THE WASHINGTON PSYCHIATRIC SOCIETY News

MAY/JUNE 2008

Defining Mental Illness

By Anjali Dsouza MD and Roger Peele MD, DLFAPA

The words illness, disorder, and disease are not strangers to us. We use these terms many times in one day and, sometimes, interchangeably. Our sense is that the use of illness vs. disorder vs disease is arbitrary. An accepted definition of mental illness is important to medicine, to the making of health care policies, and to its use in a variety of other settings, such as schools, the workplace, and the courtroom. What is mental illness? Let's look first at the DSM-IV's definition of mental illness:

"In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflicts is a symptom of a dysfunction in the individual, as described above."

Is this clear to you? ? Not to us. This definition leans on concepts such as "distress," "disability," and "dysfunction,": all of which are nebulous. It is not surprising, then, that when the question of whether a person has a mental illness comes up, the DSM IV definition, as far as we know, has never been used!

What about the International Classification of Disease, Tenth Edition? Has ICD-10 been able to articulate a more succinct representation?

The ICD-10 states that a mental disorder is "a clinically recognizable set of symptoms or behaviors associated in most cases with distress and interference with personal function."

This definition leans on words such as "function." and is also too broad. It would appear to include almost all illnesses, mental or otherwise, that interfere with personal function

Definitions of "mental disorder" have followed two paths: socio-cultural or scientific. Jerome C Wakefield, DSW, PhD, of NYU's School of Social Work, has tried to bridge the gap and has written extensively on this problem. He has proposed "harmful dysfunction (HD)" as central to the definition of mental illness. Wakefield's definition of mental disorder is: a failure of natural mental or behavioral mechanisms to function as designed in evolution, resulting in conditions judged negative by socio-cultural standards.

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Wakefield uses the example of illiteracy to reinforce HD as a useful concept. He states that illiteracy on its face is not considered a disorder, even though it is disvalued and harmful in our society. However, illiteracy as a condition that is due to a lack of ability to learn to read, because of some internal neurological flaw or psychological inhibition, is considered a disorder. This approach avoids potentially harmful socio-cultural value judgments. However, it adds a theory of failed evolution to the definition of mental illness. If accepted, this would take the DSM away from its avowed intention as atheoretical.

Without a specific de finition of mental illness, many of us consider "mental illness" to be the aggregate of all disorders in the DSM-IV. However, the numerous NOS options remove almost all borders. They do not include the criteria, "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning," which are

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The President's Column

By Michael J. Houston, M.D..

It has been an interesting year. Last May, when I began my term as president of WPS, there were a few issues that raised my anxiety level a bit higher than I had expected. Our Executive Director had resigned and our financial reserves, while not depleted, had suffered from several years of budgets that didn't seem able to stay on track. I recall at least one restless night punctuated by dreams of captaining a ship with neither a rudder nor an engine. A colleague of mine from child psychiatry provided some guidance by offering his number one rule for psychiatrists: "Never worry alone." Thankfully my anxieties were lessened by having beside me an experienced and resourceful Board of Directors, whom I knew I could rely on for support, guidance, and consolation.

One year later: While my anxieties do not appear in retrospect to have been without merit, they have been, for the most part, happily resolved. The board, in its wisdom, had the courage to see the benefits of not hiring a new executive director. Instead we, as is often the case for the Washington Psychiatric Society, set a new course and contracted with an outside group of professionals, led by Pat Troy, to take over the administrative functions of the Society. This has freed us from payroll and office expenses, leading us to finish the year in the black and with a budget for next year that will do the same.

Another bright spot in the past year has been working with Eliot Sorel and the group he assembled for a series of talks for residents and members in training entitled *"Developing our Careers, Enhancing our Leadership Skills."* Dr. Sorel put together eight teams consisting of senior WPS members matched with resident members. The teams developed brief presentations on topics ranging from the Development of Leadership Skills to Keeping your Life in Balance that were presented to residents at each of our four area training programs. To his credit and the credit of the WPS, the program was selected to receive an Honorable Mention District Branch Best Practice Award by the Assembly of the APA at the annual meeting.

