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JUNE 2004

VOL. 20, NO. 6 • (pages 61-72)

Lost in translation? LEP patients often are seen and not heard

Interpreter errors are common and can have serious consequences

A Spanish-speaking mother brings her infant daughter to a hospital emergency department because of a skin rash on her baby's face. Because a professional interpreter is not available, the woman's older child first translates the mother's information about the patient. Then, the child translates doctor's instructions on treatment to the mother.

The recommended treatment, however, will likely never be delivered because the young girl, asked to quickly interpret complicated medical information, instructs her mother to spread the prescribed hydrocortisone cream across the baby's entire body.

Such misinterpretation may seem comical in this case, but the actual consequences of mistaken translations in health care can be deadly.

Although federal regulations require health care providers to provide assistance to patients with limited English proficiency (LEP) — including translation and interpretation services when necessary — there are no objective standards or guidelines for who may work as an interpreter for health encounters.¹

As a result, most hospitals and primary care providers have sketchy programs for communicating with non-English-speaking patients.

"What often happens is they ask a bilingual employee, who may not be fully fluent in both languages, to step back and serve as interpreter," says **Beverly Treumann**, a state-certified Spanish interpreter at UCLA Medical Center and president of the California Healthcare Interpreting Association (CHIA). "For a lot of people, Spanish-speakers for example, Spanish may be their first language and the language they hear at home. But that is not the language they learned in school — if they grew up in this country — and they don't have formal knowledge of the language, both written and verbal, [as well as] its grammar and structure."

Asking bilingual employees to serve as interpreters during health care encounters raises important questions about patient privacy and

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confidentiality as well. But, Treumann and others say they are primarily concerned because inaccuracies in translation can lead to dangerous medical mistakes.

Interpreters not only have to be conversant in both languages, but they must also be able to understand complex medical terms and a great deal of technical vocabulary in both tongues.

In addition, nontrained interpreters are

unlikely to use the basic professional practices of trained interpreters to ensure accuracy, Treumann adds. Medical interpreters, for example, know to re-state what each party said, verbatim, if possible, and minimize any shadings of the meaning.

"This may sound like common sense, but you'd be surprised how many people, when asked to interpret for someone else, will not understand that they are to repeat, in exact detail as possible, what each party says," she notes.

Professional interpreters are often trained to pause after translating to allow each person to respond, and are also trained to ask for more time to "catch up" in the conversation without disturbing the interaction between patient and physician or inserting themselves into the visit.

"You are always going to get behind, no matter how good you are," she says. "You have to be able to acknowledge that and ask people to slow down or repeat what they said to ensure you are accurate."

Study indicates problems

Even when professional interpreters are used, the results are not always perfect, says **Glenn Flores, MD**, associate professor of pediatrics, epidemiology, and health policy at the Medical College of Wisconsin in Milwaukee and director of the school's Center for the Advancement of Urban Children.

In 2003, Flores and colleagues conducted a study aimed at evaluating the accuracy of medical interpreters working during clinical visits.² They audiotaped 13 clinical encounters in a pediatric clinic where Spanish interpreters were used. Investigators then used trained interpreters and documentation of the visits to evaluate the accuracy of the interpreters' work.

Of the 13 visits, there were a total of 396 interpreter errors — an average of 31 errors per encounter — ranging from as few as 10 errors in one visit to as many as 60.

Most were errors of omission, Flores says, where the interpreters left out information stated by either party. In 16% of the visits, "false fluency" was a problem — interpreters simply invented words that did not actually exist in the language. In 8% of the visits, interpreters added incorrect information that the physician or patient did not state. Other problems emerged when the designated interpreters frequently inserted their own opinions.

Of the errors, 63% were deemed to have potential

Medical Ethics Advisor® (ISSN 0886-0653) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Medical Ethics Advisor**®, P.O. Box 740059, Atlanta, GA 30374.

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Statement of financial disclosure: In order to reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, board members have reported the following relationships with companies related to the field of study covered by this CME program. Dr. Cranford, Dr. Hofmann, and Ms. Rushton report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Dr. Banja reports receiving grant funding from the Agency for Healthcare Research and Quality. Dr. Derse, Mr. Guss, and Mr. Miller did not provide disclosure information.

This publication does not receive commercial support.

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Subscription rates: U.S.A., one year (12 issues), \$469. With CME: \$519. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Two to nine additional copies, \$375 per year; 10 to 20 additional copies, \$281 per year. For more than 20, call customer service for special handling. **Back issues,** when available, are \$78 each. (GST registration number R128870672.)

