from my lips. I struggled to maintain composure during that sad period of my life. Often engulfed by tension, I used the following “system of comfort” to reduce the stress:

Whenever I found my shoulders tightening or my legs aching, I did relaxation exercises, and I talked to myself out loud about accepting the worst and moving on. When I thought of going to jail, I countered with, “The worst is that I will go to jail. Well, Gandhi went to jail. If I have to, so be it. Murderers start a new life after incarceration. I will do that too.” I did not realize that I had broken any laws, and there was no chance of me going to jail.

When I thought about losing my medical license, I told myself, “There are many people who are not doctors. They live full lives. I can open a 7-Eleven store.” My mantra became, “I will cross the bridge when I see the bridge.”

Whenever I felt that I was projecting my anger onto my patients, I would say, “I am generalizing. It is unfair to the innocent others.” I repeated my concept of the serenity prayer so that I could focus on things that were in my control: “May I have the serenity to accept that I have no control over the outcome of the suit. Let me have courage to continue my practice, serve my patients, earn money, and prepare for the suit. Let me have wisdom that the lawsuit is not in my control, but my ability to fight is under my control.”

The trial

The attorney invited me to prepare for the trial. “Do you have time?” he asked. “Yes, it is 2 PM,” I answered. He returned, “I did not ask what the time is. Your response should be ‘Yes, I have the time.’ If I ask, ‘What is the time?’ You should say, ‘2 PM.’ Do not give more information than what he [the opposing attorney] asks. You may be giving self-incriminating answers. I will be listening. If there is a fact that you need to clarify, I will ask later.”

Jury selection was completed, and the trial began in mid-2009. The plaintiffs had a lawyer, and the hospital and I (the defendants) had separate lawyers. A couple of days were spent going over the case with the judge to come up with an opening statement. The three lawyers agreed on the following statement: “Mr Kulik jumped out of the window and died.” The lawsuit would decide whether the hospital and the doctor did their jobs.

Engineers gave testimony about the window—its quality and manufacture. The patient’s sons and wife, the internist, the nursing director, and the nurse in charge gave testimony. The latter had visited Mr Kulik every hour that night up to 40 minutes before he was discovered missing. They all said that Mr Kulik had been improving, and there were no talk or behavioral changes to alert anyone of a problem. When it was my turn to take the stand, I was determined to remain consistent in my testimony. During the testimony:

• I kept a pleasant disposition in spite of my inner anxiety.
• I answered in lay language: I used my knowledge about bipolar disorder, suicidality, and interviewing, and I made sure that what I said did not conflict with the hospital chart, form C (3), and my deposition.
• I looked straight into the eyes of the lawyers, except when I was asked to explain to the jury; I then made direct eye contact with the jurors.
• The plaintiff’s attorney asked, “Why didn’t you ask Mr Kulik about suicide?” I explained and enunciated the inappropriate affect, talk, and facial expressions of Mr Kulik. Thus, I showed the jury that Mr Kulik was not capable of giving reliable answers to my questions.
• I recorded the duration of my consult and follow-up visit on the hospital records. It was my practice for billing purposes and for Medicare audit. That habit proved to be a blessing. On the first day, I spent 55 minutes with the patient and on the second day, 25 minutes. The plaintiff’s attorney could not harass me about my short notes when he saw those numbers.
• My attorney confirmed that the statement “My father likes you; I will like to bring him to you after discharge from the hospital,” was made by the patient’s son during his testimony.

The jury deliberated. I was unsure whose side made more sense to the jury and worried about their decision. Finally the verdict came in: the hospital was found negligent because a nurse had seen a faulty window but did not report it and get it repaired in time. I was found not guilty of negligence.

I left the building. I wanted to celebrate by shouting with joy; however, I kept the dignity of a doctor. The family was standing outside in the parking lot. They saw me coming, the son approached me, and he said, “You are a good doctor, but we had to do this. He was our father you know?”

