Massachusetts Psychiatric Society

your information source for psychiatry in Massachusetts

Issue 142 March 2014

www.psychiatry-mps.org

FROM THE PRESIDENT

Janet E. Osterman, M.D., M.S.

Come Celebrate Our 50th Anniversary

The Massachusetts Psychiatric Society will celebrate its 50th anniversary on April 30, 2014 and I hope that you will join us! As with all Golden Anniversary's, this event has much meaning and requires thoughtful planning with the hope that all will attend and enjoy the celebrations. The three primary plans to achieve are: the date, the place, and the keynote speaker. The date is always easy as it is pre-determined by the anniversary. The next task is to find a place to celebrate that has special meaning to most members and a significant link to the organization. The final task is the selection of a speaker, preferable someone who has made major efforts to promote the interests of the organization through public service or organizational leadership, or someone who knows deeply the suffering and needs of those who have had or recovered from mental illness and/or substance use disorders through his or her personal experience or family life.

The location for our 50th anniversary is the John F. Kennedy Presidential Library and Museum in Columbia Point, Boston. This selection recognizes that the birth of MPS came in the same year as President Kennedy's Community Mental Health Centers Construction Act or more commonly called the Community Mental Health Act that heralded a new era in mental health care delivery. Celebration of two significant events that impacted the practice of psychiatry in Massachusetts will be blended with our 50th Annual Meeting celebration.

The John F. Kennedy Library as the venue pays tribute to the dream that President Kennedy articulated for those suffering mental illness and mental retardation (now referred to as intellectual disabilities). His vision, presented to the nation on February 5, 1963, described a society that strove to move institutionalized patients to a meaningful life in the community. This eloquent speech set the stage for two bills that were to forever change the approach to helping people with mental illness and intellectual disabilities, the Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act (October 24, 1963) and the Mental Retardation and Community Mental Health Centers Construction Act (October 31, 1963) (1,2,3). These bills began the evolution of a series of subsequent federal and state bills to address the inequities in care for citizens with behavioral health (the umbrella term for the expanded focus on psychiatric disorders and substance use disorders) and intellectual disabilities.

In this pivotal speech President Kennedy defined the plight of people with mental illness and intellectual disabilities. Selected quotes reflect not only his eloquence but his compassion and commitment to care of these marginalized citizens (see Reference 2 for the complete speech).

> "mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition." "Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial State institutions. The average amount expended on their care is only $4 a day--too little to do much good for the individual, but too much if measured in terms of efficient use of our mental health dollars." "But the anguish suffered both by those afflicted and by their families transcends financial statistics." "This situation has been tolerated far too long. It has troubled our national conscience--but only as a problem unpleasant to mention, easy to postpone, and despairing of solution." "Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release."

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Auralyd Padilla, M.D.

Four years ago I found out that I was moving to Massachusetts. Aside from the change in weather, it did not seem that daunting at the time to think of "jumping the puddle", as we say back home. One of the issues that were pressing in my mind, was the fact that I always thought I would become a doctor to help people in my island. But, seeing the diversity of cultures, and ethnicities that UMASS attends, particularly the Latino community, made me feel like I would still have a chance to serve a piece of my country from far away. As a Latino resident fellow member, working with Latino patients, and listening to their views on their cultural differences, and expectations for treatment, has been eye opening, and thought provoking. Many, even after living in the states for many years, believe that having a clinician from their ethnic group would make it easier for them to be understood and better served. I have thought a lot about this perception, and believe that it is a complicated issue for both the patients, and for the people trying to care for them.

At first, feeling that extra connection with Latino patients was a blessing, but I have realized the big responsibility it is. I also believe that it can be unfair for other doctors with different cultural backgrounds who are capable, and interested in taking care of these patients. On the other hand, even though Puerto Rico is a territory of the United States, and we are raised with plenty of access to American culture, there are multiple ways in which my customs and beliefs are different, so I experience how this affects communication and relationships for me. I can see where these patients are coming from.

Multiculturalism continues to grow in the United States. In Massachusetts there is approximately 25% of non-White population, so it is fair to say that during our training and career we will be faced with the situation of having to care for a patient of a different ethnic and cultural background. As mental health providers we need to consider how a patient's own beliefs, traditions, and understandings affect the presentation of their symptoms, and attitude towards treatment. This topic should be an ongoing conversation and for this reason I am very excited to announce that the Massachusetts Psychiatry Society has opened a new Multicultural Psychiatry Committee, to be chaired by Dr. Astrid Desrosiers.