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clinical consequences, Flores says.

"These were errors in interpreting information about the history, past medical history, the history of present illness, or their understanding of treatment instructions and follow-up," he explains. "The average was 19 errors of potential clinical consequence per encounter, ranging from five to 49."

Flores and colleagues also found that ad hoc interpreters — friends, fellow patients, social workers, clinic personnel, or relatives who spoke Spanish but were not trained interpreters — were significantly more likely to make errors of potential clinical consequence than the trained hospital interpreters, he adds.

"Their rate was 77% vs. 53% for the trained interpreters, which is highly statistically significant," he notes. "As an example, there was an 11-year-old girl used as an interpreter for her mother and an infant child, and 84% of the 15 errors she committed had potential clinical consequences, including some pretty impressive ones. "The most pressing ones we saw were omitting questions about drug allergies, omitting key information about the past medical history, omitting crucial information about the chief complaint or symptoms, and errors about the antibiotic dose, frequency, and duration.

The interpreters working for the clinic often had other difficulties, Flores states.

One interpreter, a social worker, actually turned to the patient and indicated that the doctor was going to ask detailed questions about sexual history and drug use and advised the patient not to answer the questions. And another interpreter told the patient an antibiotic was prescribed for the flu, which is never done.

"Then, there was a mom who clearly said to the interpreter that her child had already had a rectal swab for culture and the interpreter did not tell the doctor so the child got another swab," he adds.

Since that time, the hospital has improved training for its professional interpreters, and their rate of errors has dropped significantly, he says.

In many cases, it is unfair to ask bilingual employees to serve as interpreters, as is often the case in many health care settings, adds Treumann.

Hoping to avoid the cost of professional interpretation and translation services, some providers hope to kill two birds with one stone and hire personnel who are bilingual in the hopes they will serve as interpreters.

Just because someone is bilingual, it does not mean he or she will be an accurate and reliable

interpreter. And the pressure from one's employer to do something they have not been trained to do can be acute.

"They may not feel comfortable serving as an interpreter for a person who speaks the same language because of concerns about how well they know the language, and [may also be uncomfortable] taking such a personal role," she says.

If bilingual health care personnel are adequately trained and want to serve in that capacity — that's another story, she notes.

"Many physicians from other countries, while awaiting licensure here, want to serve as interpreters. They can be ideal because they have usually had a high level of formal education in their native language, and they have the medical background as well," she says.

Enormous potential for disaster

Today, more than 47 million people in the United States speak another language, and 21.4 million people have LEP.

"There has been a tremendous growth over the last decade in those populations. It is not an inconsequential number of patients seeking care in U.S. hospitals," he explains. "And the available data suggest that lack of available trained interpreters is not uncommon for millions of these patients. One study found, for example, that no interpreter was used for 46% of LEP patients, and when an interpreter was used, 39% of the interpreters had no training."

Currently, there are no objective certification processes, licensing bodies, or training programs for health care interpreters, says Treumann. Most professional certification comes from learning to interpret and translate for the legal system.

However, health care interpreting has its own set of unique challenges that warrants special training.

Court legal proceedings are adversarial in nature, and the interpreter is not required to be an advocate for the patient. However, in health care settings the interpreter may have certain ethical and moral obligations to the person presenting for care that he or she would not have working in the legal system, she says.

Health care interpreters not only need training in how to serve as accurate and reliable interpreters, but also must receive education about the ethical complexities of the patient encounter as well — information about privacy and the principles of informed consent are particularly compelling.

SOURCES

- **Glenn Flores, MD**, Center for the Advancement of Urban Children, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226. Web: www.mcw.edu/peds/compeds/index.html
- **Beverly Treumann**, The California Healthcare Interpreting Association, One Capitol Mall, Suite 320, Sacramento, CA 95814, Telephone: (916) 669-5305. E-mail: chia@chia.ws

CHIA developed standards of practice for health care interpreters, and they can be found at www.chia.ws/index.php on the organization's web site.

The results of his study and others like it also provide ample justification for third-party reimbursement of translation and interpretation services, says Flores. The potential reduction in increased health care costs due to preventable medical errors and unnecessary care should more than offset the costs to the health care system, he notes.

Currently, only 10 states require third-party payer coverage of interpreter services.

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National guidelines for palliative care developed

Blueprint for new and existing programs

In an effort to better standardize and improve the quality of palliative care services available nationwide, a consensus group has released new clinical guidelines detailing what services a palliative care program should include and where providers can go for more information and support.

