

## LETTERS

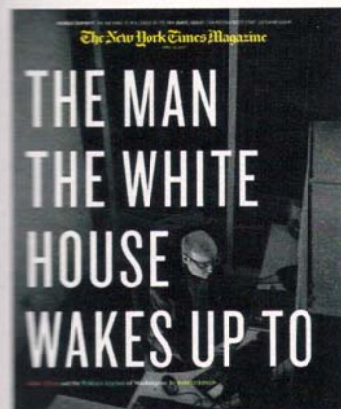
IN RESPONSE TO THE 4.25.10 ISSUE

# Mind Over Meds

Is it possible that Americans are still inundated by mental-health professionals who peddle a one-size-fits-all therapy to anyone who walks in the office? Let's hope that Daniel Carlat becomes both savior and saboteur of what has become a grossly misguided, albeit well-intentioned, field of practice.

Since they are charged with such a risky and weighty mission, mental-health professionals would certainly benefit from Carlat's unique brand of honesty about the limitations of picking a psychomethodology and hanging out the matching shingle. His ability to recognize a more holistic and personalized problem-solving approach is progressive, although in truth, it should be the de facto standard of care.

SHARI EDELSON DOHERTY *New Paltz, N.Y.*



I applaud Daniel Carlat for having the courage not only to question the standard of care of his chosen profession but to change the way he practices and then write intelligently about the subject. As a pediatrician I have similar concerns, particularly regarding the standard of care for A.D.H.D. (attention deficit hyperactivity disorder).

Stimulant medication does improve attention and positively affect school performance and self-esteem. But children with A.D.H.D. are usually seen by pediatricians who focus on symptoms and medication for 30 minutes every three months. Significant life events may not be

addressed and medication may be prescribed based on a visit with only one parent, with no opportunity to explore the parents' relationship with each other. (Recent studies have shown that family conflict is a significant risk factor in A.D.H.D.) I hope that we are headed away from the "mindless" period of psychiatry for children as well as adults.

CLAUDIA M. GOLD, M.D.  
*Great Barrington, Mass.*

Daniel Carlat was courageous to admit that after treating his patients for a long time, he realized he barely knew them. He was educated under a system that had forgotten that knowing the complex narrative of a patient's life is a necessary part of treating him or her. In his first attempt to get out of the box imposed on him by the narrow constructs of psychopharmacology, he turns to another narrow theory, cognitive behaviorism.

It's a start, but I hope he discovers the far more complex ways of understanding human lives that have evolved in fields like psychoanalysis, which looks not only at irrational thoughts and biologically tinged symptoms

but also unconscious motivation, narcissism and ideals, trauma and anxiety, guilt and conflict.

PRUDENCE L. GOURGUECHON, M.D.  
*President  
American Psychoanalytic Association  
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As members of the "golden" generation of psychiatrists, we applaud Daniel Carlat for his candor in exposing the severe limitations imposed by the "split treatment" model of psychiatry. Unfortunately, this is the only known form of treatment in most areas of the country. Insurance companies have proffered this treatment to save money, which is another example of economics taking the place of sound clinical practice. There is little consideration of the patient's receiving cohesive treatment, which leads to the serious potential for fragmentation and communication errors.

Of course, there have been marvelous advances in psychopharmacology that allow psychiatrists to effect quality-of-life improvements; however, our need to understand our patients' conflicts and create an empathic treatment environment has all but vanished from many residency-training programs, psychiatric offices and clinics around the country.

We, along with our "dinosaur" colleagues, will continue to endorse the holistic approach to psychiatry and hope that renewed interest in providing the benefits of both psychotherapy and medication will follow us. Thank you, Dr. Carlat, for speaking out for the patients and doctors who endorse the integrated-treatment model.

SEYMOUR H. BLOCK, D.O.  
ALLAN I. STEMPLER, M.D.  
*Great Neck, N.Y.*  
*Block and Stempler are past presidents of the Nassau Psychiatric Society of the American Psychiatric Association.*

Clinical psychologists like myself receive a doctorate degree after completing at least six years of postbachelor's training in the theory, science and practice of mental-health treatment. This involves thousands of hours of patient contact, supervision with licensed psychologists and course work. Many receive an education devoted specifically to empirically supported treatments, like cognitive-behavioral therapy. As Daniel Carlat says, "psychopharmacology was infinitely easier to master than therapy." Of course, many psychiatrists seek additional training and supervision after their residencies in order to become excellent therapists, but not all do. If I were seeking a therapist for myself, I would certainly want someone who possesses a specialized training in therapy.

Moreover, integrated treatment does not have to be provided by the same practitioner. Rather, it could entail a treatment team that regularly consults one another on changes in the patient's symptoms and life circumstances, as well as medication noncompliance or side effects. As a psychologist specializing in the treatment of eating disorders and depression, I believe it is imperative that I regularly speak with the internists, psychiatrists and nutritionists involved in my patients' care. While this approach to treatment may not save money in the short term, it may ensure improved outcomes and lower rates of relapse, making it a better approach for our patients in the long term.

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