Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone number and e-mail address. Letters related to material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych. org. Letters reporting the results of research should be submitted online for peer review (http://appi.manuscriptcentral.com).

Elimination of Seclusion and Restraint: A Reasonable Goal?

To the Editor: I am writing in regard to the special section on seclusion and restraint in the September 2005 issue. The assumption that seclusion and restraint can be "ultimately eliminated" from psychiatric practice to "improve the quality of people's lives," a proposition highlighted in the articles in the special section, is laudable in idealism but lacking in clinical reality.

Smith and colleagues' (1) findings of markedly reduced use of seclusion and restraint in the Pennsylvania state hospital system should be viewed in light of clinical realities, including the increased use of PRN medications and the enormous transinstitutionalization of aggressive persons with serious mental illness to prisons where seclusion and restraint are much more frequent and damaging to patients than in hospitals.

The fact that the rate of staff injuries was not reduced in the Pennsylvania state hospital system despite a marked reduction in the use of seclusion and restraint suggests that staff security did not improve with decreased use of these procedures and that aggressive episodes did not materially change. Other hospitals also have reported failure to reduce the incidence of aggression when using similar modes of verbal communication aimed at "talking down" and debriefing patients displaying aggressive behavior (2–4). Increases in the rate of aggression and injuries with verbal interactions are likely, given the contingent social reinforcement that is associated with the enhanced staff engagement, attention, and solicitude characteristic of these interventions.

In California where hospitals are mandated to implement a less restrictive, recovery model of care, a discouraging increase has been noted in aggression toward patients and staff. Atascadero has seen a 66 percent increase in aggressive acts in the last two years. During the same period, aggressive acts at Metropolitan State Hospital in Los Angeles County have increased by 50 percent. When state mental health systems use the rationale that a "recovery" and "empowerment" model of care reduces the need for seclusion and restraint, supervision, and security, dangerous behavior may increase because staff feel more vulnerable and are intimidated by some patients who exploit the new policies.

Still relevant today are the findings and recommendations of the American Psychiatric Association's task force on seclusion and restraint (3), which highlighted the nonaversive use of behavior therapies, such as overcorrection, contingent observation, required relaxation, reinforcement of appropriate behavior, and positive programming. Use of a time-out area that offers time-limited privacy away from the location where aggression occurred has been shown to be effective in 74 percent of episodes (4).

The special section in the September issue offers further evidence, already well-documented in the literature, that the use and abuse of seclusion and restraint can be reduced by administrative policies, leadership, and monitoring as well as by positive programming of planned and scheduled activities and educational programs for staff. However, to press for elimination of seclusion and restraint and its more effective and humanistic derivatives from applied behavior analysis is fatuous. Ideological straitjackets have failed many times in the history of psychiatry, and it would be regrettable if polemics replace sound clinical judgment and empirical evaluation based on the full picture of management of assaultive behavior.

Robert Paul Liberman, M.D.

Dr. Liberman is distinguished professor of psychiatry at the Semel Institute of Neuroscience and Human Behavior at the University of California, Los Angeles.

References

1. Smith GM, Davis RH, Bixler EO: Pennsylvania State Hospital system's seclusion and restraint reduction program. Psychiatric Services 56:1115–1122, 2005
2. Khadivi AN, Patel RC, Atkinson AB, et al: Association between seclusion and restraint and patient-related violence. Psychiatric Services 55:1311–1312, 2004
3. Donovan A, Plant R, Peller A, et al: Two-year trends in the use of seclusion and restraint among psychiatrically hospitalized youths. Psychiatric Services 54:987–993, 2003
4. Nijman HLL, Merckelbach HLG, Alertz WFE, et al: Aggressive incidents on a closed psychiatric ward. Psychiatric Services 48:694-698, 1997
5. Tardiff K (ed): The Psychiatric Uses of Seclusion and Restraint. Washington: American Psychiatric Association, 1984.

In Reply: The Pennsylvania state hospital system has achieved a culture change that rejects the use of seclusion and restraint. We believe that these traumatizing procedures produce significant barriers to a recovery and have no clinical value. The total elimination of these interventions is a clinical reality for Pennsylvania state hospitals and for many psychiatric facilities worldwide. As of this date, six of our eight state hospitals have eliminated the use of seclusion and two

hospitals have eliminated the use of mechanical restraint.

