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Psychotherapist-Psychiatrist Collaboration in Providing Transcranial Magnetic Stimulation (TMS), a Revolutionary Approach to Treating Depression

By Michael Reed, M.D. and Philip Chanin, Ed.D., ABPP, CGP

My interest in Transcranial Magnetic Stimulation (TMS) began in April, 2013, when I had my first session with a 40-year-old male patient, whom I shall call James, who had just gone through a terrible winter episode of seasonal affective disorder, which began during the Christmas holidays. He described being scared, despondent, and close to suicidal. He told me that his psychiatrist was Dr. Michael Reed. James had tried five different medications, with significant side effects. He told me that Dr. Reed was now recommending a trial of TMS.

When I saw James ten days later for his 3rd psychotherapy session, he had just had his initial TMS treatment the day before, and had then only been able to sleep for 2 and ½ hours. Dr. Reed concluded that James had had a hypomanic reaction to TMS, had given him a new diagnosis of Bipolar Type II, and had decided to discontinue the TMS treatment. Instead, Dr. Reed told the patient that he should break a Zyprexa tablet into powder, and put a small amount on his tongue, and that they would also very gradually add Lamictyl. I was impressed with Dr. Reed's approach, and decided to keep him in mind for future TMS referrals.

Nine months later, in January of 2014, I had my first session with a 33-year-old patient, whom I will call Linda. As I sat there in my office and listened to her story and her description of her depression, and suicidal ideation, I had the sense that she was so depressed, despite being on antidepressant medication, that something else was needed in addition to talk therapy. I feared that she and I could talk for a very long time without making significant progress. Two weeks later, I decided to refer her to Dr. Reed for consideration for TMS. I sent him the following email:

"Dr. Reed,

I am referring Linda to you for an evaluation. I put her depression symptom inventory in the mail to you, and I want to elaborate here a little more. I have been seeing her for once

or twice-weekly psychotherapy. She had an initial severe episode of depression two years ago, with suicidal ideation, and was hospitalized at Parthenon for four days and says she 'probably left too soon.' Her depression included 'overwhelming anxiety' and she states that she had not slept at all for four months. She says that she has 'always been very hyper.' She was put on Cymbalta at Parthenon, continued on it, and is upset about a 50 pound weight gain which she attributes to this medication. She also currently takes Ambien for sleep, which she says is now the only thing she looks forward to, as 'I can forget and stop thinking.'

Linda has a powerful family history of depression, including both of her parents. She says her father, now a recovering alcoholic, suffered from depression 'his whole life' and was hospitalized at Parthenon and given ECT three years ago. Paternal grandfather was also alcoholic and made a suicide attempt with a razor, in Linda's presence, when she was 11. Linda describes her mother as having been depressed a lot, off and on, when she was a child.

Linda's current 2nd episode of major depression appears to have begun several months ago, in the fall, which also was the approximate time of the first episode. She is very frightened of again going through an immobilizing depression and lacks hope of getting well. I have referred her to you partly observing the similarity with our mutual patient James's symptomatology—worse in the fall/winter with a very significant anxiety component, and sleep problems. I'm wondering if there is a bipolar element to Linda's depression as well. I informed her about the magnetic therapy and she is excited about that possibility. I told her that you might want to try some medication changes before going that route.

I look forward to hearing from you about your diagnostic impressions and recommendations."

A week later, I received the following email from Dr. Reed:

"Thanks so much for referring Linda to me. She is a sweet lady who is clearly suffering terribly. I concur that she is an excellent candidate for TMS, which has been scheduled. In the interim, I will be addressing her insomnia and have increased her Cymbalta to 120 mg. In addition, I am starting her on Vyvanse, which I find can be helpful in cases of refractory depression. We will be doing pertinent lab analysis as well. Clearly she is benefitting from the psychotherapy work she is doing with you. I appreciate the opportunity to work along with you in providing care to your patients."

