintenance medications during pregnancy.

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Prescribing psychologists

Because psychiatric medications are complex to manage, I oppose psychologists being certified to prescribe. During medical school, I received 4 years of advanced training in physiology and pharmacology. After medical school, I completed a full year of preliminary internal medicine and an additional 3-year psychiatry residency to further increase my knowledge in managing mental illness. I am certified by the American Board of Psychiatry and Neurology, a process that included written and oral examinations over 2 years after residency to prove my expertise in psychopharmacology, diagnosis, treatment, risk assessment, and psychotherapy. I provide medications and psychotherapy for my patients as indicated. This is the rigorous path most physicians take to becoming a psychiatrist in the United States.

One of my biggest concerns about psychologists prescribing is lack of medical training to make a complete differential diagnosis that includes medical causes of a mental disturbance, limited knowledge of drug-drug interactions, and potential to harm patients because of their lack of medical training. For example, a patient taking the blood thinner warfarin may have their ability to clot fatally impaired by a psychotropic drug because of a lack of adequate medical evaluation by a "prescriber" who has limited training in medical management and pharmacology. Another example of the need for medical training to fully evaluate psychiatric patients is an apathetic, depressed patient who continues to be treated with antidepressants while his or her underlying neurologic problem, thyroid condition, or undeclared substance abuse goes undiagnosed.

Lithium is the gold standard medication for bipolar disorder, but if managed incorrectly, without considering the patient's overall medical condition, drug interactions, and daily physical activities, this drug can lead to kidney failure, coma, brain damage, and death. Many, if not all, psychotropics require ordering and interpreting diagnostic laboratory blood testing before and after initiating treatment to monitor for life-threatening complications, including diabetes and neuroleptic malignant syndrome, and changes in white blood cell count, potassium and sodium levels, and ECG data.

Medical education is long and challenging because the human body—especially the mind—is a complex system that requires a great deal of study to comprehend. A physician's duty is to do no harm; extensive training is the most important tool for preventing unnecessary harm.

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