

Nats Beat Blue Jays, 5-2; S. Williams Upset at Wimbledon | SPORTS, E1

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SUNDAY, JUNE 26, 2005

M1 M2 M3 M4 M5 V1 V2 V3 V4

Weather

Today: Mostly sunny, humid. High 91. Low 71.
Monday: Partly sunny, humid. High 87. Low 71.

Details, C12

128TH YEAR No. 203 M1 DC



FAMILY PHOTO

Sgt. Leigh Ann Hester, who fought insurgents in close combat outside Baghdad, is the first woman to receive the Silver Star since an Army nurse in World War II.

Silver Stars Affirm One Unit's Mettle

Women Play Key Roles In Combat Near Baghdad

By STEVE FAINARU
Washington Post Staff Writer

BAGHDAD — The two soldiers crept along the trench line, bullets thumping into the dirt around them. One was a lanky family man, 36, with two young sons and a 15-year career at International Paper Co. The other was a petite, single woman, 23, the floor manager at a Nashville shoe store.

Sgt. Leigh Ann Hester handed Staff Sgt. Timothy Nein a grenade. He had the better arm. Nein hurled it at the insurgents, who were crouched in the same trench, firing their AK-47 rifles at the Americans in the early afternoon.

Hester and Nein inched forward, the two recalled, Hester firing her black M-4 assault rifle next to Nein's ear. By the time the soldiers climbed out of the trench, their lips were chapped from the heat, their faces smeared with dirt, and four insurgents lay dead or dying nearby.

"I really don't know who killed who," said Hester, who stands 5-foot-4, speaks with a twang and walks with a swagger. "He could have got three, I could have got one, I don't know. I know for sure I got at least one."

The U.S. military handed out combat citations last week for the March 20 battle, in which a military police

See SILVER STAR, A21, Col. 1

MIND AND CULTURE | Psychiatry's Missing Diagnosis

Patients' Diversity Is Often Discounted

Alternatives to Mainstream Medical Treatment Call for Recognizing Ethnic, Social Differences

First of three parts

By SHANKAR VEDANTAM
Washington Post Staff Writer

When UCLA researchers reviewed the best available studies of psychiatric drugs for depression, bipolar disorder, schizophrenia and attention deficit disorder, they found that the trials had involved 9,327 patients over the years. When the team looked to see how many patients were Native Americans, the answer was . . .

Zero.

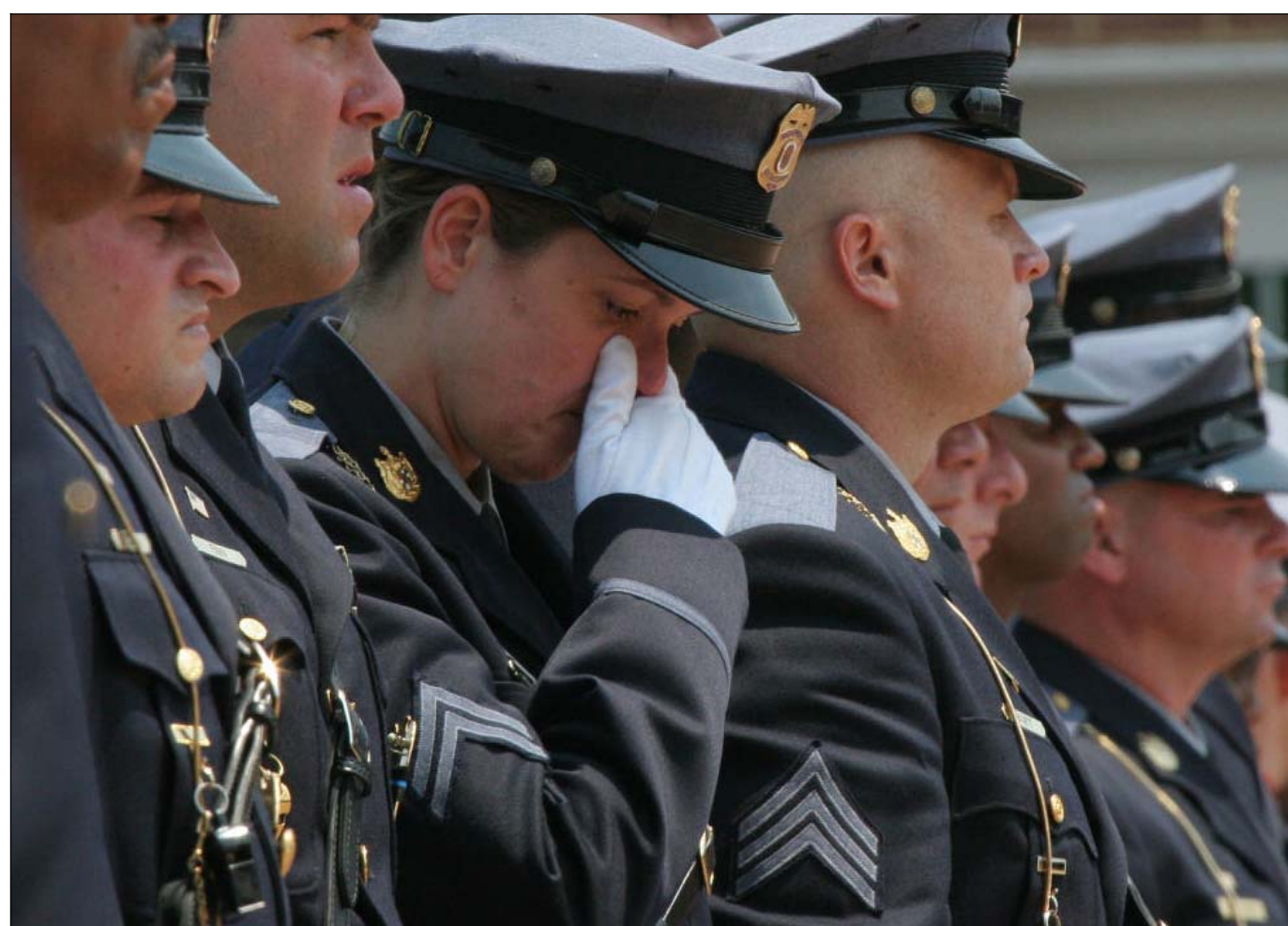
"I don't know of a single trial in the last 10 to 15 years that has been published regarding the efficacy of a pharmacological agent in treating a serious mental disorder in American Indians," said Spero Manson, a psychiatrist who heads the American Indian and Alaska Native Programs at the University of Colorado Health Sciences Center in Aurora. "It is stunning."

Native Americans are not the only group for whom psychiatrists write prescriptions with fingers crossed, the researchers at the University of Califor-

nia at Los Angeles found as they reviewed the data for a U.S. surgeon general's report: Of 3,980 patients in antidepressant studies, only two were Hispanic. Of 2,865 schizophrenia patients, three were Asian. Among 825 patients in bipolar disorder or manic depression studies, there were no Hispanics or Asians. Blacks were better represented, but even their numbers in any one study were too small to tell doctors anything meaningful.

In all, just 8 percent of the patients studied were

See PSYCHIATRY, A10, Col. 1



BY NIKKI KAHN — THE WASHINGTON POST

A Sea Of Grief For Md. Officer

At Riverdale Baptist Church in Upper Marlboro, Prince George's police Cpl. Katie Hart tries to gather her composure while waiting with other officers for the funeral of Prince George's Sgt. Steven F. Gaughan. Mourners recalled the mischievous and compassionate sides of Gaughan, who was shot Tuesday while chasing a suspect. Story, C1.

Rove Taking a More Public Role

Bush Adviser Playing Messenger for Second-Term Agenda

By DAN BALZ
Washington Post Staff Writer

He has risen to the highest ranks of the White House, carries the title of deputy chief of staff and presides over a broad portfolio of domestic and foreign issues. But even as he has morphed from political operative to policy adviser, Karl Rove retains the instincts of the direct-mail specialist he once was in Texas.

The verbal strike he aimed at liberals and liberalism during a speech to the New York Conservative Party on Wednesday night came straight out of the direct-mail manual: pithy, provocative and designed to energize one side by torching the other.

Rove's flamboyant remarks — in which he roused

conservatives by saying liberals prefer "therapy and understanding" for terrorists instead of retaliation — has put President Bush's top strategist back on stage. It's a place where he has seemed increasingly comfortable of late.

Through much of last year, by contrast, Rove remained largely in the shadows, avoiding on-the-record interviews or television appearances and the controversy that inevitably would have followed. A political lightning rod, whom Democrats accused of unfairly injecting the war on terrorism into the 2002 midterm elections, Rove let others in the campaign attack the Democratic nominee, Sen. John F. Kerry (Mass.), and

See ROVE, A7, Col. 1



BY YURI GRIPAS — REUTERS

Strategist Karl Rove has become increasingly visible in his new role as deputy chief of staff.

Viruses, Security Issues Undermine Internet

Experts Contemplate New Version

By ARIANA EUNJUNG CHA
Washington Post Staff Writer

DENVER — E-mails were flooding in from all over the country. Something strange was going on with the Internet, alarmed computer users wrote. Google, eBay and other big sites had suddenly disappeared. Kyle Haugsness scanned the reports and entered crisis mode.

