

Letters from readers are welcomed. They will be published at the discretion of the editor as space permits and will be subject to editing. They should be a maximum of 500 words with no more than five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to authors for possible reply. Address letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, APA, 1400 K Street, N.W., Washington D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Physical Examinations

To the Editor: In their survey on pelvic and rectal examinations of psychiatric inpatients reported in the June 1999 issue, Varner and Hollister (1) found that these examinations are not done routinely, despite guidelines to the contrary from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). However, the authors do not discuss possible reasons for this pattern except for "the perception . . . that providing psychiatric care is not the same as providing primary care."

The question of why psychiatrists omit pelvic and rectal (as well as breast) examinations merits further consideration. I believe we frequently do so out of a legitimate desire to minimize possible psychological sequelae of such intimate examinations. Although it is true, as the authors state, that "psychiatric patients are expected to be given a physical examination," this fact often comes as a surprise to the patients themselves when they arrive for hospitalization.

By definition, a person being admitted to an acute psychiatric ward is in an emotionally precarious position; the performance or even suggestion of rectal, pelvic, or breast examinations may have significant impact on a patient's ability to recompensate, adjust to the inpatient setting, and trust new caregivers. I personally have had

at least one patient decline voluntary hospitalization altogether after the suggestion of a pelvic examination.

These issues will be compounded in the frequent scenario in which the examiner-psychiatrist is of the opposite gender, is a stranger, has no specialty training in these examinations, and has just finished hearing the details of the patient's personal life. The psychological fallout may be doubly compounded if the patient has any history of sexual assault or other sexual issues—facts that may well not have surfaced during the initial admission interview.

No doubt rigorous, routine pelvic and rectal examinations on all patients will turn up occult disease in a few. In the aggregate, though, will the physical benefit outweigh the potential psychiatric morbidity? This difficult question may be amenable to careful clinical study. But lacking such objective information, psychiatrists must continue to assess the indications for such exams on a case-by-case basis. They may need to follow the "first, do no harm" ethic even if it is in conflict with JCAHO policy.

Daniel R. Filene, M.D.

Dr. Filene is a third-year resident in the department of psychiatry at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire.

Reference

1. Varner RV, Hollister LE: A survey of hospital practices related to pelvic and rectal examinations of psychiatric inpatients. *Psychiatric Services* 50:825-827, 1999

Genital Self-Mutilation

To the Editor: In the July 1999 issue, Dr. Alao and associates (1) presented a case of genital self-mutilation by a woman with borderline personality disorder, posttraumatic stress disorder (PTSD), and substance dependency. They suggest that genital self-mutilation tends to occur in patients with psychosis or severe personality disorder, in transsexuals, and in persons with certain religious or cultural beliefs.

I was surprised by the authors' omission of patients with dissociative

disorders. The diagnosis of a dissociative disorder is often overlooked. It often occurs in conjunction with borderline personality disorder, PTSD, and substance abuse. Their patient had a history of prostitution, and a substantial proportion of prostitutes may have dissociative disorders.

Recently a 26-year-old woman who was later diagnosed as having dissociative identity disorder entered a partial hospitalization program for treatment of depression and recurrent suicidality. She had made two prior suicide attempts that were almost fatal. She had a history of childhood sexual abuse and had been raped as an adolescent. She had repeatedly made incisions in her vagina with razor blades or surgical scalpels and had then sewn up the introitus in the hope that she could thus permanently close her vagina and protect herself from future sexual abuse.

The patient's dissociative identity disorder remained undiagnosed for the first five years of psychiatric treatment. She had never before disclosed her childhood sexual abuse or her severe symptoms of amnesia, including total loss of memory for ten months during her adolescence. However, she readily reported this information in response to direct questions when she was first admitted to our facility.

The differential diagnosis of genital self-mutilation should always include dissociative disorders.

Richard M. Waugaman, M.D.

Dr. Waugaman is clinical professor of psychiatry at Georgetown University School of Medicine in Washington, D.C.

Reference

1. Alao AO, Yolles JC, Huslander W: Female genital self-mutilation (ltr). *Psychiatric Services* 50:971, 1999

In Reply: Dr. Waugaman's point is well taken that dissociative symptoms and dissociative identity disorder frequently coexist with borderline personality disorder, posttraumatic stress disorder (PTSD), and other psychiatric diagnoses. Dissociative identity

disorder is often associated with a high risk of self-mutilative behavior (1,2). It is therefore surprising that not much has been written about genital self-mutilation in women with dissociative disorders.

As we indicated in our letter, vaginal cutting tends to be less dramatic than castration and thus may be less frequently reported. It is also possible that clinicians are less inclined to report female genital mutilation for reasons of confidentiality. In addition, dissociative identity disorder is frequently overlooked and may be misdiagnosed as another psychiatric condition, such as schizophrenia (3) or PTSD. Patients with schizophrenia have also been found to have a tendency to dissociate (4).

