Perils of Pragmatic Psychiatry: How We Can Do Better

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Abstract

Etiologic and pathophysiologic understanding of psychiatric disorders is still in its early stages. The neurobiology of major psychiatric disorders has yet to be fully elucidated. Psychiatric diagnoses are often based on presenting symptoms, lacking reliability and stability. For a variety of reasons, many notable laboratory and clinical observations have not been tested in large trials. Lacking this validation, these potentially valuable practices have not been widely disseminated nor translated into real world practice. Pragmatic practice today requires optimum use of the available resources. This may sometimes require translating novel treatments supported by strong, evidence-based, level II evidence; but still lacking level I evidence into practice and greater utilization of evidence-based approved practices. The purpose of this paper is to highlight some common avoidable pitfalls in practice, and to offer a few psychopharmacological pearls.

Keywords: Alcohol; Anxiety; Bipolar; Depression; Insomnia; Pragmatic psychiatry; Psychiatry practice; Psychopharmacology; Schizophrenia; Substance; Suicide; Treatment; PTSD

Introduction

Etiologic and pathophysiologic understanding of psychiatric disorders is still in its early stages. Psychiatric diagnoses are often based on less reliable and inconsistent symptoms, rather than biological markers. Although standard psychiatric diagnostic systems and criteria exist for many disease processes, the imprecise utilization of such diagnostic concepts, by many practitioners, lead to unfortunate clinical consequences.

For a variety of reasons, many significant advances in neuroscience, pre-clinical studies, and phase 2 proof-of-concept studies have not been further studied or validated in large-scale trials. Thus, they have not translated to routine clinical practice. Furthermore, many other meaningful clinical observations may never be subject to high quality Randomized Controlled Trials (RCTs) or other large-scale higher quality evidence-based medicine. As such, current psychiatric practice relies on too few evidence-based treatments of modest effectiveness; rather than those, if further explored, would be more effective treatments.

Facing these realities, pragmatic psychiatric practice today requires optimal use of the resources available. This means more accurate applications of adequately studied diagnostic concepts, more widespread use of the evidence-based approved practices, and increased familiarity with novel and potentially helpful treatments. Granted however, that such treatments should themselves be based on available pre-clinical and lower quality clinical evidence (observational case reports, case series, open label trials, small RCTs) as shown in figure 1.

The purpose of this paper is to highlight some common pitfalls encountered in the practice of psychiatry, as well as to relay potential issues in making correct diagnoses. Some important, pragmatic, psychopharmacological “pearls” are also included; to potentially aid in the improvement of psychiatric practice.

Common Imprecision in Assessment and Diagnosis

Schizophrenia and related psychoses

Clinicians often record both the diagnoses of schizophrenia and schizoaffective disorder, and schizoaffective disorder, bipolar type and bipolar I with psychosis concurrently in the same patient. Assuming that further evaluation is needed to clarify between the two, the differential diagnosis should be added as a rule out diagnosis. Having both diagnoses documented together may reflect imprecise thinking or at least, imprecise record keeping. The diagnosis of schizoaffective disorder is often made incorrectly because it lacks diagnostic reliability and stability [1]. One of the criteria for schizoaffective disorder is that a major mood episode be present for the majority.