Part of the Internet was broken. For the 76th time that week.

Haugsness was on duty for the Internet Storm Center, the closest thing to a 911 emergency-response system for the global network. He and a few colleagues began investigating and discovered that a hacker

had taken advantage of yet another security hole. As many as 1,000 companies had effectively had their connections "poisoned," so when their employees typed in legitimate addresses they were taken to bogus Web destinations. Haugsness wrote up an alert and a suggested solution, and posted it on the Web.

Then, Haugsness turned back to his inbox. In the few hours he had spent sleuthing that March day, several dozen e-mails detailing other suspected issues had piled up.

Built by academics when everyone online was assumed to be a "good citizen," the Internet today is

See INTERNET, A15, Col. 1

Colleges Compete to Shrink Their Mark On the Environment

By JULIET EILPERIN
Washington Post Staff Writer

BEREA, Ky. — Professor Richard K. Olson's voice swelled with pride as he reached the final stop — the bathroom — on a tour of Berea College's newest student housing.

"The throne!" he declared, displaying a massive, cream-colored composting toilet.

With its state-of-the-art wastewater treatment system, recycled wood cabinets and low-energy fluorescent lighting, Berea's \$10 million "Ecological Village" represents the cutting edge of environmental architecture. And while this small southern Appalachian college still consumes plenty of natural resources, it has spent several years trying to preserve its surroundings by conserving energy and shifting to recycling.

While Berea has gone further than most, it is hardly alone. After decades of inertia, American colleges and universities have begun to recognize that they have lagged behind the corporate world in tackling energy conservation and efficiency, greenhouse gas emissions and trash generation, and many are taking new steps to minimize their environmental "footprint."

From the College of the Atlantic's zero-waste graduation this month in Maine to Ball State University's bio-diesel-powered shuttle fleet in Indiana, schools are moving in ways large and small to cut energy use and carbon dioxide emissions.

They are driven by everything from the rising cost of

See COLLEGES, A8, Col. 1

INSIDE

A Tale of Nine Innings

From the best seat to the worst, eight writers descended on RFK Stadium to chronicle a randomly chosen evening of baseball. The home team lost. But Washington won. **THE MAGAZINE**

Dreaming Big

It had been three years since 625-pound John Keitz sat up; it's been seven since he stood on his feet. But he's working toward his dream of a normal life: one day and one pound at a time. **STYLE, D1**



BY KATHERINE FREY FOR THE WASHINGTON POST

A Taste of the Islands

Percy "Vola" Francis dances down Georgia Avenue NW during the 13th annual D.C. Caribbean Carnival parade before tens of thousands of spectators. The carnival, which includes food and crafts, continues today. **METRO, C12**

A Light-as-Air Image Veils Kendel Ehrlich's Political Heft

By MATTHEW MOSK
Washington Post Staff Writer

Maryland Gov. Robert L. Ehrlich Jr. had just settled into a midweek board meeting when first lady Kendel S. Ehrlich burst into the room with a white-frosted cake in her arms and son Joshua strapped to her chest in a BabyBjorn.

The governor announced that it was Maryland Comptroller William Donald Schaefer's birthday and that the Ehrlichs wanted to surprise him with a rousing rendition of "Happy Birthday." After a few moments of laughter and applause, Kendel Ehrlich gave her husband a June Cleaver wink and then leaned in and kissed his cheek.

"All right, honey," she told the

governor as TV cameras rolled, "Have a good day at work."

Twenty years ago, Kendel Ehrlich was a hard-driving public defender who built a reputation for toughness by striding confidently into the state penitentiary in Jessup to meet clients, ignoring catcalls from two tiers of convicts.

These days, Ehrlich, 43, is cheerfully crisscrossing Maryland as the upbeat antidote to her bare-knuckled husband, who has spent much of his first term trading blows with the state's Democratic establishment and battling the press corps.

She has flashed her dazzling smile at the Miss USA pageant in Baltimore and stood at the gover-

See EHRlich, A14, Col. 1

Today's contents are on A2

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MIND AND CULTURE | Psychiatry's Missing Diagnosis

Doctors' Approach Might Not Account for Patients' Diversity

PSYCHIATRY, From A1

minorities.

It is but one example of a larger pattern: Scientists have broadly played down the role of cultural factors in the diagnosis, treatment and outcome of mental disorders. In part, this is because modern psychiatry is based on the idea that mental illnesses are primarily organic disorders of the brain. This medicalized approach suggests that the symptoms, course and treatment of disorders ought to be the same whether patients are from the Caribbean, Canada or Cambodia.

This model has produced striking successes. Neuroscientists have uncovered key details about how the brain functions and malfunctions, and drug companies have found many effective medications. More patients than ever before have received treatments that have been proven to work.

As the population of the United States grows ever more diverse, however, this approach is facing challenges from within the profession's own ranks. A growing number of advocates for "cultural competence," many of whom are minorities themselves, warn that doctors are harming patients by ignoring evidence about the effects of ethnicity, sex, religious beliefs, social class and national origin on mental health and mental illness.

"The [drug] companies are thinking about the average Caucasian, male patient," said psychiatrist Michael Smith, at UCLA's Research Center on the Psychobiology of Ethnicity, who bemoaned the vacuum of information about drug metabolism and side effects among various groups. Some minorities' distrust of drug trials further compounds the problem, he and other researchers said.

"This thing called psychiatry — it is a European-American invention, and it largely has no respect for nonwhite philosophies of mental health and how people function," agreed Carl Bell, a psychiatrist at the University of Illinois at Chicago.

"A lot of minority groups perceive psychiatric interventions as an ideological approach that discounts their own cultures," added Marcello Maviglia, a psychiatrist who has worked extensively with Native American patients in New Mexico. "A lot of people wouldn't be able to verbalize this, but patients know when you are discounting them, their traditions."

Leaders of mainstream psychiatry vehemently reject this critique. Darrel Regier, director of the division of research for the American Psychiatric Association, said biomedical treatments for mental disorders had been objectively shown to be superior to any other system.

"To say you want to go back to nature and have all the benefits of close-knit families take the place of psychotropic medications — that is wishful thinking and likely dangerous," he said.

Different Viewpoints

Historically, the problem is that psychiatry has been muddled by conflicting theories about the nature of mental illnesses, Regier said. While cultural variations among groups are useful to know about, he added, it is more important for psychiatrists to home in on genetic markers and the brain mechanisms that could be universal to all patients.

"Doctors in general are reductionist," he said. "A patient walks in and you have 10 minutes to find out what in their whole life story is significant. There is a tremendous screening process to cut out irrelevant material."

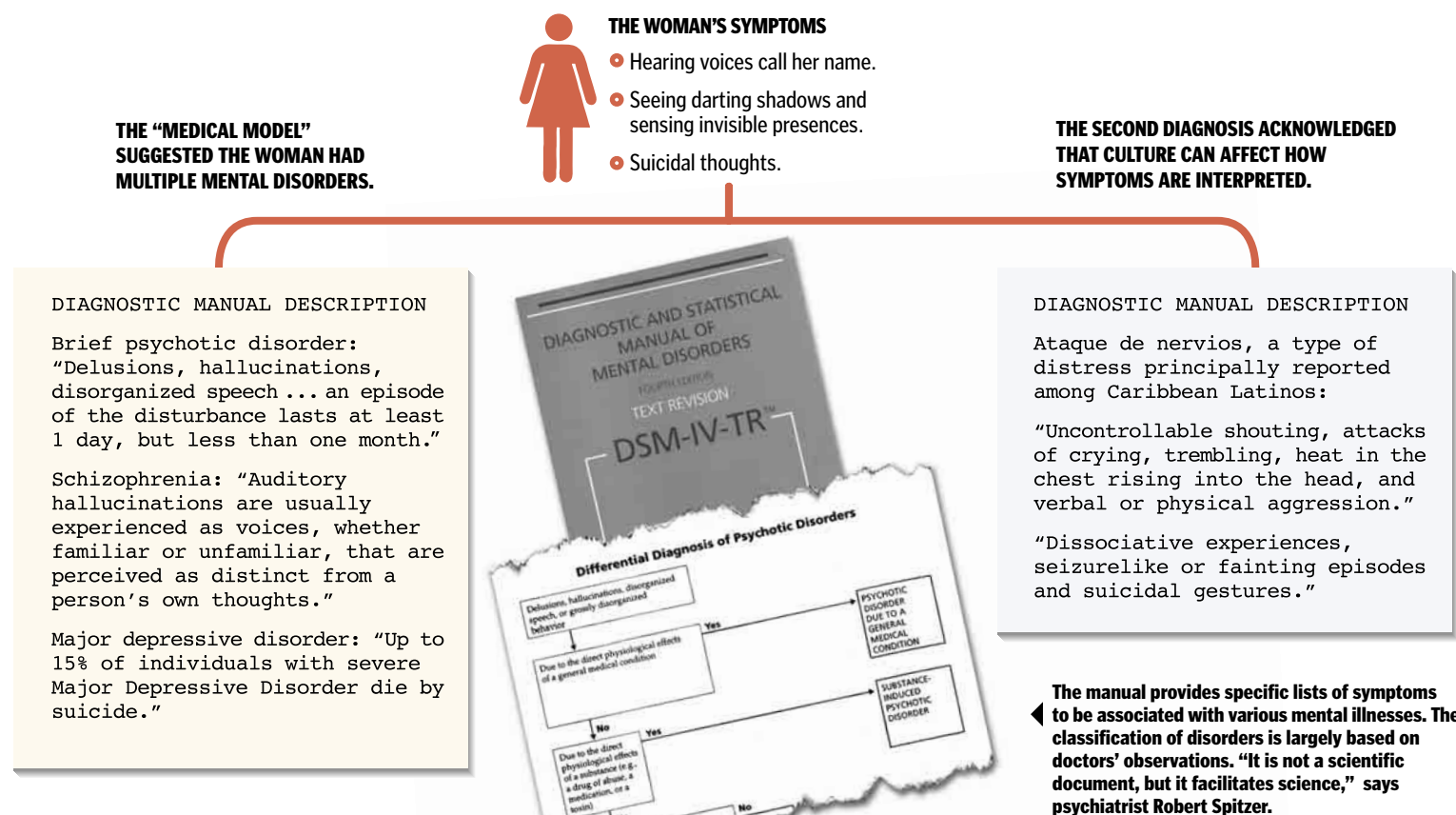
Columbia University psychiatrist Robert Spitzer, who played a key role in popularizing the medical model of psychiatry, said the cultural advocates are letting politics trump science. "They don't by and large do controlled studies. They mainly complain about the biomedical model."

