order to get him back on the road. In addition, he was generally very punctual but seemed to exhibit a new disregard for time. For example, he typically awakened early to take his son to school, but 2 days prior to admission he overslept, displaying an uncharacteristic apathy about getting his son to school on time.

Upon psychiatric admission, prazosin was discontinued. After 30 hours, Mr. A's odd behavior and dissociative symptoms resolved, and he was discharged from the hospital while still being treated with all previous medications except prazosin. Six months later, he has not experienced recurrence of these behavioral symptoms.

Prazosin is increasingly being used off-label to treat nightmares caused by PTSD. Although no behavioral side effects have been reported in studies on prazosin when used to treat hypertension or prostatic hypertrophy in patients without mental illness, it would be interesting to learn what side effects might arise in psychiatric patients.

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On-the-Record Screenings Versus Anonymous Surveys in Reporting PTSD

TO THE EDITOR: Rates of posttraumatic stress disorder (PTSD) reported for service members returning from Iraq and Afghanistan have varied (1, 2). To determine whether one population could yield different rates of PTSD, we performed a record review of on-the-record screenings for PTSD conducted at a military facility where an anonymous survey was performed earlier for a research study (3).

In both the anonymous study and clinical screenings, service members were given the PTSD Checklist, Military Version (PCL-M). Since the population and screening instrument were similar, we hypothesized that comparing the anonymous study results with the on-the-record screenings would demonstrate the effect of anonymity in determining the rates of PTSD.

Institutional Review Board approval was obtained to perform a chart review at the Naval Medical Center San Diego. This military hospital employs approximately 6,000 health care providers and frequently deploys these individuals to combat zones such as Iraq and Afghanistan. Most of these deployments are in support of Marine Corps operations. Upon returning from deployment, service members participate in a screening that includes the PCL-M. The PCL-M is a self-report instrument that has been validated against clinical criteria and other research measures (4). It can be scored for broad criteria, which matches the DSM diagnosis, or strict criteria, in which broad criteria are required in addition to a total severity score. At Naval Medical Center San Diego, those individuals who meet broad criteria are encouraged to undergo a diagnostic interview.

The number of charts assayed was 408. This number was based on a power estimate intended to detect 50% underreporting for on-the-record screenings by broad criteria. The rates of PTSD by broad and strict criteria were computed using the same methods that were used in the anonymous study (3). Statistical comparisons were determined using Mann-Whitney tests.

A retrospective review of on-the-record screenings in medical personnel returning from Iraq or Afghanistan showed that 32 out of 408 (7.8%) showed broad criteria for PTSD, and 22 out of 408 (5.4%) showed strict criteria. The previous anonymous screen (3) showed that 16 out of 102 (15.7%) service members returning from combat deployments met broad criteria for PTSD, and 9 out of 102 (8.8%) met strict criteria. The relative risk of screening positive for PTSD based on broad criteria was 0.5 when reporting was performed anonymously versus on-the-record. Mann-Whitney tests showed the difference between the rates to be statistically significant for broad criteria ($p=0.02$).

One possibility for these results is that when faced with the consequences of a positive screen for PTSD, service members underreport. However, on-the-record screenings are mandatory for all service members returning from deployment, whereas the anonymous survey required voluntary participation. Thus, it is also possible that 1) those individuals with symptoms to report were more likely to complete the anonymous form and 2) anonymous surveys overreport symptoms. Nevertheless, our results suggest that anonymity plays a role in how individuals report PTSD symptoms. Further outreach is needed to allow those individuals with PTSD to feel safe reporting their symptoms in a way that can connect them to clinical services.

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Consistency of Autobiographical Memories in Asylum Seekers

TO THE EDITOR: When applying for asylum in a new country, refugees are interviewed by immigration authorities about events they experienced prior to emigrating. Since there is usually no documentary evidence regarding past traumatic events experienced in the country of origin, legal decision pertaining to status may rest on the credibility of the applicant's narrative. If an applicant gives different (discrepant) accounts of their experiences on different occasions, it is easy to assume that they have fabricated a story in an attempt to obtain a residency permit (1). However, a study of a sample of 39 asylum seekers from the Balkans in the United Kingdom has convincingly shown that such inconsistencies between different interviews should not be relied upon as indicating a lack of sincerity or credibility among asylum seekers. Indeed, discrepancies occur even when there is no reason for fabrication. More precisely, Herlihy et al. (2) demonstrated that inconsistent accounts were associated with the presence of posttraumatic stress symptoms in this sample.