Our reliance on these interventions continues to decrease. In January 2006, during which 67,000 days of care were rendered in the civil and forensic services, seclusion was used only two times for a total of 75 minutes, and mechanical restraint was used only seven times for a total of 7.83 hours. This decrease represents a 99.9 percent reduction from the 1996 rate. The transformation occurred without increases in hospital staffing. From 1996 to 2006 the patient-to-staff ratio has remained constant, with an on-unit ratio of one nursing worker for every five patients on the first and second shifts.

The "enormous transinstitutionalization" referred to by Dr. Liberman has not been a significant issue for Pennsylvania, which, like other states, provides services to an increasing number of people who have had contact with the criminal justice system. Our approach to service is the same for this group. Indeed, use of seclusion and restraint in our hospitals' forensic centers has historically been much less than in the general (civil) psychiatric service units.

In our article we did express concern about use of unscheduled (PRN) medications as a possible substitute for the hands-on use of restrictive procedures. After publication of findings by Thapa and colleagues (1) of exposure of patients to unnecessary psychotropic medications, our hospital system conducted a 15-month study of the psychiatric use of PRN medications in its nine civil hospitals and three forensic centers. The effort showed widespread differences within the hospitals and forensic centers in exposure rates. The findings led to a uniform policy change that discontinued the psychiatric use of PRN orders in the hospital system in March 2005. Since this change, we have seen marked improvements in our patient safety measures, including further decreases in the use of seclusion and restraint, incidents of aggression, and patient-to-patient assaults with injury (2).

The work of the APA task force on seclusion and restraint cited by Dr. Liberman still represents a good start for any psychiatric facility or clinician wishing to engage in this change. We also recommend the work of the National Technical Assistance Center of the National Association of Mental Health Program Directors: (www.nasmhpd.org/ntac.cfm).

Finally, we welcome this kind of exchange and scrutiny. Pennsylvania's state hospital system has been transparent in its efforts to share its experiences. Each month we distribute data to several states in the form of a summary report that details incident data. Interested readers who desire more information or data should contact the first author (grsmith@state.pa.us).

Gregory M. Smith, M.S.
Aidan Altenor, Ph.D.
Robert H. Davis, M.D.

References:

1. Thapa PB, Palmer SL, Owen RR, et al: PRN (as-needed) orders and exposure of psychiatric inpatients to unnecessary psychotropic medications. Psychiatric Services 54:1282–1286, 2003

2. Smith GM, Davis RH, Altenor A, et al: Psychiatric use of unscheduled medications in a state hospital system. Presented at the American Psychiatric Association's Institute on Psychiatric Services, San Diego, Oct 5–9, 2005

In Reply: The assertion that seclusion and restraint can ultimately be eliminated, as evinced by Pennsylvania's remarkable achievement, stands squarely on its own merits. Pennsylvania has done what no other state has done—eliminate restraint and seclusion altogether at two state hospitals, and eliminate seclusion at seven of its nine state hospitals. Dr. Liberman's letter, which implicitly derides this extraordinary effort by describing its goal as "fatuous" and by likening its principles to an "ideological straitjacket," is remarkable for its lack of knowledge about other facilities that have eliminated seclusion and restraint, insensitivity to consumers who have suffered in a true straitjacket, and denigration of the dedicated partnership of Pennsylvania professionals, consumers, and advocates who have worked diligently toward this attainable goal.

Dr. Liberman's fundamental argument is flawed. He cites a lack of awareness of "clinical realities," which are offered without supporting data. The increased use of PRN medication is one of the "realities" offered as an example, and yet Pennsylvania effectively eliminated PRN medication one year ago throughout their state hospital system. The letter also leaves the reader wondering why 20-year-old practice recommendations are invoked when federal regulations, standards of accrediting bodies, Congressional mandates, and regulations in several states have superseded many of these guidelines (1).

Unfortunately, the arguments made do not recognize the successful efforts to eliminate seclusion and restraint at facilities throughout the country, such as Salem Hospital in Oregon, which successfully eliminated these practices by implementing a model of care based on trauma-informed care principles; Taylor Hardin Secure Medical Facility in Alabama, the state's only forensic hospital, which virtually eliminated these interventions after working for more than six years to change its treatment culture; and the Boston Medical Center intensive treatment program, which serves adolescents in a secure setting and which eliminated mechanical restraint, seclusion, and medication restraint by implementing the trauma systems therapy model developed by Glenn Saxe (2). Work at these facilities and others (3) has led to national reductions in the use of seclusion and restraint (4) and underscores how changes in practice can alter the use of these interventions.