Spitzer and Regier reflect the eagerness among mainstream psychiatrists to move away from the mushy complexities of culture and the myriad ways in which emotional problems are expressed by different groups, and toward a straightforward system that links groups of symptoms to particular disorders. Ultimately, they hope to find neurological evidence, genetic markers and laboratory tests to differentiate mental problems.

If malfunctioning genes and neurotransmitters can be shown to cause depression, for example,

Disparate Diagnoses

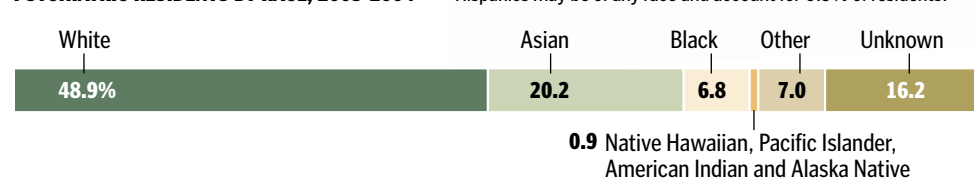
Two groups of doctors produced different diagnoses for a distressed Puerto Rican woman. The first was that she was psychotic and depressed, and she was given medication. The second diagnosis was "ataque de nervios" — expressions of distress that are fairly normal in her culture — and she was provided with family counseling. Both diagnoses are described in the "Diagnostic and Statistical Manual of Mental Disorders," the bible of mental disorders for American psychiatrists.



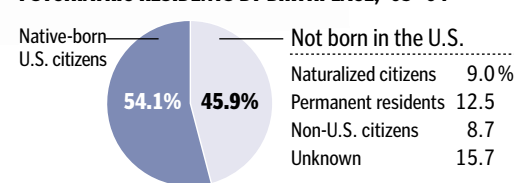
Diversity in the Profession

Many psychiatrists are stressing the importance of cultural understanding in psychiatry. Cross-cultural issues affect white patients as well as minorities: Large numbers of psychiatric residents are foreign born and non-white. Advocates for "cultural competence" say differences in language, social class and religious beliefs can also create misunderstandings between doctors and patients.

PSYCHIATRIC RESIDENTS BY RACE, 2003-2004



PSYCHIATRIC RESIDENTS BY BIRTHPLACE, '03-'04



SOURCES: American Psychiatric Association; Diagnostic and Statistical Manual of Mental Disorders; case study presented by Roberto Lewis-Fernandez published in Psychiatric Quarterly

THE WASHINGTON POST



BY JOHN GRESS FOR THE WASHINGTON POST

Psychiatry "is a European-American invention, and it largely has no respect for nonwhite philosophies of mental health and how people function," Carl Bell in Chicago says.

these experts say doctors will be able to treat such problems at their root, making diagnosis and treatment more effective, in the same way that the discovery of the virus that causes AIDS led to highly targeted treatments.

Advocates for cultural competence counter that no matter how much science learns about the brain, culture and the environment will continue to play a huge role in why people develop emotional problems, what treatments they respond to and whether they recover. Doctors, they say, cannot afford to ignore the numerous effects of culture on diagnosis and treatment that have been documented through various streams of evidence and multiple studies in peer-reviewed publications. Among them:

- Patients with schizophrenia, a disease characterized by hallucinations and disorganized thinking, recover sooner and function better in poor countries with strong extended family ties than in the United States, two long-running studies by the World Health Organization have shown.

- People of Mexican descent born in the United States have twice the risk of disorders such as depression and anxiety, and four times the risk of drug abuse, compared with recent immigrants from Mexico. This finding is part of a grow-



BY MARVIN JOSEPH — THE WASHINGTON POST

At the American Psychiatric Association, from left, Gionne Johnson, Jessica Mikulski, Darrel Regier and William Narrow discuss mental health issues. Biomedical treatment is preferable, Regier says, as it has been objectively shown to be superior to other models and leads to systematic approaches to treatment.



BY HELAYNE SEIDMAN FOR THE WASHINGTON POST

Roberto Lewis-Fernandez says miscommunication is inevitable as growing ranks of foreign-born psychiatrists encounter white America.

ing body of literature that indicates that the newly arrived are more resilient to mental disorders, and that assimilation is associated with higher rates of psychiatric diagnoses.

- Black and Hispanic patients are more than three times as likely to be diagnosed with schizophrenia as white patients — even though studies indicate that the rate of the disorder is the same in all groups.
- White women in the United

center, said that because psychiatric drugs affect behavior and change how people feel, their effects are powerfully modified by patients' beliefs.

The effects of such drugs "are not solely determined by their pharmacological properties," wrote Lin and colleagues in a book, "Psychopharmacology and Psychobiology of Ethnicity." "The prescription and use of medication is enmeshed in a process replete with social and symbolic meanings and implications."

Cultural Influence

Psychiatric diagnoses are similarly influenced by culture, said Maria Oquendo, a psychiatrist at Columbia University. Women from different cultures, for instance, face very different norms about what constitutes an ideal body weight — and this influences the course of certain disorders: "We consider anorexia nervosa to have biological underpinnings and, therefore, universal, but in less industrialized cultures, anorexia is vanishingly rare. Culture informs our decisions on what we consider normal."

"If we understand that our definition of pathological isn't pathological in other countries, we can make better decisions on when to treat, especially with medica-

tions," she added.

Advocates for culture's role in psychiatry describe many case studies to illustrate their argument: Roberto Lewis-Fernandez was a young doctor in training in Massachusetts when he encountered a patient who was 49 and suicidal at Cambridge Hospital. The Puerto Rican woman begged for help in resolving a conflict with her son, but the Harvard University-affiliated psychiatrists focused on one set of symptoms — she was hearing voices, seeing darting shadows and sensing invisible presences.

They diagnosed her as depressed and psychotic, or out of touch with reality, and medicated her. She was discharged. Soon after, the woman had an argument with her son and nearly killed herself by overdosing on the medication.

For Lewis-Fernandez, who is Puerto Rican, the suicide attempt confirmed his fears that his superiors had misjudged the situation. For months, as top psychiatrists ordered him to keep increasing the potency of her drugs, he had told himself that hearing voices, seeing shadows and sensing presences is considered normal in some Latino communities. But he dared not challenge the wisdom of the medical model.

"I wasn't sure if she was psychotic, but I treated her as if she was," he said about the case, which he wrote up in a medical journal. "I gave her the medicines."

When the hospital's outpatient unit evaluated the woman anew, doctors there came up with a different diagnosis. They concluded that her symptoms were not abnormal in the context of her culture — they were expressions of distress, not illness. Lewis-Fernandez helped her reconcile with her son. She still heard voices and saw shadows, but now, as before, they did not bother her.

Unlike anti-psychiatry groups that wish to do away altogether with drugs and doctors, advocates for cultural competence argue only against one-size-fits-all thinking. Genetic vulnerabilities and brain chemistry are undoubtedly important, said Lewis-Fernandez, but his patient was badly served because doctors assumed all her problems could be reduced to brain chemistry.

"Sure, after a certain amount of suffering for a certain amount of time, your brain reacts," he said. "The idea of mainstream psychiatry is that the pill will correct the chemical imbalance in the brain. Yes, but the imbalance keeps happening because of the situation she is in, and the pill can't correct the situation."

Minority patients are not the only ones affected: For one thing, about 40 percent of U.S. doctors training in psychiatry today are foreign-born. "There are so many international psychiatric residents that the real cross-cultural encounters are going to be between foreign physicians and white Americans," Lewis-Fernandez said. "Filipino and Indian doctors [will be] meeting your average Ohioan and saying, 'I don't understand you.'"