The purpose of this group is for psychiatrists in Massachusetts to have a place to discuss issues that we face when treating diverse populations, learn from each other's experiences, and promote cultural competence. This would be a great way for us, resident fellow members interested in multicultural psychiatry, to pair up with mentors that can help us foster our ideas. This group would also be a good way to advocate for improved access to care, and parity for all patients.

I am very enthusiastic about the opportunity to get together with a diverse group that shares an interest in serving, and better understanding the broad range of patients we serve.

Please join us in a "Meet and Greet" at the MPS headquarters in Wellesley on April 9th at 6:30PM. I look forward to seeing you.

MPS IS PLEASED TO WELCOME THE FOLLOWING NEW MEMBERS

General Members:
Andrea Stone, MD

Resident Fellow Members:
Shashwat Pandhi, MD
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Jose Rengifo, MD
Genny I Feinberg, MD
Rajan Gosain, MD
Justin Johnson, MD
JNeeta Sharma, MD

Transfer In:
Ljiljana Markovic, MD

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President Kennedy spoke of "a bold new approach" that envisioned a collaboration of federal, state, and local governments working with private foundations and individuals to develop and continue to implement and improve the care for these vulnerable citizens to return them to the family and community for a meaningful life, whenever possible, or more humane care if the person needed hospitalization, acute or chronic (1.2.3). He stated, "When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away" (2).

President Kennedy proposed a three prong program to achieve his vision that included resources for research to find the cause, cure or prevention of these illnesses, education and training of providers and teachers, and community based treatment with goal of rehabilitation and recovery (1,2,3). The first act, Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act was signed on October 24, 1963 with two major funding components, to update education and treatment programs and for prevention through prenatal and infant medical care. The Community Mental Health Centers Construction Act of October 31, 1963 authorized facility construction funds for clinical, education, and research centers for prevention, care, and treatment. These included community-based centers for the care of people with intellectual disabilities and with mental illness (1,3). In the signing ceremony President Kennedy posited, "It was said, in an earlier age, that the mind of a man is a far country which can neither be approached nor explored. But, today, under present conditions of scientific achievement, it will be possible for a nation as rich in human and material resources as ours to make the remote reaches of the mind accessible. The mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities" (1).

President Kennedy's dream captured the psychiatric nation, patients, and families to seek better outcomes for those with mental illness through research and education and through construction of welcoming centers within communities to care for those shunned by society. The shortened title the Community Mental Health Act appears to have adopted the vision of President Kennedy without acknowledging that the funding was both time-limited and for construction, not ongoing program support. President Kennedy envisioned ongoing support to achieve his "bold new approach" as coming from a collaboration of federal, state, and local governments, private foundations and individuals. This new approach, coupled with advances in treatment and now funding for constructions of community mental health centers, allowed states to transition from custodians of state hospitals housing millions of people across the United States with the promise of community care, close to family (1,2,3).

States hospitals were shuttered. These outdated, old, and overcrowded hospitals that had been costly but ineffective in treating the mentally ill and intellectually disabled were to be replaced by welcoming mental health centers in the community where people with mental illness could be treated more effectively. The cost savings did not or could not fund the proposed network of community mental health centers to treat people within their communities. The Departments of Mental Health across the country struggled to fight for sufficient funds to achieve the vision of President Kennedy. Many federal and state public servants, organizations like the MPS and others, as well as, individuals and families have long fought for funding to meet the mental health and later behavioral health needs where all could receive care to live meaningful lives in the community.

To meet the Federal mandates in President Kennedy's two acts, the Commonwealth of Massachusetts passed the Comprehensive Mental Health and Retardation Services Act in 1966 to establish community mental health centers (4). This led to the ongoing development of community mental health centers linked to a state hospital in catchment areas. A 1978-1992 federal consent decree mandated care in the least restrictive environment in the community close to the patients' home. A 1984 act required separation of services for children. In 1986 services for people with intellectual disabilities were split off from Department of Mental Health (DMH), creating the Department of Mental Retardation (4). Substance use disorders were and still are under the purview of the Department of Public Health.

From my perspective as a medical student in 1982, the community health centers, as a part of a system of care, appeared to be well-functioning. I was assigned to the North Central Unit at Worcester State Hospital that was linked to its Catchment area community mental health center. The community mental center provided psychiatric care, day programs, and resources to move patients to recovery in the community. Community based patients would be admitted when hospital level of care was needed from the community mental health center to the acute unit, once stabilized transferred to the intermediate level and then transitioned back to the community. New patients were similarly sent to this seamless system of community care. This system was knit together by the two team psychiatrists, Dr. Pilette on the North Central Unit at Worcester State Hospital and Dr. Bonner at the community health center; the linkage completed with a day exchanged at each treatment center. Patients with a variety of chronic mental illness identified both psychiatrists as their psychiatrists and all staff shared the goal of returning patients to community care. My six weeks of this system of care, albeit in an overheated, smoke filled state hospital, was a draw to psychiatry for me as I witnessed patients with serious and persistent mental illness receiving humane care focusing on providing the best quality of life in the community.

