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IN THIS ISSUE

Focus of the Month:
Psychiatric Diagnosis

Learning objectives for this issue: **1.** Describe the whole-patient approach to psychiatric diagnosis. **2.** Detail some criticisms of *DSM-5*. **3.** Evaluate some of the current findings in the literature regarding psychiatric treatment.

The "Whole-Patient" Approach to Psychiatric Diagnosis

Margaret S. Chisolm, MD
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Dr. Chisholm has disclosed that she receives book royalties from the JHU Press. Dr. Balt has reviewed this article and found no evidence of bias in this educational activity.

This month marks the one-year anniversary of the publication of *DSM-5*. Designed as an atheoretical research tool to establish a reliable and consistent way to make psychiatric diagnoses without any comment as to their underlying cause, the DSM has become the go-to clinical diagnostic resource for mental health professionals.

Unfortunately, many are unaware of the volume's scientific limitations, particularly its lack of validity. Fourteen years in the making, this latest version (*DSM-5*) has been the subject of intense global scrutiny and criticism both before and since publication (see, for instance,

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In Summary

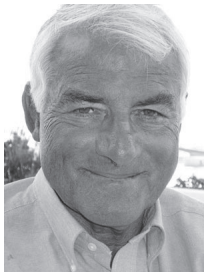
- An alternative to *DSM-5*, the whole-patient approach provides a sequential, comprehensive series of steps to create a personalized diagnostic picture for each individual patient.
- This approach considers every psychiatric patient from four points of view (disease, dimensional, behavior, and life-story) to understand how that patient's thoughts, feelings, and behavior may have gone awry.

Q&A With the Expert

The Trouble with *DSM-5*
Allen Frances, MD

Chair, DSM-IV Task Force
Professor Emeritus
Duke University School of Medicine, Durham, NC

Dr Frances has disclosed that he receives book royalties from HarperCollins Publishing and the Guilford Press. Dr. Balt has reviewed this interview and found no evidence of bias in this educational activity



TCPR: Dr. Frances, you have criticized both the process and the product of *DSM-5*. First, please tell us where you think they went wrong in the process.

Dr. Frances: In terms of the process, *DSM-5* was far too ambitious in wanting to promote a paradigm shift for the field. And, in establishing unrealizable ambitions, it incorporated suggestions that I think will do more harm than good for patients. In addition, the DSM methods were disorganized, deadlines were consistently missed, and there was no clear central direction about the level of evidence necessary before changes could be included.

TCPR: And what about the finished product?

Dr. Frances: As the result of the problems with the process, we have a product that makes worse some of the troubling trends in psychiatry that were already evident in the *DSM-IV* era. Even before *DSM-5*, psychiatry had a severe problem with diagnostic inflation, and extensive diagnosis and treatment of people who would probably do better without it. *DSM-5* is likely to make the diagnostic inflation worse.

TCPR: Can you tell us some of the particular cases of diagnostic inflation you

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the Expert Q&A with Allen Frances in this issue).

Some are concerned that the *DSM-5* will make more people mentally ill; others, that the formerly ill will be "cured," jeopardizing their access to continuing care. Unfortunately, not only has this attention cast a light on the inadequacies of the DSM, but it has also further undermined the credibility of our field, to the detriment of our patients.

An Alternative To DSM?

Alongside DSM, another conceptual model has risen, one based on concepts originally developed by Adolf Meyer and Karl Jaspers in the early 20th century. In the 1980s, these ideas were organized and later were described in the book, *The Perspectives of Psychiatry,* published in 1998 (Johns Hopkins University Press). *The Perspectives of Psychiatry's* authors, Paul McHugh and Phillip Slavney, have steadfastly viewed the DSM system as fundamentally flawed and have consistently expressed concern about its negative impact on the field.