The new guidelines were issued last month by The National Consensus Project for Quality Palliative Care (NCP), a consortium comprised of representative members from the American Academy of Hospice and Palliative Medicine,

the Center to Advance Palliative Care, the Hospice and Palliative Nurses Association, Last Acts Partnership, and the National Hospice and Palliative Care Organization.

"In palliative care, which is a relatively new field in health care, there has been extremely rapid growth," explains **Diane Meier, MD, FACP**, director of the Center to Advance Palliative Care (CAPC) in New York City. "As recently as six or seven years ago, there were relatively few programs. As of 2002, there were 950 programs. And the number of new programs is probably growing 20%-30% per year. But there are quality concerns because, without a kind of shared definition about what palliative care is or should be, there are a lot of programs doing very different things and calling it palliative care."

While many institutions have complex, interdisciplinary programs that address a variety of needs, others may have a part-time social worker who has "palliative care" included in his or her job description, and others may employ a massage therapist and consider that their palliative care program.

"A nursing home that has liberalized visiting hours may consider that their palliative care program," Meier adds. "While all of those things are good and helpful, they do not qualify as palliative care programs, at least in the opinion of those of us working in nursing and medicine."

The goal of all palliative care is to address patient suffering, she notes. Palliative care measures include aggressive treatment of pain and other physical symptoms, but also should address the patient and family's psychological, emotional, and spiritual stress. It should also provide support for daily living, helping patients and families make medical decisions, and ensuring that the patient and family's wishes are adhered to.

Palliative care is properly delivered both by providers specializing in the discipline and by providers in other specialties seeking to improve every aspect of care for seriously ill patients.

In 2001, members of the five national organizations decided to convene the consensus project in an attempt to develop national, evidence-based guidelines to help standardize the delivery and quality of palliative care services.

Over the next three years, a 20-member steering committee and 100-member advisory panel developed draft guidance that was then circulated to other stakeholders in palliative care for their feedback. The resulting document takes into account the perspectives of health care providers

in a wide variety of settings.

Sections of the guidance dealing with pediatrics and long-term care are particularly compelling, Meier says.

"We got some really helpful feedback. The draft guidelines were completely overhauled to include pediatrics and feedback from peers and colleagues in pediatrics," she explains. "Rather than assuming that the guidelines apply equally to children and adults, there are numerous sections focusing exclusively on the special needs of infants and children, as well as the children of patients."

The document addresses the specific needs of the long-term care setting, which has different financial incentives, financing patterns, and disease patterns, she says.

"This editing process, while lengthy and time consuming, was extremely valuable, and the guidelines are dramatically improved in both their applicability and their quality as a result of that process," Meier says.

Guidelines — not standards

Programs in different settings and in different stages of development will find the new guidelines useful, says **Charles von Gunten**, MD, PhD, FACP, medical director of the Center for Palliative Studies in San Diego and associate clinical professor of medicine in cancer symptom control program at the University of California-San Diego (UCSD) Cancer Center.

"There are really three groups out there," he notes. "The first group is the group that has just heard the term 'palliative care,' and they know they need to do something, but they are not sure what. The second group [is composed of] those programs that have something in place that is very limited in scope. They can use this document to see where other programs are and, really, where they should be headed. The third group [includes] institutions that have thorough programs in place but can use the document to benchmark where they are and decide where they want to go in the future."

Particular programs will continue to have unique features based upon their care setting and individual population. For example, a palliative care program in a large hospital and one in a nursing home in a smaller community will have different goals and very different patient populations, so, inherently, their programs will vary.

"That is why it is important to note that these are guidelines, not standards," he says. "We want

people to take into account that this is a relatively new specialty that has grown rapidly and has a lot of room for growth in the future."

Palliative medicine has also changed significantly in the last several years, and providers need to remember that it is an evolving specialty.

"So many times, we think of improving palliative care as doing things that we haven't been doing and should have been doing," von Gunten says. "Many institutions tend to feel ashamed and defensive or guilty, but that really doesn't serve a purpose. We need to remember that there is simply more now that we can do for our patients who are suffering than we could do in the past. Our main focus now should be on making sure that everyone in this country has the same access to these new strategies and treatments as is possible under our current medical system."

Use document as checklist

Many have told Meier that they use the new guidelines as a checklist to see where they are, and now realize the important palliative care resources they already have that may be underutilized.