As a resident in early 1986, I saw that in a larger city system, the seamlessness was less evident as more patients were homeless and, as such, the community, more poorly defined. Despite this, case managers were available to help patients keep appointments, have necessary medications, and bring them to emergent treatment, if a danger to self or others was suspected. The state hospital was the center of the catchment area; the community psychiatrist less evident to me. I believe, in retrospect, this difference was due to eroding sources of support for the continuity of care with the passage of the 1985 Omnibus Budget Reconciliation Act that changed federal support to the community mental health centers into state block grants, which allowed states to alter funding support the community health centers (5).

During the 1990's the Commonwealth of Massachusetts enacted legislation aimed at closing state hospitals to reduce state

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spending. From 1991 to 2009 six state hospitals and the Gaebler Center for Children were closed (4), case managers were significantly reduced in numbers, state day programs were closed, and inpatient psychiatric services were shifted increasingly to general and private psychiatric hospitals. The seamless system of care was split as the state continued to deplete funding for DMH services. MPS has consistently fought for increased funding for DMH. During the current administration, we have fought proposed budget cuts, often ending with restoration of level funding despite increased costs and need. The work begun by President Kennedy for those with behavioral health disorders to receive humane treatment has been carried on by many, including his brother Senator Ted Kennedy and now taking up the mantle, Senator Kennedy's son former Rhode Island Congressman, Patrick Kennedy.

The choice for our Speaker would reasonably lead one to consider former Congressman Patrick Kennedy but unfortunately, the calendars did not align. We then set about a search for someone who has fought for parity, the rights of people with behavioral health disorders to receive care, and/or someone who could speak of his or her personal experience with having or being a family member of someone with a behavioral health disorder. Ideally, our speaker would have ties to Massachusetts or the Kennedy Library. We reviewed a long list of authors, famous people, public servants, people with lived experience, and psychiatric leaders. There was one person, a Massachusetts public servant, who has long fought for parity and the rights of people to receive treatment and has told of her brother's struggle with bipolar disorder that ended in his tragic death by suicide. After a lengthy discussion, we decided to ask this public servant and person with lived experience, our current Attorney General Martha Coakley, to be our invited speaker. Since coming to the office in 2007, she has been a friend of those with behavioral health disorders. [A disclaimer: theAttorney General was invited and accepted in her role solely as Attorney General based on her record on behavioral health and parity and as a person with lived experience. The fact that she is campaigning for another office will not be mentioned, it is not the reason to invite or not invite the Attorney General, and it does not reflect an endorsement by the MPS for any current or future political aspirations].

As a person with lived experience, Attorney General Coakley brings a family perspective on the personal cost of mental illness to her office. The death of her brother by suicide, whose bipolar disorder was untreated, is a poignant story. As Attorney General, she has used the power of the office to fight for parity and to ensure that people with behavioral health disorders will be protected in having access to care. Soon, she will be distributing grants worth $8 million for programs for mental health and substance use disorders with funds from a suit of a pharmaceutical company. Attorney General Coakley holds the distinction of being one of the most active Attorney Generals in protecting psychiatric patients' rights to treatment.

The 50th anniversary celebrates not only the fact that MPS, as a district branch of the American Psychiatric Association, was created (6), but to note the dedication and tradition of psychiatrists in Massachusetts advocating for our profession, our patients. Our celebration, its venue, and its speaker will ensure a vibrant annual meeting. I look forward to seeing you on April 30th!

1. Kennedy JF: Special Message to the Congress on Mental Illness and Mental Retardation, Feb 5, 1963. http://www.jfklibrary.org/JFK/JFK-in-History/JFK-and-People-with-Intellectual-Disabilities.aspx. Accessed 2/8/2014

2. John F. Kennedy: "Special Message to the Congress on Mental Illness and Mental Retardation." February 5, 1963. Online by Gerhard Peters and John T. Woolley, The American Presidency Project. http://www.presidency.ucsb.edu/ws/?pid=9546. Accessed 2/9/2014

3. Act of October 31, 1963 ("Mental Retardation Facilities and Community Health Centers Construction Act of 1963"), Public Law 88-164, 77 STAT 282 National http://research.archives.gov/description/299883. Accessed 2/8/2014

4. The History of the Department of Mental Health. 2014. http://www.mass.gov/eohhs/gov/departments/dmh/about-the-department-of-mental-health.html Accessed 2/9/2014

5. The NIH Almanac. http://www.nih.gov/about/almanac/organization/NIMH.htm, Accessed 2/15/2014.

6. Obenauf WH: The District Branch of the APA: Its Origin, Present Status, and Future Developments. Am J Psych 1959; 416-422.

