3 new trends in psychiatry to take note of

Dr Marcelle Stastny,
psychiatrist in private practice and reviewer of the new South African Society of Psychiatrists' guideline

The landscape of psychiatry is rapidly expanding and evolving. It is exciting to be able to help our patients in more ways. As our understanding of psychiatry evolves, so does the role of the GP and the psychiatrist.

What's new: **an increased awareness of treatment resistance.** The concept of starting every depressed and anxious patient on a selective serotonin reuptake inhibitor (SSRI) and then waiting for six to eight weeks to assess response, is weighted against the evidence that after two treatment failures the chances of recovery decrease.

The GP would help their patients far better by matching patients to the correct medication from the beginning. This can be done by matching symptom clusters to appropriate medications.

For example, mirtazepine or trazadone is useful if there is severe insomnia, brintillex if the depression is accompanied by cognitive deficits, serotonin and norepinephrine reuptake inhibitors (SNRIs) or tricyclics for melancholic depression, duoloxetine if there is pain, fluoxetine if there is an eating disorder, buproprion if there is significant fatigue. SSRIs and SNRIs are useful in anxiety, but titration needs to be slower and benzo cover might well be needed.

In addition to trying to match correctly from the beginning, response to treatment needs to be checked sooner. The current recommendation is that there must be at least a 35% response within the first month, otherwise things need to be reconsidered. The only way that the physician can get a sense of response is if they do a rating scale (such as PHQ9 and GAD7) at the start of treatment and at follow-up.

Secondly, **there is an increased understanding of the metabolic load of psychiatric medications**. It is clear that psychiatric medications have substantial side effects. Especially if you are treating with efficacy and response as a goal, rather than just tolerability. As such, trying to address perpetuating lifestyle factors such as sleeping pattern, alcohol and substance misuse, diet and exercise should be actively done. Monitoring and addressing weight, glucose and cholesterol is essential.

In an ideal world, the psychiatrist would manage the treatment resistance and the GP would carefully monitor metabolic side effects. This can only happen if there is good communication between the various parties of the multidisciplinary team.

Thirdly, **an understanding of other treatment options.** Neuromodulation (electroconvulsive therapy [ECT], transcranial magnetic stimulation [TMS] or ketamine) is increasingly being used to balance efficacy of medication versus the systemic effects of increasing dosages and polypharmism.

ECT has a bad reputation, but it is undeserved. It is highly effective, and the cognitive impairments are probably over exaggerated.

TMS is rapidly gaining popularity in South Africa as a safe and effective augmentation strategy. Unfortunately, medical schemes are not covering it yet.

Ketamine infusions work and work fast. This is especially useful when there is suicidality. Unfortunately, the effects tend to taper out, but it at least gives us the chance to get the meds right.

Concluding remarks

The GP and the psychiatrist are not the only members of the team needing to skill up. Psychologists simply do not have the luxury of years of therapy. Interventions need to be targeted at symptom reduction and used in an evidence-based way. Dieticians must be brought on board before excess weight gain when using weight gaining drugs. In keeping with the chronic disease model patients are part of the team keeping them well. SF

Psychologists do not have the luxury of years of therapy and need to skill up.