

## MIND AND CULTURE | Psychiatry's Missing Diagnosis

# Better Tailored Treatments Could Improve Outcome

PSYCHIATRY, From A10

Springfield.

Mainstream psychiatrists say such examples are interesting but insist that the field stay focused on biology and brain chemistry. That is the only way to integrate psychiatry with the rest of medicine and to produce objectively verifiable treatments, said Regier, of the American Psychiatric Association.

"If you had to choose between a Western model of diagnosis and treatment and, let's say, an ayurvedic treatment model, what would you take?" he asked, referring to a traditional system of healing in India. "Whether with AIDS therapy, which the South Africans resisted, or psychotropic medicines, there is something objectively superior to a medical model of treatment of psychiatric illness."

## A Common Vocabulary

Through much of the 20th century, the long shadow of Sigmund Freud hung over psychiatry. Just as doctors today talk about serotonin and brain structures such as the amygdala, doctors at mid-century evaluated patients through the lens of Freudian concepts such as transference and repression. Without common definitions of the symptoms they encountered, psychiatrists often disagreed over what ailed their patients. Show a patient to 10 psychiatrists, the joke went, and you would get 10 diagnoses.

In response, Columbia's Robert Spitzer led efforts to update American psychiatry's manual of mental disorders in 1980 and again in 1987. Experts drew up lists of specific symptoms associated with particular mental disorders — and gave the field a common lexicon. The "Diagnostic and Statistical Manual of Mental Disorders," commonly known as DSM, became the bible of the medical model of psychiatry.

Yet, as Spitzer readily acknowledged in a recent interview, the DSM classifications did not rest on new scientific data.

"The DSM is not a scientific document," Spitzer said. "It is a bunch of smart people who studied the literature and then came up with the best way to define diseases — very few of the categories have an empirical base." As doctors wrestled with overlapping symptoms, he said, subsequent editions greatly expanded the number of disorders: "It is not a scientific document, but it facilitates science."

Spitzer said he had never oversold the scientific credentials of the manual. But powerful factors heightened its prominence.

Drugs were shown to help patients with various symptoms, yielding hard data that most talk therapies and social interventions could not readily produce. Neuroscientists showed that many mental disorders had genetic components.

Insurance companies found that paying for pills was cheaper and simpler than paying therapists to address the interpersonal causes of suffering — especially because general physicians could write most of the prescriptions. Patient advocates realized that defining mental illnesses as brain diseases reduced the stigma attached to depression and psychoses — a patient could hardly be blamed for having an organic disease.

Then came Prozac. Introduced in 1988 and backed by aggressive marketing, the drug brought relief to millions and popularized the notion that depression was essentially an imbalance in brain chemistry. In short order, Prozac and other psychiatric drugs began grossing billions of dollars. Millions flowed back into television advertising, marketing to doctors and grants to organizations that supported the treatment approach.

"The pharmaceutical industry didn't create the notion of the biological revolution in American psychiatry, but it hijacked it," said Lawrence Diller, a pediatrician in Walnut Creek, Calif., and the author of "Running on Ritalin."

While defending the rise of biological psychiatry, Spitzer said his field had tried to accommodate cultural nuances. The newest versions of the diagnostic manual do include references to the role of cul-

ture, he noted. One section describes conditions that affect only small groups of people, such as "ataque de nervios," the very condition — limited to Latinos, especially from the Caribbean — that afflicted the woman whom Lewis-Fernandez treated in Cambridge.

But while the section on cultural formulations had a constituency, Spitzer said it lacks scientific support: "They insisted that these things are being ignored, so it is there, but I doubt it is used very much. I don't think the people who have developed that have done any studies to show its value. That's the difference between critics of DSM and us."

Regier, at the psychiatric association, said some advocates of cultural competence deserve credit for trying to marry cultural insights with epidemiological studies, but others are unscientific.

"You've got the cultural people who don't know how to do statistics and say you must only study individuals," Regier said. "That's like the psychoanalysts who say, 'I can't replicate it but I know it works' — it is not a scientific discipline."