Nor are misunderstandings limited to issues of ethnicity. Differences between clinicians and patients in language, social class or religious belief can also be pitfalls, the advocates warn. Janice Egeland, a behavioral scientist who has worked nearly three decades with the Amish, said she realized something was very wrong when an Amish man went to a friend's house to watch baseball on TV. In the context of Amish culture, which shuns material luxuries and modern technology, his seemingly ordinary action alerted Egeland to a problem that might have been missed by a less experienced clinician. She soon discovered the man had not merely watched the game.

"He was jumping all around, pretending to run the bases," she said. After a thorough evaluation, she realized he was suffering from manic depression, a disorder characterized by alternating bouts of euphoria and depression.

In Illinois, a truck driver was diagnosed as psychotic after he said he frequently saw the devil sitting near him, warning that his life was going to take a turn for the worse. Then a doctor trained to pay attention to cultural issues realized the man was an evangelical Christian whose allegorical religious expression had been misunderstood as a hallucination by secular physicians, said Gary Myers, a clinician at Southern Illinois University in

About This Series

TODAY

Modern psychiatry asserts that mental illnesses are basically organic disorders of the brain. But a growing number of psychiatrists, many of whom are minorities, say doctors are ignoring the role of ethnicity, sex, nationality and religious beliefs in the origin and outcome of mental disorders.

TOMORROW

A little-known study by the World Health Organization discovered that the outcome of schizophrenia, a deadly mental illness involving hallucinations and disordered thinking, is better in poor countries with limited medical infrastructure than in rich countries such as the United States. Scientists have struggled for decades to explain why.

TUESDAY

Blacks and Hispanics in the United States are far more likely to be diagnosed with serious psychotic disorders than whites. Now, a group of experts who advocate "cultural competence" are asking whether bias may influence psychiatric diagnosis.

MIND AND CULTURE | Psychiatry's Missing Diagnosis

Better Tailored Treatments Could Improve Outcome

PSYCHIATRY, From A10

Springfield.

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

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

A Common Vocabulary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

'Hardly Objective'

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

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

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

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

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

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

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

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

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

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



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



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



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

PHOTOS BY JOHNNY SUNDBY FOR THE WASHINGTON POST

Healers Prescribe Tribal Tradition

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

By SHANKAR VEDANTAM
Washington Post Staff Writer

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

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

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

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

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

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

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

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

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

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

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

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

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

"The medicine man listened to her and

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

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

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

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

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

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

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

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

An Untested Aspect

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

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

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

THE WASHINGTON POST

Birdie Kim Wins U.S. Women's Open on Final Hole | SPORTS, E1

The Washington Post

MONDAY, JUNE 27, 2005

M1 M2 M3 M4 M5 V1 V2 V3 V4

DISTRICT & MARYLAND FINAL

35¢

Prices may vary in areas outside metropolitan Washington. (See box on A2)

Weather

Today: Humid, storms. High 84, Low 70.
 Tuesday: Partly sunny, storms. High 84, Low 72.

Details, B6

128TH YEAR No. 204 M2 DC MD

Settler Resistance in Gaza



Israeli soldiers scuffle with a Jewish settler trying to prevent army bulldozers, back right, from demolishing uninhabited beachfront buildings outside the Jewish settlement of Shirat Hayam in the southern Gaza Strip. Hard-line settlers tried to take over the buildings to protest Israel's planned withdrawal from the area. Story, A12.

BY SHOHAM HADAD — ASSOCIATED PRESS

U.S. Plans New Tool to Halt Spread Of Weapons

Measure to Target Assets of Anyone Tied to Suspect Firms

By DAFNA LINZER
Washington Post Staff Writer

The Bush administration is planning new measures that would target the U.S. assets of anyone conducting business with a handful of Iranian, North Korean and Syrian companies believed by Washington to be involved in weapons programs, U.S. officials said yesterday.

The latest action is outlined in a draft executive order administration officials are hoping President Bush will sign before attending the Group of Eight summit in Scotland on Saturday. Officials who agreed to discuss the details only on the condition of anonymity said that the order's success would rely heavily on U.S. intelligence and that it is modeled in part on measures the government took against al Qaeda's finances shortly after the terrorist strikes of Sept. 11, 2001.

According to an internal government memo, it would provide a new tool in the efforts to stop trafficking in weapons of mass destruction "by authorizing the blocking or 'freezing' of assets of WMD proliferators and their supporters, and thereby prohibiting U.S. persons from engaging in transactions with them."

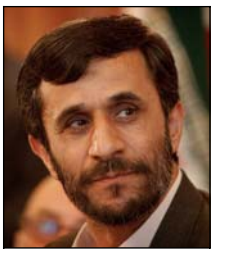
The effort would begin by targeting just eight entities, seven of which are suspected of working on missile programs, and not on chemical, biological or nuclear weapons. According to a government list obtained by The Washington Post, three companies identified are North Korean; four are Iranian, including the country's energy department; and one is a Syrian government research facility. Three of the eight companies have been targeted

See IRAN, A12, Col. 1

Iranian Defends Nuclear Program

In his first post-election news conference, incoming president Mahmoud Ahmadinejad affirms Iran's right to nuclear technology for peaceful uses.

WORLD, A12



U.S. Talks With Iraqi Insurgents Confirmed

Goal Is Sunnis' Political Inclusion, Rumsfeld Says

By DANA PRIEST
Washington Post Staff Writer

The U.S. military in Iraq has been holding face-to-face meetings with some Iraqi leaders of the insurgency there, Defense Secretary Donald H. Rumsfeld and the U.S. commander in charge of Iraq confirmed yesterday.

The talks are part of the military's revised campaign to drive a wedge between the Iraqi and foreign insurgents, according to U.S. commanders. Pentagon officials have acknowledged the new strategy but have not, until now, spoken openly about efforts to make contact with some Iraqi insurgent leaders.

Asked to respond to a report that U.S. military representatives had meetings with several Sunni Iraqi insurgents twice in June, Rumsfeld told Fox News that "there have probably been many more than that" and described the contacts as an effort to "split people off and get some people to be supportive" of the political process in Iraq.

Other parts of the U.S. government, including the State Department and CIA, have also been holding secret meetings with Iraqi insurgent factions in an effort to stop the violence and coax them into the political process, according to U.S. government officials and others who have participated in the efforts.

The military plan, approved in August 2004, seeks to make a distinction between Iraqi insurgents who are attacking U.S. troops be-

See INSURGENTS, A11, Col. 1

Three Suicide Attacks Kill 26 in Northern Iraq

Attackers in Mosul struck a hospital, a military base and the city's police headquarters, where many remain unaccounted for.

WORLD, A11

MIND AND CULTURE | Psychiatry's Missing Diagnosis

Social Network's Healing Power Is Borne Out in Poorer Nations

Second of three articles

By SHANKAR VEDANTAM
Washington Post Staff Writer

RAIPUR RANI, India — Psychiatrist Naren Wig crossed an open sewer, skirted a pond and, in the dusty haze of afternoon, saw something miraculous.

Krishna Devi, a woman he had treated years ago for schizophrenia, sat in a courtyard surrounded by religious pictures, exposed brick walls and drying laundry. Devi had stopped taking medication long ago, but her articulate speech and easy smile were eloquent testimony that she had recovered from the debilitating disease.

Few schizophrenia patients in the United States are so lucky, even after years of treatment. But Devi had hidden assets: a doting family and an embracing village that never excluded her from social events, family obligations and work.

Devi is a living reminder of a remarkable three-decade-

long study by the World Health Organization — one that many Western doctors initially refused to believe: People with schizophrenia, a deadly illness characterized by hallucinations, disorganized thinking and social withdrawal, typically do far better in poorer nations such as India, Nigeria and Colombia than in Denmark, England and the United States.

The astounding result calls into question one of the central tenets of modern psychiatry: that a "brain disease" such as schizophrenia is best treated by hospitals, drugs and biomedical interventions.

European and U.S. psychiatrists were so shocked by the initial findings in the 1970s that they assumed something was wrong with the study. They repeated it. The second trial produced the same result. The best explanation, researchers concluded, is that the stronger family ties in poorer countries have a profound impact on recovery.

See PSYCHIATRY, A6, Col. 1



Much has changed in and around Bentonville, Ark., where the visitors center stands on the site of Sam Walton's original discount store, left, and the population has boomed in Benton County. At the Market in Rogers, Susan Ang prepares an order of sushi.



PHOTOS BY SPENCER TIBBY FOR THE WASHINGTON POST

Upscale Tastes Invade Wal-Mart's Hometown

Migration of High-Priced Executives Transforms Arkansas County

By MICHAEL BARBARO
Washington Post Staff Writer

BENTONVILLE, Ark. — Wal-Mart's folksy, baseball cap-wearing founder, Sam Walton, so despised public displays of wealth that, after his death in 1992, the billionaire's heirs decided to enshrine his prized possession, a battered Ford pickup, behind a simple storefront on the town square here.

But Walton's spirit of restraint is harder to find next door to the museum at Fusion, a new fine-arts gallery that sells \$2,500 abstract paintings and \$1,200 urns. Or at the nearby Landers Hummer dealership, crowded with \$62,000 sport-

utility trucks. Or inside Shadow Valley, a gated community where four-bedroom houses fetch \$1 million.