As our year draws to a close I would like to thank the members of WPS for giving me the rewarding, though not altogether stress free, opportunity to serve as their president. Seeing the organization weather a few storms and emerge stronger only contributes to my overall sense of optimism for our society and for the individuals who count themselves among its members. Knowing that I will turn the gavel over to someone as knowledgeable and experienced as Harold Eist only adds to my optimism. ■

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Thanks for helping us to improve our services to you.

Notes from the Bureaucracy

By Harold I. Eist, M.D., DLFAPA

This is a flash message to the members of WPS.

Congress is considering a bill that would send a cadre of people to doctors' offices to teach them the truth about pharmaceuticals. These enlightened souls would be the government's alternative to those pharmaceutical Reps who currently are manipulating stupid, uneducated, and poorly trained physicians into prescribing the medications that they market.

The new educators would be nurses and pharmacists because of their special expertise in educating doctors who would otherwise be putty in the hands of wily, extraordinarily attractive communication majors working as pharmaceutical representatives with next to no scientific knowledge except for their canned talks. As a counter measure, the government will assure that none of these specially trained individuals will be physically attractive. In fact, the less attractive they are, the better. According to our government, this will help to save the money of the suffering public and will employ the plain who by virtue of their plainness would not be a distraction.

The expense of this will be borne by the public who will no longer have to endure the stupidity of medical doctors. As with many, if not most other costly government programs, this is predicted to save a lot of money. ■

WPS Selected for District Branches Best Practice Award

Developing Our Careers, Enhancing Our Leadership Skills, the WPS membership development and excellence initiative for early career psychiatrists and psychiatric residents, chaired by Dr. Eliot Sorel, was presented with the Honorable Mention award by the APA Assembly of District Branches' Best Practice Award Committee. The Award was presented to the WPS Delegation to the APA Assembly on Sunday May 4th. ■

Obituaries

Claus J. Dietze, MD, Life Member

Claus J. Dietze, 86, who specialized in Child and Adolescent Psychiatry in his private practice in Manassas and Falls Church, died Feb. 4, 2008 of complications of cancer at his home in Vienna, VA.

Dr. Dietze was born in Leipzig, Germany, grew up in Dresden, and received his medical degree from the University of Leipzig in 1945.

He was a physician in Munich after the war, practicing Internal Medicine and Pathology, and worked with an international refugee organization.

In 1952, Dr. Dietze immigrated to Norfolk, VA, where he did a surgical residency. Two years later, he moved to Mount Pleasant, Iowa to run a clinic affiliated with the state mental hospital.

In 1956, he moved to Winchester, Massachusetts to serve as a doctor at Metropolitan State Hospital in Waltham. Always interested in mental health, Dr. Dietze did a psychiatric residency at Harvard University and was Assistant Professor of Medicine at Tufts University.

Dr. Dietze moved to Vienna,VA in 1965 and practiced Psychiatry until 2006 and served on the staffs of Inova Fairfax and Prince William Hospitals.

Dr. Dietze was a life member of the American Society of Adolescent Psychiatry and the American Psychiatric Association and a member of the Northern Virginia Medical Society.

A daughter, Verena Hoag, died in 1998.

Survivors include his wife of 58 years, Edith P. Dietze of Vienna; three children, Holger Dietze of Chantilly, Ralph Dietze of Leesburg and Monika Dietze of Vienna; and eight grandchildren.

Bernard Angelo Nigro, MD, Life Member

Bernard Angelo Nigro, 73, of West Palm Beach, FL, formerly of Buffalo, NY and Alexandria, VA passed away unexpectedly on December 27, 2007.

Born on February 1, 1934, Dr. Nigro had a long and distinguished medical career. His most recent position was as Psychiatric Consultant to the VA Medical Centers in the southeast Florida area. He loved his work and especially enjoyed the opportunity to assist veterans of the Armed Services

Dr. Nigro was a graduate of Canisius College, Buffalo,NY and Georgetown Medical School, Washington, DC. He was a commissioned officer in the U.S. Navy and served aboard the Polaris class missile ship USS Observation Island.

He practiced Psychiatry in Alexandria, VA from 1968 - 1995. Dr. Nigro was Chairman of the Department of Psychiatry of Alexandria Hospital, was Clinical Professor of Psychiatry at Georgetown University Medical School, and School Psychiatrist at Episcopal High School in Alexandria.

