

# LETTERS

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## Quick Reference Guides for APA Practice Guidelines

**To the Editor:** In a brief report in the July 2002 issue, Drs. Milner and Valenstein (1) compared guidelines for the treatment of schizophrenia. They stated that the format of the practice guideline developed by the American Psychiatric Association (APA) (2) makes it more difficult to use and operationalize than some of the other available guidelines. Since the publication of the guideline, APA has addressed these important issues through separate but linked initiatives.

Although not part of the originally published version of the practice guidelines, the Quick Reference Guides are, as their name implies, designed for easy use by busy clinicians. They consist of algorithmic flowcharts and condensed bulleted lists of the key recommendations in each guideline. The Quick Reference Guides are available in a compendium (3) and on the Internet (4).

In addition to facilitating the use of guidelines in clinical practice, the Quick Reference Guides should promote operationalizing the guideline

recommendations. For the practice guideline on major depressive disorder, the APA committee on quality indicators is collaborating with physicians in other specialties to identify and operationalize quality indicators. Available indicators may be obtained from APA ([qips@psych.org](mailto:qips@psych.org)). Opportunities are being sought to develop quality indicators based on recommendations of the other APA guidelines, such as the guideline on the treatment of schizophrenia.

With the development of the Quick Reference Guides and continuing work on operationalizing quality indicators, APA aims to promote ease of implementation while simultaneously preserving a major strength of the APA guidelines—the provision of a detailed yet readable summary of the current evidence base for key recommendations.

Finally, readers may be interested in knowing that a revision of the APA "Practice Guideline for the Treatment of Patients With Schizophrenia" is under way. Publication of the revised guideline and its Quick Reference Guide is scheduled for spring 2004.

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## The Medical Expertise of Psychiatrists

**To the Editor:** I was disappointed to read the following statement by Dr. Dickey and her coauthors in the discussion section of their article in the July 2002 issue (1): "At the very least, psychiatrists must be alert to medical problems and take care to ensure that referral to appropriate medical treatment is provided." That is an unacceptably low standard of medical care to expect from psychiatrists, and, in effect, suggests that they have no more medical expertise than non-physicians.

There is a considerable amount of confusion about the medical treatment that psychiatrists provide. Many of the studies are surveys of psychiatrists or of a sample of practices. Dr. Dickey and her colleagues cite several studies in their literature review, including one that has been cited as evidence that the medical care delivered by psychiatrists is substandard and that important conditions are missed. The study was uncontrolled and used nonrepresentative samples of patients.

The medical expertise of psychiatrists is obvious in the books, practice guidelines, and journal articles that they write and in clinical settings. The work that a psychiatrist does in conducting a diagnostic evaluation, making a medical diagnosis, and obtaining appropriate care for a patient is not written about and will probably never be adequately studied. Recent reviews by the Institute of Medicine (2) show that the use of survey methods to examine the quality of care can demonstrate a high level of problems—including missed diagnoses—in practically any medical specialty. Data from surveys should not be used to conclude that psychiatrists do not provide adequate medical care, especially in the context of reports of the high prevalence of medically unexplained physical symptoms among cohorts of medical outpatients and the high level of distress these symptoms can cause (3,4).

On a typical day, an inpatient psychiatrist assesses patients for medical

emergencies, acute nonemergency conditions, comorbid medical illnesses, and baseline conditions that affect psychiatric treatment. Inpatient settings provide an environment in which patients can be educated about health care maintenance. The necessary screening tests can be ordered, and referral to primary care physicians for follow-up can be arranged. Psychiatrists in these settings need to be more knowledgeable about classes of nonpsychiatric medications. In looking over the records of the inpatients whom I discharged in the past year, I find that the number of drug classes from the *American Hospital Formulary Service* (5) that I was responsible for prescribing was more than twice the number of classes prescribed in a typical outpatient psychiatric practice. The correct prescription of these compounds includes determining whether or not there is an interaction or a contraindication. Among the patients with psychoses whom I treat, I also routinely diagnose and treat all of the eight common medical disorders that Dr. Dickey and her coauthors mention in their article. I refer these patients to primary care physicians for follow-up of these disorders.

Thousands of psychiatrists go to work every day, and they are acutely aware of the medical illnesses of their patients. To suggest a lower level of medical expertise among psychiatrists relegates them to nonmedical status or seriously compromises expectations about the quality of the medical care they provide. A better conclusion might be to recognize that because psychiatrists are squarely at the intersection of medicine and mental health, it is time to give them what they need to do a better job.

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## “Iatrogenic Malingering” in VA Substance Abuse Treatment

**To the Editor:** We read with interest the Datapoints column by Humphreys and Horst (1) in the August 2002 issue about the shift in substance abuse treatment from inpatient to outpatient services within the Department of Veterans Affairs (VA). The data prompted us to share some anecdotal observations from working on two inpatient psychiatry wards at a large VA hospital.

Although current admission criteria do not permit hospitalization of patients with substance use disorders alone, such patients nevertheless seem to constitute an increasing majority of our inpatients. Most are admitted with a dual diagnosis based on ubiquitous complaints of depression, suicidality, a potential for violence, or “hearing voices.” However, in our experience, many of these complaints represent mislabeled, embellished, or feigned symptoms that often rapidly abate within the protective milieu of the ward, with sobriety, and without the need for standing psychotropic medications.