The hard-nosed retailing tactics of Wal-Mart Stores Inc. have transformed communities across the country, but none more so than the one in its own back yard. Benton County, once a sedate backwater, is quickly morphing into a swanky oasis in the middle of the Ozarks.

Wal-Mart's unchallenged dominance in American retailing—it now sells about 30 percent of many household consumables—has persuaded scores of suppliers to open satel-

See WAL-MART, A8, Col. 1

INSIDE

Pencils Ready?

A new feature joins the comics pages: Sudoku, a daily number puzzle that doesn't require arithmetic.

STYLE, C13

A Sorry State Of Affairs

Politicians are demanding apologies right and left lately — test your knowledge of who said what in a game where "Sorry" is always a possible answer.

STYLE, C1

Annual Survey Of Executive Pay

The corporate elite reap rich rewards, even in some cases as stock prices fall.

WASHINGTON BUSINESS, D1

Today's contents are on A2



For Mexico's Fox, a 'Revolution' Unfulfilled

By KEVIN SULLIVAN and MARY JORDAN
Washington Post Foreign Service

MEXICO CITY — Five years after his historic election on July 2, 2000, as President Vicente Fox enters the twilight of his term and the nation moves toward elections next year in which he is not eligible to run, even his critics say he has made government more honest and transparent, fortified the economy and championed democracy.

But the idea of Fox as a revolutionary, a powerful figure who would energize and modernize a nation long strangled by corrupt and authoritarian government, has died. And many of his closest advisers say that despite his image, Fox succumbed far earlier than anyone realized, and sooner than they wanted to admit at the time.

Several advisers said that within weeks of the election, major problems emerged, including Fox's distaste for confrontation and his rejection of get-tough politics with the Institutional Revolutionary Party, or PRI, which ruled Mexico for seven decades until Fox became president. In addition, he was nearly paralyzed by concern that adversaries, if provoked, could destabilize the economy with strikes or protests.

Within a year, the advisers said, the bold promise of his administration had all but evaporated.

"The Fox revolution died in the transition," said Adolfo Aguilar Zinser, a key aide to Fox and architect of his presidential campaign, referring to the five months between his election and inauguration.

See MEXICO, A10, Col. 1



Contents © 2005 The Washington Post Company

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MIND AND CULTURE | Psychiatry's Missing Diagnosis

Treatment Strategies Place Differing Emphasis on Family

PSYCHIATRY, From A1

"If you have a cardiovascular problem, I would prefer to be a citizen in Los Angeles than in India," said Benedetto Saraceno, director of the department of mental health and substance abuse at WHO's headquarters in Geneva. "If I had cancer, I would prefer to be treated in New York than in Iran. But if you have schizophrenia, I am not sure I would prefer to be treated in Los Angeles than in India."

Most people with schizophrenia in India live with their families or other social networks — in sharp contrast to the United States, where most patients are homeless, in group homes or on their own, in psychiatric facilities or in jail. Many Indian patients are given low-stress jobs by a culture that values social connectedness over productivity; patients in the United States are usually excluded from regular workplaces.

Indian families sit in on doctor-patient discussions because families are considered central to the problem and the solution. In America, doctor-patient conversations are confidential — and psychiatrists primarily focus on brain chemistry.

Norman Sartorius, the former head of WHO's mental health program, spearheaded the schizophrenia studies. He says there is much the United States and Europe could learn from villages such as Raipur Rani.

In an interview at his home in Geneva, he said Western countries could financially help families take care of their relatives, which would save money on hospitalization and incarceration. Caregivers might be given time off from jobs. And doctors could enlist recreational and religious groups to replace the social networks that patients lose.

"Social factors play a major and important role in the outcome of disease," Sartorius said. "Very few solutions are medical in medicine."

Decades of research have supported the WHO findings, but they have met with stony silence in the United States, in part because anti-psychiatry groups have argued erroneously that the studies prove that drugs and doctors are useless. Most U.S. psychiatrists see schizophrenia as an organic brain disorder, whose origins and outcome depend on genes and brain chemistry. They acknowledge the psychosocial aspects of disease, but the challenges of connecting patients with jobs, schooling and social networks are neglected — often because they fall outside the bounds of traditional medicine.

Asked whether he would agree that schizophrenia patients might be better off in Nigeria than in New York, Darrel Regier, director of research at the American Psychiatric Association, was blunt: "God, no!"

Regier is not alone. Patient advocacy groups are also uneasy about giving families a central role because, in a previous era, a now-discredited theory blamed schizophrenia on poor parenting.

Drug manufacturers, too, are focused elsewhere. "Pharmaceutical companies, which control the scientific production of research at universities, are not interested in saying, 'Social factors are more important than my drug,'" said Jose Bertolote, a WHO psychiatrist. "I'm not against the use of medication, but it's a question of imbalance."

Western doctors cannot write prescriptions for stronger family ties, Bertolote said. But Indian psychiatrists, unlike their Western counterparts, dispense not only drugs but also spiritual advice, family counseling — even matchmaking services. Indian doctors are seen not only as medical experts, but as wise authority figures.

In the south Indian city of Chennai, psychiatrist Shantha Kamath writes prescriptions for better family ties: When a father asked for her help in arranging the marriage of his daughter, who has schizophrenia, Kamath's written instructions told the parents how to interact with their daughter and listed the skills the young woman needed to learn before the doctor would arrange a match.

Trend Emerged Slowly

The International Pilot Study on Schizophrenia was launched in 1967 to determine whether the disease existed in all countries and whether it could be reliably diagnosed and treated.

The study quickly established that the disease occurs everywhere. Only gradually did it emerge that patients in poor nations had better



Psychiatrists Naren Wig, center, and Arun Misra meet with Krishna Devi and her grandson Nikhil in Raipur Rani, India. Devi took part in a long-term study tracking patients with schizophrenia in poor and rich countries, and her doctors say that strong social supports played an important role in her recovery.

washingtonpost.com

The complete series can be viewed at www.washingtonpost.com/nation. Washington Post staff writer Shankar Vedantam will be online at noon tomorrow at www.washingtonpost.com/liveonline to discuss his series about how culture influences the diagnosis, treatment and outcome of mental illness.

outcomes. The second study, which had more rigorous guidelines, included Naren Wig's patients in Raipur Rani village.

In all, the study tracked about 3,300 patients, Sartorius said, and 30-year follow-ups confirmed the initial trends. The study spanned a dozen countries — capitalist and communist, eastern and western, northern and southern, large and small, rich and poor.

The results were consistent — and surprising. Patients in poorer countries spent fewer days in hospitals, were more likely to be employed and were more socially connected. Between half and two-thirds became symptom-free, whereas only about a third of patients from rich countries recovered to the same degree, Sartorius said.

Nigerian, Colombian and Indian patients also seemed less likely to suffer relapses and had longer periods of health between relapses. Doctors in poorer countries stopped drugs when patients became better — whereas doctors in rich countries often required patients to take medication all their lives.

A separate study, in rural China, recently revealed that low doses of medication could be as effective as high doses, and virtually eliminated side effects, said Martin Gittelman, a clinical professor of psychiatry at New York University. And older medications, largely discarded in wealthier countries, were as effective as newer, expensive anti-psychotic drugs.

The secret? The "hand labor" of extended families and primary care workers to constantly monitor patients and bump up medication dosages at the earliest sign of psychotic flare-ups, Gittelman said. Nuclear families in more urbanized societies are often unable to provide that kind of help and monitoring, he added: "Urban Shanghai may look closer to urban New York than to rural China."

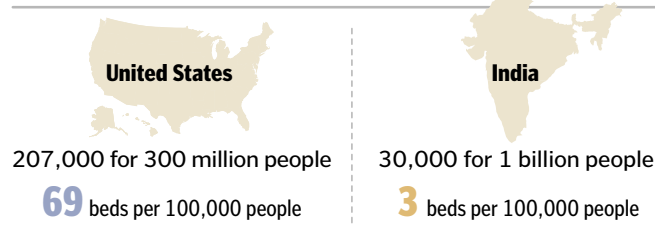
"A culture like ours is oriented around individual autonomy and accomplishment," said William Carpenter, a psychiatrist at the University of Maryland in Baltimore who helped run a wing of the WHO study in the Washington area. In countries such as Denmark, "if you were psychotic, you were on disability for life. Virtually nobody who had schizophrenia had a job."

In country after country, WHO found that strong social and family connections trumped high-tech medical facilities. Wig, the Indian psychiatrist, had just launched a psychiatry department in the north-

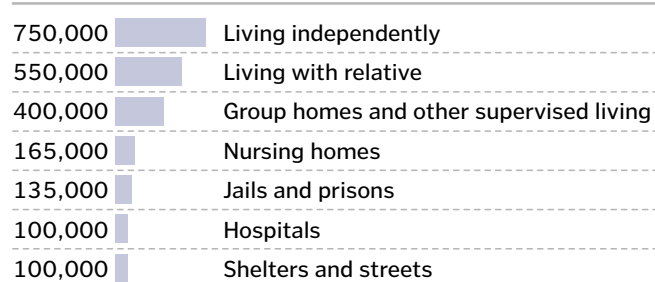
Care and Remission

Most patients with schizophrenia in India are cared for by relatives and other social networks. The United States, by contrast, relies much more on medical and public infrastructure.

