Dear Editor:

In their recent paper, Dr Polimeni and Dr Reiss discussed how schizophrenia may fit with the theory of evolution (1). They considered whether schizophrenia may be a disadvantageous byproduct of human brain evolution or whether there may be individual advantages or advantages for kin.

Another possibility may be that schizophrenia continues to exist, despite the obvious disadvantages to its carriers, because these individuals live in a protected environment. This argument is similar to reasoning that pertains to why unusual species exist, first discussed by Darwin in the *Origin of Species*.

The genera *Ornithorhynchus* (platypus) and *Lepidosiren* (lunfish), for example, would not have been less aberrant had each been represented by a dozen species, instead of as at present by a single one, or by two or three. We can, I think, account for this fact only by looking at aberrant groups as forms which have been conquered by more successful competitors, with a few members still preserved under unusually favourable conditions (2).

Could this also be true for a person with schizophrenia? For many years, patients with this condition were protected in asylums. Now, they are protected and treated with antipsychotic medications. Surely, they have not been less aberrant had each been represented by a dozen species, instead of as at present by a single one, or by two or three. We can, I think, account for this fact only by looking at aberrant groups as forms which have been conquered by more successful competitors, with a few members still preserved under unusually favourable conditions (2).

Likewise, consider that natural selection usually takes place over a very long time. If a condition does not confer a large enough disadvantage in an evolutionary sense, it could be perpetuated until the rest of the species has a new advantage that is selected. Given that our species, *Homo sapiens*, is thought to have evolved approximately 200 000 years ago (3), this could be tens or hundreds of thousands of years more. It may be that humans as a species have not been around long enough for schizophrenia to become an extinct disease.

Further, although schizophrenia is associated with reduced fertility rates, it is possible that, compared with the recently relatively low fertility of the rest of humankind (4), it is not low enough to eradicate the disease.

I agree with your view about the increasingly noxious influence of the pharmaceutical industry—much as I may have enjoyed the odd free dinner while only too often suffering the speaker. It may be instructive to read Healy’s *Creation of Psychopharmacology* (1). We don’t reiterate often enough that none of our drugs are curative; however, they usually make life easier for patients and psychotherapy, which brings me to the deplorable state of the latter. Far too few graduates have a solid training in this art. Too many do not know their psychopathology; instead, they throw medication at the patient, and they want “shared care,” which, while often effective, at times only serves the purpose of arriving at a DSM-IV cookbook diagnosis, leaving the psychodynamics or the need for psychological support untouched.

I have met few psychiatrists, who, after having received their training during the last 12 years, could correctly define transference and, more important, countertransference. The keynote speaker at the last Ontario Psychiatric Association meeting had not heard about Bowlby until 1988! I have seen too many patients who, for years or decades, were tried on every conceivable drug (try to get the list of patients from a hospital 40 overdoses later!), but no one had dealt with their anger or helped them to find other solutions than an overdose or slashing. A whole body of psychodynamics soon will be forgotten.

It is time for our postgraduate directors to reconsider their programs and choose their residents more carefully. We need more reentry places. Interestingly, a teacher at an unnamed university recently described the brightest and most knowledgeable product as a “disturber”—yes, it can be challenging to be asked awkward

---

Re: 2002—Defining the 21st Century II

Dear Editor:

Your remarks were timely. Yes, it is important that psychiatrists be trained as generalists, and it is hoped that some choose further training. As in internal medicine or surgery, psychiatrists in subspecialties must work as generalists when on call. In child psychiatry, there is the added factor that, when children comment on one’s advanced age, it may be time to shift to more adult work.

---

References


Jamie Karagianis, MD, FRCPC

*St John’s, Newfoundland*

---

Re: 2002—Defining the 21st Century II

Dear Editor:

Your remarks were timely. Yes, it is important that psychiatrists be trained as generalists, and it is hoped that some choose further training. As in internal medicine or surgery, psychiatrists in subspecialties must work as generalists when on call. In child psychiatry, there is

---

Letters to the Editor
questions by a thinking student. I am delighted that a few intelligent and empathetic physicians choose psychiatry and become outstanding in this specialty, despite the poor pay, rather than choosing a specialty for lifestyle or subsidy reasons, as I learned at another university when giving a seminar.

Psychiatry should be the brain of medicine. Is it the stigma that patients still experience, or is it because of our own prevalent inadequacy that we, too, are stigmatized?

Reference


Ruth Kajander, MD, FRCPC
Thunder Bay, Ontario

Re: Unfree Associations: Inside Psychoanalytic Institutes

Dear Editor:

Dr Paul Steinberg’s interesting review (1), of Unfree Associations: Inside Psychoanalytic Institutes, by D Kirsner (2), raises several points that concern all of us who belong to professional organizations.

