

Don't Analyze This

Wall Street Journal 20/06/2005 JOLIE SOLOMON

If the icon of American psychiatry was for years a couch, it is now arguably a pill. And that change in focus has brought to prominence a new type of psychiatrist: the psychopharmacologist.

The term usually refers to a psychiatrist who concentrates on the pharmaceutical treatment of complex mental illnesses. This kind of doctor is unlikely to be administering talk therapy, and probably wouldn't handle many cases that called for prescribing a single drug, such as Prozac. THE JOURNAL REPORT

See the complete Personal Health report.

Instead, these doctors frequently prescribe complex cocktails of drugs for patients with multiple diagnoses of mental illnesses, and sometimes prescribe other drugs to counterbalance side effects from the primary drugs.

The rise of psychopharmacologists has been spurred in part by the explosion of medicines for treating psychiatric conditions, and in part by the rise of managed care, which encourages prescription drugs as a less expensive alternative to extended talk sessions.

But it also signals a new chapter in a long-running debate about the nature of mental illness: How much treatment should focus on patients' thoughts, feelings and personal history, and how much should focus on what happens in the neural pathways of their brains?

The approach taken by some psychopharmacologists disturbs some in the mental-health field, even those who believe strongly in the biological part of the equation.

"Fragmenting [the profession] into brain specialists and mind specialists...is a perversion of good psychiatric care," says Barry F. Chaitin, chairman of the Council on Healthcare Systems and Financing for the American Psychiatric Association in Arlington, Va. Such an emphasis on medicine, Dr. Chaitin says, is really the "devolution...of managed care."

Juan Riestra, associate director of medicine in the department of psychiatry at Mountainside Hospital in Montclair, N.J., says a psychopharmacologist is often someone "using a trendy word as a marketing device."

Keeping an Open Mind

Still, even more-traditional psychiatrists find themselves turning to these specialists for help with difficult cases. New York psychiatrist and author Stanley Turecki, who is on the boards of two major hospitals and has plenty of experience dealing with severely troubled adolescents, for years emphasized nondrug therapy. Some people wrongly concluded that he was "antimedication," he says. But earlier this year, he declined to accept a case of a 16-year-old girl diagnosed with attention-deficit/hyperactivity disorder, and instead referred her to a psychopharmacologist. The girl was taking daily doses of a stimulant for the ADHD, but this was exacerbating her symptoms of anxiety. Her skin was scarred from her relentless picking at it, and her relationship with her parents was deteriorating.

Dr. Turecki referred the girl's case to Harold S. Koplewicz, a pediatric psychopharmacologist and director of the New York University School of Medicine's Child Study Center. Dr. Koplewicz made a new diagnosis: The patient had not only ADHD but also obsessive-compulsive disorder. SHOULD YOU SEE ONE?

A patient may visit a psychopharmacologist once, for an evaluation that includes blood work and other medical tests, or on a continuing basis. It may be appropriate to consult a physician with this specialty if:

- **You've been on a medication** for a psychiatric problem and it hasn't worked.
- **The side effects of a psychotherapeutic medication** are particularly problematic.
- **You're using a psychotherapeutic medication** for the first time, and you are particularly sensitive to medication or already taking medications for other conditions.
- **Your primary-care physician** or therapist can't answer all of your questions about your psychiatric diagnosis, or you have gotten conflicting diagnoses.

Sources: NYU Child Study Center; WSJ reporting

Dr. Koplewicz changed her medications to a mixture of two stimulants, Ritalin and Concerta, and

added Celexa, an antidepressant. Five weeks later, he says, the girl's symptoms diminished, and parents and daughter were talking again.

Sending the patient directly to a psychopharmacologist "reflects the evolution in my own thinking," says Dr. Turecki. "We have to take [medication] more and more into account."

Just as the role of psychiatrists and nicknames such as "shrink" have worked their way into the American vernacular, so is the more technical mouthful of psychopharmacologist. Television personality Jane Pauley and actress and novelist Carrie Fisher – both of whom have written books based on their own bipolar illnesses -- have referred in interviews to their psychopharmacologists. Patients in blogs and chat rooms trade advice that they're receiving from psychopharmacologists. A new "Find a Psychopharmacologist" service, organized by ZIP Code, is part of a planned upgrade for a Web site run by the American Society of Clinical Psychopharmacology, based in Glen Oaks, N.Y.

For decades, the American model for addressing mental-health problems focused on personal and interpersonal dynamics. Talk therapy was the dominant course of treatment. Medication was reserved either for the most debilitating conditions -- such as schizophrenia or manic-depression -- or was considered a last resort when therapy failed to alter a patient's approach to life.

That view began changing in the 1970s, as more effective medications came on the market. And the trend accelerated in the 1980s, with large-scale clinical trials of psychiatric medications. But the biggest shift has come in the past 10 years, with new classes of medications like the antidepressants referred to as SSRIs, or selective serotonin reuptake inhibitors, which include Prozac; and antipsychotic medications such as Risperdal. Sales of psychotherapeutic drugs totaled \$26.7 billion last year, according to NDCHealth Corp., an Atlanta-based health-information company. Fueling this growth, consumer advertising has increased demand and lessened the stigma attached to using such drugs.