Wishing to move US psychiatry beyond the DSM, they have voiced the utility of their more comprehensive framework for understanding psychiatric conditions (see, for instance, McHugh PR and Slavney PR, *New Engl J Med* 2012;366:1853–1855, available at bit.ly/1lZlf2Q). Their model translates into a pragmatic "whole-patient" approach to psychiatric diagnosis in which a clinician considers every psychiatric patient from four points of view (disease, dimensional, behavior, and life story) to understand how that patient's thoughts, feelings, and behavior may have gone awry.

The Whole-Patient Approach

The whole-patient approach (sometimes called the "Perspectives of Psychiatry" approach) acknowledges that, whereas general medical conditions are consistently understood as diseases arising from a diseased entity or "broken part," not all psychiatric conditions can be understood that way. Different psychiatric disorders have different natures.

This systematic whole-patient approach differs from eclectic holistic approaches, such as George Engel's biopsychosocial model (Engel GL, *Am J Psychiatry* 1980;137:535), which merely provides a list of "ingredients" relevant to psychiatric diagnosis. Instead, the whole-patient approach also provides the recipe—a sequential, comprehensive series of steps—to turn that list of ingredients into personalized formulations for individual patients.

The following are the four perspectives to consider for each psychiatric patient when using the whole-patient approach to diagnosis.

Disease perspective. Physicians are most familiar with the disease perspective portion of this model. From this point of view, the etiology of a patient's troubles is understood as arising from a pathophysiologic process within a specific organ or organ system, which leads to the presenting syndrome.

For example, the disruption in mental life faced by patients with dementia may be understood as developing from physical changes in the brain. The questions one asks when approaching a patient from the disease perspective are "What is the broken part? and, "What disease does the patient *have*?"

Dimensional perspective. For many psychiatric conditions, the disease perspective is inadequate to fully explain the distress with which patients present. The dimensional perspective thus provides a framework for understanding those psychiatric conditions that arise from variations in an individual's physical or psychological attributes. These endowments may lead the patient to react to certain things with an individual set of pathological responses.

Someone who has either too little or an overabundance of a particular personality trait may be especially vulnerable to experiencing psychiatric distress. Such a patient's symptoms are not from a "broken part" in the brain, and a psychiatrist can best serve this type of patient by asking, "Given my patient's particular strengths and vulnerabilities, how can I best guide him toward success?" He must attempt to understand what kind of person the patient *is.*

Behavior perspective. As its name implies, the behavior perspective can be helpful in understanding psychiatric problems that stem from a maladaptive behavior. This perspective is based on the concept that an individual's psychological drives, shaped partly by conditioned learning, influence his or her choice in whether or not to engage in goal-directed behavior.

Recognizing maladaptive behavior in patients, and considering the factors that can initiate and sustain such behaviors, is critical to treating many psychiatric disorders, including substance use and eating disorders. The behavior perspective prompts psychiatrists to ask, "How can my patient's distress be explained by, and how can I help by changing, what he *does?"*

Life story perspective. Lastly, some individuals seeking psychiatric help are burdened not by a disease they have, by who they are, or by things they do, but by what they have encountered in life. Such psychiatric disorders are best understood by using the life story perspective. This perspective uses the logic of narrative—a sequence of events within a particular setting and leading to a specific

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outcome—to understand a patient's psychiatric state.

For example, a recent widow may seek treatment for feelings of sadness following the death of her husband. Using the life-story perspective, her psychiatrist may understand the presenting symptoms as arising from the loss and use psychotherapy to help the patient "rescript" her life story in a way that enables her to regain a feeling of mastery over her circumstances. In the life story perspective, the psychiatrist must consider what the patient *encounters*.

A Case Study of the Whole-Patient Approach

To illustrate how a common patient presentation might be addressed using this approach to psychiatric diagnosis, consider the case of a 60-year-old female social worker who comes for outpatient evaluation for worsening irritability and depressed mood. Of note, the patient was raised by a foster family until the age of 12 when, after a teacher suspected physical abuse, social services intervened and the patient was moved to her eventual adoptive family. They provided a loving and secure home, although they passed away not long after the patient graduated from high school, leaving her without resources for college.