I wanted to yell at them and curse them for wasting 4 years of my life. I thought that they did not have to apologize, but they did. It was my turn to be gracious. I said, “Understand, but it was very hard on me.” All of them smiled wishing me good-bye. I moved on.

Eight days later, I received a letter. “Ordered that a judgment be and is hereby entered in favor of the defendant, Harish Malhotra, MD, and the complaint be and is hereby dismissed with prejudice and without costs.”

The dismissal was “with prejudice,” which was significant. It meant that the matter can never be reinstated against me anytime in the future, for any reason.

The following are some lessons I learned from this suit:

• The service you have provided is the one that you document; if it is not documented, you did not perform it. Always record the amount of time you spent with the patient.
• Make it a habit to question all patients about suicidality, violence, and adverse effects—and document that you did; if they are present, document a rational reason for your decisions, actions, or inactions.
• In your record, use the word “because” frequently; it conveys that you are reflective and rational.
• Dictate records and work hard to improve your handwriting—it is embarrassing when you cannot read your own writing.
• Be sure that all collateral information and its sources are included in the record.
• A lawyer is your best friend during a lawsuit—you are very lucky if you get a good one.
• Please read about malpractice to learn precautions that you need to take and ways to deal with a malpractice suit.

Dr Malhotra is Clinical Associate Professor at Rutgers New Jersey Medical School in Newark. He reports no conflicts of interest concerning the subject matter of this article.

Acknowledgment—I am thankful to the US judicial process for its fairness.

COMMENTARY

Correcting Psychiatry’s False Assumptions and Implementing Parity

by Eric M. Plakun, MD

It is a source of shame for our nation that for most Americans in need—especially those with serious mental illness—the mental health system is dysfunctional. Provision of population mental health services is a complex systems issue that requires multiple stakeholders to work in partnership to improve it. Federal and state governments (as funders of both care and research), clinicians, hospitals, accountable care organizations, and insurers, as well as patients and their families, are key stakeholders. Only the federal government has authority to convene all of the former, but Washington’s current dysfunction makes this unlikely. Nevertheless, we can fix some of the ways the system is broken. I will focus here on 2 critical areas—the paradigm of clinical care and implementation of parity.

Psychiatry’s false assumptions
Psychiatry clings to 3 false assumptions despite evidence to the contrary, and psychiatrists, our patients and their families, and our nation pay a price as a result. The assumptions are that:

• Genes = disease
• Patients present with single disorders that respond to single evidence-based treatments
• The best treatments are pills

**Genes = disease**
Mental disorders are clearly heritable. Molecular genetic research teaches us that there are 2 kinds of genes—those that make proteins and those that regulate other genes, often in response to the environment. We hoped that sequencing the human genome would lead to identification of the genetic underpinnings of mental disorders, but genes turn out to be rough plans rather than detailed blueprints for an individual.

Over 125 relevant genetic loci have been identified in schizophrenia, which indicates that heritability of this and other psychiatric disorders is far more complex and multifactorial than we expected. Single nucleotide polymorphisms (SNPs) are associated with some cancers, type 2 diabetes mellitus, and inflammatory bowel disease. Genome-wide association studies of depression were unable to find meaningful SNPs that illuminate genetic underpinnings of this common disorder.¹ No biomarkers for depression have been found, and the search for them has been likened to that for the Holy Grail.

