

Complementary and Alternative Medicine in Psychiatry

Two articles^{1,2} in this month's *Journal* focus on "complementary and alternative medicine" (CAM). What is CAM, and what can these 2 articles from Freeman et al teach us?

CAM is a hodgepodge of practices and products "not presently considered to be part of conventional medicine."³ Not only does CAM comprise nostrums that grow in the ground or on trees, but it encompasses such diverse techniques as light therapy, acupuncture, massage, and exercise.

Many "natural" products are long established within Western medicine and have impressive evidence of efficacy and, often, considerable hazards; examples are digitalis, morphine, lithium, and aspirin. But although they are natural products, acceptance of these drugs by "conventional medicine" disqualifies them for inclusion under the CAM rubric. Almost by definition, CAM includes only products and techniques of unproven safety and efficacy.

Modern medicine distinguishes itself from healing cults by claiming that our diagnostic and treatment approaches are derived from science. Often they are.

But what, after all, is scientific knowledge? How certain can doctors be about any of our interventions?

Knowledge in medical science typically starts with a theory. Studies in animals or observations in humans can lead to hypotheses about pathophysiology or possible treatments. Epidemiologic studies and naturalistic observations often strengthen hypotheses, paving a road to systematic prospective studies. The "gold standard" of medical knowledge in recent years has been the randomized controlled clinical trial. But every experiment represents a series of compromises, usually involving limits on internal and external validity. Finding "truth" usually requires multiple studies that employ different methods but reach a similar conclusion.

Some areas in psychiatry generate more heat than light. Practitioners often develop strong belief systems. Add to that the vested interests and personal gratification that come with speaking, writing books, and receiving attention from the lay press and income from practice. The result is that questioning some therapeutic approaches can generate strong reactions and "push-back." Believers in CAM sometimes show an almost religious fervor, although they are not alone among psychiatric practitioners in allowing passion to threaten rigor.

When I chaired the American Psychiatric Association's (APA) Committee on Research on Psychiatric Treatments (a component of the Council on Research), APA members deeply vested in CAM came to the Association requesting a task force to assess the entirety of CAM in psychiatry. Our committee accepted the challenge but decided to focus on 1 psychiatric condition, major depressive disorder. We empanelled a group of experts, and, with characteristic courage and energy, Marlene P. Freeman, MD, Vice–Editor in Chief of the *Journal*, agreed to chair the task force. The task force's report appears in this issue.¹ Along with it is a meta-analysis of studies examined by Dr Freeman and her colleagues at the Massachusetts General Hospital that assesses methodological aspects of CAM versus standard antidepressants studied for the treatment of MDD.²

The prime finding of the meta-analysis was a lower placebo response rate in trials involving CAM compared to those involving antidepressant medications for MDD. This finding should be useful for investigators planning future studies and may shed additional light on increasing problems of signal detection for treatments of MDD.

The APA Task Force report is more directly applicable to practice. The authors concluded that a number of CAM treatments show "promising results." Several among these—notably, omega-3 fatty acids, exercise, and mindfulness psychotherapies—appear relatively safe and offer additional health benefits. Other treatments reviewed show interesting but limited data. The authors reasonably call for "more rigorous and larger studies" that are adequately powered.

What is a sensible approach to CAM for psychiatrists in 2010? A treatment is a treatment, whether it is a synthetic compound, natural product, surgical intervention, new diet, or psychotherapy. If a medical doctor is to recommend or prescribe it, there should be converging lines of scientific evidence that support its safety and efficacy. Today, few CAM approaches

meet these standards. When an approach does qualify, it by definition exits the CAM territory and enters that of conventional medicine.

Like any treatment, CAM approaches require informed consent. This means that safety, efficacy, and limits of knowledge must be discussed. And just as with all other medical algorithms, we should start with the safest approach that has the best evidence of efficacy. Recommending a healthy diet and appropriate level of exercise, for example, seems reasonable today for psychiatric patients—including those with MDD. In mild MDD cases, the patient might be observed and followed carefully for a short while to see if diet, exercise, and time suffice or if better established treatments, like psychotherapy or antidepressant medications, should be used.

At the very least, today's psychiatrist should be aware of CAM treatments. Whether or not you recommend one, your patient is likely to be considering or using one. Many of these treatments carry their own adverse effects, uncertain purity and composition, and potential to interact with prescribed medicines. Ask patients about their use of CAM treatments at initial assessment and periodically.

When someone I care about falls ill, I want my loved one to receive the best medical care possible. I expect the physician to be knowledgeable, share information, and reach a collaborative decision on treatment. The public today also expects medical doctors to be free of financial conflicts of interest in their recommendations, but also to be neutral, fair, and objective in interpreting scientific evidence. When we accept the mantle of the physician, we are asked to put aside self-interest and prejudices and dedicate ourselves solely to the well-being of each patient.

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Alan J. Gelenberg, MD

Editor in Chief

agelenberg@hmc.psu.edu

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