Cultural Issues And Their Impact On Mental Health

Report of The Surgeon General
On Mental Health

The following report by
The Surgeon General was presented
five years ago, yet it clearly identifies
disparities and challenges that may
still exist today as we examine cultural
issues and their impact on mental health.

The U.S. mental health system
is not well equipped to meet
the needs of racial and ethnic
minority populations. Racial
and ethnic minority groups are generally
considered to be underserved by the
mental health services system
(Neighbors et al., 1992; Takeuchi and
Uehara, 1996). These historical forces spurred
greater recognition of the problems that
minority groups confront in relation to
mental health services.

see Cultural Issues on page 8

Mental Health After 9/11:
Community Resilience In The Context Of Ongoing Threat

By Randall D. Marshall, MD
and Yuval Neria, PhD

On the third anniversary of the
most devastating attack on
U.S. soil since Pearl Harbor,
it is natural to take stock of
our progress in recovery. Research in
the community shortly after the attacks
found very high rates of PTSD related to
the 9/11 attacks in the greater New York
area (8-11% of adults) as well as, re-
markably, across the U.S. Follow-up
studies also confirmed the expectation
that the majority of persons with clini-
cally significant symptoms, perhaps as
many as 75%, no longer had clinically
significant disability.

We believe this is, paradoxically,
both a cause for relief and concern. A
fracture in our community now separates
the tens of thousands of people who con-
tinue to suffer from the effects of 9/11
from the rest. Persons with PTSD feel
alienated and misunderstood, and unfor-
tunately this impression can have a basis
in reality. A retreat into silent suffering
is typically the response.

Although a considerable body of re-
search shows that vulnerability to PTSD
is not a reflection on the moral character
of a person—in fact, one way of under-
standing PTSD is as a disorder of en-
hanced empathy and imagination—our
patients still blame themselves, and feel
weak and fragile in comparison to the
many others who are, at least on the sur-
face, coping well again.

It is likely that threats of new attacks
will exacerbate 9/11-related symptoms and
worsen anxiety and affective disor-
der symptoms in many. The full impact
of ongoing threat and actual exposure in
persons with prior traumatization and
active or past PTSD symptoms is an-
other important and relatively unstudied
question.

Resilience In The Context
Of Ongoing Threat

It is noteworthy that virtually all of
the psychotherapy trials with civilians
have been conducted in the U.S. and
Europe during peacetime. Research also
shows that treatment results have been
consistently better with civilians than
with war veterans, in both medication
and psychotherapy studies. Is this be-
cause these are different disorders, dif-
ferent populations, or different types of
trauma?

One of our patients is a Vietnam vet-
eran. He had suffered with PTSD since
returning from the war but found a way
to live with his symptoms until

see After 9/11 on page 48

Randall D. Marshall, MD
be helpful in this context, but whether
these approaches need modification, and
whether therapy should be combined
with medicine at the outset of treatment,
are open questions that we hope to
answer.

see After 9/11 on page 48
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Mental Health News wishes to express its deep appreciation to the members of our Advisory Council for their inspiration, guidance and support.

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To make referrals, please call 203-384-3292 and speak to the charge nurse, who will complete a telephone screening and arrange for an admission assessment.
Mental Health Education For The Latino Community: Meeting The Challenge

By Ira H. Minot, CSW, Founder and Publisher, Mental Health News

What better time to rally around the launch of our new bilingual publication Salud Mental than in this fall issue. Our cover story, “cultural issues and their impact on mental health,” speaks volumes on the need to address the disparities that exist today in helping a culturally distinct community better understand and utilize the mental health world around them.

We believe that Salud Mental will become a benchmark in cross cultural mental health education. This fall marks the fifth year in print of our award-winning Mental Health News. Our ability to provide up-to-date, cost-effective, quality mental health education directly to the community has become a pivotal element in the recovery process for people with mental illness. To us, this is our bottom line—to provide the resources, hope and encouragement necessary to help thousands of people with mental illness and their families. We hope to do the same for thousands more who we have not as yet been able to reach in the Latino community.

We are committed to launching the premier issue of Salud Mental this winter. It won’t be an easy task for us. We will need to learn how to talk about mental health issues to a new audience and develop a format that will be accepted by a diverse community.