Meanwhile, Tully and colleagues² offer us a glimpse of the importance of environmental factors in depression by demonstrating that mothers who are depressed during childrearing often have depressed adolescents—whether their children share their genes or are adopted. Other studies of early adversity demonstrate that it is a veritable “environment marker,” associated with a high risk of mental illness, substance use, and medical disorders—not just with PTSD.³

Emerging evidence shows us that disease is not simply encoded in genes, but that gene-by-environment interactions (“epigenetics”) are central in understanding disorders. Yet as a profession, psychiatry has shifted toward what former APA president Steve Sharfstein called in his presidential address the “bio-bio” model. Many in psychiatry have moved away from and some times deride the biopsychosocial model. Ironically, this has happened as the above evidence from genetics has cautioned us to take environmental factors more seriously. Numerous studies demonstrate the effectiveness of psychodynamic psychotherapy and CBT for multiple individual and complex comorbid disorders—with the ability to distinguish therapy responders from non-responders on imaging.⁴

The assumption that disease is all about genes and biology does help reduce blame and stigma. Nevertheless, the assumption doesn’t fit the evolving data, and clinging to it risks crippling our ability to understand and treat our patients’ problems in nuanced and sophisticated ways that attend to biological and environmental factors in a “both/and” rather than “either/or” model. After all, another way to say “epigenetics” or “gene-by-environment interactions” is “biopsychosocial.”

**Patients present with single disorders that respond to single evidence-based treatments**
Our practice guidelines and our randomized trials assume that most patients have single disorders that respond to evidence-based treatments—especially in carefully selected non-comorbid patient samples. Yet, clinicians know from practice-based evidence what the research evidence shows: most patients have multiple comorbid disorders and failure rates for our best treatments are high.

For example, in depression, 78% of patients in the large STAR*D sample presented with comorbidity or suicidal ideation that would have excluded them from randomized trials; however, these comorbid patients had lower response to treatment and lower remission rates.⁵ So if you feel, as many clinicians do, that the patients you work with are sicker than those a drug was tested on, you are right about 4 times out of 5.

Again using depression as an example, we are learning how important comorbid personality disorders are to treatment outcome—especially comorbid borderline personality disorder (BPD). The large, multisite Collaborative Longitudinal Personality Disorders Study (CLPS) concluded that the presence of personality disorders, especially BPD, “robustly predicted persistence” of MDD, suggesting diagnosis and treatment of personality disorders are essential in treating depression lest it become treatment-resistant.⁶

However, in our focus on the medical model, personality disorders...
Implementing Parity

Continued from page 57

orders are underdiagnosed. In DSM-IV, the most frequent Axis II diagnosis made was “deferred,” and there is no reason to think this will change with DSM-5. Biological tunnel vision can lead to missing the reality of clinical complexity and interfere with provision of optimal patient care.

The best treatments are pills

We have overestimated the efficacy of antidepressants by about a third when all studies are considered, and 75% of antidepressant effect is placebo effect. 14 The CATIE schizophrenia study showed that patients do not find that the benefits of our pills outweigh the adverse effects. 15 Our pills work, but not as well as we might hope, while the effect sizes of psychotherapy studies are actually larger than those for medications. 16 In some disorders, the combination of psychotherapy and medications is superior to medications alone, and when early adversity includes sexual abuse, medications may add little to the outcomes achieved with psychotherapy alone. 17

Psychiatry has refined skills in diagnosis and prescribing medications as defining characteristics. If we take seriously the message that genes and environment matter in the causation and treatment of disorders, we will need to focus much more on training in and the practice of psychosocial factors in the causation and treatment of mental disorders is the unfunded APA Psychotherapy Caucus. The Caucus originated in 2014 as a grassroots effort by a dozen APA members concerned that the APA leadership saw no reason to establish or fund such a group within its Components. The Caucus has grown from 12 founding members in early 2014 to over 200. All interested psychiatrists are invited to join by contacting me at Eric.Plakun@austenriggs.net.

Psychiatry would be well advised to rethink its identity and to reaffirm the biopsychosocial paradigm to improve patient care. Attending to the importance of psychosocial or environmental factors also means taking more seriously the contributions of psychoanalytic theory, which has studied environmental influences for over a hundred years and, as Nobel laureate neurobiologist Eric Kandel 18 stated, offers the most nuanced and sophisticated model of the mind that we have.