"For example, many hospitals have extensive case management capabilities, but they don't work with the people who do symptom management and goals of care discussions with family," she explains. "And many hospitals have contracts with hospices on paper but not in an operational way. Just having that list was a way for people to really appreciate the riches they already had in front of them that they didn't know about."

Meier has been pleasantly surprised at the reception the consensus project and its work have received, and she feels it indicates a great deal of support for improved palliative care nationwide.

"When we presented this to the American Academy of Hospice and Palliative Medicine in January, we weren't sure if anyone would show up. It was standing room only," she notes. "Just as I was shocked that there were 7,000 downloads within the first 24 hours that they were live. People knew about what we were doing, and they were interested."

At a time when there are so many disagreements about strategies to improve the health system, this is one area that everyone can agree on, adds von Gunten.

"I don't think you can find anyone who doesn't think more effort needs to go into improving palliative care and who doesn't feel that they want to do it," he states.

SOURCES

- **Diane Meier**, Center to Advance Palliative Care, Mount Sinai School of Medicine, 1255 Fifth Ave., Suite C-2, New York, NY 10029-6574. E-mail: www.capc.org
- **Charles von Gunten**, 4311 Third Ave., San Diego, CA 92103. Web site: www.sdhospice.org/index.htm

The new guidelines, and information on the National Consensus Project for Quality Palliative Care, are available on the web at: www.nationalconsensusproject.org ■

Study: More people receive mental health treatment

Reduced stigma leads more to seek help

More than one in four U.S. adults has received treatment for a mental health problem in the past two years, via talk therapy, medication, or a combination of the two, according to a new Harris Interactive poll, "Therapy in America 2004." Harris Interactive is a national research and polling firm best known for conducting the Harris Poll, which is a survey of public opinion on a variety of topics.

The study was conducted in March using a nationwide phone survey of 501 adults, with a follow-up on-line survey of 1,731 people known to have needed or received treatment. The national magazine, *Psychology Today*, its Internet-based companion *Therapy Directory*, and Los Angeles-based PacifiCare Behavioral Health, a national behavioral health care organization, sponsored the survey. Key findings include:

- **Mental health treatment has become an important part of American life.** Twenty-seven percent of adults, or an estimated 59 million people, received treatment in the past two years. Of these, the large majority report high levels of efficacy and satisfaction, regardless of the type of treatment received.
- **More than one in three persons who need treatment are not getting it.** The leading barriers to receiving care include cost, lack of confidence that treatment helps, and lack of health insurance.

- **Eighty-one percent of those with a treatment history report taking a prescription medication.** Forty-seven percent have used medication alone, 34% have used drugs and psychotherapy, and 19% have received psychotherapy only.
- **Consumers lack key information for selecting a therapist.** Respondents seeking a therapist make their choices based on physicians' recommendations, their health plans' network, and geographic considerations. They have little opportunity to learn in advance about the therapist's personal style or listening skills — the factors that they identify as being most associated with successful therapy.

The survey design weighted the responses of participants in the survey to extrapolate the results received to the U.S. population as a whole.

The telephone portion of this project was conducted within the United States between Feb. 16 and March 5, 2004, among a nationwide cross-section of 501 adults. Figures for age, sex, race, education, region, household income, number of adults, and number of voice/telephone lines in the household were weighted where necessary to bring the total population of all adults in line with their actual proportions in the population.

According to Harris Interactive, it is expected that 95 % of surveys with samples of this size would produce results that were within ± 4 percentage points of what they would be if the entire adult population had been polled using the same methods.

The on-line portion of this survey was conducted within the United States between Feb. 27 and March 1, 2004, among a nationwide cross-section of 1,731 adults who qualified for the survey on the basis of having needed and/or received mental health treatment within the previous two years, according to the definitions of "need" and "treatment" used in the survey.

Figures for age, sex, race, education, region, and household income were weighted where necessary to bring them into line with their actual proportions among those in the general population meeting these same mental health criteria.

"Propensity score" weighting was also used to adjust for respondents' propensity to be on-line. With probability samples of this size, one could say with 95% certainty, that the results have a statistical precision of ± 3 percentage points of what they would be if the entire adult population had been polled with complete accuracy. The on-line sample is not a probability sample.

The term “need for treatment” was determined based on responses to the Life Status Questionnaire, an assessment tool used and clinically validated by PacifiCare Behavioral Health. The respondents’ self-perceived need for mental health treatment was also considered, as well as the fact that they had spoken to a primary-care doctor about this at some point within the past two years.

