

**Creating new dogma**

In “Shattering dogmas” (From the Editor, CURRENT PSYCHIATRY, January 2011, p. 12-16), Dr. Henry A. Nasrallah’s statement that “similar to a revolution to depose a dictator, the demise of a dogma will have a salutary effect on medical practice” is merely evidence of how a reactionary, overly medicalized approach to psychiatry ends up reproducing the very system it seeks to replace. Instead of exploring the nuanced aspects of dogmas, he makes one-sided global assertions, which do little to further our understanding of the topics.

For instance, his assertion about contemporary practitioners not touching their patients being “irrelevant in modern-era psychiatry” discounts that there is a spectrum of clinical practice and the implications of a physical exam performed by a psychiatrist engaged in intensive psychotherapy or psychoanalysis with a patient are much different from those of a psychiatrist doing once-monthly medication management checks. At a minimum, consideration of the nature of the treatment and the particulars of the relationship should inform the individual practitioner’s decision-making process on this issue.

Furthermore, blanket statements such as “whether we like it or not, the pharmaceutical industry is the only source of new medication” shifts our attention away from the problematic nature of the too cozy relationship that has developed between academic psychiatrists and industry and diverts our efforts away from political efforts to demand more funding from the public sector. Unfortunately,



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such global assertions only result in the promulgation of Dr. Nasrallah’s own dogma, which—much like that of Freud—relies heavily on military metaphor, and leaves little room for either exploration or dissent.

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**Dr. Nasrallah responds**

*In my opinion piece, in addition to being provocative to stimulate opposing points of view, I was speaking not as a “therapist” but as a psychiatric physician who has additional critical medical responsibilities to carry out. Although I believe in and practice a medical model of psychiatry, I provide my patients with several types of psychosocial treatments—including psychodynamic psychotherapy, in which I was heavily trained 3 decades ago. If you were in my shoes, supervising medical students and training psychiatric residents to treat seriously mentally ill patients who have grave medical comorbidities, you would agree that some of the dogmatic dictums*

*of the past are hard to reconcile with modern psychiatric or medical practice. As for the “cozy” relationship between academics and the pharmaceutical industry, you should be complimenting rather than demeaning that relationship because as their expert consultants and advisors, we often warn the industry about publishing abuses, such as concealing negative findings or poor research trial designs that are unfair to competing products, or inappropriate marketing of medications, etc. We also conduct FDA studies with industry and provide feedback about research design, and we demand additional data analyses beyond what the FDA requires. It is unfortunate that aspersions are cast on anyone who collaborates with the “demonized” industry without which the mentally ill would have no medications. I certainly wish our government would develop psychiatric drugs at the National Institute of Mental Health, but that enterprise would require hundreds of billions of dollars, which will have to come from substantial new taxes, the prospects of which are practically nil.*

**Henry A. Nasrallah, MD**  
Editor-in-Chief

**‘Primordial’ psychiatry**

I was shocked to read Dr. Henry A. Nasrallah’s “Shattering dogmas” (From the Editor, CURRENT PSYCHIATRY, January 2011, p. 12-16), in which he referred to an aspect of doctor-patient boundaries as a dogmatic holdover from the “primordial phase of psychiatry (aka psychoanalysis) ...” If a psychopharmacologist chooses to monitor blood pressure or check for cogwheeling, no psychoanalytically oriented psychiatrist would object.

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Your “dogma” is a caricature that reflects poorly on a genuine appreciation of sound psychological treatment. A lot of money is wasted on acute repeat hospitalization after ineffective treatment of axis II patients by biologically oriented psychiatrists. All reductionism deprives patients of ideal care. Referring to psychoanalytic principles with derision is in itself “primordial.” There has never been a time when the relational aspects of human development have been established so incontrovertibly nor has any psychoanalyst ever chastised a colleague who chooses to use a sphygmomanometer. Context counts. Brain maturation, gene-environment interactions, early life stress, attachment disorders, mirror neurons, resilience, etc. have emerged in support of psychoanalytic perspectives—including the judicious absence of careless physical contact in a complex, intense relational treatment. Boundary violations still are malpractice and clinically astute discipline is not dogma. Perhaps you’ll clarify your point.