To accomplish our task we will need the help of many individuals and the resources required to implement the project and sustain it for years to come. We have been holding planning meetings over the past year and a half, which has given us the framework for the project. Some of the necessary components of the task ahead are as follows:

**Goals Of Salud Mental**

- To provide vital mental health education (psychoeducation) for Latinos suffering from mental illness and substance abuse problems,
- To increase psychoeducation for clinicians that treat Latinos with mental illness and substance abuse problems, by creating a forum for professionals to continue learning about the bilingual/bicultural needs of Latinos,
- To encourage early intervention and reduce drop-out and poor compliance rates in treatment facilities by Latinos, and to encourage an increase in culturally sensitive and relevant services that meet the needs of Latino clients,
- To provide mental health education and support to the family’s of Latinos suffering from mental illness and substance abuse problems,
- To reduce the stigma associated with mental illness for those who seek treatment within the Latino Community,
- To provide: culturally sensitive educational articles about the clinical nature of mental illness and substance abuse,
- To provide culturally sensitive display advertising for local Latino mental health programs, clinics and community resources available to this community,
- To provide culturally sensitive messages of hope and encouragement to the Latino family of the person with mental illness or substance abuse problems.

Thanks to a generous grant from the United Way of New York City, we have the funds needed to go to press on our premier issue of Salud Mental this winter. Now our challenge is to secure the funds required to continue to deliver Salud Mental past the first issue and for years to come.

We have been quietly working behind the scenes to make new friends in the Latino community. The reaction to our plan to provide mental health education to the Latino community has been unbelievable. We have many clinicians who are eager to submit articles. Many leaders of Latino organizations are applauding our idea and we are hopeful that they will support this effort by sponsoring advertisements highlighting their good work. One idea that has been highly successful in Mental Health News is our use of regular columns that appear in each issue. We are hoping that several major organizations will wish to support a regular column about their initiatives, or work with us to develop special supplements in the new Salud Mental.

You can join with us to help make this project a resounding success. Below is a clip-out form that we hope you will mail back to us—and pass along to others. Let us know your thoughts and ideas, or ways that you can contribute.

We are looking for many talented people who can help us bring this project to the attention of funders, clinicians, service providers, advocacy and educational institutions and state mental health agencies. It is never easy to explore uncharted territories. What you try to do is to listen to the advice of many skilled experts—and always try to get everyone’s blessings on the project before you begin. With your help we will succeed and by next fall we will be able to celebrate the 1st anniversary of Salud Mental.

Have A Great Autumn!

**From The Publisher**

**Ira H. Minot, CSW**

Going From Concept To Creation

- Raise Start-up and Future Funding.
- Internal Components: staff, equipment, operating expenses, production and distribution.
- Leadership Building: Salud Mental Advisory Council, area committees, fundraising campaigns.
- Creating A Roadmap To Services: by enlisting the support of regional service providers to place low-cost display ads highlighting their vital services to readers in the Latino community.
- Creating Content: building a following of clinical experts who will contribute articles of interest.
- Creating a Salud Mental website.
A

Roman Centurion had come to a blacksmith earlier in the day to order 12 nails for that day’s crucifixions. That blacksmith was a Gypsy. He would need to make the nails on that very day. It was only after 9 of the 12 nails were delivered that the Gypsy learned that on this particular day the prisoners were to be nailed with 4 instead of 3 nails; the fourth nail on each prisoner was to be driven through his heart. One of the men, the carpenter’s son and preacher, was Jesus. Learning this, the blacksmith gave his son the remaining three nails and ordered him to flee. Jesus is said to have seen the boy from atop the cross and smiled. God from that day on gave the religious Gypsies the privilege of stealing without it being a sin. A befitting gift was granted to the people of the Blacksmith and his son who saved God’s Son from an even more gruesome fate.

Approximately 2000 years later, a Gypsy pickpocket is arrested by police in Times Square. He seems to be in an altered state of mind, with marked agitation. A psychiatrist is called to the jail to evaluate him. Among many of the peculiar things this Gypsy states to the psychiatrist is that he should not be arrested because it is a Gypsy’s birthright to lie. Perhaps it is a sign of radical narcissism or self-justification. Because it is a Gypsy’s birthright to lie, we may be skeptical of this patient’s account of events. Yet, as mental health professionals, I am more suspicious of this patient’s account of events. Yet, as mental health professionals, I am more suspicious because it is a Gypsy’s birthright to lie.

Among many of the peculiar things this Gypsy states to the psychiatrist is that he should not be arrested because it is a Gypsy’s birthright to lie. Perhaps it is a sign of radical narcissism or self-justification. Because it is a Gypsy’s birthright to lie, we may be skeptical of this patient’s account of events. Yet, as mental health professionals, I am more suspicious because it is a Gypsy’s birthright to lie.