Dr. Nigro served as a consultant to many other organizations throughout his career. Among his favorites were the Children's Hospice International and other hospices.

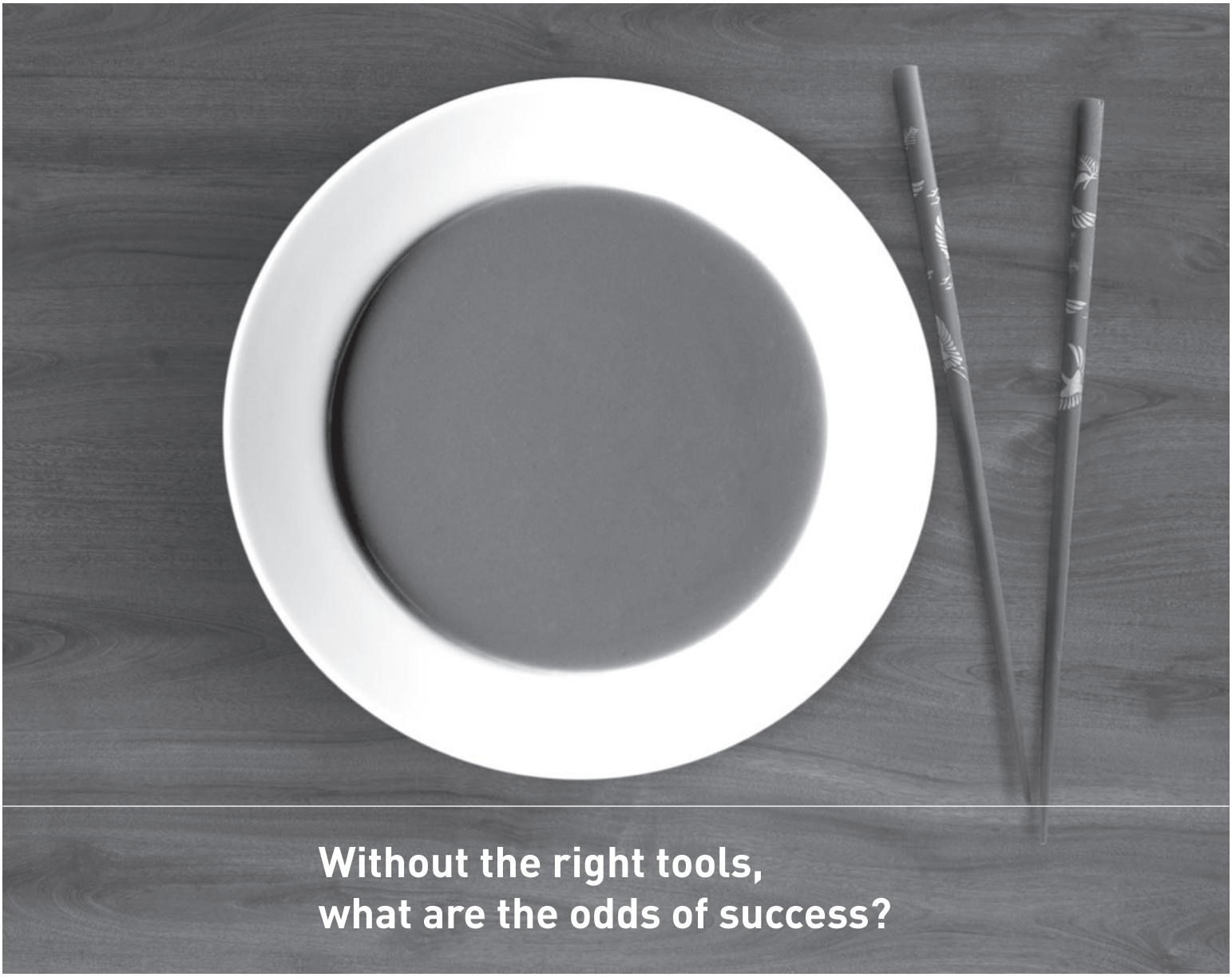
Bernie is remembered as kind and generous with a unique and sweet sense of humor and an endearing personality. He was much loved and will be missed by his family and friends. He is survived by his devoted wife, Cynthia Postula Nigro. His children: Barry Nigro and wife Stacey Sovereign; Nancy Redwine and husband Gene; Ted Nigro; Kevin Nigro and wife Eileen. His former wife Judy Nigro. His grandchildren, Andy and Alexis Delrio and Nicholas and Natalie Nigro. His sisters Marie Puliafito and Kitty Koscielny, his brother Anthony Nigro and many other relatives and friends. Those who wish may make a donation to Hospice of Palm Beach County, 5300 East Avenue, West Palm Beach, FL 33407, (561) 848-5200. ■

