kappas between 0.2 and 0.4. We indicated that such kappas might be acceptable with low-prevalence disorders, where a small amount of random error can overwhelm a weak signal. Higher kappas may, in such cases, be achievable only in the following cases: when we do longitudinal follow-up, not with a single interview; when we use unknown biological markers; when we use specialists in that particular disorder; when we deal more effectively with comorbidity; and when we accept that "one size does not fit all" and develop personalized diagnostic procedures.

Greater validity may be achievable only with a small decrease in reliability. The goal of DSM-5 is to maintain acceptable reliability while increasing validity based on the accumulated research and clinical experience since DSM-IV. The goal of the DSM-5 field trials is to present accurate and precise estimates of reliability when used for real patients in real clinics by real clinicians trained in DSM-5 criteria.

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HELENA CHMURA KRAEMER, PH.D.
Palo Alto, Calif.

DAVID J. KUPFER, M.D.
Pittsburgh

DIANA E. CLARKE, PH.D.
WILLIAM E. NARROW, M.D., M.P.H.
DARREL A. REGIER, M.D., M.P.H.
Arlington, Va.

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Social Phobia and Social Anxiety Disorder: Effect of Disorder Name on Recommendation for Treatment

TO THE EDITOR: A decade ago, researchers (1) raised the question of whether the name "social phobia"—which initially described the fear of specific social situations such as public speaking or eating in front of others—contributed to a minimization of the impairment associated with the disorder. In fact, data suggest that social phobia may not be recognized, by patients or providers, as warranting treatment (2). Those with social phobia show greater delays in seeking treatment and considerable failure to do so at all compared with those with other anxiety and mood disorders (3). Recognizing the pervasive and impairing nature of the condition, the alternative name "social anxiety disorder" was included in DSM-IV.

Using data collected from a telephone survey of residents of New York State, we investigated whether the disorder name affects the perceived need for treatment. The Stony Brook University Center for Survey Research collected data between April and June 2011. Random-digit dialing was used to obtain phone numbers, and the adult resident with the nearest birthday was interviewed. In total, 806 people participated. Weights based on population estimates of six demographic variables (gender, age, education, race, region within New York, and income) were applied to compensate for lower response rates in some groups.

Respondents heard a brief vignette describing a person who experiences discomfort in social situations and often avoids social events. These symptoms were labeled as either social phobia or social anxiety disorder, and respondents indicated whether the person should seek mental health treatment. Fifty-eight respondents either replied that they did not know (N=40) or declined to answer (N=18). Of the remaining 748 respondents, 83.2% believed the symptoms labeled as social anxiety disorder warranted treatment compared with 75.8% who believed that symptoms labeled social phobia warranted treatment (χ_2=6.34, df=1, p=0.012). However, the effect size was small (odds ratio=0.663, 95% confidence interval=0.443–0.905) and was not moderated by respondent age, gender, or ethnicity.

These findings are encouraging. Despite a slightly greater likelihood of recommending treatment for social anxiety disorder, the overwhelming majority of respondents endorsed seeking help regardless of diagnosis name. Although the impact of social phobia has been underestimated historically, efforts by researchers, health care providers, and the health care industry appear to have increased public awareness. Still, rates of treatment seeking among these individuals are low. Our findings suggest that using the term "social anxiety disorder" increases the likelihood that the condition will be perceived as requiring treatment. Making social anxiety disorder the official diagnostic label in DSM-5 is appropriate.

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LAURA C. BRUCE, M.A.
RICHARD G. HEIMBERG, PH.D.
Philadelphia

MEREDITH E. COLES, PH.D.
Binghamton, N.Y.

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A Fatal Case of Adynamic Ileus Following Initiation of Clozapine

TO THE EDITOR: In patients with treatment-refractory schizophrenia, clozapine is considered the most effective antipsychotic medication (1). However, it has side effects that can limit its usage (2). A seldom-encountered but significant side effect is adynamic ileus. We present here the case of a patient with schizophrenia who developed adynamic ileus within 9 days of initiation of clozapine.