“Therapy” was defined as follows: “When we use the word ‘therapy,’ we mean talking to a mental-health professional (such as a psychiatrist, psychologist, social worker, or marriage-and-family therapist) on a regular basis about problems or things that are bothering you. This can be either alone, on a one-on-one basis, or in a group setting.”

Treatment widely accepted

According to the survey results, if you are not in treatment, chances are you’re sitting next to someone who is. From co-workers to family members, a substantial number of Americans have friends or loved ones who have received talk therapy or medication. And, respondents also believe that many of their closest associates and relatives would benefit from treatment.

- In the last two years, 27% of the general adult population have either seen a mental health professional for therapy or taken a prescription medication for a personal, emotional, or mental health problem.
- Eighty percent of those who have received treatment have found it effective.
- Eighty-five percent report that they are satisfied with treatment, and more than half (54%) are either very or extremely satisfied.
- Women are disproportionately represented among those likely to have needed treatment (making up 58% of the total), as well as among those who have received it. Of the group that has received treatment, women make up 63%, vs. 37% for men.
- Almost half of those surveyed (49%) know someone who has been in treatment, and almost two-thirds (61%) say they do not view the choice to receive therapy as a sign of character weakness.
- Almost four out of five (79%) respondents believe that if a co-worker were in therapy it would make no difference in his or her ability to do the job. Seven percent of respondents say it would actually make the co-worker better able to do the job.
- Forty percent of adults think that their parents

would have benefited from therapy.

“We’ve gained extraordinary insight into a part of life that usually takes place behind closed doors,” said **Jo Colman**, publisher of *Psychology Today* and the *Therapy Directory*. “We did not expect to find so many people had taken advantage of the treatment options now available to them, or the extent to which the stigma surrounding the subject appears to have subsided.”

Many needing treatment still don’t get it

While the majority of Americans are familiar with mental health treatment — either through their own experience or that of a family member or friend — a sizable number of those who appear to have needed treatment have not received care. These people are doubtful about the efficacy of treatment, stymied by cost, or concerned about stigma, the survey results indicated.

- **Thirty-seven percent of those who report having experienced distress sufficient enough to warrant treatment have not received it.** This represents an estimated 24 million, which are just more than one in 10 people in the general U.S. adult population.
- **Cost and doubt about its efficacy are cited as the top reasons for not receiving treatment among those who have needed mental health treatment but not gotten it.** Thirty-nine percent report that it is too expensive, 35% say that their problems have not been serious enough to warrant professional attention, 32% do not think treatment would help, and 26% cite concern about lack of insurance coverage.
- **Stigma inhibits some respondents from getting needed care:** The fear that therapy would go on their “record” is mentioned by 22%, and the concern that friends or family could find out is mentioned by 19%. Such concerns are cited more often by men than by women.
- **More than half (52%) of the general adult population believes that it is somewhat or very difficult to access mental health treatment.**
- **Thirty-seven percent of all insured respondents are unsure of whether their health insurance covers mental health care.**

“These survey results confirm what we’ve always believed and validate the direction in which we’re moving,” said **Jerry Vaccaro, MD**, president and chief executive officer of PacifiCare

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- **PacifiCare Health Systems Inc.**, 5995 Plaza Drive, Cypress, CA 90630.
- **Harris Interactive**, 135 Corporate Woods, Rochester, NY 14623-1457. Web: www.harrisinteractive.com

Behavioral Health, a subsidiary of PacifiCare Health Systems. "We're in the process of developing new programs that identify and reach out to these people so they can get the help they need."

Medication preferred over talk therapy

The fact that most of those receiving treatment are being treated with medication alone is one of the survey's more controversial findings.

For those with a treatment history, 81% percent, or an estimated 48 million people, report taking or having taken a prescription medication for a personal, emotional, or mental health problem in the past two years. In contrast, only 53% report undergoing psychotherapy.

Yet, only 25% of American adults who have taken prescription drugs for a mental health problem did not report the level of distress typically associated with those in need for therapy. One-quarter of those taking only medication have received a recommendation from a doctor that they receive talk therapy as well, but have not done so. And older Americans (ages 50 and older) are significantly more likely to receive medication alone than are those between the ages of 18 and 49.

"Clearly, medication has made it possible for many more people to seek and receive treatment, especially men who historically might have shied away from therapy," Vaccaro says. "We know, however, that not all medications work effectively on all people. Talk therapy, particularly goal-focused cognitive therapy, has been shown to be as effective alone or in concert with medication for many patients. Our role as a consumer health organization is to help consumers get the right treatment at the right time."

