Stigma Kills Psychiatric Patients and Is Now Killing Clinical Research Too

To the Editor: Amazingly, the National Institute of Mental Health (NIMH) has stopped funding clinical trials in favor of basic research. No other institute in the National Institutes of Health has taken this approach, and none can understand the destruction of the mission of the NIMH. In their JCP commentary, Markowitz and Milrod[1] summarized this draconian state of affairs: "NIMH changed policy, consigning the vast preponderance (~90%) of its budget to neuroscience....Research Domain Criteria (RDoC), the vague, poorly articulated orthodoxy NIMH promulgated 13 years ago, rang the death knell of the traditional clinical trial in mental health."

It is hard to define exactly how we arrived at such a disastrous state of affairs, but it would appear that stigma about psychiatric illness played a crucial role. Stigma has long been directed at patients with the notion that psychiatric illness is not real and is "all in the patient's head." From this stigma emerged another: the general view that clinical researchers in psychiatry are "soft" on trial design and methodology. Only a PhD could save the field, the line of thinking goes, and only neuroscience research will reveal the origins and treatment of psychiatric illness.

This abandonment of clinical research proved to be a double whammy. Not only did RDoC and related basic science not yield (any) new important treatment discoveries, but the absence of clinical trials also left patients and their treating physicians at a loss as to how to best use, sequence, and combine available treatments for more optimal outcomes.

Childhood onset bipolar illness serves as a good example. Early onset illness is associated with long delays to first treatment, and both are associated with a poor outcome in adulthood. There is virtually no consensus as to how to best treat these children, and accordingly, the rates of dysfunction, disability, and suicide are skyrocketing.[2] Birmaher et al,[3] using polygenic risk scores and a risk calculator, can identify children at high risk for bipolar disorder. However, there are no funded studies to attempt early intervention with medicines. NIMH claims to want to encourage early intervention, but this is a complete fabrication, as without clinical trials, there is no ability to intervene early with pharmacologic treatment even if one wanted to.[4]

What needs to be done? The NIMH research portfolio needs to be rebalanced, with clinical trials receiving equal or majority funding. The RDoC experiment needs to be completely shut down. The guiding figures of NIMH policy need to be repopulated with clinicians (who are aware of the dreadful care so many of our patients receive) and with clinical research investigators (who are invested in finding which treatments work best).

The last decade has been associated with immense harm to psychiatric patients. Whatever philosophies, rationales, and, yes, stigma generated such abhorrent policies must be revised and reversed immediately. This will not happen without drastic and dramatic protests from patients and their advocacy groups and acts of courage from NIMH leaders and advisory boards who must step away from their callous and misguided strategy.

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Robert M. Post, MD[a,*]

[a]George Washington University School of Medicine, Bipolar Collaborative Network, Chevy Chase, Maryland

**Corresponding author:* Robert M. Post, MD, George Washington University School of Medicine, Bipolar Collaborative Network, 3502 Turner Lane, Chevy Chase, MD 20815 (robert.postmd@gmail.com).

Published online: November 28, 2022.

Relevant financial relationships: Dr Post has been a speaker for Sunovion.

Funding/support: None.

J Clin Psychiatry 2023;84(1):22l14716

To cite: Post RM. Stigma kills psychiatric patients and is now killing clinical research too. *J Clin Psychiatry*. 2023;84(1):22l14716.

To share: https://doi.org/10.4088/JCP.22l14716