Current Psychiatry

Is clinical judgment enough to restrict driving?

In "Driving with dementia: How to assess safety behind the wheel" (CURRENT PSYCHIATRY, December 2008, p. 36-48) the authors provided helpful suggestions on how to implement driving restrictions. The algorithm, however, relies too heavily on costly driving evaluations at the expense of clinical judgment.

Although the American Medical Association and the National Highway Traffic Safety Administration may not feel that a dementia diagnosis is sufficient to restrict driving, this opinion is not unanimous. In 2000 the American Academy of Neurology issued a practice parameter standard that patients with a Clinical Dementia Rating of 1 should not drive. This rating is equivalent to probable Alzheimer's disease (AD) with mild impairment.[1]

Furthermore, although the clock-drawing test, visuospatial copying tasks, and trail making test B might not have absolute utility in identifying those at risk of driving impairment, measures of attention and visuospatial skills have been found to correlate with on-road driving performance.[2]

Given that visuospatial testing evaluates an area of cognition that is necessary for driving and impairment of visuospatial functioning in AD is significantly correlated with anosognosia,[3] a prudent clinician may choose to restrict driving privileges based on bedside examination and clinical impression alone.

Ben Schoenbachler, MD
Assistant professor
Director, Memory Disorders Program
University of Louisville
Louisville, KY

December 2008

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The authors respond

We agree with Dr. Schoenbachler's comment that "a prudent clinician may choose to restrict driving privileges based on bedside examination and clinical impression alone," and certainly do not wish readers to disregard the results of patient history, examination, or cognitive evaluation. Indeed, visuospatial testing has been shown to have moderate correlations with driving in the review that Dr. Schoenbachler cites. However, a recent systematic review[1] highlighted the inconsistency of this evidence and reported that only 6 of 11 analyses of the relationship between visuospatial skills and driving showed significant associations.

Although our article emphasized the limitations of evidence on the predictive value of the clinical evaluation of driving fitness, we encourage physicians to use their clinical judgment to decide when a patient's cognitive deficits or behavioral symptoms preclude safe driving. The algorithm emphasizes the role of on-road testing in cases when the clinician is uncertain. When impairment is so severe or obvious that the patient clearly is unsafe to drive, in-depth testing is not needed. For less severe cases, clinicians will need to determine if they have enough information to decide or if an on-road assessment is warranted.

Mark Rapoport, MD
Carla Zucchero Sarracini, BA
Nathan Herrmann, MD
Department of psychiatry
University of Toronto
Sunnybrook Health Sciences Centre
Toronto, Ontario, Canada
Frank Molnar, MD
University of Ottawa
Ottawa Health Research Institute
Ottawa, Ontario, Canada

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Should dissociative identity disorder be in DSM-V?

Dr. Henry Nasrallah's editorial, "Should psychiatry list hubris in DSM-V?" (From the Editor, CURRENT PSYCHIATRY, December 2008, p.14-16), touches upon an important subject related to psychiatry's place among medical specialties and the respect—or disrespect—our field gets. I shudder to think that "Excessive Nose Picking" could be listed in DSM-V with a fancy name such as "Rhinotelexomania" or "Excessive Nail Biting" with a sexy label such as "Onychophagia." Psy-

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chiatry has been under attack for being pseudoscientific and not worthy of the respect that other medical specialties command. There is no need to add insult to injury.

Dissociative identity disorder (DID) is another controversial diagnosis that may have been very appealing to Hollywood moviemakers but does the field, patients, and their families a great disservice. Although DID is listed in DSM-IV-TR, criterion A—the presence of 2 or more distinct identities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self—is a definition rather than a useful guideline. Who, when, and how does this "presence" become present? What is the clinician's role in the face of the first-person authority?

In other medical specialties, it is recommended—rather strongly encouraged—that the practitioner constantly challenge his or her basic assumptions about a possible diagnosis through a methodic process of inclusion, exclusion, and hypothesis testing. Gullibility, lack of scrutiny, lack of skepticism, and not having a high index of suspicion are signs of poor clinical practice. To use Donald Davidson's words, the skeptic's attempt to investigate dissociative phenomena—especially DID—is bound to break on the rocks of the first-person authority.[1]

The antipsychiatry movement, despite its excesses, helped psychiatry do some introspection and look at its own excesses. It helped the field evolve from pseudoscientific psychoanalytic traditions to the evidence-based practices of today. The polarizing DID diagnosis is not only a difference of opinion between proponents and opponents, nor is it a harmless abstract controversy or just about "opinion" or "belief." Patients and families are harmed by the diagnosis and the practice of its proponents.

For economy, I refer readers to the 2-part, 2004 review of DID in the *Canadian Journal of Psychiatry*, which came to following conclusions:

- there was no proof that DID results from childhood trauma
- DID could not be reliably diagnosed
- DID cases in children were almost never reported, and
- consistent evidence of blatant iatrogenesis appeared in the practice of DID proponents.[2,3]

The DID controversy is not a symmetrical argument of personal opinion vs another or 1 dogma vs another. Rather, it is like the Celestial Teapot parable of Bertrand Russell. An almost impossible belief persists because it can't be proven wrong.

Numan Gharaibeh, MD
Principal psychiatrist
Western Connecticut Mental Health Network
Danbury, CT

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Add avoidance/anxiety to DSM-V stuttering criteria

With advances in the understanding of stuttering and development of pharmacologic therapies,[1] modifications to the classification and treatment of this disorder are indicated. Research has shown that stuttering improves with pharmacologic therapy, and neurologic abnormalities have been identified.[2]

With DSM-V on the horizon, stuttering classification should be expanded to include an additional criterion of avoidance and/or anxiety around speaking situations related to stuttering.[3] By adding this criterion, we recognize and can offer treatment to patients who do not have marked disturbances in fluency but experience avoidance and/or anxiety around certain feared words or situations.

We also recommend distinguishing childhood-onset, developmental stuttering—by far the predominant presentation—on Axis I separate from the adult-onset forms. Stuttering symptoms acquired as an adult—usually through neurologic injury[4]—are better coded under Axis III. Stuttering symptoms also rarely may be manifestations of conversion or malingering, and in cases such as this are better classified under these conditions.

As the understanding of stuttering leads toward a more physiologic etiology, clarification of DSM-V criteria will ensure that millions of individuals who stutter will have greater access to comprehensive care, including emerging pharmacologic therapies.

Gerald A. Maguire, MD, DFAPA
Victoria Huang, BA
C. Scott Huffman, MA
Department of psychiatry
School of medicine
University of California, Irvine

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