## 'Hardly Objective'

Advocates for culture's role in psychiatry say such criticism is disingenuous — because it suggests the medical model itself is objective and free of bias. They point out that doctors cannot examine two brain scans and tell which belongs to a healthy person and which belongs to a patient with schizophrenia, or depression, or bipolar (manic-depressive) disorder, let alone the hundreds of other disorders in the diagnostic manual.

"Psychiatry is hardly objective," Columbia psychiatrist Oquendo said. "The instrument in psychiatry is the doctor. You talk to people in making diagnoses — how can you say that's objective? We don't have a lab test to make a single diagnosis."

Despite its limitations, the cultural advocates say Spitzer's diagnostic model has acquired the status of gospel. Psychiatrists are too focused on fitting patients into Spitzer's categories, said psychiatrist Keh-Ming Lin, "instead of finding out from the patient where they are coming from."

"Whatever doesn't fit gets ignored, and whatever doesn't lead to medications gets ignored," Lin said.

Here and there, the advocates have made inroads. In 1999, a U.S. surgeon general's report concluded that the effects of culture on mental health "have been historically underestimated — and they do count."

Prodded by advocates, professional organizations have added discussions of the role of culture to their meetings, and accrediting groups mandate that young doctors study how ethnicity and culture affect illness and treatment.

Insurance companies have also shown interest, said Arthur Kleinman, a psychiatrist and anthropologist at Harvard. Some HMOs, for example, have encouraged immigrants to seek out doctors who speak their native tongue. Kleinman and others welcome such moves but also worry they sometimes amount to lip service: HMO demands for efficiency, for example, have limited interactions between doctors and patients. Discussing cultural issues with a patient might add five minutes, Kleinman said, and "that's five minutes beyond an interview that usually lasts five minutes."

Driven by social, economic and technological forces, the reductionist medical approach to psychiatry is increasingly the norm around the world. Clinicians in distant countries are grappling with Spitzer's classifications in the same way that the theories of Freud once traveled from the parlors of Vienna to New York and Washington.

"What is happening with neurobiological therapy is the same thing that happened with psychoanalysis in the 1950s," said Renato Alarcón, a psychiatrist at the Mayo Clinic, referring to those who once believed Freudian therapy held all the answers.

"When science becomes a religion, it becomes scientism," he said. "There are fundamentalists among the scientists."



Justina Arapahoe, 19, adorns her hair for a naming ceremony in Rapid City, S.D. A Lakota healer says that traditionally, children are given tribal names at birth. Those who do not have such names are believed to lack a strong foundation for mental health.



Bradley Randall, 16, has a snack of pemmican during the ceremony. Ethleen Iron Cloud-Two Dogs, a healer at the Pine Ridge reservation, says a Lakota name is part of the federally funded care plan. "We look at Lakota mental health needs in a holistic way," she says.



Monique Giago prepares Justina Arapahoe for the ceremony, at which she is named Oyate Iyuskiyan, "She Makes the People Happy." The woman at right is unidentified.

PHOTOS BY JOHNNY SUNDBY FOR THE WASHINGTON POST

# Healers Prescribe Tribal Tradition

'White Man's Medicine' Is Secondary to Time-Honored Customs

By SHANKAR VEDANTAM  
Washington Post Staff Writer

When a chronically depressed 9-year-old girl at the Pine Ridge Indian Reservation in South Dakota became so sad that she stopped eating, Ethleen Iron Cloud-Two Dogs came up with a treatment plan: a spiritual assessment, followed by a healing ceremony at a Lakota purification lodge that represents the womb.

"There is a hole dug in the middle and rocks that are heated," she said. "Because we believe that everything has a spirit, rocks are addressed as grandfather spirits. The water is taken in and poured on the rocks — the steam that results is the breath of the grandfathers which then purifies and renews us."

Over the next three months, the girl recovered, said Iron Cloud-Two Dogs, who treats emotionally disturbed and suicidal children at a federally funded Native American mental health program called Nagi Kicopi, "Calling the Spirit Back." The healer dismissed those who demand evidence that her techniques work — or the notion that the girl should have been treated with antidepressant drugs.