Respecfully,

Janet E Osterman MD

Janet E. Osterman, M.D., M.S
President
Mass Psychiatric Society

Are you eligible and interested in applying for Fellow or Distinguished Fellow Status?

Contact the MPS Office
(781) 237-8100
mpatel@psychiatry-mps.org

We would be glad to assist you in completing your application.

Managed Care Committee
Gregory G. Harris, MD, MPH, Chair

Gratitude to the members of the APA Committee on RBRVS, Codes and Reimbursement:

I am writing to MPS members this month with a somewhat different column from usual; this is more of an op-ed than my usual straight reporting of updates and changes. I hope that you will indulge me in something a bit different this month.

Over the past two years, I have reported on changes in the CPT coding system for psychiatrists that went into effect in January 2013. Although these codes are not without problems both in the documentation requirements and implementation by insurers, we in the Managed Care Committee have argued that they are more reflective of the complexity of work that psychiatrists perform in caring for patients and provide the possibility for greater remuneration and incentives for taking care of patients with a higher degree of medical risk and complexity.

MPS nominated Ronald Burd, MD, a colleague in clinical practice from Fargo, ND and Chair of the APA Committee on RBRVS, Codes and Reimbursement for an APA award due to his work on advocating for this positive change. He ultimately was chosen for the award and accepted it on behalf of the work of the Committee. An acknowledgement he well deserved.

I didn't know the half of it, however. I recently accepted an appointment to this APA Committee and was invited to attend two AMA meetings in February, as an observer and possible future active participant on behalf of APA. These meetings were the AMA CPT (the forum for creation of new codes and changes in existing codes) and AMA RUC (the forum for the valuation and revaluation of existing codes). These two meetings are highly structured and apply to all physicians of all specialties and to all other providers of healthcare services. There is a "firewall" between them; the creation of new codes is separate from the valuation of codes, although issues with the codes might bounce back and forth to the two committees. CMS is a participant and advisor in both meetings. AMA is a CMS contractor to create the codes via the CPT meeting. However, the valuation of codes via the RUC are merely recommendations, with CMS free to disregard, which they did last year with the new psychiatric codes, and corrected this year after a lengthy "survey" process that Dr. Burd and the APA Committee directed.

Why am I going into all this minute detail about these meetings? I feel that we are indebted to APA and our psychiatric colleagues for their unsung work in advocating on behalf of psychiatrists and the complex practice of psychiatry to our colleagues in the rest of the "house of medicine". That's neurosurgeons, orthopedists and every other specialty. The previous codes that psychiatrists used were so different and unstructured compared to other medical coding that they were slated for devaluation. Our APA colleagues successfully argued for the true complexity of psychiatric practice and were able to produce a workable new coding scheme to describe the issues of risk and medical necessity that psychiatrists face taking care of patients. They then successfully argued that these codes should be created and funded in two huge meetings, where a gain for one specialty potentially means a loss for another. As I sat in on both of these meetings I truly understood just how daunting a process this actually is and how fortunate we are to have such strong advocates sent to this meeting by APA and representing us. I listened to proposals by surgeons, radiologists and other specialists and for advocates of scores of new laboratory and radiological tests. Every advocate feels their services are essential. Our advocates were able to successfully convince all of these colleagues and competitors that psychiatric services were under-valued due to the structure of our codes and that these codes should be changed to better match up with those of other medical specialities and to allow a higher reimbursement rate based on medical risk and complexity. A monumental effort and a major victory that affects every psychiatrist in practice and all of our patients. This work prevented the potential disaster of a planned devaluation of all psychiatric codes.

So, I'd like to conclude this column by expressing my gratitude to our APA colleagues:

Becky Yowell is APA staff to the committee, which could not function without her.

APA Committee members who attended these meetings in February and previously:
Ronald Burd, MD & Allan Anderson, MD are our advocates to the AMA RUC
Jeremy Musher, MD & David Nace, MD are our advocates to the AMA CPT.

Thanks to all of them for all their hard work on our behalf.

Remember, all are welcome at the Managed Care Committee Meetings, which occur on the third Tuesday of the month (from 7-9 PM; dinner served!) at the MPS offices in Wellesley. Check the MPS website for details or contact me at gregorygharris@sprynet.com

APA ANNOUNCES WINNERS OF THE 2014 ELECTIONS

The Committee of Tellers approved the following results for the 2014 APA National Election.