Steinberg, and apparently not quoting Kirsner, diagnoses 4 psychoanalytic training institutes in New York, Boston, Chicago, and Los Angeles, as being “pathologically functioning,” “dominated by narcissistic characters,” and exhibiting “childlessness and fratricidal behaviour.” He further states that they have “irredeemable narcissism, even paranoia.” Such psychopolitical descriptors are usually reserved for books concerning fascists, dictators, or the present “war on evil,” and appear politically dismissive rather than offering useful dynamic insights or objective criticism. He wonders about comparing the functioning of psychoanalytic institutes with other institutions, such as universities and hospitals and their leaders. My recent books (3,4) have attempted to look at some of these factors that faced the founders and affected the functioning of the Clarke Institute of Psychiatry and the Toronto Psychoanalytic Institute. Many of these shortcomings cross the boundaries of most, if not all, professional groups. Possibly, some of the factors mentioned are intrinsic, especially in groups wherein charismatic founders devote themselves and attempt to control others to establish certain goals.

There is much to be critical about with respect to these “elite groups,” especially the politics that invariably go with founding and maintaining values, theoretical positions, and even ideologies in all these organizations. They do have much to be humble about, especially at times when interpersonal differences have been exploited and people’s feelings have been overlooked yet their leadership, their energetic involvement, and their command are often necessary to establish such organizations, even when there is also bias and obvious self-interest. Eventually, founders and initial leaders become a hindrance, are counterproductive to the now-established groups’ aims, and are, in fact, functionally replaced, even though they are still listed as a professor or as a training analyst.

Gedo’s book, Spleen and Nostalgia, is quoted and conveys the bitterness of one of America’s most important and decorated analysts, who also feels overlooked and irrelevant at the end of his productive career. It is not only the people in psychoanalytic organizations who feel they didn’t get the chance to influence change and scientific thought who have resentments: some of the very leaders who apparently had been ambitious and successful feel they have not accomplished what they had hoped and have not been acknowledged for what they have accomplished. I will not criticize Dr Steinberg for merely being the messenger of Kirsner’s concerns and criticisms regarding the psychoanalytic institutes’ apparent practice of “anointment, . . . claimed knowledge and implied qualifications” in place of substantive educational accomplishments or an egalitarian interest for the society.

It is unfortunate to focus primarily on the failures of organizations and to describe their functioning primarily in terms of personality pathology. This does a disservice to many and does not enlighten those who wish to avoid the mistakes of the past or to convey to the reader the complexities of emerging professional group dynamics.

References


Douglas H. Frayn MD FRCPC
Toronto, Ontario

Re: Strategies of Collaboration Between General Practitioners and Psychiatrists: a Survey of Practitioners’ Opinions and Characteristics

Dear Editor:

Congratulations to Lucena and others for their scholarly survey of practitioners’ opinions on collaboration between general practitioners (GPs) and psychiatrists (1). The varied acceptance of different degrees of collaboration reported is in keeping with our experience. In 2 initiatives, GPs have made limited use of opportunities for collaborative care with psychiatrists. On both occasions, this was contrary to GP-stated perceived needs.
In 1997, ACCESS, a national continuing medical education (CME) program on psychosis management for primary care physicians, was delivered (2). The needs assessment identified GPs’ perceived lack of access to, and collaboration with, psychiatrists as a primary clinical and (or) educational need. The program’s educational design attempted to address this need. Groups of 8 to 10 GPs and a psychiatrist consultant facilitator were formed. They met locally in their communities for 2 separate case-based educational sessions. Between sessions, the GPs had telephone access to their psychiatrist consultant. This was included as part of the educational program to foster collaboration and access to psychiatrists, to specifically meet the identified need. Funding for psychiatrist availability was provided. Telephone logbooks for documentation were developed, and interactions were tracked. However, the telephone contacts were rarely if ever used. Most psychiatrists received no calls from the GPs.

A second clinical experience demonstrated a similar unexpected outcome (3). In 1996, GPs at North York General Hospital expressed dissatisfaction and frustration with a poor, noncollaborative relationship and a lack of access to psychiatry. In response, the hospital department of psychiatry implemented a Primary Care Psychiatric Outreach Program. If requested by the GP, a psychiatrist would provide timely on-site collaborative clinical educational consultations in the GP’s office. This almost immediately satisfied the GP outcry for improved access and markedly improved the psychiatry–family practice department relations. Still, the Primary Care Psychiatric Outreach Program was and continues to be rarely, if ever, used. Despite having 381 GPs on staff at our hospital, we average 1 or 2 requests each month from the same few physicians. Meanwhile, our traditional outpatient clinic remains extremely busy, with approximately 120 new GP referrals each month.

Models of collaborative and shared mental health care have many proposed benefits (4). Our benevolent, liberal-minded sentiments toward collaborative care had us hopeful that collaboration would be eagerly embraced and appreciated. In hindsight, this was a naïve, overly simplistic vision for mental health delivery. The survey by Lucena and others demonstrates that issues of collaborative care are more complex. Many practitioners are uninterested in close collaboration, including GPs. Lucena and others’ work adds important information at a time when delivery systems and third-party payers are struggling with ways to better provide mental health care to their populations.