Room for Both

Most psychiatrists still provide both therapy and prescription medications, according to the APA. Many studies suggest that this combination is the most effective treatment. At the same time, millions of psychotherapeutic prescriptions are written by professionals outside the mental-health field, such as internists or pediatricians.

It's increasingly common, however, for mental-health patients to see psychopharmacologists just for medication. Psycho-pharmacology isn't a board-certified specialty, like cardiology or oncology. Those who practice it are mostly psychiatrists who have extensive training in how to use a wide range of medicines, including some that aren't typically prescribed for mental illnesses; how these drugs affect functions such as metabolism or heart rate; and how they interact with other medications.

A consultation can include a detailed personal and family history, blood work and other tests. After diagnosing or stabilizing a patient, the doctor will often see the patient just a few times a year, in short sessions, lasting 10 to 30 minutes, during which the doctor will check to make sure that the medications are working right and that side effects are under control. From 1998 to 2002, the percentage of psychiatrists' patients seeing their doctors just for medication jumped to about 30% from about 20%, says Darrel Regier, director of research for the APA.

The rise of managed care, as well as changes in Medicaid and Medicare, has pushed patients and doctors toward the use of prescription drugs. A 2003 APA study on "financial disincentives" for psychotherapy found doctors could earn about \$263 an hour for doing three 15-minute "medication management" sessions, versus about \$156 for a single 45- to 50-minute therapy session. That represents an hourly pay cut of 41% for doing only therapy, the APA study said. (Insurance and reimbursement policies have also encouraged health-care professionals who aren't medical doctors to practice as psychopharmacologists. Some psychiatric nurses, for example, do the work under the auspices of a doctor or a hospital.)

Twenty years ago, psychiatrists had to justify using only medication to treat patients, says Scott Spier, a Baltimore psychiatrist. Now, he argues, doctors respect their patients enough to believe that they have a disease that can be treated with drugs, and that they're not necessarily at fault. Dr.

Spier, who is aware of the controversy surrounding the practice, hesitates to identify himself as a psychopharmacologist. But in interviews and in annual lectures to medical residents about the role of psychopharmacology, he likes to say provocative things about the medicine-only idea. For example, he uses a line about a patient who comes to a doctor because of a troubled marriage, but who in fact has a mental illness. "Sometimes, the best 'couples counselor' is an antidepressant," Dr. Spier quips.

Dr. Spier occasionally gives speeches sponsored by pharmaceutical companies.

There's widespread agreement in the mental-health field about the need for deeper understanding of medicines and their effects. Dr. Koplewicz cites headlines in the news in the past year about the risk of suicide in children being treated with antidepressants. Regulators have cautioned that extra care must be taken in treating depressed children with antidepressants. Dr. Koplewicz and others believe that these are often cases in which medication was prescribed by primary-care physicians without enough expertise to make the right diagnosis or to monitor their patients' use of the medications.

What troubles critics is the premise behind much psychopharmacological work -- that diagnosis and medication can be split off from the rest of psychiatry. "We're not just molecules," says Dr. Riestra. "To me, a psychopharmacologist is a psychiatrist who doesn't want to talk to the patient...who [doesn't] believe that your life has anything to do with your illness."

Dr. Riestra sees many patients just for medication, but he coordinates their care closely with a psychologist or social worker at his hospital who handles their therapy, he says. Without that cooperation, he warns, doctors can miss things, and patients can get mixed messages. When a psychopharmacologist sees 30 or 40 patients a day, as some do, Dr. Riestra says, "it becomes like a factory."

And critics worry about the message it sends to patients. "It's more socially acceptable [for some patients] to think that all they need is a fine-tuning of the neurotransmitters," says Glen Gabbard, a psychiatrist at Baylor College of Medicine in Houston. "They can say, 'I'm a victim of a chemical imbalance,' rather than 'I'm in some way responsible for my problems.' "

Biology First

But for some psychiatrists, it's no use working on behavior and family dynamics "until you get the biology under control." In recent years, that has become the focus for Rosalie Greenberg, a pediatric psychopharmacologist in Summit, N.J.

Deirdre Collier brought her son, now 8, to Dr. Greenberg after three agonizing years during which various psychiatrists diagnosed him with attention-deficit disorder, developmental delays and schizophrenia. At one point, says the Basking Ridge, N.J., mother, the boy's medication gave him hallucinations.

Dr. Greenberg ordered an EKG and blood work and took a detailed family history -- things the other doctors hadn't done, says Ms. Collier. The doctor then diagnosed him as having bipolar disorder and prescribed a combination of Risperdal and Trileptal, an anticonvulsant that's used as a mood stabilizer. Now Dr. Greenberg sees Ms. Collier's son once a month for about 20 minutes, monitoring his dosages, keeping an eye on seasonal mood swings and watching for a range of side effects, such as weight gain or cognitive problems. The boy sees a psychologist separately for behavioral therapy.

He is now doing well in a new school recommended by Dr. Greenberg, and he recently took a threeday

trip with his father to Florida. His mother will go back to school herself this fall, for her doctorate in accounting. "None of this would have been possible before," says Ms. Collier.

"It's not that I don't love therapy," says Dr. Greenberg. "I'm a firm believer." But she takes particular satisfaction in cases where she can solve the biological puzzle.

"You can give children back their childhoods," she says. "You can really change lives."

--Ms. Solomon is a writer in Maplewood, N.J.