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Renee L. Binder, MD

Treasurer -
Frank W. Brown, MD

Trustee-At-Large -
Anita S. Everett, MD

Area 2 Trustee -
Vivian B. Pender, MD

Resident-Fellow Member Trustee-Elect (RFMTE) -
Ravi N. Shah, MD

Establishing a Psychotherapy Caucus: MPS members lead the way

By Eric Plakum, MD

At its December meeting, the APA Board of Trustees approved establishment of a Psychotherapy Caucus. This means that once again psychiatrists interested in psychotherapy have a place within the organizational structure of the APA. And it is a step in the direction of reducing the often biologically reductionistic stance of the field.

Psychotherapy in psychiatry has sometimes been on tenuous ground as psychiatry's focus has shifted toward pharmacotherapy. In the late 1990s the ACGME Psychiatry Residency Review Committee (RRC) realized that, given the biological emphasis of psychiatric training and treatment, the field was in danger of losing psychotherapy as part of the identity, training and skill set of psychiatrists. Because of this, the RRC required that residency training include teaching several schools of psychotherapy to a measurable level of competence during residency. Training in supportive, cognitive behavioral and psychodynamic psychotherapy is now a mandated part of every residency curriculum. Concurrently the APA also recognized that psychotherapy was dwindling as part of the practice of psychiatrists, and established a Commission that later became a Committee on Psychotherapy by Psychiatrists (COPP) within the Components of the APA. Over the roughly dozen years of its existence, this committee promulgated evidence about the efficacy of psychotherapy and its association with brain change, organized psychotherapy related programs for the annual meeting and Institute on Psychiatric Services, developed the Y-model for teaching psychotherapy across schools in an integrated, evidence based way, produced several APA Position Statements and informational documents on psychotherapy that were adopted by the APA, and conducted a survey of psychotherapy practice patterns among US and Canadian psychiatrists. Because of financial concerns, COPP was sunset in 2008 along with many other components of the American Psychiatric Association. Efforts to reinstate a committee on psychotherapy were unsuccessful. However, in 2012 an Assembly Action Paper authored by Roger Peele led to the creation of a Psychotherapy Task Force in the APA Assembly. The 12 member Task Force includes 4 Massachusetts psychiatrists: Eric Plakun, serving as chair, Samar Habl, David Flynn and Elizabeth Weinberg, all medical staff members at Austen Riggs. Other members include Paul Lieberman from Brown, Bart Blinder from the University of California at Irvine, Allison Cowan from Wright State University, Randon Welton from the VA system, Andrew Gerber from Columbia, Donna Sudak from Drexel, Eve Caligor from NYU School of Medicine and Evan Leibu, a resident at Mount Sinai in New York.

As determined by the Action Paper that established it, and using no APA resources, the Task Force shepherded the completion of a revised position statement on psychotherapy by psychiatrists. The Task Force also realized that, if a top down APA committee on psychotherapy was not going to be formed, then it could use APA operational bylaws to develop a Psychotherapy Caucus from the grass roots up. Letters were gathered and mailed to APA president elect and MPS member Paul Summergrad, who took the request to the APA Board of Trustees, where a Psychotherapy Caucus was formally approved in December 2013.

It seems particularly auspicious that a Psychotherapy Caucus exist at this moment in time when, ironically, even as the evidence for the efficacy for psychotherapy grows, there is evidence that the provision of psychotherapy by psychiatrists is declining. In 2008 Mojtabai and Olfson reported that over the ten-year period from 1996 to 2004-2005, the percentage of psychiatric office visits involving provision of psychotherapy declined from 44% to 29%. In 2010 results of a survey carried out by COPP and APIRE (and led by COPP member J. Christopher Perry and Joyce West, PhD of APIRE) were reported at the Institute for Psychiatric Services. This study found that from 2002 to 2010 there was a 20% decline in provision of therapy to patients by psychiatrists from 68% to 48% of office visits reported by 394 psychiatrists. Those providing therapy to their patients tended to be over 65, white, U.S. medical graduates, and half their patients were self-pay or privately insured. Obstacles to provision of psychotherapy cited by psychiatrists included significant debt burden, lower compensation for psychotherapy compared to other services, and intrusive and time-consuming utilization review burdens. Concurrent with this decline, a growing body of evidence demonstrates that multiple kinds of psychotherapy are effective for a range of single disorders and complex comorbid disorders, while we have also learned that the efficacy of some medications has been overestimated by as much as a third, as in the case of anti-depressants (Turner et al 2008), and much of their effect is placebo effect (Kirsch et al 2008).

