See article by Franco et al

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The Silo Effect in Research on PTSD

John H. Shale, MD, JD,[a,*] and Abril S. Atherton, PharmD, BCPP, BCPS[b]

The article by Franco and colleagues[1] in this month's issue of *The Journal of Clinical Psychiatry* reports on the generalizability of results from pharmacologic and psychotherapy clinical trials for PTSD. The authors found that patients seeking treatment for PTSD were much more likely to be excluded from pharmacologic trials than from psychotherapy efficacy trials. In their closing paragraph, the authors suggest that in future, "pharmacologic clinical trials should carefully consider the trade-offs between the application of each exclusion criterion and its impact on representativeness."[1(p e980)] They also suggest that developing "integrated forms of pharmacotherapy and psychotherapy that simultaneously target commonly overlapping psychiatric disorders may yield more informative results for mental health care providers and research funding agencies."[1(p e980)] This suggestion begs the question of why such integrated studies are not already routine.

One might simply argue that psychotherapy studies and pharmacologic studies tend to be done by different people. Those doing psychotherapy studies tend to be nonphysicians and those doing pharmacologic studies tend to be physicians. This disparity is sometimes called a "silo effect," which has been implicated in patient safety problems.[2] It was not always so.

Sargant and Slater,[3] both physicians, published an article in *The Lancet* 75 years ago on the treatment of "acute war neuroses," commonly termed *shell shock*, which today would be called PTSD. The initial treatment included simple supportive measures of adequate sleep, rest, and food followed by a combination of psychotherapy and pharmacotherapy—most prominently, sodium amobarbital.[3] But as George Santayana wrote a century ago, "Those who cannot remember the past are condemned to repeat it."[4]

Until the middle of the last century, physicians training in psychiatry spent the bulk of their time learning psychotherapeutic methods for dealing with mental illness. And these psychiatrists in training were supervised by psychiatrists.

Then came the relatively rapid introduction of medications for the treatment of specific mental illnesses. Lithium was introduced in Australia in 1949 for the treatment of manic depressive psychosis,[5] though it was not approved for that use in the United States for another 20 years.[6] Then came the advent of pharmacotherapy for depression with the introduction of imipramine[7] and for schizophrenia with the introduction of chlorpromazine.[8]

Over the next 25 years, many new drugs were introduced for the treatment of depression and schizophrenia. Typically the medications for depression were tricyclic compounds similar to imipramine, while the treatments for schizophrenia were primarily phenothiazines.[9] But some new types of compounds were also being introduced. Monoamine oxidase inhibitors, such as phenelzine, were developed for depression and "high-potency antipsychotics," such as fluphenazine, trifluoperazine, and the butyrophenone haloperidol, were developed for schizophrenia.[9]

When I (J.H.S.) started psychiatric residency in 1975, the majority, or at least the plurality, of training time was still devoted to learning psychotherapeutic techniques. What had changed was who supervised the training. Only on the inpatient service were the supervisors all psychiatrists. In the outpatient clinic, clinical psychologists routinely supervised psychiatric residents. Supervisors for group therapy included 1 masters-level social worker who was also the most sought after because of her clinical skills. What was important was that physicians—the psychiatry residents—worked with and were supervised by nonphysicians. Many clinicians were recommending that early-career psychiatrists involve themselves in regular psychotherapy with patients under the supervision of an experienced therapist.[10]

Contemporaneous with the changes in available treatments in mental health in the decades after World War II were changes in the economics of health care wrought by World War II. The wage and price controls initiated to contain the costs of war production led many employers to seek ways to entice workers to join their particular companies. This led to the addition of the "fringe benefit" of health insurance that the IRS ruled was not part of the worker's wage.[11]

World War II private health insurance became increasingly popular for those individuals who did not receive health insurance as part of their employee benefits. Then in the 89th Congress (1965/1966), President Johnson pushed Medicaid and Medicare through and provided health insurance to the poor and the elderly.[12]

Thus, third-party payment by insurance companies became the rule not the exception. The disconnection of use of services from direct payment for the services was associated with an increase in demand for health services.

One may argue about causality, but there is no question about the temporal association between the widespread growth of health insurance and the increased demand for

[a]Department of Psychiatry and [b]School of Pharmacy, University of Utah, Salt Lake City

*Corresponding author: John H. Shale, MD, 4227 Fern Dr, Ogden, UT 84403 (jhshale@gmail.com).

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health care. This increase included the growth of treatment for mental health issues as part of health insurance, which has become even more pronounced as a result of parity laws regarding mental health. The health insurance companies (third-party payers,) started limiting how much they would pay for specific services from tonsillectomies to individual weekly psychotherapy.

Weekly psychotherapy, once the common community standard, is inherently labor-intensive and expensive. And it was also commonly provided by both physicians and nonphysicians. But the economics of limited payment for psychotherapy became such that psychiatrists did much less psychotherapy and much more pharmacotherapy.

Over time, psychiatric research moved in the direction of pharmacotherapy and away from psychotherapy. Conversely, research by nonphysician practitioners of psychotherapy moved in the direction of pharmacotherapy. I submit that this led to the silo effect where mental health practitioners were doing research on particular problems such as PTSD in a nonintegrated manner.

Today, PTSD is a topic of general interest to universities and large public health care systems in the context of natural disasters and terrorist attacks such as those of September 11, 2001. But PTSD is a particular focus of interest to the Department of Defense and the Department of Veterans Affairs. Thus, there are multiple agencies providing mental health care for PTSD in terms of psychotherapy and pharmacotherapy.

These agencies also have mental health departments that include physicians and nonphysicians and are equipped to do research on treatment for PTSD.[13,14] They are well equipped to overcome the silo effect if they are willing to work together as in the Chinese phrase, "gung ho."

I would respectfully suggest that those interested in doing research seeking effective treatments for PTSD combine their efforts so that physicians and nonphysicians develop the methods together to assure inclusion and exclusion criteria might "yield more informative results for mental health care providers and research funding agencies."[1(p e980)]

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