According to the patient's daughter, her mother had always been able to weather life's difficulties. She created a loving and stable family of her own and enjoyed a close network of friends. She never used any illicit substance and did not drink alcohol.

In fact, the patient's life was stable and relatively uneventful until five months ago when her husband of 35 years was diagnosed with dementia, after worsening confusion over the past year. Since her husband's diagnosis, the patient's mood has been more irritable and sad. She has had more difficulty falling asleep, and has lost weight.

On mental status examination, her mood is sad and does not brighten as the interview progresses. She cries frequently, especially when discussing her husband's condition. She describes poor energy/motivation and difficulty concentrating. She feels guilty and has little hope for the future. She denies thoughts of suicide and evidences no psychotic symptoms.

In this case, you must consider the patient from the life story perspective as a way of understanding her symptoms. The patient has endured a number of childhood stressors, both psychological and physical, but she had the resilience and optimism to overcome these past adversities.

Her current symptoms follow on the heels of her husband's diagnosis with dementia. It may be tempting to propose that her symptoms may be the result of this event, but they do not fit with how she has reacted to stresses in the past. As a result, it would be prudent to defer any conclusion about the cause of her present condition until considering her problem from the other perspectives.

Because she does not appear to be on any extreme of either cognition or temperament (confirmed by her daughter) and has successfully weathered other challenges in the past, it does not appear that the patient's present condition is arising from who she is as a person, and thus cannot be understood primarily from the dimensional perspective.

The behavior perspective also says little about her current presentation. She has no evidence of primary sleep, eating, or sexual disorders; and denies the use of licit and illicit substances.

This brings you to the disease perspective. Disease reasoning begins with the identification of a clinical syndrome, so the first thing one needs to decide is whether the patient's current psychiatric presentation fits well with a clinical syndrome. The decline in her mood, sleep, appetite, energy, concentration, along with guilt and hopelessness, may indeed represent a case of major depressive disorder.

The fact that a stressful circumstance preceded her symptoms in no way changes the fact that they add up to a clinical syndrome. Given that this patient's syndrome emerged in the context of her husband's diagnosis, you can construct a plausible, meaningful narrative to explain her syndrome as arising from this stressful life circumstance.

However, you must consider whether or not the symptoms represent a new theme in her life. If so, her symptoms may be better explained as arising from an abnormality in the structure or function of her brain rather than from the stressful life event that she has encountered. Depressive symptoms often arise in the setting of stressful life events and, although patients and clinicians often draw on storytelling to help understand these symptoms, not every story we tell may be true.

Clinicians risk falling into a "trap of meaning" (Lyketsos & Chisolm, *JAMA* 2009;302:432–433) when they invoke meaningful explanations to understand new symptoms that can also be caused by a disease process. In this case, a clinician shouldn't let a meaningful explanation obscure recognition that the true nature and origin of a patient's suffering can be the clinical syndrome of major depressive disorder.

Although the patient's depressive symptoms may be partly due to her husband's recent diagnosis of dementia, which may have overpowered the resilience she had demonstrated through most of her life, they are most likely not

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The Four Perspectives of Psychiatry

Perspective	Disease	Dimensional	Behavior	Life Story
Explanatory Method	Etiology ↓ Pathophysiologic Process ↓ Syndrome	Potential ↓ Provocation ↓ Response	Drive ↓ Choice ↓ Learning	Setting ↓ Outcome ↓ Sequence
"What the patient…"	"Has"	"Is"	"Does"	"Encounters"

Expert Interview
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worry about in *DSM-5*?

Dr. Frances: For starters, the most controversial suggestion was the one that allows major depressive disorder to be diagnosed after just two weeks of sadness, loss of interest, loss of appetite, trouble sleeping, and reduced energy in someone suffering from bereavement. Grief is a completely normal aspect of human being/mammalian functioning. It would be abnormal if people *didn't* have those five symptoms after two weeks of losing the love of their life. Bereavement, as defined in *DSM-IV*, did not need fixing. In *DSM-IV*, major depression could be diagnosed if someone had symptoms of suicidal ideation, psychosis, severe agitation, severe retardation, or inability to function. Real depressions were not going to be missed, even when they occurred during bereavement. The changes in *DSM-5* perpetuate a longstanding problem: too often, what we call "major depressive disorder" is not major; it is not depressive; and it is not really a disorder.