The Psychotherapy Caucus offers psychiatrists interested in psychotherapy an opportunity to communicate with one another, to network and transfer knowledge across generations and across the country, develop symposia and workshops on psychotherapy, and learn about emerging evidence of the efficacy of psychotherapy. A Caucus meeting is planned at the APA Annual Meeting in New York, Monday, May 5th from 2-4 PM in the Riverside Suite 3rd Floor at the Sheraton New York Times Square Hotel . Contact Eric Plakun at Eric.Plakun@AustenRiggs.net for further information.

Save the Date

Wednesday
April 30th, 2014

MPS 50th Anniversary and
Annual Meeting

John F. Kennedy
Library Boston, MA

**Our Keynote speaker
will be The Honorable
Martha Coakley,
Attorney General
of the Commonwealth
of Massachusetts**

In Transitional Space: The Bereavement Exclusion and DSM-5

Ronald Pies, MD

Each month, I highlight an aspect of the DSM-5 that has undergone notable changes. Last month, I wrote about the elimination of the Bereavement Exclusion from an informational rather than editorial perspective. I was delighted to hear from MPS member Dr. Ronald Pies that as someone with expertise in the area of bereavement he was up for providing members with an editorial perspective in favor of the exclusion being eliminated. I encourage other MPS members to contact me if they would like to participate in future columns or have suggestions regarding an area of the DSM-5 they would like to be the focus of a future column. Please welcome Dr.Pies as a guest columnist this month! -Carlene MacMillan, MD, cmacmillan@partners.org

In her recent “Transitional Space” column, Dr. Carlene MacMillan nicely summarized many of the controversies surrounding the removal of the so-called “bereavement exclusion” (BE), in DSM-5. Without question, this was one of the most contentious decisions the DSM-5 work groups made—and, by some lights, the most controversial decision by the APA since homosexuality was removed from the list of psychiatric disorders, in 1973. While I was not directly involved with the DSM-5 mood disorders work group, my colleagues and I were participants in an often contentious debate(1,2,) sometimes fueled by sensational or misleading reports in the media; for example, by claims that “psychiatrists want to make normal grief a mental disorder,” or that, “DSM-5 medicalizes mourning.”

In truth, the DSM-5 criteria for major depressive disorder (MDD) merely say that the subset of persons who meet the full symptom-duration-severity criteria for major depression within the first few weeks after bereavement (the death of a loved one) will no longer be excluded from the set of all persons with major depression. Put another way: bereavement does not immunize the patient against major depression, and often precipitates it. Indeed, grief and depression—despite some overlapping symptoms, like sadness, sleep disturbance and decreased appetite—are distinct constructs, and one does not preclude the other.(2)

The bereavement exclusion was eliminated from the DSM-5 for two main reasons: (1) there have never been any adequately-controlled, clinical studies showing that major depressive syndromes following bereavement differ in nature, course, or outcome from depression of equal severity in any other context—or from MDD appearing “out of the blue”(2); and (2) major depression is a potentially lethal disorder, with an overall suicide rate of about 4%.(3) Disqualifying a patient from a diagnosis of major depression simply because the clinical picture emerges after the death of a loved one risks closing the door on potentially life-saving interventions. The “exclusion” principle also fails to recognize that MDD is often a highly over-determined process, involving multiple, interacting causes; e.g., someone who develops a major depressive syndrome a few weeks after a loved one’s death may also be depressed owing to hypothyroidism, pancreatic cancer, marital problems, or a recent setback in business.(4)

It is true that the DSM-IV criteria provided a way to “override” the bereavement exclusion; for example, if the depressed, bereaved patient were psychotic, suicidal, psychomotorically slowed, preoccupied with feelings of worthlessness, or functioning very poorly in daily life. Unfortunately, these override features did not address those bereaved patients whose depressive symptoms were indeed severe, but who did not “qualify” for the specific override criteria; for example, bereaved persons with profoundly impaired concentration, significant weight loss, or severe insomnia. Under the DSM-IV “rules”, these seriously depressed individuals probably would not have received a diagnosis of MDD and appropriate treatment.

It is sometimes argued that bereaved, suicidal patients would not have been excluded from an MDD diagnosis, using the DSM-IV override “rules.” In theory, that was true. But not every depressed patient openly acknowledges suicidal ideation or intentions to a clinician—some fear that doing so will result in involuntary hospitalization. Moreover, the risk of suicide in MDD is not conferred solely by the presence of suicidal ideation; rather, both overall severity of depression and hopelessness also elevate risk of eventual suicide.(5) Yet neither factor was specifically included in the DSM-IV’s list of features that allowed one to override the bereavement exclusion. The preponderance of data suggest that, compared to MDD emerging in other contexts, such as job loss or recent divorce--or to MDD arising “out of the blue”-- bereavement-related major depression (BRMD) differs very little in symptom picture, course, outcome, or response to treatment. Thus, there is no strong rationale for “privileging” BRMD for exclusion.