Psychoanalytic psychiatry, which is the intersection between general psychiatry and psychoanalytic theory, deserves renewed attention as part of fixing a broken system. This does not mean offering individual psychoanalysis to more patients, but it does mean including psychoanalytic perspectives in our work with patients. This can occur through the practice of “psychodynamic psychopharmacology” that attends to the meaning effects as well as the neurochemical effects of medications, through knowledge of individual and group dynamics and defense mechanisms to help psychiatrists be better therapists and better treatment team leaders, and through faithful attention to the authority, agency, and competent voice of the patient in negotiating an alliance and in treatment. 19

Psychoanalysis is not the only psychosocial treatment worth our attention. CBT, DBT, and other behavioral therapies, as well as group and family therapy, have much to offer. Attention to common factors shared by evidence-based behavioral and psychodynamic therapies offers hope of training those psychiatrists who will never master a manualized therapy to better treat difficult patients, such as suicidal patients with BPD. 14,15

There are more issues that must remain unaddressed here, such as future directions in diagnosis and why the NIMH spends the vast bulk of its research dollars studying with 88.7% of physicians in other medical specialties. 14 The data further revealed significantly lower Medicare and Medicaid acceptance rates among psychiatrists than physicians in other medical specialties. Low rates of reimbursement for mental health services; quantitative limits, such as annual limits on numbers of sessions or dollars available for care; and non-quantitative limits, such as utilization review hurdles for prior authorization account for much “opting out” of the system of care.

Though understandable given the context, these high “opt out” rates are a national embarrassment. The Mental Health Parity and Addiction Equity Act (MHPAEA, or parity law) offers hope of a remedy, since it forbids quantitative or non-quantitative mental health care limits more restrictive than those in medical and surgical care. For persons with diabetes mellitus, arbitrary annual limits in the number of office visits or dollar limits for services would be unthinkable, but such limits are often imposed for people with mental disorders.

Similarly, the managed care stance that patients with mental disorders should be treated either as inpatients or outpatients, with no access to intermediate levels of care (such as residential treatment), seems inconsistent with parity legislation. Would a man with a stroke be told that once he was no longer in need of acute inpatient treatment, he had to return to outpatient treatment, with no access to intermediate levels of care to begin to learn to speak, walk, and resume self-care?

Despite parity legislation, many insurance companies continue to deny access to care based on such arbitrary exclusions. Successful legal challenges can establish case law fully implementing mental health parity. The good news is that such lawsuits, some as class actions, are under way and are gaining traction.

In December 2014, the CBS show 60 Minutes devoted part of an episode to a lawsuit (Wit et al v United Behavioral Health) about arbitrary denial of residential treatment to patients with complex comorbid mood, eating, and substance use disorders. The segment made clear the devastating consequences to seriously ill patients of a pattern of reflexive denial of care by managed care reviewers. In another class action suit (Craft et al v Health Care Service Corporation) in March 2015, the judge ruled against the insurance company’s motion to dismiss, which claimed the lawsuit lacked merit because the insurance contract specifically excluded residential care. The ruling is promising to the plaintiffs because it means the judge sees exclusion of residential treatment as a non-quantitative limit prohibited by parity. Other cases hold managed care organizations accountable for other quantitative and non-quantitative limits on care. Their outcomes have the potential to force reform of egregious managed care practices that are part of what is broken in our mental health system.

Together our voices matter. Please consider joining “Biopsychosocial Matters,” for discussion of issues such as these at www.meaningmatterscommunity.org.