It's important to remember that receiving a diagnosis is a remarkably important moment in a person's life, and an accurate diagnosis can bring enormous benefits and reduce the lifetime burden of illness.

Allen Frances, MD

TCPR: What else do you see as problem diagnoses?

Dr. Frances: Another controversial suggestion was to include somatic symptom disorder, which requires the patient to have only one somatic symptom that the doctor thinks is more distressing than it should be. This is a remarkably loose definition. In the one field study trial, one-fourth of chronic pain patients, one-fifth of cancer patients, and six percent of the general population would be diagnosed with somatic symptom disorder (Freedman R et al, *Am J Psychiatry* 2013;170:1–5; Regier DA et al, *Am J Psychiatry* 2013;170:59–70). Many people with unexplained physical problems are absolutely ballistic about this, and I think they are right. Their fear—and their experience—is that doctors face uncertainty when diagnosing their problems, and say that it is all in their heads. This may result in inadequate medical evaluation.

TCPR: And what else?

Dr. Frances: I am concerned about the inclusion of mild neurocognitive disorder, which is impossible to distinguish from the normal forgetting of aging given current tools. It will be some years before we will have a biological test or cure for Alzheimer's. Because of *DSM-5*, a large number of diagnoses of mild neurocognitive disorder will encourage people to do all sorts of testing that lacks sensitivity and specificity.

TCPR: One your strongest criticisms regards the overdiagnosis of ADHD. Please tell us about how *DSM-5* contributes to this.

Dr. Frances: *DSM-5* makes it easier than ever to diagnose ADHD. It is particularly easier for adults to be diagnosed, and in adults it is virtually impossible to distinguish a desire for greater concentration and cognitive performance from ADHD. Every psychiatric condition under the sun causes attention problems, so making it easier to jump to ADHD means that other diagnoses may be missed. We also have a huge secondary market in the use of stimulants. Thirty percent of college students and 10 percent of high school students take drugs that have been diverted from people who have legal prescriptions. We don't need an adult population that is bathed in stimulants for fake ADHD.

TCPR: And you say that with these increased diagnoses, drug companies see greater potential for marketing medications, leading patients to request these drugs, further feeding the overdiagnosis.

Dr. Frances: Yes, take binge eating disorder for example. It's possible that 10 to 20 million patients may be labeled with a mental disorder because they binge eat one time a week for a few months. Drug companies are already jumping on this. One company's stock prices went up dramatically because it reported a positive result using stimulants for binge eating.

TCPR: Where else do you think this tendency to overdiagnose comes from? When did we start to narrow what is considered "normal" so dramatically?

Dr. Frances: Many of our experts have an intellectual conflict of interest. I have never met an expert who ever said, "Let's narrow my diagnosis." They are always worried about missed patients and under-recognized conditions. They are interested in more research dollars for their area to legitimize what is within the DSM. My sad feeling is that if anything can be misused in diagnosis, if there is a loophole, the world will drive a truck through it. Drug companies have the freedom to advertise directly to consumers in this country—which they have nowhere else in the developed world, except New Zealand. Finally, insurance carriers require a diagnosis before paying bills. It would be better, as it is in many countries, if you didn't have to make a diagnosis on your first visit. You could provide an extensive evaluation period of five or six visits, during which time many patient's problems would resolve without a diagnosis, without the stigma, and in many cases without long-term treatment with unnecessary medication.

TCPR: Your newest book is called *Saving Normal*. What exactly is "normal" and why is it so hard to define?