As Dr. MacMillan noted, there have been some recent epidemiological studies that appear to show lower risk of recurrence for some types of BRMD, compared with “standard” (non-bereavement) MDD.(6,7,8) These data—derived from ECA (Epidemiologic Catchment Area) and NESARC (National Epidemiologic Survey on Alcohol and Related Conditions) surveys of community residents—were obtained by lay interviewers; and, as with all surveys, are subject to recall bias on the part of participants. More important, subjects in the two groups (BRMD vs. “standard” MDD) were not matched for severity, duration, or degree of impairment during the index depressive episodes. This makes it impossible to know whether bereavement per se, or some other risk factor for recurrence (such as melancholic features), accounts for the group differences. Furthermore, in the Gilman et al study, even those with excluded bereavement-related depression had “clinically significant depressive episode[s]”(8)—i.e., episodes that were not clearly “normal grief.” Indeed, the propensity to recur is merely one index of a depressive condition’s clinical significance—and a reduced tendency to recur does not necessarily point to “non-disordered sadness,” as some have claimed.

While definitive controlled studies of BRMD vs. “standard” MDD have not been carried out, one recent study used rigorous methods to tease out the role of bereavement. Hamdan et al9 studied a cohort of parentally-bereaved youth and non-bereaved controls, over approximately 5 years. Three groups were assessed for symptoms, severity, duration, and risk for recurrence: (1) bereavement-related depression (BRD, n = 42), with onset of depressive episode within the first 2 months after parental death; (2) later bereavement depression (LBD, n = 30), with onset at least 12 months after pa-

(continued on page 8)

(continued from page 7)

rental loss; and (3) a non-bereaved control group with depression (CD, n = 30). The study found that bereavement-related depression was similar to LBD and CD, with respect to number of symptoms, severity, functional impairment, duration, and risk for recurrence. While the study population was small and limited to youths, the authors concluded that their findings "...support the removal of the bereavement exclusion."(9)

It is important to understand that the DSM-5 criteria merely allow the diagnosis of MDD when the recently bereaved person meets all required symptom, severity, duration, and impairment criteria for MDD. Nothing in the manual compels a diagnosis of MDD after bereavement. The DSM-5 clearly states that,

> "...periods of sadness are inherent aspects of the human experience. These periods should not be diagnosed as a major depressive episode unless criteria are met for severity...duration... and clinically significant distress or impairment." (DSM-5, American Psychiatric Association, 2013 p. 168)

Indeed, if the clinician's best judgment—and, as Dr. MacMillan wisely noted, sound judgment is needed!--points to normal, bereavement-related grief, the "V Code" of "Uncomplicated Bereavement" (V62.82) may be used. (The "V" codes, of course, are not "mental disorders"). The DSM-5 provides useful guidance on when to apply MDD in the post-bereavement period; e.g., the footnote on p. 161 of the manual lists several features that help differentiate ordinary grief from a major depressive episode. For example, in bereavement-related grief, self-esteem is usually preserved; in MDD, feelings of worthlessness and self-loathing are common. In ordinary grief, the emotional pain is usually accompanied by positive emotions and fond recollections of the deceased; in MDD, pervasive misery and unhappiness are typical. Another important distinction --highlighted by Dr. Kay R. Jamison in her book, Nothing Was the Same--is that the normally grieving person is "consolable" by friends, family, and even literature; the person with MDD usually is not).

To be sure, the two week minimum duration for diagnosing MDD is often too brief to reach a confident diagnosis, particularly in the post-bereavement period. But this 2-week duration criterion has applied to all instances of MDD (e.g., after job loss, divorce, etc.) since the DSM-III appeared in 1980. (Curiously, few critics of the DSMs objected to the two-week period until the matter of bereavement arose, in advance of the DSM-5). Moreover, in clinical practice, it is quite rare for a patient with "normal" grief to seek professional treatment within two weeks of the death of a loved one. When medical treatment is sought so soon after a death, the patient usually (a) has "self-selected" treatment, owing to profound distress or incapacity; or (b) has been referred by family members, who believe the patient is suicidal, psychotic, or unable to carry out the activities of daily living. Under such dire circumstances, the DSM-IV bereavement exclusion would not have applied anyway. As for the fear that removal of the bereavement exclusion will lead to hordes of bereaved patients being inappropriately diagnosed with MDD, the epidemiological data do not support this view. For example, in the overall NESARC sample, only 0.5% of subjects met criteria for "bereavement-excluded depression."(8)