Psychiatry has played a great leadership role in efforts to achieve the goal of eliminating seclusion and restraint—efforts that preceded those of Philippe Pinel and that continue today. The steadfast work of Elizabeth Childs, M.D., commissioner of the Massachusetts Department of Mental Health, will lead to the promulgation of some of the most progressive seclusion and restraint regulations in the Unites States on April 3,

2006 (5). These new regulations articulate the goal of elimination and are designed to prevent the use of these interventions and implement alternatives, which will mitigate harm to consumers and staff. It is a sad commentary that not all members of the psychiatric community can accept a vision of care without seclusion and restraint and adopt advancing standards of practice to mutually further this important work.

Janice LeBel, Ed.D.
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Dr. LeBel is affiliated with the child and adolescent division of the Massachusetts Department of Mental Health in Boston. Ms. Huckshorn is affiliated with the National Technical Assistance Center for State Mental Health Planning and the National Coordinating Center to Reduce and Eliminate the Use of Seclusion and Restraint of the National Association of State Mental Health Program Directors in Alexandria, Virginia.

References

1. Zusman J: Restraint and Seclusion: Understanding the JCAHO Standards and Federal Regulations. Marblehead, Mass, Opus Communications, 2001
2. National Executive Training Institute: Training Curriculum for Reduction of Seclusion and Restraint. Alexandria, Va, National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning, July 2005
3. LeBel J, Goldstein R: the economic cost of using restraint and the value added by restraint reduction or elimination. Psychiatric Services 56:1109–1114, 2005
4. Glover R: Reducing the use of seclusion and restraint: a NASMHPD priority. Psychiatric Services 56:1141–1142, 2005
5. Commonwealth of Massachusetts, Department of Mental Health Regulations 104 CMR 27.00: Licensing and Operational Standards for Mental Health Facilities. Available at http://mass.gov/eeohhs2/docs/dmh/rsri/104cmr27.doc. Accessed Feb 27, 2006

In Reply: We appreciate the thoughtful perspective offered by Dr. Liberman. At the heart of the issue is a central tension: How do we maintain safety and order on psychiatric units, where patients are by nature severely mentally ill and potentially subject to erratic and unpredictable behaviors, while at the same time maintaining the dignity, humanity, civil liberties, and therapeutic milieu of psychiatric settings? How do we achieve the appropriate balance between these two potentially conflicting aims? On the one hand, recent data suggest that the rates of interpersonal violence in psychiatric settings are high (1), while on the other we know that some of the institutional measures of safety and control that are frequently used are often perceived as frightening or humiliating by those on the receiving end of such practices (1,2).

The complete elimination of seclusion and restraint may eventually prove clinically unrealistic. Clearly, some individuals with violent tendencies can be found in psychiatric hospitals. However, certain forms of seclusion and restraint would seem to violate the dignity of patients just by being used. They also may be inhumane not only because of the manner in which they are applied but also for the capricious reasons that are frequently offered to justify their use (2). Perhaps it is time that we reconsider the fundamental principle of crisis prevention and intervention training, which is to eliminate the antecedent to a crisis.

For example, how does something like handcuffed transport to a psychiatric hospital, which had been experienced by 65 percent of the respondents in our sample (1), set the tone for the mental health care that is subsequently provided? What kind of message does handcuffed transport send to distressed and vulnerable patients as they begin an episode of psychiatric care? Although there may not be a clear consensus on what should be the end goal for changes in the use of seclusion and restraint—"ultimately eliminated" or "markedly reduced"—it seems we could all agree that there is vast room for improvement on this issue—an issue that is critical to the care of people with mental illness.

B. Christopher Frueh, Ph.D.
Anouk L. Grubaugh, Ph.D.
Cynthia S. Robins, Ph.D.

References

1. Frueh BC, Knapp RG, Cusack KJ, et al: Patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatric Services 56:1123–1133, 2005
2. Robins CS, Sauvageot JA, Cusack KJ, et al: Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. Psychiatric Services 56:1134–1138, 2005

Clinical Case Management, Case Management, and ACT

To the Editor: The authors of the article "Comparison of ACT and Standard Case Management for Delivering Integrated Treatment for Co-occurring Disorders" (1) in the February issue use the misleading adjective "standard" to describe the comparison intervention. As described in the article, the "standard case management" used was actually a sophisticated "clinical case management team" (2–4) that provided multidisciplinary, integrated treatment with ongoing expert consultation. The clinical case managers had a larger caseload than the assertive community treatment team, and cases were assigned to individual case managers rather than to a team. However, even with these differences, the clinical case management approach used in the study has much in common with the assertive community treatment model.