Dr. Frances: Unfortunately, there is no definition of normal that works very well. It is necessarily going to be at least a somewhat arbitrary and subjective construct. One of the problems is epidemiology. Epidemiological studies all exaggerate the rate of mental disorders. Most have the systematic bias of lay interviewers who don't ask about—and can't judge—clinical significance. As a result, rates given in epidemiological studies are at the upper screening limits. The National Institute of Mental Health (NIMH) now reports that 25 percent of the population has had a mental disorder in the past year, and 50 percent have at any point during the lifespan (Reeves WC et al, *Morbidity and Mortality Weekly Report* 2011:60(03);1–32). So psychiatry has steadily expanded its boundaries from the six disorders in the first DSM, all of which resulted in long-term asylum care, to the now couple of hundred disorders, many of which are indistinguishable from normal life and human distress. This results in often harmful and unnecessary treatments for people, and also has led us become a pill-popping society.

TCPR: As a psychiatrist, surely you agree that accurate psychiatric diagnosis can help a large number of people.

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Expert Interview

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Dr. Frances: Yes. While we are overdiagnosing and overtreating people who may not need it, we are neglecting psychiatric patients with severe mental illness. In the past 50 years we have closed a million psychiatric beds in the US as part of deinstitutionalization. The assumption was that much of the money saved would follow patients to the community, to provide treatment and decent housing. Instead, mental health budgets have always been austere, and in recent years have been the victim of severe cuts. We now have a million psychiatric patients in prison or jail, usually for nuisance crimes that could have been avoidable had there been adequate community care and decent housing. Police are now the first responders to psychiatric troubles, and they have learned that taking someone to the ER is usually futile because there will be no bed or crisis outpatient appointment available. Unfortunately, psychiatric patients are the most likely to do poorly when incarcerated.

TCPR: How do you suggest that psychiatrists might deal with this?

Dr. Frances: I think clinicians should make sure before giving a diagnosis that the patient has undergone a very thorough medical and psychiatric evaluation and that the symptoms are severe and persistent enough to cause clinically significant distress or impairment. Even though those are subjective terms, they provide a rough and ready guideline that would keep us from diagnosing mental disorder in people we have seen for only a few minutes with mild problems that often take care of themselves.

TCPR: Don't we as psychiatrists already have roles as gatekeepers in preventing overdiagnosis?

Dr. Frances: Well, first off, 80 percent of psychiatry is not done by psychiatrists. The drug companies know that there are 10 times more primary care doctors than psychiatrists and direct their marketing to them. Primary care doctors prescribe 80 percent of all medications: 90 percent of anti-anxiety agents, 80 percent of antidepressants, 60 percent of stimulants, and even 50 percent of antipsychotics. Often the prescription or the free sample is offered after a seven-minute evaluation on a first visit without sufficient time or sufficient longitudinal follow-up. Primary care doctors have been marketed to aggressively with the messages that mental disorders are easy to diagnose, due to a chemical imbalance, and treatable by a pill. This leads to sloppy, fast, careless diagnosis and treatment.

TCPR: What else can be done?

Dr. Frances: One recent endeavor is the Choosing Wisely initiative, established by the professional medical organizations in the United States, including the APA. Each organization is trying to identify which tests are unnecessary, which treatments are being overdone, and which diagnoses are not being handled well. So even though we, as individuals, may not have control over diagnostic inflation and drug companies, I think all of medicine is beginning to realize that loosening thresholds for diagnoses, and the widespread use of screening tests, does not improve outcome, might actually harm patients, and increases healthcare costs for individuals and for society. Even with this initiative, a separate problem lies with the NIMH, which funds most psychiatric research in this country. There has been a reduction in the mission and research protocol with the NIMH away from encouraging clinical research, social systems research, and health services research. Instead, the NIMH has become a mere brain institute, and this neuroscience focus becomes more intense with each passing year. As a result, the last 30 years of research has been so remarkably productive in teaching us how the brain works, but so remarkably *unproductive* in helping our patients.

TCPR: In closing, what should we as psychiatrists keep in mind when approaching patients?