Finally, nothing in the DSM-5 will prevent the prudent clinician from undertaking a period of "watchful waiting" during the first few weeks after a bereaved patient presents with depressive symptoms, in order to ascertain the "trajectory" of the patient's condition. Some patients will show marked improvement in their depressive symptoms, even though their grief--quite understandably—may persist for weeks, months, or years. (Contrary to frequent misrepresentations in the press, the DSM-5 sets no pre-ordained "time limit" on normal grief). Even if post-bereavement MDD is diagnosed, nothing compels the psychiatrist to begin antidepressant treatment. For mild-to-moderate, non-melancholic presentations of MDD, "talk therapy" alone may suffice. As for concerns that primary care doctors will be induced by the new criteria to prescribe antidepressants inappropriately, my colleagues and I believe this hypothetical concern is best addressed through continued medical education and enhanced psychiatric consultation with PCPs—not by preemptive gerrymandering of our diagnostic criteria for MDD.(2,10)

In sum: while the data are not conclusive, the best available evidence suggests that the DSM-5 was justified when it eliminated the bereavement exclusion. No, we must not "medicalize" normal grief-- but neither should we "normalize" the serious disorder of major depression, simply because it occurs in the context of bereavement.

Dr. Pies is a member of MPS, and is Clinical Professor of Psychiatry at Tufts University School of Medicine. He wishes to thank Dr. MacMillan and Bev Dupuis for the opportunity to provide this guest column.

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April 8
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Marc Galanter, MD
Director of the Division of Alcoholism and Drug Abuse, NYU
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May 13
Managing Pain in Patients With An Addiction History

Janice F. Kauffman RN, MPH, LADC ,CAS
Vice President, Addiction Treatment Services
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June 10
Assessment and Management of Opioid Use Disorders in the General Hospital Setting
Joji Suzuki, MD
Director, Division of Addiction Psychiatry
Instructor in Psychiatry, Harvard Medical School
Department of Psychiatry
Brigham and Women's Hospital
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July 8
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Maria A. Sullivan, MD, PhD
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August 12
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Associate Professor, Departments of Behavioral Science & Psychiatry
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Council	March 11, 2014 at 7:00 PM at MPS	bdupuis@psychiatry-mps.org
Committee for Women	March 14, 2014 at 12:00 Noon - 2:00 PM at MPS	kealey@psychiatry-mps.org
Managed Care	March 18, 2014 at 7:00 PM at MPS	bdupuis@psychiatry-mps.org
WMPS - Cannabis in MA with Manuel Pacheco, MD	March 19, 2014 at 6:15 PM at Delaney House, Holyoke	bdupuis@psychiatry-mps.org
2014 Risk Avoidance & Risk Management Update	**March 22, 2014 from 8:30 AM - 3:30 PM** **MMS, Waltham**	**kealey@psychiatry-mps.org**
Forensics	March 24, 2014 at 7:00 PM at MPS	mpatel@psychiatry-mps.org
Executive Committee	March 25, 2014 at 7:00 PM at MPS	bdupuis@psychiatry-mps.org
Geriatric Committee Meetimg - CBT in Geriatric Patients with Elizabeth Mulligan, PhD	March 26, 2014 at 8:00 PM at MPS	kealey@psychiatry-mps.org
College Health	March 27, 2014 at 7:00 PM at MPS	bdupuis@psychiatry-mps.org
Integrated Care Conference	**March 29, 2014 at 8:30 AM** **MMS, Waltham**	**kealey@psychiatry-mps.org**
Council	April 8, 2014 at 7:00 PM at MPS	bdupuis@psychiatry-mps.org
Meet and Greet with the Multicultural Diversity Committee	April 9, 2014 at 6:30 PM - 8:00 PM at MPS	bdupuis@psychiatry-mps.org
Managed Care	April 15, 2014 at 7:00 PM at MPS	bdupuis@psychiatry-mps.org
WMPS - Open Dialogue Therapy with Chris Gordon, MD	April 16, 2014 at 6:15 PM at Delaney House, Holyoke	bdupuis@psychiatry-mps.org
Executive Committee	April 22, 2014 at 7:00 PM at MPS	bdupuis@psychiatry-mps.org
MPS 50th Anniversary and Annual Meeting	**April 30, 2014 at 6:00 PM** **at John F. Kennedy Library Boston, MA**	**mpatel@psychiatry-mps.org**