NUMBER OF PSYCHIATRIC BEDS

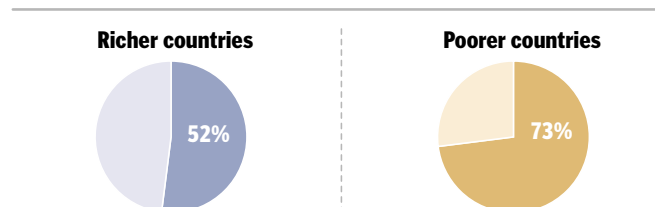


WHERE PEOPLE WITH SCHIZOPHRENIA LIVE IN THE UNITED STATES

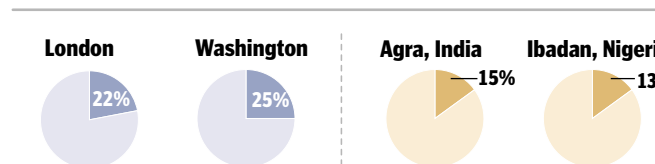


People with schizophrenia in poorer countries such as India appear to fare better than those in richer countries.

PATIENTS WITH FULL OR PARTIAL REMISSION FIVE YEARS AFTER DIAGNOSIS



PERCENTAGE OF PATIENTS WHO SPENT 75 PERCENT TO 100 PERCENT OF THE TIME IN ACUTE PSYCHOSIS FIVE YEARS AFTER DIAGNOSIS



SOURCES: Indian Journal of Medical Research, August 2004; "Surviving Schizophrenia," by E. Fuller Torrey; World Health Organization studies published in 1992 and 1996; U.S. Substance Abuse and Mental Health Services Administration

THE WASHINGTON POST



Misra visits his patient Surjit Kaur, whose grandmother Purni Kaur stays with her at the hospital. Psychiatrists at the Chandigarh hospital say relatives can soothe agitated patients better than professional nurses.

ern Indian city of Chandigarh when the second phase of the WHO study began in 1978. He had no nurses. Out of necessity, he asked families to stay with patients 24 hours a day.

Relatives became the nurses. The practice persists to this day.

The tight security found at most American psychiatric wards is absent in Chandigarh: For one thing,

it is unaffordable, but Wig also found that relatives are more effective than strangers in calming agitated patients.

Patients at the Chandigarh hospital today pay a dollar a day. That includes meals. As the WHO study got underway, Wig realized there were many patients in India who could not afford even the inexpensive hospital care. The study therefore included patients in the nearby village of Raipur Rani, where doctors could dispense outpatient care.

Krishna Devi was 22 when she was enrolled in the study. Doctors noted that her thinking was disordered — she talked about irrelevant things and turned aggressive without reason. She was paranoid and hallucinated that a man was chasing her, said Arun Misra, a psychiatrist who treated her and maintained neat, handwritten records in bound folders of now-yellowing sheets of paper.

The villagers had their own explanations for Devi's behavior — no one had heard of schizophrenia. And Devi's odd behavior was seen as no reason to keep her isolated. She got married and had five children. Devi's husband, a potter, was supportive, as were other relatives. Neighbors helped too, and in time, she said, she got better.

Wig, who trained as a psychiatrist in England, keeps up with the latest research, but mostly he tells his patients about religious figures who overcame obstacles. He never tells them schizophrenia is a chronic, incurable brain disease. And he encourages patients to complement his treatment with faith-healing techniques.

"In India, people do not accept the medical model of schizophrenia," Wig said. "The medical model says, 'This is a genetic, biochemical thing and you have to keep giving medicine and there is nothing else that can be done.' ... Indian patients continue to sustain hope."

Families Play a Crucial Role

Lakshmi Ramachandran lived in Detroit, but she decided to take her son back to India after he was diagnosed with schizophrenia in his early twenties. The family had moved to the United States when Rajesh was 2, but after he fell ill it was decided he would do better in Chennai.

"He likes the crowds — in Detroit, you had to motivate yourself to socialize," the mother said in an interview in Chennai. "Here, the neighbors come and ask, 'Hi, Rajesh, how are you?'"

Families are the reason Indian patients have better outcomes, said psychiatrist R. Thara Srinivasan, who heads a nonprofit treatment facility called the Schizophrenia Research Foundation (SCARF) in Chennai. The foundation has independently verified the WHO study results.

"My theory is that the family here ensures they take medication properly," said the psychiatrist, who prefers to be identified by the single name Thara. "Compliance is a problem in the West."

If patients refuse medication, Thara instructs families to crush the pills and disguise the medicine

in food. During a reporter's visit, another SCARF psychiatrist, Shantha Kamath, paid a small amount of money to her patient for taking an anti-psychotic injection — a reward he has now come to expect.

Westerners have criticized such practices, but Thara argues that patient-doctor relationships in India are fundamentally different from those in America: The relationships may be paternalistic, but the benefits are lower costs and less fragmentation. On an annual budget of \$67,000, SCARF treats 1,200 patients, dispenses free drugs, runs three residential facilities for 150 patients and offers vocational training each day for 100 patients.

Social connectedness for patients is seen as so important that the psychiatrists tell families to secretly give money to employers so that patients can be given fake jobs, work regular hours and have the satisfaction of getting "paid" — practices that would be unethical, even illegal, in the United States.

While work and family are clearly beneficial for patients, Thara acknowledged that caregivers, who are usually women, pay a price.

"My parents told me to get married," said one Chennai woman, C. Chitra, whose marriage was arranged when she was 23. Her in-laws, who came from a wealthier family, had told her only that her husband-to-be sometimes "got angry."

Chitra thought nothing of it: "Everyone gets angry."

But her 34-year-old husband had schizophrenia. "He hit me without reason," she said.

Chitra did not consider divorce: She felt her options as a poor, divorced woman would be worse. Shortly thereafter, her husband's brother moved in with them — and he had schizophrenia, too. Chitra cared for both men, dealt with their psychoses and calmed them when they turned violent.

Her husband slowly got better. Chitra had a baby, and she said she finally is happy. But when her in-laws wanted to arrange a marriage for her husband's brother, she put her foot down. She did not want another woman to go through what she had endured.

Battling Social Withdrawal

Prince George's County outside Washington was one of the sites of the pioneering WHO study — William Carpenter helped treat about 90 schizophrenia patients at three hospitals. That experience brought home to him the fact that medications primarily control patients' delusions and hallucinations, not the "negative" symptoms that cause patients to disappear into silent, inner worlds.

"The bias has always been in the direction of reducing psychosis," said Carpenter, director of the Maryland Psychiatric Research Center. "Psychosis is public and bothersome. ... Negative symptoms bother you if it's your child, but it doesn't create a public disturbance."

Anti-psychotic drugs that help quell the outward symptoms may actually exacerbate social withdrawal, he said: "While we treat one part of the illness, we potentially complicate another part of the illness."

New medicines are being aimed at the negative symptoms. But Carpenter and other experts said it is clear that drugs cannot replace social supports.

Treating schizophrenia without anti-psychotic drugs is unthinkable, Wig and Saraceno said. But the current system in wealthy countries merely brings patients who are in crisis into hospitals, stabilizes them with drugs and discharges them after a few days. Saraceno said that approach is doomed to end in a new crisis — the familiar "revolving door."

Ronald Manderscheid, a public health expert at the U.S. Substance Abuse and Mental Health Services Administration, said policymakers have come to understand that the key to treating schizophrenia lies in integrating cultural and social supports with medicine, as villages such as Raipur Rani have long done.

"Is it possible that a mental health system which is poor, deprived, with no resources, no drugs is providing better and more humane and sensible service to the population rather than in rich countries?" WHO's Saraceno asked. "Good mental health service doesn't require big technologies but human technologies. Sometimes, you get better human technologies in the streets of Rio than in the center of Rome."

About This Series

YESTERDAY

Modern psychiatry asserts that mental illnesses are basically organic disorders of the brain. But a growing number of psychiatrists, many of whom are minorities, say doctors are ignoring the role of ethnicity, sex, nationality and religious beliefs in the origin and outcome of mental disorders.

TODAY

A little-known study by the World Health Organization discovered that the outcome of schizophrenia, a deadly mental illness involving hallucinations and disordered thinking, is better in poor countries with limited medical infrastructure than in rich countries such as the United States. Scientists have struggled for decades to explain why.

TOMORROW

Blacks and Hispanics in the United States are far more likely to be diagnosed with serious psychotic disorders than whites. Now, a group of experts who advocate "cultural competence" are asking whether bias may influence psychiatric diagnosis.

The Washington Post

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Prices may vary in areas outside metropolitan Washington. (See box on A2)

TUESDAY, JUNE 28, 2005

M1 M2 M3 M4 M5 V1 V2 V3 V4

Weather

Today: Partly sunny, hazy.
High 88. Low 72.
Wednesday: Thunderstorm,
humid. High 88. Low 72.

Details, B8

128TH YEAR No. 205 5 DC

From Memos, Insights Into Ally's Doubts On Iraq War

British Advisers Foresaw Variety of Risks, Problems

By GLENN FRANKEL
Washington Post Foreign Service

LONDON — In the spring of 2002, two weeks before British Prime Minister Tony Blair journeyed to Crawford, Tex., to meet with President Bush at his ranch about the escalating confrontation with Iraq, Foreign Secretary Jack Straw sounded a prescient warning.