Dr. Frances: It's important to remember that receiving a diagnosis is a remarkably important moment in a person's life, and an accurate diagnosis can bring enormous benefits and reduce the lifetime burden of illness. I don't think there is enough emphasis on how much time and effort it takes to give a diagnosis and how sacred a moment it is to the patient. I do not like to make a diagnosis on the first visit unless the presentation is crystal clear and classic. Hippocrates said it is more important to know the patient who has the disease, rather than the *disease* the patient has. So, I think the training in psychiatry, to me at least, has to go back to a richly humane biopsychosocial model that understands people, not just disorders, and tries to find the very best treatment without being restricted to just prescribing a pill.

TCPR: Thank you, Dr Frances.

Dr. Frances is the author of *Essentials of Psychiatric Diagnosis* (The Guilford Press 2013) and *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (HarperCollins Publishers 2013).

The "Whole-Patient" Approach to Psychiatric Diagnosis

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solely due to this. Rather, the symptoms probably arise from the interaction of an unknown pathologic process in her brain provoked by stressful occurrences, for which a combination of psychotherapy and pharmacotherapy are indicated.

In Summary

The whole-patient approach incorporates all four perspectives—disease, dimensional, behavior, and life story—in a systematic and personal way. It enables you to understand your patient to a depth and breadth that is impossible to achieve with the DSM alone. Although the DSM organizes psychiatric conditions reliably, it is not enough to simply run through a check list of non-specific DSM signs and symptoms to make a diagnosis. Psychiatric illness doesn't occur in a vacuum—it arises from and is shaped by an individual's life.

TCPR'S VERDICT: The whole-patient approach helps to sharpen and clarify clinical reasoning about patients, especially those with chaotic lives and multiple problems. It enables treatment recommendations tailored to the specific person and has been disseminated widely to help psychiatrists think more deeply about their patients. When used in tandem with the DSM, it allows for individualized care and productive collaboration with the patient.

Research Updates IN PSYCHIATRY

Section Editor, Glen Spielmans, PhD

Glen Spielmans, PhD, has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

ALZHEIMER'S DISEASE

Citalopram May Help with Agitation in Alzheimer's Disease

Agitation is common in Alzheimer's disease (AD), and while antipsychotics are frequently given for agitation, they can also increase risk for cardiac and cerebrovascular events. What to do? A group of researchers recently investigated the possibility that an antidepressant, citalopram (Celexa), may be an alternative choice.

The Citalopram for Agitation in AD Study (CitAD) was a randomized, placebo-controlled, double-blind study of 186 patients with Alzheimer's disease and clinically significant agitation. All participants received a psychosocial intervention, consisting of counseling sessions, educational materials, and 24-hour crisis management. Investigators measured levels of agitation as well as overall function and cognitive and physical safety.

Participants were randomized to either citalopram (n=94) or placebo (n=92) for a nine-week trial. They were permitted to continue taking cholinesterase inhibitors and/or memantine for AD, but no other psychiatric medications. (Lorazapam and trazodone were permitted as "rescue" mediations when needed.) Patients with depression or psychosis requiring treatment with an antipsychotic were excluded from this study.

Citalopram doses were titrated from 10 mg/day up to 30 mg/day during the first three weeks as tolerated. In the final analysis, those who received citalopram showed significant improvement in the main outcome measures, the 18-point Neurobehavioral Rating Scale agitation subscale (NBRS-A) and the modified Alzheimer's Disease Cooperative Study-Clinical Global Impressions of Change (mADCS-CGIC).

At nine weeks, participants in the citalopram group had an average NBRS-A score of 4.1, and those in the placebo group, 5.4 (p=.01) (higher scores indicate more agitation). Similarly, 40% of participants taking citalopram improved from baseline on the mADCS-CGIC, versus 26% of the placebo group.

On the other hand, citalopram was correlated with cognitive worsening in comparison to placebo (-1.05 points on the MMSE, 95% CI, -1.97 to -0.13; p=.03). There were more falls (3.4% vs. 0%) and upper respiratory tract infections (18.9% vs. 10.5%) in participants taking citalopram, but these were not statistically significant.