References


Thomas E Ungar, MD, Med, CCFP, FRCP C, ABPN Toronto, Ontario

Reply to Dr Ungar

Dear Editor:

We are happy that our work can help the effort to increase shared mental health care. First, it is important to bear in mind that only some GPs and psychiatrists are ready to engage in on-site collaboration. Dr Ungar’s experiences validate the results of our survey: closer schemes of collaboration tend to involve only a few physicians. They are far from being the most accepted model of clinical practice for GPs and psychiatrists. For example, Dr Ungar stated that, of 381 GPs at North York General Hospital, only a few physicians request closer collaboration. Most GPs still rely on referral to the psychiatric outpatient clinic as the main approach to psychiatric patients.

Our survey indicates that strategies focusing on telephone access may be more fruitful. The failure of the ACCESS project may relate to the fact that psychosis management deals with a disorder rare in general practice, compared with common disorders such as depression, anxiety, substance abuse, or somatoform disorders. New efforts may be more productive if they concentrate on the latter disorders first.

Ricardo Lucena MD, MSc, PhD
Alain Lesage MD, MPhil
Montréal, Québec

Fungal Dermatitis with Olanzapine in Schizophrenia

Dear Editor:

Premarketing studies of olanzapine found a 2% incidence of fungal dermatitis vs 0% with placebo (1). To our knowledge, there are no other published reports of olanzapine funga dermatitis. We report a patient with schizophrenia who developed fungal dermatitis soon after starting olanzapine.

Case Report

Mr A, age 24 years, was recently diagnosed with DSM-IV schizophrenia, paranoid type. His psychiatric history included 2 brief admissions for psychosis in other hospital centres. On both occasions, the patient stopped taking his medication immediately after discharge. Medical history, including a history of dermatologic disease, was otherwise negative. At the time of presentation to our hospital centre, Mr A denied using any psychiatric medication for 4 years. He initially received 1 dose of haloperidol
for agitation and began olanzapine 20 mg daily, with lorazepam 1 mg daily, as needed. A physical examination revealed no physical abnormalities, including no dermatologic abnormalities.

Two weeks after beginning olanzapine, Mr A noticed a new, pale tan, circular, scaly, mildly pruritic patch on the anterior of his right shoulder. Three weeks later, the dermatologic abnormality persisted, and dermatology was consulted. The dermatologist confirmed the diagnosis of a fungal dermatitis, tinea versicolor, and prescribed topical ketoconazole cream. The infection appeared to be improving after several weeks. The patient was discharged but was noncompliant with follow-up.

Discussion

Tinea versicolor, a superficial mycosis, is caused by several of the species of the genus, Malassezia (2). It occurs primarily in the tropics but is not rare in North America (2). Other reported dermatologic adverse effects of olanzapine include vesiculobullous eruption, pruritus, and peripheral edema (3). Although other antipsychotic agents have been associated with various dermatologic manifestations—including exanthems, pruritus, photosensitivity, angioedema, exfoliative dermatitis, and cellulitis—none except for ziprasidone have reported occurrences of fungal dermatitis linked with their use (3). In this otherwise healthy patient with a negative history of fungal dermatitis, the infection arose 2 weeks after the initiation of pharmacotherapy, which supported the strength of this association. Resolution of the dermatitis after antifungal treatment, despite continuing olanzapine, makes it difficult to be certain about the causal nature of this relation. Nevertheless, physicians should be sensitive to the possibility of fungal dermatitis as a complication of olanzapine pharmacotherapy.

References


Tomas Fogl, MD
Howard C Margolese, MD, CM, FRCPC
Montreal, Quebec

Re: Canadian Psychiatric Inpatient Religious Commitment

Dear Editor:

Dr Watters is somewhat disingenuous in using his “critique” (1) of the study by Baetz and others (2) to advocate his well-known view of “religion as the most destructive of human inventions.” The search for finding meaning and guidance about life and death has been around for thousands of years and can hardly be described as an “invention.” It has been expressed in what we choose to call “religion” in many ways that have changed over time but are present in all cultures. These philosophical considerations, however, were not the issue in the paper by Baetz and others.

Their study is welcome. It attempts to bridge the gap between 2 aspects of human behaviour that are frequently seen in isolation: psychopathology and religious observance. They also admit to the limitations of their investigation. One could add that answers to 3 questions on a Gallup Poll (3) can only provide a simplistic view of an individual’s belief system. Moreover, religious commitment seemed restricted to adherence to the Christian religion, perhaps inevitable in the demographic distribution of the study population. Similarly, length of stay in hospital is, at best, a rough indication of clinical status.

Nevertheless, the paper by Baetz and others is a welcome start, and a more detailed investigation into the relation between overt psychopathology and religious beliefs and practices could lead to useful dialogue and enhancement of our therapeutic armamentarium.

References


Hans F Reichenfeld, MB
Ottawa, Ontario