"The rewards from your visit to Crawford will be few," Straw wrote in a March 25 memo to Blair stamped "Secret and Personal." "The risks are high, both for you and for the Government."

In public, British officials were declaring their solidarity with the Bush administration's calls for elimination of Iraq's weapons of mass destruction. But Straw's memo and seven other secret documents disclosed in recent months by British journalist Michael Smith together reveal a much different picture. Behind the scenes, British officials believed the U.S. administration was already committed to a war that they feared was ill-conceived and illegal and could lead to disaster.

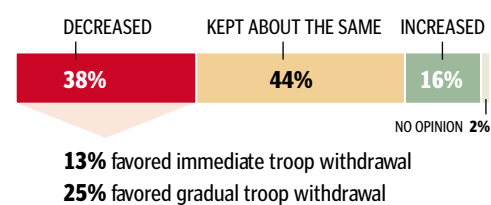
The documents indicate that the officials foresaw a host of problems that later would haunt both governments — including thin intelligence about the nature of the Iraqi threat, weak public support for war and a lack of planning for the aftermath of military action. British cabinet ministers, Foreign Office diplomats, senior generals and intelligence service officials all weighed in with concerns and reservations. Yet they could not dissuade their counterparts in the Bush administration — nor, indeed, their own leader — from going forward.

"I think there is a real risk that the administration underestimates the difficulties," David Manning, Blair's chief foreign policy adviser at the time, wrote to the prime minister on March 14, 2002, after he returned from meetings with Condoleezza Rice, then Bush's na-

See BRITAIN, A10, Col. 3

Two Americans die in helicopter crash north of Baghdad. | A12

Q: Do you think the number of U.S. military forces in Iraq should be increased, decreased or kept about the same?



Survey Finds Most Support Staying in Iraq

Public Skeptical About Gains Against Insurgents

By RICHARD MORIN and DAN BALZ
Washington Post Staff Writers

As President Bush prepares to address the nation about Iraq tonight, a new Washington Post-ABC News poll finds that most Americans do not believe the administration's claims that impressive gains are being made against the insurgency, but a clear majority is willing to keep U.S. forces there for an extended time to stabilize the country.

The survey found that only one in eight Americans currently favors an immediate pull-out of U.S. forces, while a solid majority continues to agree with Bush that the United States must remain in Iraq until civil order is restored — a goal that most of those surveyed acknowledge is, at best, several years away.

Amid broad skepticism about Bush's credibility and whether the war was worth the cost, there were some encouraging signs for the president. A narrow majority — 52 percent — believes that the war has contributed to the long-term security of the United States, a five-point increase from earlier this month.

The findings crystallize the challenges facing Bush this evening in his nationally televised address from Fort Bragg, N.C., an event the administration sees as a critical opportunity for the president to restate the case for his Iraq policies. The goal is to reinvigorate public support for a war that has grown unpopular over time

See POLL, A10, Col. 1



Chief Justice William H. Rehnquist leaves his home in Arlington yesterday for the Supreme Court. Rehnquist, 80, who has thyroid cancer, did not announce his retirement, as many had expected.

Court Declines Reporters' Appeal

Two reporters who refused to tell a grand jury about their sources may go to jail.

NATION, A7

Town Wins Domestic Violence Case

Supreme Court finds no guarantee of specific police action after a complaint.

NATION, A4

MIND AND CULTURE | Psychiatry's Missing Diagnosis

Racial Disparities Found in Pinpointing Mental Illness

Last of three articles

By SHANKAR VEDANTAM
Washington Post Staff Writer

John Zeber recently examined one of the nation's largest databases of psychiatric cases to evaluate how doctors diagnose schizophrenia, a disorder that often portends years of powerful brain-altering drugs, social

ostracism and forced hospitalizations.

Although schizophrenia has been shown to affect all ethnic groups at the same rate, the scientist found that blacks in the United States were more than four times as likely to be diagnosed with the disorder as whites. Hispanics were more than three times as likely to be diagnosed as whites.

Zeber, who studies quality, cost and access issues for the U.S. Department of Veterans Affairs, found that differences in wealth, drug addiction and other variables could not explain the disparity in diagnoses: "The only factor that was truly important was race."

The analysis of 134,523 mentally ill patients in a VA registry is by far the largest national sample to show

broad ethnic disparities in the diagnosis of serious mental disorders in the United States.

The data confirm the fears of experts who have warned for years that minorities are more likely to be misdiagnosed as having serious psychiatric problems. "Bias is a very real issue," said Francis Lu, a psychiatrist

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Pentagon Limits Contractor's Work

D.C. firm will get no further awards under 2002 deal. CEO steps aside as links to lawmaker are probed.

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EPA draft rule would permit agency to consider human tests of pesticides, without some safeguards earlier recommended by National Academy of Sciences.

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In chilling detail, Dennis L. Rader describes committing murders that terrorized Wichita for decades.

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D.C. City Administrator Robert C. Bobb says he never ordered anyone to give his former associates contracts.

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Nats Caught in a TV Rundown

Rights to Air Games At Center of Dispute

By TIMOTHY DWYER
Washington Post Staff Writer

There have been times in this inaugural season of the Washington Nationals when Mel Proctor and Ron Darling, the TV voices of the team, have sat in the booth talking into their microphones and thinking this crazy thought: No one out there was watching.

"Well, it was so strange early in the year when we were doing games that nobody was seeing," Proctor said. "That was one of the weirdest things I've ever done. Like this one night I gave out my cell phone number on the air and I said, 'If anybody's watching anywhere, call this number.' And the only one who called was the tape operator from the truck."

By now, they're used to the complaints. "We always ride the Metro back when we're at home," Darling said, "so invariably the question we get all the time is, 'Where are you guys on TV? What channel are you on? Where are you going to be tomorrow?' And literally, we don't have many answers."

A team enjoying surprising success in a city eager to embrace baseball for the first time in 34 years, the Nationals on many nights can be watched on TV only by the 185,000 subscribers to RCN, a small ca-



BY RICKY CARROTT — THE WASHINGTON POST

Because of a legal battle between Orioles owner Peter Angelos and Comcast, many fans are unable to tune in to Nats games.

ble provider, and the 1.3 million customers of DirecTV, a satellite subscription service. Millions of other potential viewers are unable to watch the new team because of a dispute between two formidable and now estranged business partners — Baltimore Orioles owner Peter Angelos and Comcast Corp., the giant communications company that provides cable service to two-thirds of the households in the Washington-Baltimore region.

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MIND AND CULTURE | Psychiatry's Missing Diagnosis

In Treating Mental Health, Race May Shift Balance

PSYCHIATRY, From A1

at the University of California at San Francisco. "We don't talk about it — it's upsetting. We see ourselves as unbiased and rational and scientific."

As the ranks of America's patients and doctors become more diverse, psychiatrists such as Lu are spearheading a movement to address the problem. Clinicians need to be trained in "cultural competence," they say, to prevent misdiagnosis and harm.

Psychiatrist Heather Hall, a colleague of Lu's, said she had to correct the diagnoses of about 40 minorities over a two-year period. She estimated that one in 10 patients referred to her came with a misdiagnosis such as schizophrenia, a disorder characterized by social withdrawal, communication problems, and psychotic symptoms such as delusions and hallucinations.

Unlike AIDS or cancer, mental illnesses cannot be diagnosed with a brain scan or a blood test. The impressions of doctors — drawn from verbal and nonverbal cues — determine whether a patient is healthy or sick.

"Because we have no lab test, the only way we can test if someone is psychotic is, we use ourselves as the measure," said Michael Smith, a psychiatrist at the University of California at Los Angeles who studies the effects of culture and ethnicity on psychiatry. "If it sounds unusual to us, we call it psychotic."

When hospitals diversified their staffs to include Spanish-speaking doctors, many cases of psychotic behavior were reassessed, he said: "Half the cases were re-diagnosed as depression. Some doctors think if you don't make eye contact, you can be diagnosed. In some communities, eye contact is a sign of disrespect."

Zeber and a team of other researchers said they do not know why doctors were more likely to diagnose schizophrenia among blacks and Hispanics. Perhaps diagnostic measures developed primarily with white patients in mind do not automatically apply to other groups, said Zeber, who published his results in the journal *Social Psychiatry and Psychiatric Epidemiology*.

"Race appears to matter and still appears to adversely pervade the clinical encounter, whether consciously or not," Zeber and his colleagues wrote in their October 2004 report.

Darrel Regier, director of the division of research at the American Psychiatric Association and U.S. editor of the journal, said the study had been carefully conducted. He agreed that cultural differences between patients and doctors could result in misdiagnosis.

"I believe bias exists, and there is a risk a psychiatrist with a different cultural experience than a patient can misinterpret the expression of a psychiatric symptom," he said. "If you have a very religious group of patients and a very secular psychiatrist who thinks beliefs in spirits or hearing the voice of God is not normal, you are going to have misses."

But he added that Zeber's study did not explain what caused the diagnostic disparity among the veterans. Regier also questioned whether the veterans in the study were representative of the general population, or even representative of all veterans. Different ethnic groups seek care in different ways within and outside the VA, he said, and blacks tend to seek care when they are sicker than white patients.