Other SSRI side effects were no more common with citalopram than with placebo, except for diarrhea (27.8% vs. 14.0%). Interestingly, the FDA advisory about high citalopram doses causing QTc prolongation was announced while this study was being conducted (August 2011). As a result, the investigators immediately initiated a stricter ECG monitoring protocol. ECG data were available for 48 participants; citalopram was associated with an average 18.1 ms increase in QTc vs. placebo (p=.004), and three participants taking citalopram had clinically significant QTc prolongation (>450 ms for men, >475 ms for women) compared to one taking placebo.

TCPR's Take: The reason why citalopram might help agitation in AD is unclear, and while this study suggests that citalopram significantly reduces agitation relative to placebo, its side effects included mildly reduced cognition and QTc prolongation. Further research should help determine which patients are more likely to respond to citalopram, and whether benefits persist beyond the nine weeks of this trial. The authors also plan to study lower doses of citalopram to determine whether the FDA's lower limit of 20 mg/d limits the benefit of this intervention.

ANTIDEPRESSANTS

Non-Physical Adverse Effects of ADs May Be Underreported

All antidepressants have the potential to cause physical adverse effects, such as dry mouth, drowsiness, and dizziness. But patients often report psychological and interpersonal effects, too, and the fear of these adverse reactions sometimes leads patients to refuse these drugs.

How common are non-physical side effects, such as apathy and feelings of detachment? To find out, researchers in New Zealand created an online survey and invited patients who had been prescribed antidepressants at any time during the last five years. The questionnaire featured 47 questions, inquiring about 20 biological, emotional, and interpersonal adverse effects of these medications.

Eight of the 20 effects analyzed were reported by more than half of the 1,829 participants. These included sexual difficulties (62.3%), feeling emotionally numb (60.4%), failure to reach orgasm (59.5%), drowsiness (57.8%), dry mouth (57.6%), weight gain (56.4%), "withdrawal effects" (54.9%), and "feeling not like myself" (52.4%).

A slight majority (52%) reported taking antidepressants for three or more years. SSRIs were the most widely prescribed, with smaller percentages reporting tricyclics and SNRIs. About two-fifths (39%) reported multiple antidepressants, and most respondents (83.6%) received prescriptions from a general practitioner.

Some symptoms were often identified as more severe than others. In particular, "feeling emotionally numb" was rated as moderate or severe by 35.5% of participants, while 29% reported moderately or severely "not feeling like myself." Sexual difficulties (unspecified) and failure to reach orgasm were reported as moderate or severe by 39.1% and 40.7% of participants, respectively. Young people (18 to 25 years old) reported the greatest incidence of emotional numbness, not feeling like oneself, and suicidality.

Unpleasant side effects were reported as the reason for discontinuing medication by 47.5% of the respondents who were "not currently taking medication." Despite the high frequency of adverse reactions, the majority (82.8%) reported that antidepressants had "reduced their depression" and half (49.2%) reported that their quality of life was "greatly improved" while taking antidepressants, although these respondents were also less likely to report adverse effects (Read J et al, *Psychiatry Res* 2014;2016:67–73).

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CME Post-Test

This CME post-test is intended for participants only seeking AMA PRA Category 1 Credit™. For those seeking ABPN self-assessment (MOC) credit, a 13 question pre- and post-test must be taken online. For all others, to earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by May 31, 2015. As a subscriber to *TCPR,* you already have a username and password to log on www.TheCarlatReport.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning objectives are listed on page 1.

1. The disease perspective of the whole-patient approach can be best summarized by which of the following (Learning Objective #1)?
   [ ] a) The etiology of a patient's troubles is understood as arising from a pathophysiologic process within a specific organ or organ system.
   [ ] b) Psychiatric conditions arise from variations in an individual's physical or psychological attributes.
   [ ] c) An individual's psychological drives influence the individual's choice as to whether or not to engage in a goal-directed behavior.
   [ ] d) Some individuals seeking psychiatric help are burdened not by a disease they have but by what they have encountered in life.