Rather than demonizing such complaints, we view them as a rational response to changes in the accessibility of psychiatric and social services to substance abusers and have come to call such behavior “iatrogenic malingering”—the willful misrepresentation of symptoms in order to gain access to more comprehensive or higher-quality care.

Given the option of treatment in a noninpatient setting, in which medical and psychiatric care—and sometimes housing—are lacking and in which confrontational approaches are often used in addiction therapy, the desire to seek inpatient hospitalization as an alternative seems natural enough.

This is an age-old problem. However, we believe that the shift in substance abuse treatment to outpatient settings that started in 1995 and the denial of federal disability income to patients whose disability is due solely to a substance use disorder, as mandated in the Contract With America Advancement Act of 1996, has created a climate in which having or feigning symptoms of comorbid psychiatric disorders can, more than ever, result in tangible benefits for patients. Our observations echo data from VA studies showing an increase in substance-related inpatient admissions and an apparent increase in psychiatric comorbidity among such patients since these policy changes were implemented (2). Our observations also support the provocative finding of an increase in the reported incidence of hallucinations at post-treatment follow-up among VA substance abuse patients (3).

It is not our intent to discount the considerable suffering endured by patients with substance use disorders. Rather, our concern is that recent policy changes have further reduced patients’ incentives to accept the notion that substance abuse may be at the core of their suffering and that treatment should thus be focused on substance abuse. Also, clinicians may be more apt to give a patient “the benefit of the doubt” and diagnose a dual disorder if doing so will increase access to psychiatric, medical, social, and financial assistance. We believe that such a decision by clinicians is a disservice to patients, because they may be needlessly stigmatized by and treated for a disorder that they don’t have and put at risk of harm from side effects of medication, such as weight gain and tardive dyskinesia. Furthermore, expectations for their recovery

may be lower because clinicians and others believe that they have a dual diagnosis.

Currently, we cope with this dilemma by emphasizing careful diagnostic practice and by trying to reduce the incentives for iatrogenic malingering by teaching patients that they can receive necessary and comprehensive treatment for substance use disorders alone. Ultimately, however, the solution may require an increase in the quantity and quality of outpatient and residential services provided to patients with substance use disorders.

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## Depression and Quality of Life Among Depressed Brazilian Outpatients

**To the Editor:** Current research on the impact of depressive disorders should include studies that seek to determine how these disorders influence the quality of life of depressed persons (1,2). Studies have shown that people who are depressed have deficits in their quality of life that are directly attributable to the mood disturbance and that the degree of the decrement is proportional to the severity of depression (2,3). However,

these studies have been done almost entirely in English-speaking populations.

We conducted a study to assess all newly diagnosed depressed patients aged 18 to 75 years ( $N=43$ ) who attended the mood disorders clinic of a Brazilian university hospital between March and October 2001. The study was approved by the hospital's ethics committee. The patients in the sample were administered the cross-culturally validated versions of the World Health Organization's Quality of Life Instrument-Short Form (WHOQOL-BREF) (4) and the Beck Depression Inventory (BDI) (5). Possible BDI scores range from 0 to 63, with higher scores indicating more severe depression.

The mean $\pm$ SD age of the patients was  $49.5\pm 12.1$  years. The group consisted of 39 women (91 percent) and four men (9 percent). Of these, 35 (81 percent) were Caucasians and eight (19 percent) were African Brazilians. Twenty-five (58 percent) were married, and 39 (91 percent) had at least a high school education. Diagnoses were as follows: major depression, 32 patients (74 percent); dysthymia, six patients (14 percent); and bipolar depression, five patients (12 percent). Thirty-three patients (78 percent) had at least one comorbid axis I diagnosis. No significant differences in WHOQOL-BREF and BDI scores were found on the basis of these sociodemographic variables.

The patients were severely depressed; the mean BDI score for the sample was  $31.16\pm 8.52$ . Analyses using Pearson's coefficient showed a significant inverse correlation between the BDI score and scores on all WHOQOL-BREF domains: physical health,  $r=-.325$ ,  $p=.033$ ; psychological status,  $r=-.519$ ,  $p<.001$ ; social relationships,  $r=-.423$ ,  $p=.005$ ; environment,  $r=-.414$ ,  $p=.006$ ; and the overall measure of quality of life,  $r=-.322$ ,  $p=.035$ . Further analysis with unpaired  $t$  tests showed that the 26 patients who were more severely depressed (a BDI score greater than 29) experienced significantly worse quality of life in all WHOQOL-

BREF domains than the patients with mild or moderate depression.

Our study had several limitations, particularly the small sample and the uncertainty of the extent to which our results can be generalized to community samples. In addition, both the quality of life and depression measures depend on patients' self-reports. Nevertheless, these measures have been validated in several studies, and we believe that they are a reasonably accurate gauge of patient discomfort. Future studies are needed to replicate our findings.

Our findings suggest that the WHOQOL-BREF is a sensitive indicator of morbidity and the severity of depressive disorders and that as symptoms of depression increase among Brazilian depressed patients, the patients' quality of life significantly decreases.

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