In Switzerland, similar to most countries, the process of claiming asylum comprises several oral interviews with representatives of the immigration administration. A large proportion of asylum seekers come from Africa. These individuals have often experienced lasting traumatic events (e.g., political persecutions, war).

We assessed seven French- or English-speaking asylum seekers from sub-Saharan West Africa. All subjects had been exposed to at least one potentially traumatic event. They were asked to recall and narrate a traumatic event and a happy event of their choice on two different occasions, with a 6-week interval between the repeated narrations. A structured interview, adapted from Herlihy et al. and investigating the characteristics of the event, autobiographical memories, and intrusive thoughts pertaining to the event, was used. Participants also completed two self-report scales: the Impact of Event Scale and the Hospital Anxiety and Depression Scale. The Impact of Event Scale is a 15-item scale that assesses subjective distress after a stressful life event.

Subjects were 18 to 50 years of age (mean=26.85 years). The time between the traumatic event and arrival in Switzerland was 4 months. Consistency was assessed by comparing responses to the structured interview at the first and second evaluation. The percentage of identical responses was recorded. In this sample, consistency was not different for happy and traumatic events (82.9% and 82.3%, respectively). However, interindividual variability was greater for happy relative to traumatic memories, with higher distress scores on the Impact of Event Scale being associated with decreased consistency of happy event narratives (p=0.04). There was no significant association between memories of events and Hospital Anxiety and Depression Scale scores. Overall, discrepancies between an individual's accounts were not common.

Contrary to previous findings, our results do not show a significant distortion of traumatic memories compared with happy memories. Apart from the small sample size, differences in administrative procedures between different host countries could explain these results. In our country, individuals seeking asylum have to relate traumatic events orally on several occasions. This could increase the coherence of narratives. Additionally, consistency of traumatic memories between European and African subjects may differ. Relationships between the consistency of autobiographic memories and types of events (traumatic versus happy) appear to be mediated by affective factors such as perceived distress. These preliminary results should be tested in larger samples. Indeed, given the high number of displaced and traumatized individuals worldwide, these issues have important ethical and public health implications.

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Electroconvulsive Therapy in a Patient With Concomitant Depression and Charcot-Marie-Tooth Disease

TO THE EDITOR: Charcot-Marie-Tooth disease is a severe neurological disorder affecting both motor and sensory peripheral nerves. In patients with peripheral autonomic nervous or respiratory system involvement, anesthesia management can be difficult. A higher risk for malignant hyperthermia and succinylcholine-induced hyperkalemia during anesthesia in patients with Charcot-Marie-Tooth disease is under discussion (1, 2). These issues may limit the possibility for psychiatric patients with Charcot-Marie-Tooth disease to undergo electroconvulsive therapy (ECT). We present the first case of a successful performance of ECT in a patient suffering from both severe treatment-resistant depression and Charcot-Marie-Tooth disease.

"Mr. T," a 70-year-old man suffering from Charcot-Marie-Tooth disease type I, with pronounced muscle atrophy in the upper and lower extremities, was referred to our department with severe, delusional, first-episode depression. For almost 2 years, a loss of drive, delusions of poverty, and near mutism were the most prominent symptoms. Since the patient had previously been resistant to any antidepressant (citalopram, clomipramine, duloxetine, mirtazapine, paroxetine, reboxetine, tranylcypromine) or antipsychotic (haloperidol, olanzapine, quetiapine, risperidone), we decided to perform ECT.

Electroencephalography and magnetic resonance imaging did not reveal any pathology. Blood gas analysis showed a slight compensated respiratory acidosis (PaO_2=83 mmHg, $PaCO_2$=44 mmHg, pH=7.41, HCO_3=27 mmol/l, BE= –0.9