Linda completed a 6-week course, totaling 30 TMS sessions. About a month after finishing TMS, I received the following Thank You note from Linda: "Dr. Chanin, I just wanted to let you know how much I appreciate everything you've done for me. I have so much gratitude to you for recognizing how much help I needed. Dr. Reed and TMS have truly worked miracles on me. As I continue to grow stronger I will always remember how kind and helpful you were."

Six months after my initial session with Linda, I met for the first time with another 33-year old female patient, whom I will call Nancy. I listened to her story, including a long struggle with depression, and was also struck with how extremely immobilized she was as far as being productive with her life, despite her high intelligence and advanced degrees. After working with her for three months in weekly psychotherapy, I made a referral to Dr. Reed. Here is my email to him:

"Dr. Reed,

I have referred Nancy to you for an evaluation. She is currently on 30 mg. of Prozac and Xanax, prn. She was first diagnosed with depression in college while on a term abroad in England. She then saw a psychiatrist off and on for seven years who was very helpful to her, both with her medications and in psychotherapy. She tried going off medication but that did not go well. I believe that she has struggled with depression ever since the initial bout. She deals with a lot of chronic symptoms, and describes 'an undercurrent of negativity all the time.'

She has great difficulty being productive. She tends to oversleep and has a hard time being productive until the afternoon. She says, 'My husband tries to keep me motivated.' There is a significant anxiety component as well. She say, 'I'll panic, a couple of times a week. I'll freak out and start crying, and I don't want to be touched. My husband wants to hold and comfort me—I just want to get away.' Nancy has a virulent 'inner critic' voice and says that 'not good' is her running narrative as she struggles to work on her dissertation.

She describes her father as a life long alcoholic and in terms that suggest to me a serious narcissistic personality disorder. He was extremely hard on Nancy. She says, 'Nothing impresses him.' He became seriously depressed recently when he was forced out of his job. Nancy describes her mother as 'very insecure.'

I'm thinking that you will probably see Nancy as someone who would benefit from TMS. She is 3 months pregnant, however, so that may have to be deferred. I look forward to hearing your clinical impressions."

A week later I received the following email from Dr. Reed: "Thank you for the opportunity to work along with you in providing care to Nancy, a very pleasant 34-year-old pregnant scholar. Currently, she is moderately depressed on generic Prozac 30 mg. She describes anergy, apathy, anhedonia, and feelings of inadequacy. Her PHQ-9 score was 12. I have asked her to change back to brand Prozac and initially to continue the same dose of 30 mg. She was to see her Ob/Gyn midwife and ask her to check her vitamin D3 level and MTHFR status if not already done. She may well end up on NeevoDHA, which is essentially the prenatal version of Deplin. We discussed TMS but have decided to try the branded Prozac first. She is open-minded about TMS if it becomes necessary. Again, thank you for the kind referral."

Three months later, Nancy did begin a 6-week course of daily TMS sessions, which concluded in mid-March, 2015. The fact that she was pregnant was not a contraindication to doing TMS. Today, a year later, Nancy's life is remarkably better. She has sustained her recovery from depression and her gains from TMS treatment. She completed her dissertation, and graduated with her Ph.D. She is an involved mother of an active baby boy. She has cut off contact with her toxic parents. She is involved in a national job search and her overall mood and outlook on life are very much improved.

In summary, Linda and Nancy are two of the eight patients I have referred in the past two years for TMS to Dr. Reed and to Dr. Scott West in Dr. Reed's office. Dr. West runs the TMS Clinic and he has been particularly helpful with some of my patients who needed financial accommodations to afford TMS. The patients whom I have referred for TMS have struggled with major depression for years or decades. They have been on a variety of anti-depressant medications without gaining remission from depression. They are often discouraged and hopeless about their prospects for getting well.

Prior to learning about TMS, I was seeing severely depressed patients who were going through electroconvulsive therapy (ECT). As this involves anesthesia, they had to have someone drive them to and from appointments. They could not work while undergoing treatment, and experienced a lot of memory problems. In my view, TMS has been a great advance over ECT.