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Dear Joe,

Deja vu, all over again! Yes, I do remember our little diagnostic experiments, and I must say that our experience has influenced me all my life. In our Hillside days, we learned that diagnosis was not particularly useful when we were asked to treat patients, since from time to time, the obviously 'wrong' treatment seems to have been useful. Our random assignment imipramine, chlorpromazine and placebo studies laid the groundwork for the studies of imipramine in phobic disorders, for example.

In the 1970s, when the APA committee under Bob Spitzer was devising the present Chinese menu diagnostic scheme, I argued for consideration of biological (at the time, mainly the sedation threshold and the nascent neuroendocrine tests) and treatment results as cutting tools, arguing that the main advances in syphilis came about only after the Wasserman test was devised. Such views were disregarded as 'premature'.

From time to time I am asked to consult on complex cases, and usually I discard the diagnoses presented in favor of any diagnosis for which a treatment exists. A few weeks ago, I was sent a 25 year old man, ostensibly with schizophrenia (2 consultants agreed), with the statement that ECT was clearly useless in schizophrenia and therefore neither psychiatrist would treat the boy. This despite the record that 4 years earlier he had responded well, albeit for 13 months! We have since treated him and he is doing nicely.

Another case is that of a 56 year old confused and apathetic woman who was diagnosed as Alzheimer disease, confirmed by a neurologist, and again by a second opinion; consigned to a nursing home for 5 years. She was referred to University Hospital because of a medical condition. When she was on our medical service, our consulting team thought she was depressed. She was referred to our team, and we could not agree on a psychiatric diagnosis; but since the diagnosis of Alzheimer disease was untreatable, we suggested to the husband that since she looked depressed there was the option of a course of ECT, which could make her a little worse for a while, but if it worked . . . It did, and she has now been at her own home for more than 3 years. (When she returned home, she could not believe that her daughters were her own, for she had the Rip van Winkle syndrome, believing that her daughters were five years younger.)

Another more recent case is that of a 25 year old married mother with a history of lupus erythematosus, admitted in manic excitement, treated with haloperidol, and seen the next day in a catatonic state. Internists believed she had lupus cerebritis with epilepsy continua, and they tried various voodoo treatments including high doses of antiepileptic medications; the psychiatrist laid on the benzodiazepines (he feared antipsychotics as neurotoxic). The patient was incidentally presented to my ECT training class and after some discussion, I argued that ECT was the preferred treatment regardless of her diagnosis (lupus cerebritis or NMS or epilepsia continua) since her main symptom was catatonia. Four weeks later she was finally sent for ECT when her catatonia became the aggressive variety and she required continuous restraints. Four weeks of ECT, and she is now home, alert and well.

Of course, not all such agnostic diagnoses work as well as these did; but it only takes one such diagnosis every so often to convince me that our present disgnostic schemes in psychiatry, especially the Chinese menu approach of your Institute, is Rorschach testing in real life; and that more is in the eye of the beholder than in the face of the object, despite the professional belief in their objectivity.

Yes, I remember those experiments very well, and often tell my students about them. Perhaps we should do the experiment over and publish the results in the American Journal of Psychiatry? (Under pseudonyms, of course.)

Thanks for the very pleasant reminder. My best regards.

Sincerely yours,

Max Fink, M.D.