Dr. Plakun is Associate Medical Director of and Director of Admissions at the Austen Riggs Center in Stockbridge, Mass. He was a Harvard Medical School clinical faculty member for over 20 years. Editor of two

(Continued on page 60)

(0x0)
Implementing Parity
Continued from page 58

books, including Treatment Resistance and Patient Authority: The Austen Riggs Reader (WW Norton & Company, 2011), and author of over 40 published papers and book chapters, he has presented widely in the US and overseas. Dr Plakun is a Distinguished Life Fellow of the American Psychiatric Association, Past Chair of its Committee on Psychotherapy by Psychiatrists, and founding leader of its Psychotherapy Caucus. He is a past member of the APA Assembly Executive Committee, and Past Chair of the Assembly Task Force on Psychotherapy by Psychiatrists. Dr Plakun is a Psychoanalytic Fellow of the American Academy of Psychoanalysis and Dynamic Psychiatry and a Fellow of the American College of Psychoanalysts and the American College of Psychiatrists. He has been hon- ored as the Outstanding Psychiatrist in Clinical Psychiatry by the Massachusetts Psychi- atric Society.

References


CLINICAL

Intellectual Disability and Psychiatric Comorbidity: Challenges and Clinical Issues

by Kimberly Kendall, MBBCh and Michael J. Owen, PhD, FRCPsyCh

Intellectual disability (ID) is the impairment of general mental abilities, which affects an individ- ual’s functioning in everyday life. According to DSM-5, ID has an impact on 3 broad domains in a person’s life: conceptual (eg, language and memory), social (eg, empathy, social judgment), and practical (eg, personal care, money management).1 Individuals with ID have a higher risk of psychiatric disorders than in- dividuals with intelligence in the normal range: prevalence is as high as 40.9% based on clinical diagnosis and 15.7% based on DSM-IV-TR.2 When specific ID diagnostic criteria are used (diagnostic criteria for psy- chiatric disorders for use with adults with learning disabilities [DC-LD]), the most common comorbid psychiatric disorders are problem behavior (18.7%), affective disorder (5.7%), autistic spectrum disorder (4.4%), psychotic disorder (3.8%), and anxiety disorder (3.1%).2

Problem/challenging behavior is heterogeneous and its assessment and management are beyond the scope of this article. The focus here is on the comorbid presentation of affective and anxiety disorders, psy- chotic disorder, and autism spectrum disorder.

Challenges
Specific challenges in the field of ID can make the diagnosis of comorbid psychiatric disorders difficult. In- dividuals with ID can experience communication difficulties that vary from problems expressing psycho- logical experiences to being unable to produce speech. As may be ex- pected, this results in an under- reporting of psychiatric symptoms. Clinicians must be aware of this and be alert to this when conducting assessments.

Affective and anxiety disorders
Affective and anxiety disorders occur in individuals with ID at a rate of around 5.7% and 3.1%, respectively.3 In addition to the classic symptoms seen with these disorders, their atypi- cal presentation can include features such as aggression and self-injurious behavior.

In a study on depression symp- toms in individuals with ID, Es- Benson and Benson4 found that those with MDD and ID had a more nega- tive attributional style and lower self-esteem. We have found that because of the often challenging nature of diagnosing depression in individuals with ID, clinicians frequently find themselves relying on the biological symptoms of depression for diagnos- is: sleep and appetite disturbance, poor concentration and memory.

Mayville and colleagues5 found that persons with depression and ID had a lower food intake than those with ID who were not depressed.

A review of rapid cycling bipolar affective disorder found that hyper- somnia occurred in 70% of sleep- disturbed depressed patients with ID.3 There is little literature on the presentation of mania in individuals with ID. In their review of rapid cycl- ing bipolar affective disorder in persons with ID, Vannata and Tyer found that mood states were generally described in terms of ob- servable behavior rather than affective state. They found that signs of manic episodes typically included insomnia, increased activity, pres- sured speech, and agitation.

Because of the lack of randomized controlled trials for the man- agement of anxiety, depression, and bipolar affective disorder in persons with ID, recommended pharmacological options do not differ signifi- cantly from those for individuals with intelligence in the normal range. It is worth emphasizing that efforts should be made to identify and manage potential precipitating and perpetuating factors (eg, change in environment, disrupted sleep).

© ABSTRACT/SHUTTERSTOCK.COM