

Letters from readers are welcomed. They should be a maximum of 500 words with no more than five references. Address letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, APA, 1400 K Street, N.W., Washington D.C. 20005; fax, 202-682-6189; e-mail, [psjournal@psych.org](mailto:psjournal@psych.org).

## Advance Directives

**To the Editor:** As Srebnik and La Fond (1) indicated in their comprehensive review in the July 1999 issue, psychiatric advance directives hold great promise for ensuring consideration of an individual's preferences when he or she is unable to participate in decision making about treatment.

These documents are similar in principle to advance directives about end-of-life decisions. However, as the authors correctly note, a critical difference is the experience of the individual executing a psychiatric advance directive. Many people with serious mental illness endure recurrent episodes of acute disability and thus can offer quite explicit instructions, informed by their own past experience with psychiatric emergency care, about how they wish to be treated. Their experience often includes involuntary interventions such as civil commitment, forcibly administered medication, and seclusion and restraint.

As a result of these coercive procedures, many mental health consumers believe they have had no voice in the course of their treatment and have complied with treatment only in response to threats. Not surprisingly, they report that these procedures foster their repudiation of services that may be sorely needed.

Psychiatric advance directives could play an important role in reversing this pattern. By affording mental health consumers the opportunity to participate in treatment decisions—even during emergencies, when coercive practices have been most likely to intrude into treatment—the use of advance directives can allow mental health care providers to demonstrate that they value consumers' views and

respect their choices. In so doing, mental health systems may begin to reverse the consumer antagonism that now contributes to the revolving door of the psychiatric hospital.

To help mental health consumers gain access to treatment on their own terms and, ultimately, to avert the negative consequences of dropout from treatment, the Bazelon Center for Mental Health Law has developed a prototype mental health advance directive, which is available on the Internet at [www.bazelon.org/advdir.html](http://www.bazelon.org/advdir.html).

**Robert Bernstein, Ph.D.**

*Dr. Bernstein is executive director of the Bazelon Center for Mental Health Law in Washington, D.C.*

## Reference

1. Srebnik DS, La Fond JQ: Advance directives for mental health treatment. *Psychiatric Services* 50:919-925, 1999

**To the Editor:** Srebnik and La Fond provide a useful review of the potential role of psychiatric advance directives in their article in the July issue. We would like to add a few points.

First, although we endorse the authors' list of possible practical benefits of psychiatric advance directives, the strongest argument in their favor is ethical: such directives made while a patient has the capacity, or competence, to make treatment decisions provide the soundest ethical basis for nonconsensual treatment when capacity is lost. Indeed, when capacity becomes the determinant of whether a patient receives psychiatric treatment without consent, the question arises whether it should not become the justification for all involuntary treatment. A radical revision in mental health legislation would logically follow; for example, an "Incapacity Act" might replace a "Mental Health Act" (1).

Thus for advance directives, capacity assumes center stage. Three levels need to be defined: first, the patient must have a certain level of capacity to make an advance directive; second, capacity must fall below a certain level to trigger the advance directive; and third, the patient must have a level of capacity greater than the second level

and possibly the same as the first level to revoke the directive (2). Few mental health professionals are experienced in thinking about capacity, and it will take some time for us to acquire the requisite skills. The fact that patients will have previously lost and regained capacity, often in a stereotyped way, will facilitate individual specification of the relevant levels.

Our second point is that crisis planning that is not legally binding has the potential to achieve many of the benefits being sought through advance directives. The results of a pilot study of the use of "crisis cards" conducted by our team in London support this view (3). Such cards can be carried by the patient and may contain information ranging from persons to contact to details of treatment shaped by various contingencies.

Third, if, as many have suggested, one of the major benefits of an advance directive is clearer communication between the patient and the clinical team, then computer-assisted guides to making a directive are not desirable. We suggest that there are two types of both crisis cards and advance directives. The first follows a plan of treatment agreed to by the patient and the clinical team; the second is drawn up by the patient without discussion with the team (3). The latter is likely to prove less satisfactory.

Finally, important conceptual issues must be sorted out concerning advance consent to treatment rather than the more conventional advance refusal. An advance directive carries the same weight as a contemporaneous request for a specific treatment. Just as a clinician will not comply with an inappropriate treatment request by a patient who has capacity, neither would the clinician comply with an advance directive asking for inappropriate treatment. Here again, prior agreement with the clinical team would be highly advantageous.