Survey respondents reported several challenges in accessing information that would enable them to choose a therapist able to meet their needs. This may play a role in the large number of people using medication without

therapy, he speculates.

The pragmatic factors that people consider when choosing a therapist, including geographic proximity and cost, fail to address a crucial element of treatment: a good therapist-client match.

There is a clear discrepancy between the criteria people use to select their practitioner and the criteria they identify as conducive to successful therapy, the survey indicated. For example:

- The most common factors cited in the choice of a mental health professional include recommendation from a doctor (28%), whether the therapist is part of the individual's health plan network (26%), proximity to home or work (22%), and cost (17%).
- In contrast, the factors ranked as most important in making therapy successful include the therapist's listening skills (63%), the therapist's personality (52%), the personal connection with the therapist (45%), the therapist's being active in the session (38%), and the cost (38%).

The publishers of *Psychology Today* have attempted to improve access to information about therapists via their on-line *Therapy Directory* (which can be found at www.psychologytoday.com), Colman states. The directory provides consumers with a flexible way to search a directory of 20,000 licensed professionals. Therapists identify their areas of expertise, interests, training, and cost per session. Many include personal introductions and photos. ■

Treatment of depressed children questioned

Bipolar disorder and other illnesses may be missed

Record numbers of U.S. children are being treated for depression and receiving prescriptions for antidepressants. Some mental health experts, however, fear many of these patients actually suffer from more severe illnesses and are being misdiagnosed.

According to researchers at Washington State University in Pullman, the rate of diagnosis of depression in children has more than doubled from the early 1990s to 2001. And the rate of prescriptions of antidepressants for them has more

than tripled during the same time period.

The Washington researchers used information from the U.S. National Ambulatory Medical Care Survey, an annual survey of office visits to physicians, grouping the survey data into three time periods: 1990-1993; 1994-1997; and 1998-2001. In the final period, researchers found that diagnoses of depression in children 5 to 18 years of age rose to 31.1 per 1,000 office visits from the initial level of 12.9 diagnoses per 1,000 office visits in the first four-year period.

The information was presented in May at the annual meeting of the American Psychiatric Association in New York City.

While it is true that many children may suffer from depression, some experts fear that the increase — and similar increases in the number of adults using antidepressants — are largely driven by the number of general practitioners diagnosing and prescribing treatment for patients with mood and behavior problems.

Often primary care providers do not have the appropriate training to distinguish clinical depression from other mental illnesses, such as bipolar disorder, which may leave large numbers of people treated inappropriately, says **Thomas W. Brown**, MD, assistant professor of psychiatry and behavioral science at Wake Forest University Baptist Medical Center in Winston-Salem, NC.

“When one (particularly a nonpsychiatrist) promiscuously puts people on antidepressants, a certain number of [the patients] will actually be dysphoric bipolars,” Brown says. “The abnormal high-energy mood is irritability, unhappiness, and the sense of ‘nothing’s right; nobody’s pleasing me, etc.’ If given an antidepressant, this mood is *intensified* — not alleviated.”

Understanding bipolar disorder

Specialists in psychiatry and neuroscience are just beginning to understand that bipolar disorder manifests itself in many different ways besides the “classic” cycling of extreme high-energy euphoric mania followed by deep depression, he says.

“In the area of bipolar disorder, one of the things that is true (or we are now finding to be true) is that any combination of abnormal affect, either the depressed side or the elevated side, is how bipolar can present,” he explains. “On the elevated side, it can be euphoric, or it can be irritable, or it can be happy, or it can be anxious. And any combination in terms of being purely

euphoric, depressed; partially depressed, partially euphoric; extremely irritable, partially depressed — any combination you can imagine occurring however it might over time — either cycling slowly or rapidly is how bipolar can present. There are no rules.”

Diagnosing bipolar disorder is extremely difficult and requires a complex and lengthy evaluation — something for which primary care providers have little time.

General practitioners attempt to stay abreast of new treatments for a variety of chronic ailments — from diabetes and rheumatoid arthritis to heart disease. Understanding the complexities of mental illness in sufficient detail to differentiate between them is too difficult a task for the generalists, Brown notes. And diagnosing patients with dysphoric bipolar disorder (irritable bipolar disorder) is particularly difficult.

Patients may feel that they are depressed because they feel in a negative mood all of the time, he says. Thus, they may present in a physician’s office and say they believe they are depressed.

However, it’s important to distinguish the classic symptoms of clinical depression (exhaustion, lack of sleep, inability to function, extremely sad or negative thoughts) with the higher energy negativity of dysphoric manic episodes.