Case Report

"Mr. B.," a 65-year-old man with schizophrenia, was involuntarily admitted for psychotic exacerbation. On admission, he was taking 30 mg/day of olanzapine to abate symptoms of psychosis, aggression, and dangerous wandering. Despite intensive case management and adequate trials with haloperidol, risperidone, and olanzapine, he was refractory to treatment and required annual hospitalizations. Mr. B had not had a previous trial of clozapine. After obtaining informed consent, we initiated treatment with clozapine and increased the dosage by 12.5 mg/day, while olanzapine was gradually reduced with plans to discontinue. Docusate sodium, 100 mg b.i.d., was initiated prophylactically. He was not taking additional anticholinergic medications.

Shortly after the initiation of clozapine, Mr. B complained of malaise and anorexia followed by nausea, vomiting, and diarrhea. Nine days after initiation of clozapine, which was now at a dosage of 100 mg/day and the olanzapine dosage at 10 mg/day, he became tachypneic and hypotensive. He was transferred to the intensive care unit, treated with pressors, and intubated.

Mr. B's medical history included gastroesophageal reflux disease, a prostatetectomy for benign prostatic hyperplasia, and a remote history of small bowel obstruction that was managed conservatively, while olanzapine was continued for treatment of psychosis.

While in the intensive care unit, a CT scan of the abdomen led to the diagnosis of adynamic ileus. A chest X-ray revealed an infiltrate suggestive of aspiration, and colonoscopy demonstrated diverticulosis without evidence of malignancy. Clozapine was discontinued, and olanzapine, which had been discontinued during evaluation in the intensive care unit, was restarted. The patient stabilized after 3 weeks and was returned to the psychiatric unit.

Within 10 days, the patient again developed diarrhea, tachypnea, and tachycardia requiring medical stabilization. He died 3 days later. Although an autopsy was not performed, it was suspected that he died from complications of ileus.

Discussion

Adynamic ileus is an infrequently encountered but serious complication of clozapine with a mortality rate approaching 28% (3). Anticholinergic effects are thought to be the cause (4). One study found that the median time from the first dose of clozapine to onset of ileus was greater than 1,500 days (4). In this case, the patient developed ileus within 9 days of initiation of clozapine and died 5 weeks later. He had no known risk factors for ileus such as malignancy or recent surgery; however, he was taking olanzapine, another highly anticholinergic medication, at the time of decompensation. It is possible that the combination of these two drugs, even for a brief duration for cross-tapering, contributed to this patient's rapid development of ileus and subsequent death. This case highlights the importance of carefully monitoring patients taking clozapine for potentially fatal gastrointestinal side effects, especially when treatment includes other anticholinergics, as this may result in serious consequences in a much shorter time frame than the literature has suggested (4).

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SARAH M. FAYAD, M.D.
DAWN M. BRUIJNZEEL, M.D.
Gainesville, Fla.

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Mental Health Insurance Parity in Oregon

To the Editor: While I found the article by McConnell et al. (1) in the January issue to be of great interest, I believe there may be other factors contributing to cost control in Oregon than those addressed by the authors. It is my impression, albeit without specific evidence, that insurance reimbursement rates in Oregon are lower than those in many other states, and I am definitely aware that insurance companies have been lowering such rates in recent years. Related to this, we are seeing a declining number of psychiatrists in Oregon as retirement attrition continues, with fewer new psychiatrists starting practices. In addition, insurance companies have highly restrictive panels that make it difficult to find nurse practitioners, social workers, and psychologists.

As a result, we are seeing more colleagues who have 3-month or longer waiting lists or who are closing practices to new patients. I believe that lack of supply is helping to keep costs down, but there has been a significant impact on the availability and quality of care.

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CHARLES H. KUTTNER, M.D.
Portland, Ore.

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Response to Kuttner Letter

To the Editor: We appreciate the opportunity to respond to Dr. Kuttner's observations that reimbursement rates in Oregon are lower than in many other states. He speculates that declining reimbursement, combined with restrictive networks, may have led to a shortage of behavioral health pro-