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1. Szmukler G, Holloway F: Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin* 22:662-665, 1998
2. Halpern A, Szmukler G: Psychiatric advance directives: reconciling autonomy and nonconsensual treatment. *Psychiatric Bulletin* 21:323-327, 1997
3. Sutherby K, Szmukler G, Halpern A, et al: A study of "crisis cards" in community psychiatric service. *Acta Psychiatrica Scandinavica* 100:56-61, 1999

## Medication in Depression

**To the Editor:** Self-reports of behaviors are strongly influenced by the specific wording, format, and context of a researcher's questions (1). For this reason, the accuracy of the findings in the study reported by Green-Hennessy and Hennessy (2) in the February 1999 issue may be compromised by a discrepancy between the reference period associated with a question about major depression and the reference period for a question about medication use.

Using data from the National Health Interview Survey, the authors identified 1,189 persons who responded positively when asked if they had experienced an episode of major depression within the past 12 months. A related question asked if the subjects had taken prescription medication "for any ongoing mental or emotional condition" (emphasis added).

Given that the average duration of a depressive episode is less than 12 months, it is likely that many of the individuals who responded positively to the question about experiencing an episode of major depression were not suffering from an ongoing condition. They may have taken medication for the duration of their depressive episode and yet could have truthfully answered no to a question about use of medication for an ongoing condition. Based on the wording of the questions, it is possible that the reported data are most accurate for a subset of

individuals who suffered from chronic rather than episodic depression.

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### References

1. Schwarz N: Self-reports: how the questions shape the answers. *American Psychologist* 54:93-105, 1999
2. Green-Hennessy S, Hennessy KD: Demographic differences in medication use among individuals with self-reported major depression. *Psychiatric Services* 50:257-259, 1999

## The Doctor-Patient Relationship

**To the Editor:** In his article on the depersonalization of health care in the March 1999 issue, Dr. Zealberg (1) takes us on a nostalgic journey back to the roots of the healing professions, namely, the sanctity of the relationship between the doctor-therapist and patient. He uses Buber's I-Thou, I-It paradigm to illustrate how dehumanization in health care erodes this relationship and can interfere with caring for the patient.

Those of us who have worked with combat veterans know that dehumanization is an essential ego defense that makes war possible. When the enemy is perceived as a nonhuman, it becomes easier to kill. In the extreme, this type of objectification leads to the commission of atrocities (2,3). The recent events in Yugoslavia remind us just how quickly such a defense can erupt; the Holocaust of World War II serves as yet another reminder.

When I was in training over 20 years ago, I learned about the healing power of the doctor-patient relationship. My mentors spoke of the healing professions as a "calling" rather than a career choice. I was taught that people pursue this calling in response to a "reparative need" (4,5) and that caregivers who are successful temper their own needs in deference to the patient's needs. Patient and therapist create a therapeutic alliance—a sacred bond in which transference (and

countertransference) reactions, once fully understood, promote healing.

The 1980s were exciting times for psychiatry. An explosion of scientific discoveries in molecular biology, neuroscience, and psychopharmacology led to the development of a panoply of more effective psychotropic agents. These discoveries pushed psychiatry into new frontiers in medicine, promoting the Talmudic mandate of "tikkun olam," literally translated from the Hebrew as "mending or repairing the world." Yet, without the I-Thou relationship, no healing could take place, for a "dose of the doctor goes with every prescription" (4,5). When we sit and help our patients bear their suffering, we enter an intimate and sacred space—a spark of the divine rests between therapist and patient.

On the dawn of a new millennium, we seldom hear the term "calling" in reference to our professions. Dr. Zealberg reminds us that despite managed care, the business of medicine remains that of healing and caring for the sick. If we are to survive as caring practitioners, we must attend to the sacred within each of us and within each of our patients. Once the I-It relationship becomes the model, we cannot guarantee that we will "do no harm."

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### References

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2. Gault W: Some remarks on slaughter. *American Journal of Psychiatry* 128: 82-85, 1971
3. Langner H: The making of a murderer. *American Journal of Psychiatry* 127:950-953, 1971
4. Nadelson T: *The Doctor-Patient Relationship*. Boston, Tufts University School of Medicine, 1988
5. Balint M: *The Doctor, His Patient, and the Illness*, 2nd ed. New York, International Universities Press, 1972