## The Short-Term Effect of the Recent Great Earthquake on the General Functioning Status of Psychiatric Patients Near Tokyo

To the Editor: Kitasato University East Hospital is located about 40 km southwest of Tokyo. During the earthquake on March 11, 2011, the movement around us measured upper 5 on the Japan Meteorological Agency seismic intensity scale. During the first week after the earthquake, I treated 155 psychiatric patients, of whom 141 had regularly consulted me before. These included 120 outpatients (54 with a diagnosis of epilepsy, 32 with schizophrenia, 11 with a mood disorder, eight with an adjustment disorder, five with dementia, and 10 others) and 21 inpatients (two with epilepsy, nine with schizophrenia, four with mood disorder, five with adjustment disorder, and one with dementia). No patients with acute stress disorder came to see me during the first week after the earthquake, and almost all of the patients who did come for treatment expressed their fear of the quake and the aftershocks.

Of those 141 regular patients, five (three outpatients and two inpatients) experienced either a marked increase in seizure frequency or a marked decrease in score on the Global Assessment of Functioning Scale (GAF) during that first week. An outpatient with epilepsy was admitted to another hospital for the treatment of status epilepticus that might have been related to aspiration pneumonia after the quake. An inpatient with temporal lobe epilepsy has been experiencing complex partial seizures every time an aftershock occurs, and an inpatient with schizophrenia saw for the first time vivid visual hallucinations of clouds of eels crawling on the floor (the patient's GAF score decreased from 55 to 30). An outpatient with delusional disorder expressed her strong wish to have committed suicide before the terrible quake (her GAF score decreased from 50 to 35), although she did not attempt it. An outpatient with adjustment disorder needed a new prescription (her GAF score decreased from 85 to 60). Interestingly, two outpatients with schizophrenia reported that their sleep-wake cycle had somehow improved after the earthquake. The remaining patients showed no major change in their functional status during the first week after the earthquake.

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## Studying the Efficacy of Psychodynamic Psychotherapy

To the Editor: In the January 2011 issue of the *Journal* (1), Andrew Gerber, M.D., Ph.D., and colleagues from APA's Ad Hoc Committee on Research on Psychiatric Treatments meticulously reviewed the quality of existing randomized controlled trials of psychodynamic psychotherapy and identified important problems in a significant percentage of the studies. However, two issues not specifically addressed by the authors should be highlighted.

The first issue is that randomized controlled trials of psychodynamic psychotherapy have tended to focus on patients with one specific DSM axis I diagnosis, such as depression, generalized anxiety disorder, social phobia, and posttraumatic stress disorder. Symptom-focused studies do not reflect the clinical reality that many patients treated with psychodynamic therapy present with complex problems that may include but are not limited to a single axis I disorder (2). Patients with more complex problems typically require and do better with longer-term psychodynamic psychotherapy. Only 12 of the 94 studies included in the review by Gerber and colleagues evaluated the effects of individual psychodynamic psychotherapy lasting 1 year or longer.

The second issue is that many investigators have questioned whether randomized controlled trials are truly representative of how psychodynamic psychotherapy is actually practiced in the real world. Seasoned clinicians do not adhere strictly to empirically supported techniques prescribed by the manual for their particular school of therapy. The most effective clinicians use a blend of approaches and switch strategies according to the patient's needs at any given moment during treatment (3, 4).

In everyday clinical practice, patients frequently bring more than one illness to therapy, and their therapists often introduce more than one empirically supported treatment in endeavoring to help them.

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## Response to Douglas Letter

To the Editor: While we agree that the general issues raised by Dr. Douglas are important ones, we believe that there is insufficient evidence to accept either of her arguments as fact, nor is there reason to be too skeptical about the findings of randomized controlled trials on these bases. First, it is not clear that randomized controlled trials do not include complex cases. Barber (1) argued that randomized controlled trials will often include patients with pathology that is as significant and comorbid as seen in private practice, because patients who cannot afford private practice fees often seek out research studies. Furthermore, many contemporary ran-