"They will say, 'Where's the proof, where's the research base, how can you document this?' — all the Western aspects of clinical interventions," she said. "We understood from the beginning that we would get those reactions, so our stance is, 'We are Lakota people and these are Lakota children, and we will use the methods that have worked for thousands of years and that's all there is to it.'"

Nagi Kicopi is only one example of a deep divide between mainstream psychiatry's approach to mental disorders and subcultures with very different notions of why people become emotionally disturbed and how they can be cured.

Many Native American patients rebel against the notion that mental illnesses are

primarily brain disorders to be treated with drugs, said several experts who work with such patients. Native tribes volunteered for drug studies in the 1950s, '60s and '70s, but they saw very little benefit and are now reluctant to participate in such research, said Spero Manson, a psychiatrist at the University of Colorado.

"Native communities feel they have been used as guinea pigs for research purposes to support the agenda of the biomedical world," he said.

They might be willing to volunteer for research again, he added, but it would have to be for science they believe is relevant and that is respectful of native traditions. Some demand that traditional healing techniques be studied alongside drug-based treatments, but pharmaceutical companies, which conduct most drug studies, are not interested.

William Lawson, chairman of psychiatry at Howard University, said the lack of data is troubling because suicide rates are high in some Native American communities: "You would think there would be studies on depression."

Lawson is one of the scientists who has received grants from the National Institutes of Health to increase the participation of minorities as research subjects in clinical trials.

Other clinicians are devising novel ways to bridge the gap between mainstream and traditional approaches. Iron Cloud-Two Dogs's healing program includes a psychotherapist, she said, but the "Western" therapist takes a back seat to traditional healers.

Anthony Dekker, who directs community health care at the Phoenix Indian Medical Center in Arizona, recalled treating one Native American patient who was psychotic. When she refused to take medication — she called it "the white man's medicine" — Dekker asked her to consult a traditional healer.

"The medicine man listened to her and

said, 'You live in the white man's world and you have a white man's disease and you need to take the white man's medicine,'" said Dekker, in an interview. The woman agreed to take the drugs.

"If I said, 'Don't go to the medicine man, he has never been to medical school' — that would alienate 90 percent of my patients," Dekker added.

Reconciling the brain disease model of mental disorders with America's increasingly diverse cultural fabric is more than a matter of gaining patient trust.

A host of small studies has shown that psychiatric drugs do not have the same risks and benefits in every ethnic group: Research showed that Caucasians experience twice the side effects of Hispanics from the antidepressants Prozac and Paxil, said Michael Smith, a psychiatrist at the University of California at Los Angeles. And with an earlier class of antidepressants called tricyclics, Hispanics given half the dose had twice the side effects of Caucasians.

Blacks on some anti-psychotic drugs seem more likely than whites to suffer tardive dyskinesia — repetitive, involuntary movements. Another study found that Asians who got half the dose of an anti-psychotic drug responded better than Caucasians who received the regular dose.

Some patients have avoidable side effects, Smith said, because "standards were developed in Caucasians and were inappropriately extended to other ethnic groups."

Smith and other advocates for "cultural competence" point out that substantial differences also exist among individuals within each ethnic group. Because of the lack of systematic data about variations in drug effectiveness, Smith advises doctors to tailor drug dosages to individuals:

"Most drug companies don't acknowledge the fact that their medications require individualized dosing, because when you say that, it makes it much more difficult for the average doctor to say one dose fits all."

## An Untested Aspect

Few minorities have been included in psychiatric drug trials, leaving doctors in the dark about how risks and benefits vary in different groups, a UCLA review found in 2000.

PSYCHIATRIC DRUG TRIALS FOR . . .	NUMBER OF PATIENTS	PERCENTAGE OF PATIENTS WHO WERE MINORITIES	NUMBER OF MINORITIES			
			BLACKS	HISPANICS	ASIANS	NATIVE AMERICANS
Depression	3,980	3.9%	150	2	2	0
Schizophrenia	2,865	14.6%	376	40	3	0
Attention deficit disorder	1,657	11.0%	126	55	1	0
Bipolar disorder	825	3.9%	32	0	0	0

SOURCE: UCLA's Research Center on the Psychobiology of Ethnicity

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