Ethics Alert

By Eleanor Sorrentino, MD

Information about ethical guidelines for psychiatric practice is available on line at the American Psychiatric Association Web site at www.psych.org. By clicking on "Ethics" one can download, free of charge," The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry." This publication is the core reference work for members of the Ethics Committee of the Washington Psychiatric Society in their deliberations on complaints that come before the committee.

"The Opinions of the Ethics Committee on The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry" is also available at the same site and may be downloaded as well. The latter publication is particularly useful since it provides an opinion in response to frequently asked questions on the ethicality of specific issues that may arise in clinical practice. Entering the word "Ethics" at the APA Publishing site, www.appi.org, yields more than 70 titles of books related to topics having to do with ethics and the practice of psychiatry. A book that might be of particular interest to residents and to those teaching ethics is "The Ethics Primer." The primer has a series of essays dealing with such issues as boundary violations, gifts, confidentiality, consultations and second opinions. In addition, the site www.psychiatryonline.org allows access to articles in a number of psychiatric journals. A specific topic relating to an ethical issue can be researched and entire articles or summaries can be obtained, again free of charge. ■



Without the right tools, what are the odds of success?

Many people who depend on public assistance are denied access to the most effective tools and treatments for mental illness. Instead of benefiting from newer, safer treatments, they are often forced to change medicines or wait for authorizations. Worse yet, some must go through a "fail-first" treatment in which they are first required to use older, cheaper medications, regardless of what is considered to be the most effective treatment.

The effects of such unsettling treatment patterns can be dramatic, triggering a pattern of deterioration that can be marked by unemployment, hospitalization, imprisonment, and even homelessness.

That's why Eli Lilly and Company continues to support open and unrestricted access to all available treatments for mental illness.

We believe that, to improve the odds of recovery, mental health professionals and their patients must be given the right tools.