“This is a very subtle diagnosis. If you are not seeing these types of patients a lot of time, it is not an inherently obvious diagnosis,” Brown explains. “One of the things I do to help my patients is I say, ‘Let me understand really clearly what this misery is in your life. Are you in the kind of depression where you sit there like all the air has been let out of the balloon, there is no energy, can’t move? Or, are you in the kind of misery where, although you are miserable, your thoughts are jumping around, you are jumping around, the sky is the wrong color of blue, everything makes you angry, you are frustrated, you are miserable, but you are not sitting there like a sad sack?’ And, they say, ‘Oh, believe me, Doc, I can’t sit there. Everything upsets me; I am not sitting there doing [absolutely] nothing!’”

“The thing that really distinguishes depression from an irritable dysphoria is that the person is unhappy as all get out, but they are mentally energized,” Brown concludes. “When someone is pulling a lot from the manic side, even when there is no euphoria, it is a mentally energized thing, even if at that moment, they are so unhappy they are crying. They have a mood abnormality, though, but it is not depression. But that may be

the best word that person knew to describe their symptoms.”

Misdiagnosis can lead to tragedy

Judith S. Lederman, the author of *The Ups and Downs of Raising a Bipolar Child: A Survival Guide for Parents*, knows all too well the difficulty primary care providers have accurately diagnosing mental illness in children.

Her son, Eric, was misdiagnosed as having attention-deficit hyperactivity disorder (ADHD) at the age of 8.

“His first suicide attempt was when he was 5 years old,” Lederman recalls. “Initially, the psychologist said to me, ‘He just likes attention, and he is a very clever, manipulative child. Just ignore these behaviors.’ That was the first practitioner who really fell down on the job, and we ended up in a very dangerous situation.”

Her son’s behavior problems continued off and on for the next three years, with periodic episodes or raging and erratic behavior at school, home, and his pediatrician’s office, she continues. When he was 8, he suddenly stopped sleeping for days at a time and exhibited threatening behavior to his siblings and parents.

At the end of her rope, Lederman agreed to hospitalize her son for a 72-hour psychiatric evaluation. The result was the diagnosis of ADHD, a prescription for Ritalin and Luvox, and discharged home.

The situation got much worse.

“The Ritalin and Luvox really sent him into psychosis,” Lederman recounts. “For two weeks, we lived in hell. He was completely unaware of what he was doing. He threatened to kill us. He took knives and threatened his siblings. He tried to burn the house down.”

Finally, Lederman and her husband were able to get in to see a psychiatrist who had been recommended to them. After examining him and taking a careful family history, her son was diagnosed with bipolar disorder and treated appropriately.

“When you are monitoring children for mood disorders like bipolar, you really need to take account of their energy levels, and their moods. You have to look at the whole picture,” Lederman notes. “It presents so weirdly in children — it is not classic at all. It is not happy, happy, happy, for three months, then sad, sad, sad. You can be looking at a child with *immense* energy who is irritable and depressed and in a terrible state, and an hour later it has switched. They often have rapid cycling and

SOURCES

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you see very strange fluctuations in energy and mood.”

Lederman’s pediatrician never attempted to address her son’s altered moods, she notes, usually simply refusing to examine him when he was manic and behaving erratically.

The therapists and psychologists who performed the initial evaluation on her son also did not take a careful family history, which would have revealed a paternal grandfather with a history of similar behavior and a diagnosis of involuntional melancholia.

Bipolar disorder frequently runs in families — and children with a family history of severe depression or other mental illness are at higher risk for being bipolar.

“Child and adolescent psychiatrists I talked to all know about bipolar disorder and can recognize it. It was these practitioners along the way [who misdiagnosed the problem] and even psychologists and therapists that are not really on board in terms of making the correct diagnosis or getting the patient to someone who can make the diagnosis,” Lederman says. “That is where our medical system is falling down on the job.”

Managed care and advertising play a role

Primary care providers need to become more educated about bipolar disorder and other mental illnesses, so they will understand when a situation is so complex that they need to make a referral to a specialist, Lederman says.

“They wouldn’t try to do brain surgery on someone, but they feel comfortable prescribing mind-altering medications with no problem,” she says. “Most pediatricians will step back at the right point on other issues. [For example,] I had a pediatrician look at my daughter’s chin injury, which needed stitches, and say, ‘I can’t do this. She needs to go to a plastic surgeon. I could do it, but it is not going to look as good.’ They need to know when to step back and say, ‘You know, it

may be ADHD, or it may be something else, and even though I took this history, I'd like you to get to someone who can look at it a little more."