Although one wishes that this type of treatment were "standard," case management today too often involves a poorly trained, paraprofessional staff operating apart from other treatment interventions (5). "Comparison of ACT and Clinical Case Management . . ." would have been a more apt title for this informative article.

Joel Kanter, M.S.W., L.C.S.W.-C

Mr. Kanter is in private practice in Silver Spring, Maryland.

References

1. Essock SM, Mueser KT, Drake RE, et al: Comparison of ACT and standard case management for delivering integrated treatment for co-occurring disorders. Psychiatric Services 57:185–196, 2006

2. Kanter J: Clinical case management: definition, principles, components. Hospital and Community Psychiatry 40:361–368, 1989

3. Kanter J (ed): Clinical Studies in Case Management. New Directions in Mental Health Services, no 65. San Francisco, Jossey-Bass, 1995

4. Walsh J: Clinical Case Management With Persons Having Severe Mental Illness: A Relationship-Based Perspective. Belmont, Calif, Brooks/Cole, 2000

5. Floersch, J: Meds, Money, and Manners: The Case Management of Severe Mental Illness. New York, Columbia University Press, 2002

To the Editor: I read with interest the article "Comparison of ACT and Standard Case Management for Delivering Integrated Treatment for Co-occurring Disorders" and noted the authors' conclusion that "Integrated treatment can be successfully delivered either by assertive community treatment or by standard clinical case management."

With so much interest in evidence-based practice, and with assertive community treatment (ACT) so often touted as the model of choice for treating people with severe and persistent mental illness, this study calls into question the fundamental assumption that what has worked before will work now. One tires of professionals everywhere blindly jumping on the evidence-based-practice bandwagon. The self-congratulatory literature expounding the virtues of this or that evidence-based practice tends to do little more then champion a record of the past, limiting creativity and discouraging attempts to try something new that may in fact be better.

ACT was developed more than 20 years ago, and much has changed since then. Perhaps it is finally time to let go of what may be an antiquated and obsolete model and focus on outcomes instead of process.

Bruce Seitzer, M.A.

Mr. Seitzer is an associate director of Community Counseling Centers of Chicago.

In Reply: We agree with Mr. Kanter that "case management" services provided by nonclinicians and "case management" interventions provided by clinicians may have little overlap beyond their shared label. To be clear that clinicians provided standard case management services in the Connecticut study, we took care throughout the report to use the term "standard clinical case management." Clinicians in both the ACT and the standard clinical case management conditions received the same training and supervision in the provision of integrated mental health and substance abuse treatment—training that presumed a clinical background that included working with people with serious mental illnesses.

The term "case management" means hundreds of different things in different parts of the country. Some have noted the paradox that, as we have become more precise in describing the components of effective case management services—most importantly, increased provision of direct service rather than referrals—we also have blurred its definition (1). Clinical case management, such as in Connecticut, includes direct provision of services by clinicians, usually master's-level social workers. At the other end of the spectrum, brokered case management, in which a case manager (typically a paraprofessional worker) helps a person enroll in services, is at best a waste of money and at worst harmful (1). Brokered case management is both prevalent and ineffective (1). On the other hand, paraprofessionals, including consumers who are not clinicians, can be effective as long as they have close consultations with appropriately skilled clinicians (1).

We share Mr. Kanter's concern that substituting nonclinicians for appropriately skilled clinicians would leave consumers in need of clinical interventions with staff who are ill equipped to meet their needs. Data from the Connecticut study and dozens of others now indicate that the ability to deliver integrated mental health and substance abuse treatment should be part of the minimal skill set for clinicians working with individuals who have co-occurring disorders. Because of the training provided in the Connecticut study, clients of clinical case managers made gains comparable to those made by ACT clients.

