

INTRODUCTION TO THE SPECIAL ISSUE FOCUSED ON THE FUTURE OF
PSYCHOPHARMACOLOGICAL PRACTICE

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As introduction, I start with two stories. A mentor and retired chairman of mine once told us that when he was a resident, learning dynamic psychotherapy was very difficult with a large learning curve and that learning psychopharmacology practice was actually quite simple... He stated that he had lithium for mania, chlorpromazine for psychosis and imipramine for depression... Second, I was teaching a class to first year trainees in our program and was running through the eight available (nine if you count quetiapine and quetiapine XR, as they have different indications in the U.S.) second generation antipsychotics in chronological order of FDA approvals and secondary indications: schizophrenia, mania, bipolar depression, unipolar depression, autism, pediatric bipolar and schizophrenia... I saw the trainees' eyes glaze over and one asked how I knew and kept track of all of the data and FDA approvals? Clearly, psychopharmacologists have come a long way in providing medication management for patients with psychiatric disorders, from three medications to perhaps one hundred or more *on* or *off* label approaches.

We are able to read textbooks, whose data is a few years old by the time it reaches print, and there are textbooks available outlining the medications we use, how they work, how they should be dosed and monitored for side effects, and many editorials about how each one of us should practice now per diagnostic guidelines. I felt that this special issue might focus on current approaches to treating psychiatric patients with medications, but we decided that this issue should focus on what the clinical approach to psychopharmacologic treatment might be ten to twenty years in the future.

This issue will look at advanced psychopharmacology, genetics, neuroimaging, outcome measures, and even psychotherapy. Major depressive disorder will be utilized as a functional model for the sake of this issue, but the discussion could easily apply to any mental disorder. Clinicians in the future might be able to do a diagnostic interview using their clinical skills, and send the patient for genetic screening to see what medications might work and which might cause side effects. Next, they would send the patient for a functional brain scan to see what brain areas are hypo- or hyperfunctioning to match a medication that manipulates that brain area and its receptors back into normal functioning. They would use rating scales to make sure all symptoms remit to prevent future relapses *and then* finally write for a prescription that has better odds of working while minimizing side effects. Each of these areas alone could have a dedicated special issue or even a textbook dedicated to its content. I have chosen authors who have written on these topics and asked them what psychopharmacologic practice might look like in the future and to use their articles here to paint this picture as an example, or an overview of their specific clinical application.

My final goal is to show that psychiatric practice isn't one extreme of just providing talk therapy or quickly writing a few prescriptions for patients every ninety days. The hope is that the reader gathers that psychopharmacological practice is multidimensional, and even if we do not have curative, blockbuster new psychotropic agents hitting the shelves at pharmacies next year, we have a lot of options to make our patients well again in the future.