Managed care organizations have pressured primary care providers to see more patients, to see them in quick office visits, and not to refer to specialists, Brown says. All of these factors are leading to more missed diagnoses of mental disorders.

"More people in general medicine need to, in more instances say, 'Look, I am an internist [or] I am a family practitioner. This is not what I specialize in. You, in fact, need to see someone who does specialize in this area,'" he says.

This does not mean that every patient needs to be in talk therapy or that every patient will have to continue seeing a psychiatrist. But a psychiatrist is the best clinician to appropriately screen patients with mood and behavioral disturbances, he adds.

Because some patients may be reluctant to see a psychiatrist initially, the general practitioner can encourage them by making it clear that he or she (the primary care provider) will continue to cooperate with the specialist in providing care.

"In the same way that they take someone who has arthritis and say, 'I think you may have rheumatic illness, and I am not a specialist in differential diagnosis of rheumatoid arthritis. You need to go see the rheumatologist,'" Brown explains. "Then you say, 'When the rheumatologist does the work-up and decides the course of treatment, [he or she] will send you back with a report, and I will be glad to follow you.'"

In the same way, the physician can tell the patient that the psychiatrist needs to perform an examination to ensure the patient is actually suffering from clinical depression, can adequately be treated with medication, and appropriately monitored by the primary care provider.

The current controversy over use of the class of antidepressants that are selective serotonin reuptake inhibitors (SSRIs) is indicative both of the number of people placed on these medications inappropriately, and in the difficulty general physicians may have in adequately monitoring patients who take them, Brown adds.

"I think this is where folks are getting [into] trouble and what is hitting the antidepressants with an undeserved bad name," he says. "If you take people who are depressed and put them on antidepressants, I simply refuse to believe that those people, because of the antidepressants, are in fact developing suicidal thoughts."

However, in its warnings issued to providers about the use of SSRIs in children, the U.S. Food and Drug Administration asked providers to watch for signs of agitation, anger, and irritability, Brown notes.

"They are describing classic signs of somebody hitherto undiagnosed with bipolar disorder who, when introduced to an antidepressant, could be stimulated into something that resembles hypomania, but doesn't look like it," he says.

Increased drug company marketing of antidepressants and other psychiatric drugs to both primary care physicians and to the public is also to blame for many of the mistaken diagnoses. This could ultimately land many physicians in trouble, Brown adds.

There is an emerging trend toward developing formulations that combine antidepressant and antipsychotic medications, and then marketing these formulations to primary care providers, but not psychiatrists. This is particularly frightening, Brown explains, because some antipsychotic medications carry risks of serious side effects, such as hypercholesterolemia, diabetes, or nerve disorders.

"They are [marketing] this to primary care physicians as a way to cover all of the bases," he says. "If the patient is depressed, they have the antidepressant. And if the patient also has schizophrenia or other severe psychosis, that would be covered as well."

For someone with schizophrenia, the risks might be justifiable, but to give the drug without knowing it is the patient's only alternative could do that patient serious harm and leave the physician open to legal action.

Someone with coexisting psychosis and depression should be under the care of a specialist — not a general practitioner, Brown notes. ■

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CME Questions

21. Which group of people do NOT make ideal translators in health care settings?
 - A. Family members of the patient
 - B. Bilingual physicians from other countries
 - C. Trained and certified interpreters
 - D. None of the above
22. According to the National Consensus Project for Quality Care's new clinical guidelines for provision of quality palliative care:
 - A. The guidelines contain objective standards that every program must meet
 - B. The guidelines are meant to provide an overview of what services a palliative care program should encompass
 - C. The guidelines were developed by a committee made up only of physicians specializing in hospital-based palliative care
 - D. All of the above
23. The Harris Interactive poll, *Therapy in America 2004*, found that:
 - A. More than one in four Americans has sought treatment for a mental health problem in the previous two years
 - B. More than one in three Americans who need treatment are not getting it
 - C. Eighty-one percent of the people with a mental treatment history are taking a prescription medication
 - D. All of the above
24. According to Thomas W. Brown, MD, what condition might inaccurately be diagnosed as clinical depression?
 - A. Attention-deficit hyperactivity disorder
 - B. Schizophrenia
 - C. Dysphoric bipolar disorder
 - D. None of the above

Answers: 21-A; 22-B; 23-D; 24-C.

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