Mr. Seitzer's letter offers us the opportunity to underscore that evidence-based practices (such as ACT) are not evidence-based practices for everyone. Psychosocial treatments are, by definition, influenced by what else is going on in a person's environment. If rates of hospitalization are already low, assigning people to ACT cannot be expected to push these rates even lower. Rather, ACT is an excellent service for people who are hospitalized frequently (1) or coming directly from the hospital (2). We agree with Mr. Seitzer that, in addition to monitoring processes, it is important to monitor outcomes to identify when services that were once effective are no longer producing the expected gains and for whom these evidence-based practices are most effective. For example, integrated treatment may not be suitable for individuals with co-occurring disorders who have antisocial behaviors serious enough to keep them involved with the criminal justice system (3). We would put brokered case management and day treatment programs in the "not effective" category, whereas the overall evidence indicates that ACT is still very effective for reducing hospital use in areas where hospitals remain a common treatment alternative within the service delivery system.

Susan M. Essock, Ph.D.
Nancy H. Covell, Ph.D.
Robert E. Drake, M.D., Ph.D.

References

1. Rapp CA, Goscha RJ: The principles of effective case management of mental health services. Psychiatric Rehabilitation Journal 27:319–333, 2004

2. Essock SM, Frisman LK, Kontos NJ: Cost-effectiveness of assertive community treatment teams. American Journal of Orthopsychiatry 68:179–190, 1998

3. Drake RE, Morrissey J, Mueser KT: The challenge of treating forensic dual diagnosis clients. Community Mental Health Journal, in press

Assessment and Treatment of Iraqi Prisoners and Civilians

To the Editor: We read with interest the brief report by Griffeth and Bally, "Language and Cultural Barriers in the Assessment of Enemy Prisoners of War and Other Foreign Nationals," in the February issue (1). The mental health team described by the authors tried to do their best by using interpreters. However, the interpreters were not Iraqis and had little knowledge of the culture—and even had difficulty communicating.

We believe that the authors have made a fundamental error—that is, assuming that concepts of Western psychiatry as embodied in the *DSM* are universally valid. Western psychiatry is only one among several ethnomedical systems in the world. Western personhood emphasizes a personal and private self, whereas many cultures define a person as largely interpersonal and consensual and oriented to key roles and relationships rather than to what is deeply private. Social connectedness is a measure of value of self. In fact, among Iraqi asylum seekers in London, current social support was more closely related to low mood than a history of torture (2).

The authors are guilty of the error of "category fallacy," which is the assumption that because phenomena can be identified in different social settings, they mean the same in those settings (3). Terms such as depression and posttraumatic stress disorder and the meanings and responses that they elicit in Western societies are not directly applicable elsewhere, and many cultures do not have equivalent terms (4).

We are not sure whether it would work well for the authors to apply symptoms or even concepts of the Western world to people who may have other explanations, ranging across the physical, spiritual, moral, and political realms, and who may not conceive of illness as situated in the body or mind alone.

We also do not agree that educating interpreters in medical terminology can in itself benefit future assessment and treatment of prisoners of war and other foreign nationals unless the interpreters—or persons on the treatment team—are highly knowledgeable of the culture and of what is considered "normal" and what is not.

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References

1. Griffeth BT, Bally RE: Language and cultural barriers in the assessment of enemy prisoners of war and other foreign nationals

Psychiatric Services 57:258–259, 2006

2. Gorst-Unsworth C, Goldberg E: Psychological sequelae of torture and organized violence suffered by refugees from Iraq: trauma related factors compared to social factors in exile. British Journal of Psychiatry 172:90–94, 1998

3. Kleinman A: Anthropology and psychiatry: the role of culture in cross cultural research on illness. British Journal of Psychiatry. 151:447–454, 1987

4. Pilgrim D, Bentall R: The medicalisation of misery: a critical realist analysis of the concept of depression. Journal of Mental Health 8:262–274, 1999

To the Editor: I was delighted to read Griffeth and Bally's timely article in the February issue. Last year I was called to active duty as chief psychiatrist of Task Force 344 Med, whose mission at Forward Operating Base Abu Ghraib, Iraq, included care of thousands of foreign detainees in U.S. custody. Indeed, the problem of unreliability of assessment information is significant and due not only to linguistic and cultural barriers but also to socioeconomic differences and to the distortion of information unique to wartime circumstances.

Detainees are a heterogeneous group, including terrorist masterminds, lower-level street thugs, innocents caught in the wrong place at the wrong time, and medically ill opportunists incarcerating themselves to obtain U.S. medical care. Reports of hopelessness and suicidality were not uncommon. Some developed symptoms at the onset of incarceration; others presented later, after long family separation and mounting frustration at the pace of the Iraqi justice system.