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### Dr. Nasrallah responds

The term “primordial” is not an insult, because it refers to the early phase of development. Consider the primordial phases of internal medicine and surgery, which now are regarded as archaic (even dangerous) but a necessary step in the evolution of modern surgery or internal medicine. Unquestionably, psychoanalysis is the

*foundation of modern psychiatry, and it dominated our field for decades, although it was more theoretical than evidence-based. Psychoanalysis provided a valuable construct to understand human behavior. However, like other branches of medicine, psychiatry evolved and advances in neuroscience moved psychiatry into an eclectic medical model that emphasizes rapid treatment with medications combined with short-term psychotherapies for most mental disorders. Psychoanalysis and medical models both are criticized as being imperfect, but both have the same objective: to rapidly relieve our patients’ suffering and to help them regain their social and vocational functioning. And by the way, axis II patients rarely are admitted to a hospital unless they make a serious suicide attempt. Various types of psychotherapy help partially, but numerous studies show a benefit from selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, mood stabilizers, or atypical antipsychotics in various personality disorders. It would be dogmatic to believe that axis II disorders cannot benefit from biologic modalities, just as it would be dogmatic to believe that schizophrenia should be treated with drugs only without psychosocial therapies.*

**Henry A. Nasrallah, MD**

Editor-in-Chief

### Praise for social workers

I am writing concerning Dr. Henry A. Nasrallah’s “Recognizing the unheralded heroes of psychiatry” (From the Editor, CURRENT PSYCHIATRY, December 2010, p. 15-16).

I appreciate the attempt to praise colleagues who often go without recognition, but Dr. Nasrallah omitted a significant group of providers. Clinical social workers make up the largest group of mental health pro-

viders in the United States, and often are the only mental health providers in rural areas.<sup>1</sup> By neglecting to recognize social workers specifically, Dr. Nasrallah minimizes the importance of the services that we provide. Social workers frequently are forgotten, yet we do at least as much as our physician colleagues, with one-third the pay. Please do not forget us.

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### Dr. Nasrallah responds

Thanks for reading CURRENT PSYCHIATRY. You certainly were not left out. Even though I did not mention social workers by name, I included them in my list of heroes. Social workers are part of practically every category I listed, such as investigators, clinicians, reviewers of grants and journals, interactive mental health professionals who write letters to the editors (such as you), pro bono practitioners, assertive community treatment team members, teachers, mentors, and advocates for patients and their families. Good mental health care would be unimaginable without social workers!

**Henry A. Nasrallah, MD**

Editor-in-Chief



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## Biofeedback training

I enjoyed reading “The re-emerging role of therapeutic neuromodulation” (CURRENT PSYCHIATRY, November 2010, p. 66-74), which is an informative summary of neuromodulation in psychiatric practice. I was surprised and disappointed, however, that there was no mention of electroencephalogram biofeedback training. Increasing numbers of controlled studies have demonstrated its effectiveness.<sup>1-3</sup> It seems as if psychiatry is interested only in invasive approaches.

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## Thinking outside of the box

After reading Dr. Henry A. Nasrallah’s editorial, “Out-of-the-box questions about psychotherapy” (From the Editor, CURRENT PSYCHIATRY, October 2010, p. 13-14) I had some questions. What is the appropriate dose of 30-minute “med eval” sessions before you prescribe? What if no medicine is necessary because your patient improves after several sessions of really listening to him or her? Is the “maintenance dose” for a psychopharmacology med check follow-up really 15 minutes? Is there a cure for bored psychopharmacologists who just write follow-up prescriptions at 15-minute med checks? Is there an entity such as psychotherapy deficiency because psychiatrists are poorly trained in practicing psychotherapy and the indications for its various forms? Is

there an overabundance of lawsuits because of poorly managed therapist-psychopharmacologist treatment splits? Do nonmedical psychotherapists hear more about side effects than the prescriber because therapists see patients more often and rarely confer with the “real doctor”? Does “modern” psychiatry’s touting of medications for all maladies feed into Americans’ excess use of substances as solutions to all problems?

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### Dr. Nasrallah responds

*Thanks for joining me in thinking outside of the box. You responded to my editorial’s questions with probing questions of your own, and your questions are equally rhetorical. Your questions also are an incisive commentary on how contemporary psychiatry has been reduced to 15-minute med checks in many clinics and psychotherapy is delegated to nonmedical staff. I remind my trainees every day that they must be their patient’s physician and therapist, and be equally adept at pharmacotherapy and psychotherapy. However, to our patients’ detriment, systems of care now dictate what psychiatrists can or cannot do.*

**Henry A. Nasrallah, MD**  
Editor-in-Chief

## Mental illness and violence

I am writing in response to Dr. Henry A. Nasrallah’s “Integrating psychiatry with other medical specialties” (CURRENT PSYCHIATRY, September 2010, p. 14-15). Although it is unfortunate that many individuals with severe mental illness have ended up in the criminal

justice system, often it is unavoidable. Since deinstitutionalization, many of these people live freely in society. Persons with severe mental illness, especially when untreated, are more violent than the general population.<sup>1-3</sup> The key to destigmatizing mental illness is not to deny this truth, but to facilitate a better system of community mental health so that these individuals are treated early in the course of their illness and do not become wards of the state.