It is unclear from the existing literature how often dissociative disorders are found in cases of genital self-mutilation like those described by us and Dr. Waugaman. One suspects that genital self-injury may be linked to a history of early sexual trauma that frequently precedes the development of both severe borderline pathology and dissociative disorders. As yet, the data are insufficient to confirm this association. Careful assessment for dissociative symptoms is warranted in patients who present with genital self-mutilation. Confirmation of such a diagnosis has implications for treatment.

**Adekola O. Alao, M.D.,
M.R.C.Psych.
Jennifer C. Yolles, M.D.
Wendy Armenta, M.D.**

References

1. Zlotnick C, Mattia JJ, Zimmerman M: Clinical correlates of self-mutilation in a sample of general psychiatric patients. *Journal of Nervous and Mental Disease*:187:296-301, 1999
2. Zlotnick C, Shea MT, Pearlstein T, et al: The relationship between dissociative symptoms, alexithymia, impulsivity, sexual abuse, and self-mutilation. *Comprehensive Psychiatry* 37:12-16, 1996
3. Rosenblum M: The role of the term schizophrenia in the decline of diagnosis of multiple personality. *Archives of General Psychiatry* 37:1383-1385, 1980
4. Spitzer C, Haug H, Freyberger HJ: Dissociative symptoms in schizophrenic patients with positive and negative symptoms. *Psychopathology* 30:67-75, 1997

Rehabilitative Treatment for Combat-Related PTSD

To the Editor: Some studies have questioned the value of longer-term inpatient treatment for combat-related posttraumatic stress disorder (PTSD). The Program Evaluation Center of the Department of Veterans Affairs reported worsening of patient-rated symptoms after discharge compared with symptoms prior to admission; however, violent thoughts and actions and legal problems were diminished at discharge (1).

In 1992 a specialized inpatient PTSD unit was established at the Miami VA Medical Center to provide rehabilitative treatment for combat-related PTSD. The length of stay for an initial treatment episode was 12 weeks. The program predominately featured group interventions focused on processing trauma and the development of anger management and other interpersonal skills. To further explore which outcomes could be affected by rehabilitative treatment, we supplemented the monitoring procedures developed by the VA Program Evaluation Center with self-report and interviewer-based assessments of symptom severity and functional adjustment.

Patients presenting for consecutive admissions to the PTSD program over a 12-month period between 1996 and 1997 were evaluated during the month preceding admission and in the fourth month following discharge. The final sample of 26 patients represented 87 percent of the 30 patients evaluated; two did not complete the program, and two were lost to follow-up. All were male combat veterans (24 from Vietnam, one from Korea, and one from the Persian Gulf) with a mean age of 49.2 ± 4.9 years and an age range of 38 to 64 years. Twelve (46 percent) were white, seven (27 percent) were non-Hispanic blacks, and seven (27 percent) were Hispanic. Eleven subjects (42 percent) were married at the time of program admission.

Structured assessment confirmed diagnoses of combat-related PTSD. Twenty-three subjects (88 percent)

also met criteria for lifetime major depression. Twenty-two (85 percent) met lifetime criteria for alcohol or substance use disorders, and 11 (42 percent) met criteria for such disorders within the past year. All subjects were taking psychoactive medications, which were adjusted during their stay in the program.

Besides collection of self-report symptom ratings, the Longitudinal Interview Follow-up Evaluation (LIFE) (2) was administered by one of two master's-level psychology technicians who had been trained by clinical staff. The LIFE measures functioning in the context of employment, intimacy, and interpersonal relationships on a 5-point scale ranging from 1, absence of impairment, to 5, severe impairment. Evaluation of alcohol and substance use was supplemented by record review, including toxicology screens, and input from outpatient clinicians.

At four-month follow-up after discharge from the PTSD program, none of the subjects had been rehospitalized. Sixty-nine percent indicated complete satisfaction with their treatment in the program, and 15 percent indicated they were "pretty much satisfied." Mean ratings of PTSD and depression were unchanged. While other subscales showed a trend toward improvement, LIFE ratings for interpersonal functioning with family members improved significantly, from 3.2 ± 1.1 at preadmission to $2.7 \pm .9$ at follow-up ($t = 3.61$, $df = 25$, $p < .001$). Only one of the subjects who had abused substances in the preceding year was found to have relapsed.

These findings are far from definitive due to the limited number of subjects, unblind assessment, a single follow-up time period, and absence of a comparison group. However, the subjects' improvement in their relationships with family members stood out. We postulate that the improvement may be a carryover from having learned to apply interpersonal skills in the patient community. This possibility, along with cost considerations, influenced the decision in 1997 to restructure the program to a residential

format with a three-month length of stay, rather than maintaining it as an inpatient program. In the residential format, patients function as an autonomous community on evenings, nights, and weekends. Our expectation is that this experience will further promote learning of interpersonal skills and problem solving, thereby maintaining or enhancing the program's possible benefit to interpersonal relationships with family members.