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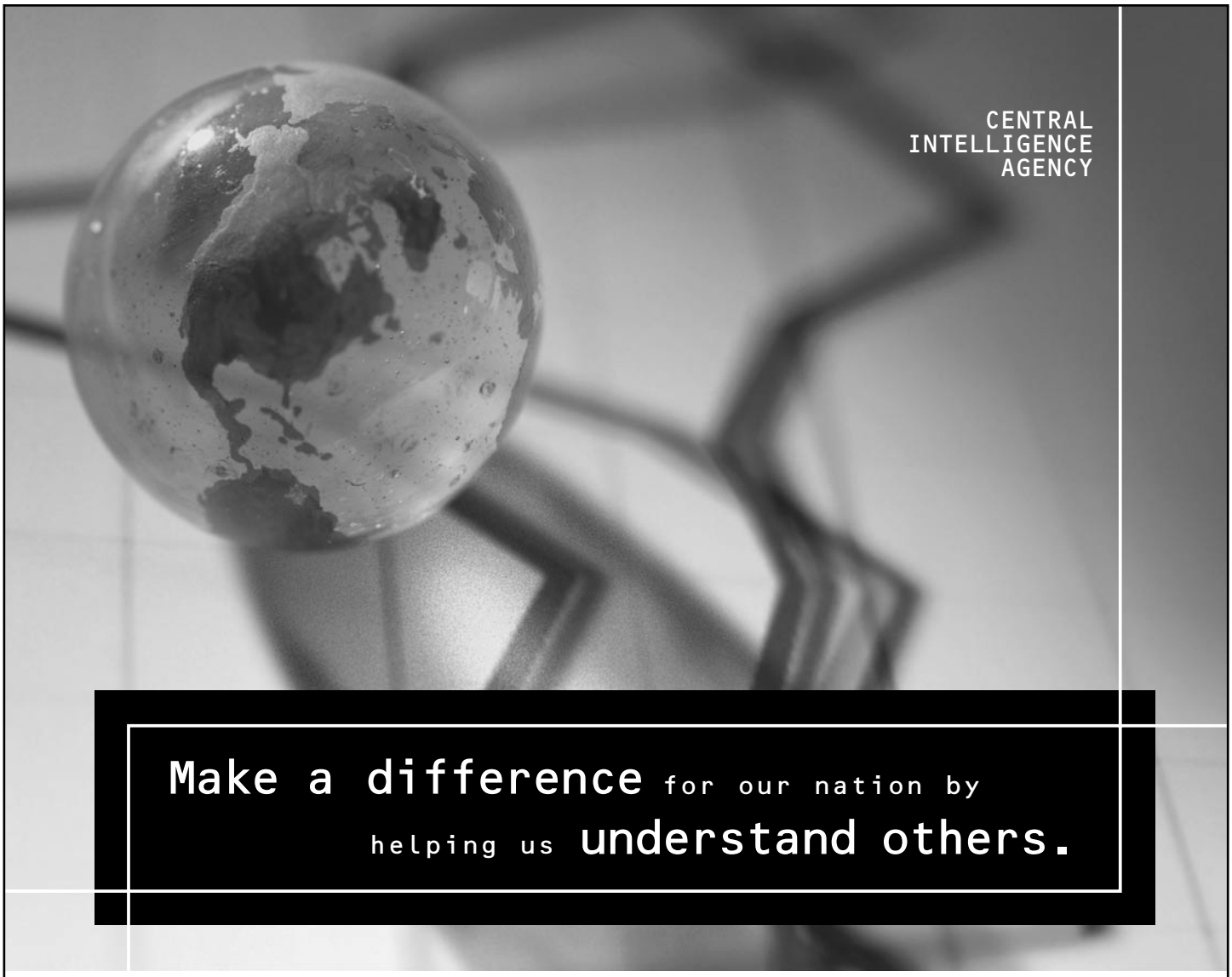

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For more information and to apply, please visit **www.cia.gov**

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Positions Available

The Psychiatric Institute of Washington (PIW), a 104-bed private psychiatric facility, is seeking four (4) Board Eligible/Board Certified Adult Psychiatrists to join our professional, stimulating environment serving Washington, DC and Prince George's County, MD. These psychiatrists would provide psychiatric services, including evaluations and medical management sessions for adult patients in three (3) inpatient and one (1) outpatient settings. We are also seeking Part-time and On-call Physicians.

Desirable qualifications include experience in the techniques of psychiatric diagnosis and treatment, including chemical dependency in an inpatient setting with a multi-disciplinary team-based approach.

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Interested candidates please send CV to Randy Kellar, Director of Human Resources, Psychiatric Institute of Washington, 4228 Wisconsin Avenue, N.W., Washington, D.C. 20016, by e-mail at rkellar@piw-dc-com, or apply through our website at www.psychinstitute.com.

Psychiatrist, Virginia License. Thriving Northern Virginia fee for service practice seeks psychiatrist to join multidisciplinary team for psychiatric consultations and medication management. Incoming psychiatrist will start with 100+ on going fee for service medication management cases with 5-8 new referrals per week. Psychiatrist who can see children, teens and adults is preferred. Position can be part or full time. Fax resume to (703) 723-4144 or call (703) 338-1138. You can review our agency and team biographies at www.ashburnpsych.com

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Defining Mental Illness
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part of many other criteria sets in the DSM-IV. If the DSM-V retains diagnoses of Not Otherwise Specified, we suggest that these diagnoses include that clause. In doing this, we can maintain some consistency in how we look at afflictions of the mind.

But, do we need to define mental illness in our diagnostic manual? General medicine seems to avoid developing an overarching definition of disease or illness. Why shouldn't Psychiatry? After all, our field is the most complex and multifactorial and we, as a part of medicine, can choose to follow our colleagues clinically and leave the rest to philosophers of medicine.

If the DSM-V retains some statement about "mental illness", we suggest that it be a description as simple as:

"An illness with behavioral, emotional, cognitive, or conative manifestations."