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### Dr. Nasrallah responds

*Our patients are only occasionally incarcerated for violent acts. Most of the seriously mentally ill are taken to jail for disturbing the peace or acting in a bizarre manner, such as being intoxicated. When we had ample psychiatric beds, these patients were hospitalized and treated with dignity as sick people. Now they are criminalized and taken to jails and prisons. If states had spent money on building modern psychiatric facilities instead of jails, there would not be crowding of correctional facilities in our country compared with many other countries. In the past, maximum-security units existed in hospitals, not only in jails and prisons.*

**Henry A. Nasrallah, MD**  
Editor-in-Chief

## SGAs for delirium?

“Atypical antipsychotics for delirium: A reasonable alternative to haloperidol?” (CURRENT PSYCHIATRY, January 2011, p. 37-46) was an interesting article. I agree that low doses of haloperidol, (0.5 to 3 mg), have low risk for causing acute dystonia, which is the major worry for its use in the ICU. However, it is my understanding that IV haloperidol has no risk of acute dystonia. If this is true, then reduced risk of acute dystonia may not be an advantage of second-generation antipsychotics.

Also, a possible obstacle to using ziprasidone is that the maximum IM dose is 40 mg/d, which may be inadequate for some patients. In my opinion, the FDA warnings have unfairly limited ziprasidone’s use, even though it has a favorable side effect profile in terms of weight gain and hypercholesterolemia. Its propensity to prolong the QTc interval is notable, but to my knowledge, this has never resulted in a death from torsade de pointes (TDP) in clinical trials. On the other hand, haloperidol has been linked to deaths from TDP.

In cases of extreme agitation in patients with delirium, I was wondering what the authors thought about using droperidol. I have found that it is perhaps one of the most sedating and calming agents one can use for delirium and agitation, but nursing staff and other psychiatrists are extremely reluctant to use it and sometimes request telemetry in addition to routine EKG before and after its administration. My feeling is that although the QTc prolongation associated with droperidol is real, it has resulted in the drug being underutilized and almost forgotten.

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### Dr. Spiegel responds

*Two studies could support Dr. Yilmaz’s statement that IV haloperidol has no risk of acute dystonia. In an early prospective study using IV haloperidol (mean dosage: 10 mg) primarily in delirium, acute dystonia did not occur after an average of 5 days of treatment.<sup>1</sup> Furthermore, in a more recent prospective study using IV haloperidol (median dose: 10 mg) in patients with behavioral emergencies, acute dystonia was not reported; however, assessment occurred every 15 minutes for 1 hour.<sup>2</sup> The former study included 4 patients and the latter 76 patients. In both studies, possible limitations include that dystonia could have developed beyond the evaluation periods (ie, 5 days and 1 hour), and the number of patients who received IV haloperidol was small. Therefore, while there were no reports of acute dystonia in these studies, it may be more prudent to state that IV haloperidol may have less risk of acute dystonia when compared with the oral formulation, but is not devoid of this risk.*

*Concerning ziprasidone and droperidol’s relationship with QT prolongation and TDP, as outlined in our article, I advocate for safety while using any psychotropic medication that can prolong QT interval or precipitate TDP. Nonetheless, 1 recent review reports that the FDA uses increases in QT interval as a proarrhythmic marker for TDP, because TDP is very uncommon and difficult to assess. Additionally, the review states there is general agreement by investigators that droperidol increases QT interval, and TDP is associated with an increase in the QT interval. But there is no established link between increased QT interval and incidence of TDP with droperidol administration.<sup>3</sup>*

*As with any treatment, a risk/benefit analysis should guide clinical decisions.*

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## Slippery slope

In the vast majority of instances, DSM defines psychotic disorders as manifesting with symptoms that, by definition, fly in the face of the physical constraints of reality. It is my opinion that the point of view Dr. Henry A. Nasrallah presents is boundless (“Are some nonpsychotic psychiatric disorders actually psychotic?” From the Editor, CURRENT PSYCHIATRY, November 2010, p. 16-19). Dr. Nasrallah’s hypothesis easily could extend to encompass circumstances such as over-reacting to being slighted by a friend or being offended by an inattentive store clerk, which may cause one to see things through (the distortion of) “grey (or perhaps rose) colored glasses.” Although with time such perceptions may grow to take on psychotic proportions, this is a slippery slope upon which one must tread carefully, being vigilant not to fall prey to “pathologizing” thoughts and feelings associated with normal human angst.

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