Thomas A. Mellman, M.D.

Gary S. Kutcher, Ph.D.

Lucero Santiago, L.C.S.W.

Daniella David, M.D.

Dr. Mellman is now with the department of psychiatry at Dartmouth Medical School in Hanover, New Hampshire. Dr. Kutcher, Ms. Santiago, and Dr. David are affiliated with the Veterans Affairs Medical Center in Miami, Florida, and the department of behavioral sciences at the University of Miami School of Medicine.

References

1. Johnson DR, Rosenheck R, Fontana A, et al: Outcome of intensive inpatient treatment for combat-related posttraumatic stress disorder. *American Journal of Psychiatry* 153:771-777, 1996
2. Keller MB, Lavori PW, Freidman B, et al: The Longitudinal Interval Follow-up Evaluation: a comprehensive method for assessing outcome in prospective longitudinal studies. *Archives of General Psychiatry* 44:540-548, 1987

Use of Telemedicine With Ethnic Groups

To the Editor: Telemedicine technology is one strategy for improving the accessibility of mental health care in the rural setting (1,2), which is the main point of contact for more than half of those suffering from mental disorders (3). This option may be particularly important for Mexican Americans, who infrequently use mental health services (4) and have a significantly more negative view of mental health treatment than other patients (5). We found no reports of telemedicine used for specific ethnic populations. In the case below, telemedicine allowed a patient to receive care in the office of her primary care physician and facilitated culturally sensitive care.

Mrs. R, a 56-year-old Mexican American woman, tearfully presented to her bilingual Caucasian primary care physician with somatic complaints nine months after the sudden death of her husband of 30 years. The physician diagnosed major depression and started Mrs. R on paroxetine 10 mg at nighttime, later increased to 20 mg. Despite four months of treatment, Mrs. R's depression persisted because she failed to consistently take the nightly dose.

No local psychiatrist spoke Spanish, and the patient was concerned about seeing a mental health professional in her community for fear of being stigmatized. Thus she was referred to the University of California, Davis, for a telepsychiatric evaluation.

The psychiatric evaluation lasted 90 minutes and was conducted by a telemedicine link with the UC Davis department of psychiatry and the UC Davis primary care clinic in Chico 60 miles away. The technology included dial-up integrated service digital network (ISDN) lines at 384 kilobits per second, Ascend Communications Multiband VSX multiplexors, PictureTel Live 100 color monitors, standard Pentium computers with 32 megabits of random access memory, and Canon VCC-1 cameras with pan-tilt-zoom local and remote control.

The interview was conducted in Spanish by a UC Davis psychiatrist introduced to Mrs. R by her primary care physician, who then left the room. Mrs. R had worked in California as a migrant field worker for 33 years, had no formal education, and spoke only Spanish. She did not drive. She described her husband's death as a great loss, resulting in many symptoms of depression. When asked about adherence to medication, she expressed concern about the safety of taking medication, but felt that her doctor's orders should not be openly questioned.

The primary care physician returned to the room for the last ten minutes of the session, and Mrs. R's concerns were discussed. Although unaccustomed to the technology, she acknowledged that talking with a psychiatrist had not been as difficult as

she had imagined, and she even felt comfortable crying freely.

One month later, Mrs. R was still depressed despite taking her medication. The primary care physician was advised to increase the paroxetine to 30 mg at nighttime. Two months later, the patient was much less depressed and was free of somatic complaints for the first time since her husband's death. The frequency of visits for medical appointments decreased from once or twice a month during the year before the telepsychiatric consultation to only a single visit in the two months after the consultation.

Gabrielle M. Cerda, M.D.

Donald M. Hilty, M.D.

Robert E. Hales, M.D.

Thomas S. Nesbitt, M.D.

Dr. Cerda is assistant clinical professor of psychiatry at the University of California, Davis, where Dr. Hilty is assistant professor of clinical psychiatry and Dr. Hales is professor and chair of the department of psychiatry. Dr. Nesbitt is associate professor of family and community medicine at UC Davis.

References

1. Preston J, Brown FW, Hartley B: Using telemedicine to improve health care in distant areas. *Hospital and Community Psychiatry* 43:25-32, 1992
2. Hilty DM, Servis ME: Psychiatry and primary care, in the American Psychiatric Press Textbook of Psychiatry, 3rd ed. Edited by Hales RE, Yudofsky SC, Talbott JA. Washington, DC, American Psychiatric Press, 1999
3. Regier DA, Goldberg ID, Taube CA: The de facto US mental health services system. *Archives of General Psychiatry* 46:971-982, 1978
4. Karno M: The enigma of ethnicity in a psychiatric clinic. *Archives of General Psychiatry* 14:516-520, 1966
5. Lawson HH, Kahn MW, Heiman EM: Psychopathology, treatment outcome, and attitude toward mental illness in Mexican-American and European patients. *International Journal of Psychiatry* 28:20-26, 1982