Our description removes the complexities of trying to comprehend what distress, disability, or dysfunction mean, and can be applied more consistently and universally. It could be argued that this would lead to "too many" people being seen as mentally ill . But, is not such an argument a function of stigma? After all, aren't all human beings sometimes medically ill? Why should psychiatrists fear a description of mental illnesses that implies they are generally common, even if some forms of mental illness are uncommon?

In summary, we would suggest that psychiatry be consistent with the rest of medicine in not defining "illness" and that we use a description of mental illness that is atheoretical, such as, "An illness with behavioral, emotional, cognitive, or conative manifestations." ■

APA Reports

APA, Mental Health Advocates Discuss Need for Medicare Parity

Urge Change of 50 percent Medicare Coinsurance Requirement for Mental Health Services

ARLINGTON, Va. (April 18, 2008) –The disparity of the 50 percent Medicare coinsurance requirement for mental health services reflects an outmoded benefit design on obsolete understandings of the nature of mental disorders and our ability to successfully treat people with these serious illnesses said American Psychiatric Association President Carolyn Robinowitz, M.D., during a Senate briefing held today by the APA and the Mental Health Medicare Equity Coalition.

The APA currently chairs the national coalition which is comprised of 15 national healthcare organizations representing patients, health professionals, health care systems and family members. The coalition advocates for parity coverage of mental health services in Medicare Part B.

Medicare Part B, the part of Medicare that covers outpatient care, does not provide parity coverage. While Part B covers 80 percent of the cost of most services, for most mental health care it only covers 50 percent of a patient's costs.

Legislation (S. 1715) sponsored by Senators Olympia Snowe (R-Maine) and John Kerry (D-Mass.) would phase the 50 percent coinsurance rate for outpatient mental health services down to 20 percent over six years. A companion bill (Seniors Access to Mental Health Act of 2007, H.R. 1571) has been introduced in the House. The Children's Health and Medicare Protection (CHAMP) Act bill (H.R. 3162), which passed the House in August 2007, contains a provision that would immediately drop the coinsurance rate to the usual rate that applies to outpatient services.

The 50 percent coinsurance policy according to the Coalition creates obstacles to care and increases costs. "Medicare beneficiaries have an elevated need for mental health services, and data points to the coinsurance requirement as a serious barrier to appropriate services," said Robinowitz. "Of those beneficiaries who use mental health services, use of outpatient services is comparatively low, while use of costly inpatient services is high. These data paint a dismal picture of the coinsurance policy: high-needs patients are kept from care and costs escalate."

The high coinsurance is a major barrier to needed services. According to Robert Roca, M.D., M.P.H., Vice President and Medical Director, Sheppard Pratt Health System, "Medicare was established to serve two vulnerable populations – the elderly and people with disabilities – groups that have high mental health needs. Ironically, the 50 percent coinsurance represents an unusually high barrier for people who have a particular need for mental health services," he said.

According to Roca, access barriers have resulted in large numbers of people not receiving the care they need. "Looking at older adults generally, the epidemiological evidence tells us that they are as likely as other adults to experience mental illnesses," he said. "Unfortunately, the implications of access barriers and untreated mental illness are serious and have resulted in large numbers of people not receiving the care they need."

In fact when you look at analysis of the Medicare program, it demonstrates a prevalence of mental disorders that is higher than that of the general population. In a 2006 review of prevalence data researchers at the George Washington University found:

- 26 percent of Medicare beneficiaries have mental disorders, compared to 21 percent of the general population. (is that significant)
- 59 percent of Medicare beneficiaries with disabilities have a mental disorder, and 37 percent of them have severe disorders.

In 2002, the federal Center for Mental Health Services reported on this treatment gap in Medicare. It found that 85.5 percent of Medicare beneficiaries 65 and over who needed mental health treatment did not receive it. For beneficiaries under 65, 64 percent were unable to receive needed services due in part to limited outpatient treatment and high cost sharing.

Other featured speakers at the briefing included Ron Manderscheid, Ph.D., Director of Mental Health and Substance Use Programs, Constella Group; and, David Shern, Ph.D., President and CEO, Mental Health America. ■

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