One phenomenon seen repeatedly was that a single intervention with detainees who reported suicidal ideation was often sufficient to relieve such ideation and restore adaptive thinking and behavior. The pattern of symptoms and response seems to validate the "social integration" theories of Okasha that are cited by the Griffeth and Bally (1). Intervention often took the form of a heated discussion on a variety of topics ranging from hope versus despair, to the current affairs and future of Iraq, to questions of God's benevolence, to the feelings of the American people toward Iraqis and Arabs. Interventions were held out of earshot of other prisoners but, typically, within their line of sight. To give a prisoner in a yellow jumpsuit and sandals an audience with a field-grade U.S. Army officer in "full battle rattle," with a military entourage of other officers and enlisted team members, likely conferred a sense of respect for the individual's opinions and elevated the detainee's self-esteem, even if only temporarily.

I found it useful to acknowledge that I could not accelerate the resolution of their legal situation, but as a U.S. Army officer, I could assure them respect for their rights and dignity, safety while in U.S. custody, opportunity to redress grievances, and access to medical care. Detainees often expressed gratitude and affirmed a restoration of their will to live and to cope with life in the camps.

We do not know what individual patients told their tent-mates after these intense interlocutory sessions; patients could have offered any explanation, including one that further enhanced their esteem in the eyes of other detainees. In line with the theories of Okasha, it is plausible that an audience with "the American Army officers" altered the patient's status and role within his immediate social

group and thereby played a therapeutic role in altering his mental status.

Regarding language barriers: over the course of a tour of duty, one can learn dozens of Arabic words and phrases. To begin and end conversations directly with patients in their native language and to communicate such thoughts as, "Kulna Ichwan?" ("Are not all men brothers?") or "Inshallah, t'kon zien" ("With God's help, may you be well") helps break down barriers and advance a therapeutic alliance.

Larry H. Pastor, M.D.

Dr. Pastor, who is a lieutenant colonel in the U.S. Army Reserve, is associate clinical professor of psychiatry and human behavior at George Washington University Medical Center in Washington, D.C., and assistant adjunct professor at the Uniformed Services University of the Health Sciences in Bethesda, Maryland.

Reference

1. Okasha A: Mental health in the Middle East: an Egyptian perspective. Clinical Psychology Review 19:917–933, 1999

In Reply: We read with interest the letter about our brief report by Dr. Mathews and colleagues. We agree with several points, especially with the need to assess social connectedness. We did find fewer issues of anxiety and depression among the Iraqi civilians than among the prisoners of war, which may well be attributable to social connectedness. The civilians formed a community while on board the ship that served as our treatment setting, whereas the prisoners were not allowed to for safety reasons.

We also strongly agree that we were not the best suited for the job of assessing and treating Iraqis. However, we were the only trained personnel available to these wounded persons. Our paper was not intended as research but as a report of the difficulties of practicing in a different culture and through interpreters who also may have had problems understanding the culture. As such, we did not reify a nosological category developed for a particular cultural group and then apply it to members of another culture for whom it lacks coherence and for whom its validity has not been established (1).

We did not use *DSM-IV* diagnoses but looked at the broader concepts of depression and anxiety without trying to "shoehorn" our patients into diagnoses that did not fit culturally. In fact, the language barrier kept us from forming any formal *DSM-IV* diagnoses; therefore, I do not think that we committed a categorical fallacy. An example of the type of intervention that we made was teaching a friend of one of the blinded prisoners to organize his dinner plate so that he could feed himself.

We also strongly disagree with the statement of Dr. Mathews and colleagues that having medically trained interpreters would not benefit future assessment. As we mentioned, we spent a great deal of time having to explain medical and mental health concepts to our interpreters before we could assess the first patients. Providing this education before the need for it arises would decrease the response time of providers.

Finally, one important difference between the views expressed by Dr. Mathews and colleagues and our experience is the difference between the theoretical best and the real world. We agree that the best of all possibilities for these patients would have been to obtain an Iraq-born and Iraq-practiced psychiatrist; however, this was not a possibility. To some degree we had to "fight with what we brought." This meant having to learn, as Western mental health providers and interpreters, to bridge the gap between ourselves and our patients. This phenomenon is not new, and it has been well documented. The real world does not always provide the best fit for our patients.

Benjamin Griffeth, M.D.
Ralph Bally, Ph.D.

Reference

1. Kleinman A: Anthropology and psychiatry: the role of culture in cross cultural research on illness. British Journal of Psychiatry 151: 447–454, 1987