2. From which perspective of the whole-patient approach might the psychiatrist ask, "How can my patient's distress be explained by, and how can I help by changing, what he *does*?" (LO #1)?
   [ ] a) Disease perspective [ ] b) Dimensional perspective [ ] c) Behavior perspective [ ] d) Life-story perspective

3. According to Allen Frances, under *DSM-5* people with chronic pain and cancer may "qualify" for which of the following psychiatric disorders (LO #2)?
   [ ] a) Major depressive disorder [ ] b) Generalized anxiety disorder [ ] c) Somatic symptom disorder

4. In the CitAD study, what percentage of participants taking citalopram improved from baseline on the mADCS-CGIC, versus 26% of the placebo group (LO #3)?
   [ ] a) 18.9% [ ] b) 26% [ ] c) 40% [ ] d) 61%

5. In the Read et al study of antidepressant side effects, how many of the 20 effects analyzed were reported by more than half of the 1,829 participants (LO #3)?
   [ ] a) 5 [ ] b) 8 [ ] c) 10 [ ] d) 12

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News of Note

Half of People Who Commit Suicide Have No Psychiatric Diagnosis

A recent study shows that even though 83% of people who commit suicide have had healthcare services in the year before their deaths, only about half of these had a mental health diagnosis.

The research, published in the February 2014 issue of the *Journal of General Internal Medicine* (http://bit.ly/1mVVvAR) used longitudinal data from the Mental Health Research Network (MHRN), a multi-state consortium of HMOs serving over 11 million people.

Nearly 6,000 suicides were identified in this population over a 10-year period. Of these, half had actually seen a healthcare professional within the month prior to suicide, but only 24% of these had a psychiatric diagnosis, illustrating a greater need to screen for suicidality in the primary-care setting.

Furthermore, the suicide victims who had received healthcare services in the year prior to death were more likely to be women, older age (65+), and of higher socioeconomic status. The researchers also concluded that greater outreach should be made to target younger age groups and men in suicide-prevention efforts.

Research Agenda Aims to Cut Suicide Rate by 20%

The Action Alliance for Suicide Prevention has released the details of a research plan aimed at reducing suicides in the US by 20% in five years. The public/private partnership (which works through grants from Substance Abuse and Mental Health Services Administration [SAMHSA] and the Department of Health and Human Services [HHS]) examined the research that shows the most promise in reducing suicides and identified where gaps in current suicide research exist.

They have organized their agenda around six key questions:

1. Why do people become suicidal?
2. How can we better or optimally detect/predict risk?
3. What interventions are effective? What prevents individuals from engaging in suicidal behavior?
4. What other types of preventive interventions (outside health care systems) reduce suicide risk?
5. What new and existing research infrastructure is needed to reduce suicidal behavior?

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Research Updates

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TCPR's Take: While emotional and other non-physical side effects sometimes do occur in patients who take antidepressants, the present research does little more than shed a sliver of light on an unfortunately poorly studied area. Recruiting subjects via "media releases, interviews with the researchers, and advertisements" to an internet survey is likely to attract a self-selected population of subjects who have had poor experiences with medication. That said, the high rate of adverse events cannot be solely attributed to those with an axe to grind, as only 8.2% reported having a reduced quality of life while on antidepressants. Informing patients about potential emotional and psychological effects of antidepressants is important, but the frequency and severity of the problem clearly deserves further study.

News of Note

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Dr. Tom Insel, the director of the National Institute of Mental Health (NIMH) and the public sector co-lead for this project, wrote on his blog on February 5, 2014, that while the death rates for conditions such as heart disease and cancer continue to decrease, the rate of death by suicide has not changed. "This grim reality contrasts with the successes achieved in other areas of medicine and prevention," he wrote. "To reduce suicide, we need to know how to target our efforts: to be able to reliably identify who is at risk, how to reach them, and how to deter them from acting on suicidal thoughts."

This Month's Focus:
Psychiatric Diagnosis

Next month in *The Carlat Psychiatry Report*: Marijuana in Psychiatry

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