While agreeing that even more comprehensive analyses are possible, Zeber stood by his findings. The study had carefully eliminated a host of confounding variables, he said, and the analysis had not found that black patients were any sicker than whites. "Access issues or selection bias are unlikely to account for our findings," the paper concluded.

"If you have an African American patient presenting with elevated paranoia, that has been referred to in some quarters as healthy paranoia based on how they perceive society," said Zeber, who works at the Veterans Affairs Department's Health Services Research and Development center in San Antonio. "If you base your diagnosis on that symptom, you can



Kevin Moore's symptoms were misdiagnosed as schizophrenia until he met psychiatrist Heather Hall, who determined that he had depression.

Diagnostic Bias?

PREVALENCE OF SCHIZOPHRENIA

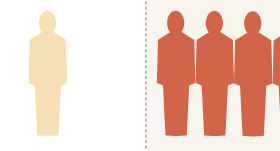
White Nonwhite



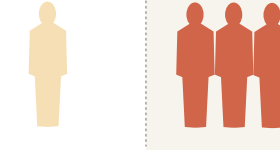
Comprehensive national surveys have found that the prevalence of schizophrenia is about even among whites and nonwhites — about 1 percent across all ethnic groups.

DIAGNOSIS OF SCHIZOPHRENIA

White Black



White Hispanic



But a large national study has found that in a clinical setting blacks were more than four times as likely as whites to be diagnosed with schizophrenia. Hispanics were more than three times as likely.

SOURCES: "Lifetime Prevalence of Specific Psychiatric Disorders in Three Sites," *Archives of General Psychiatry*; "Ethnicity and Diagnostic Patterns in Veterans With Psychoses," *Social Psychiatry and Psychiatric Epidemiology*

be misled."

Zeber's argument is supported by a panel of academic experts who helped draft a research agenda in 2002 for the next edition of psychiatry's manual of mental disorders.

They wrote: "Misdiagnosis due to a different cultural perspective of bizarreness is rather frequent." Inattention to the role that social standards and cultural factors play in diagnosis has caused patients to be stereotyped, they added, "with obvious negative consequences for diagnosis and treatment."

Rethinking a Diagnosis

The patient was a young black man named Kevin Moore. He had been picked up by police — after his mother called 911 and said he was making threats. The police brought him to San Francisco General Hospital.

Moore already had a diagnosis from previous stints at other hospitals: schizophrenia.

But psychiatrist Heather Hall thought something was wrong. Patients with schizophrenia can seem to shrink into their own world.



Veterans Affairs researchers John Zeber and Laurel Copeland have found racial disparities in psychiatric diagnoses.



"We see ourselves as unbiased and rational and scientific," said psychiatrist Francis Lu, who advocates "cultural competence" for clinicians.

Superficially, Moore matched that description. He was uncommunicative. But when Hall looked closer, she noticed something else.

"A schizophrenic would be flat, he would be staring blankly into space," Hall said in an interview about Moore's case, given with his permission. "His expression wasn't moving, but he wasn't blank. He looked really, really sad."

After a thorough evaluation, Hall changed Moore's diagnosis to depression and reconfigured his medication regimen. She spent hours with Moore, coaxing him to talk. Within weeks, he began opening up about a host of interpersonal problems.

Moore said he was first diagnosed with schizophrenia when he was 16 or 17. In an interview at the San Francisco hospital, he was dressed in a baggy sweat shirt and sported his hair in cornrows. His braces made him seem younger than his age — 24 at the time.

He said the police had picked him up because he had talked of getting a gun. A quarrel with a

friend had escalated into a fight, and his mother had called the police. Moore thought his mother had overreacted, and he was sulen and uncommunicative when the police forcibly took him to the hospital.

"I probably didn't want to talk to any people," he said. "I didn't want to be there."

The particularly close attention that Hall paid to Moore was not the only unusual thing about his treatment. Moore was treated at one of the hospital's "focus units" — inpatient psychiatric centers that focus on how culture and ethnicity influence psychiatric diagnosis and treatment.

The units pay attention to everything — the decor as well as the treatment: The Black Focus Unit, for example, had African and African American art and icons on the walls. The occupational therapy room had photos of Vanessa Williams, Maya Angelou and Oprah Winfrey. The hospital also had an HIV-AIDS and a Lesbian, Gay, Bisexual and Transgender Focus Unit, as well as a Latino/

washingtonpost.com

The complete series can be viewed at www.washingtonpost.com/nation. Staff writer Shankar Vedantam will be online today at noon at www.washingtonpost.com/liveonline to discuss his series about how culture influences the diagnosis, treatment and outcome of mental illness.

Women's Focus Unit. The Asian Focus Unit had bulletins printed in multiple Asian languages.

The specialized units have been hailed as an innovative way to put patients at ease, but they have also faced criticism.

Psychiatrist Sally Satel described them as a type of "apartheid." Satel, who is affiliated with the American Enterprise Institute and is the author of "PC, M.D.: How Political Correctness Is Corrupting Medicine," said such divisions can prompt patients to avoid examining the real source of their mental problems.

"In its worst form, it is not really counseling," she said of what she called multicultural therapy. "It is a support group between two people who want to blame the outside world."

Moore and psychiatrist Hall are both black, but the hospital does not match doctors and patients by ethnicity. Every unit had staff members and patients from diverse backgrounds, and psychia-

trist Lu said the wishes of patients and special needs such as language and prior history determined where patients were assigned. Every unit had specialized training — staff members at the Asian Focus Unit, for example, spoke 14 languages.

Hall said Moore was a perfect example of why the Black Focus Unit is important: "Maybe because I am an African American psychiatrist, maybe he was able to show me a little more of himself for me to make an accurate diagnosis and change his treatment to a more accurate treatment."

She added, "Because the people who work on our unit are sensitive to the issues of African Americans, we are much more likely to look at our patients with eyes that aren't clouded by preconceived notions."

The psychiatrist recalled another case of a black man diagnosed as delusional. The man had talked about going to another city and getting revenge on people who had killed his son.

"The treatment plan was filled out by someone who was not part of our focus unit," she said. "She assumed it was a delusion — she said, 'This man has a delusion that his son was killed in a hate crime.'" Hall checked out the man's account. It turned out to be true.

"People say minorities don't follow up" in psychiatric care, Hall said. "Maybe on their first session they are not heard. Why would they come back? If I tell a therapist I am being brutalized and he thinks I am delusional, why would I come back?"

Other clinicians echo such views. UCLA's Smith, who speaks Spanish, said that while making rounds with residents, he once asked an interpreter to check whether a Spanish-speaking patient wanted to commit suicide: "The patient said, 'I feel so bad I could die.'" But rather than convey the sense that the patient was in distress and felt terrible, Smith said, the interpreter told the residents, "She's suicidal."

Carl Bell, a Chicago psychiatrist, said he once went through the medical records of minority patients at Jackson Park Hospital in Chicago and found many misdiagnoses. One 30-year-old woman was talking fast, was calling people at all hours and did not seem to need sleep — classic symptoms of bipolar disorder, or manic-depression. But her charts showed she had been hospitalized for schizophrenia and treated with injectable medications, which suggested that her doctors thought her schizophrenia was particularly severe.

"How does a woman with a college education, a job . . . she has euphoria, pressured speech, decreased need for sleep — how do you get schizophrenia, chronic schizophrenia?" asked Bell, still incredulous.

Advocates for cultural competence say both clinicians and patients are unwilling to acknowledge that race might matter: "In a cross-cultural situation, race or ethnicity is the white elephant in the room," said Lillian Comas-Diaz, a psychotherapist in Washington, who added that she always brings up the subject with patients as a way to get hidden issues into the open — and increase trust.

"I say, 'You happen to be Pakistani, and I am not — how do you feel about that?' Sometimes they say, 'Oh, it's not important,' but when certain things happen [later] in therapy, people remember you opened the door and they come inside," she said.

Tina Tong Yee, a psychologist in charge of ensuring San Francisco's mental health services are culturally competent, said Western medicine's secular notions of normality are sometimes an uneasy fit in a deeply religious and increasingly diverse America.

"Seeing ghosts in my family was part of growing up," she said. "If I brought it up in therapy, you don't want someone to make that delusional."

Behavioral problems are different than other kinds of ailments, she added: "What you are reading is not a pulse, but how people act and behave and how you react to it. In a cross-cultural setting, it's ripe for misunderstanding."

About This Series

SUNDAY

Modern psychiatry asserts that mental illnesses are basically organic disorders of the brain. But a growing number of psychiatrists, many of whom are minorities, say doctors are ignoring the role of ethnicity, sex, nationality and religious beliefs in the origin and outcome of mental disorders.

YESTERDAY

A little-known study by the World Health Organization discovered that the outcome of schizophrenia, a deadly mental illness involving hallucinations and disordered thinking, is better in poor countries with limited medical infrastructure than in rich countries such as the United States. Scientists have struggled for decades to explain why.

TODAY

Blacks and Hispanics in the United States are far more likely to be diagnosed with serious psychotic disorders than whites. Now, a group of experts who advocate "cultural competence" are asking whether bias may influence psychiatric diagnosis.