The study of individual cultures is called “anthropology,” specifically “cultural anthropology.” Any truthful, insightful and revealing exploration of cultures and subcultures would represent this discipline. Margaret Mead’s Coming of Age in Samoa, Bronislaw Malinowski’s The Sexual Life of Savages, David Chase’s The Sorrows and John Steinbeck’s Cannery Row can all be good examples of treatises on a given culture or subculture. Such examinations may be factual and scholarly, or they may take the form of an informed and insightful fiction based on an author’s experience. Everyone is influenced in their behaviors and worldviews by the culture and subcultures in which they live. Those in the business of evaluating individual’s behaviors must educate themselves (e.g., reading, watching TV and film, travel and exploration, listening to their patients) about cultures. We often think of cultures as the ethnic, racial, religious, and national, to which people belong. Subcultures, as represented by associations with certain neighborhoods or groups, may be every bit as potent an influence on an individual as the culture or subcultures. Such examinations may be factual and scholarly, or they may take the form of an informed and insightful fiction based on an author’s experience. Everyone is influenced in their behaviors and worldviews by the culture and subcultures in which they live. Those in the business of evaluating individual’s behaviors must educate themselves (e.g., reading, watching TV and film, travel and exploration, listening to their patients) about cultures.

One of the most influential and productive psychiatrists of the 20th century was Professor Gerty Klerman MD. He passed away several years ago, and it had been my privilege to work for him for many years. We worked together on a number of large tracts of behavior, Psychiatric Illnesses and their treatment. More than once, Dr. Klerman told me that he wanted one thing to live on after his death as “Klerman’s Law” it was that “People really do represent their cultural stereotypes.” Of course, he did not mean that all individuals within a given culture share exactly the same world view, but that on the whole there were shared cultural stereotypes recognized within each group as normative. A mental health professional evaluating individuals needs to examine human beings within their cultural contexts.

“Cultural Diversity” these buzz words repr
Cultural Issues from page 1

Research documents that many members of minority groups fear, or feel ill at ease with, the mental health system (Lin et al., 1982; Sussman et al., 1987; Scheffler & Miller, 1991). These groups experience it as the product of white, European culture, shaped by research primarily on white, European populations. They may find only clinicians who represent a white middle-class orientation, with its cultural values and beliefs, as well as its biases, misconceptions and stereotypes of other cultures.

Research and clinical practice have propelled advocates and mental health professionals to press for “linguistically and culturally competent services” to improve utilization and effectiveness of treatment for different cultures. Culturally competent services incorporate respect for, and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs and value systems (CMHS, 1998). Without culturally competent services, the failure to serve racial and ethnic minority groups adequately is expected to worsen, given the huge demographic growth in these populations predicted over the next few decades (Takeuchi & Uehara, 1996; CMHS, 1998; Snowden, 1999).

This section of the chapter amplifies these major conclusions. It explains the confluence of clinical, cultural, organizational and financial reasons for minority groups being underserved by the mental health system. The first task, however, is to explain which ethnic and racial groups constitute underserved populations, to describe their changing demographics, and to define the term “culture” and its consequences for the mental health system.

Introduction To Cultural Diversity And Demographics

The federal government officially designates four major racial or ethnic minority groups in the United States: African American (black), Asian/Pacific Islander, Hispanic American (Latino), and Native American/Asian American/Alaskan Native/Native Hawaiian (referred to subsequently as “American Indians”) (CMHS, 1998). There are many other racial or ethnic minorities and considerable diversity within each of the four groupings listed above. The representation of the four officially designated groups in the U.S. population in 1999 is as follows: African Americans constitute the largest group, at 12.8 percent of the U.S. population; followed by Hispanics (11.4 percent), Asian/Pacific Islanders (4.0 percent), and American Indians (0.9 percent) (U.S. Census Bureau, 1999). Hispanic Americans are among the fastest-growing groups. Because their population growth outpaces that of African Americans, they are projected to be the predominant minority group (24.5 percent of the U.S. population) by the year 2050 (CMHS, 1998).

Racial and ethnic populations differ from one another and from the larger society with respect to culture. The term “culture” is used loosely to denote a common heritage and set of beliefs, norms and values. The cultures with which members of minority racial and ethnic groups identify often are markedly different from industrial societies of the West. The phrase “cultural identity” specifies a reference group—an identifiable social entity with whom a person identifies and to whom he or she looks for standards of behavior (Cooper & Demer, 1998). Of course, within any given group, an individual’s cultural identity may also involve language, country of origin, acculturation, gender, age, class, religious/spiritual beliefs, sexual orientation, and physical disabili ties (Lu et al., 1995). Many people have multiple ethnic or cultural identities.

The historical experiences of ethnic and minority groups in the United States are reflected in differences in economic, social and political status. The most measurable difference relates to income. Many racial and ethnic minority groups have limited financial resources. In 1994, families from these groups were at least three times as likely as white families to have incomes placing them below the federally established poverty line. The disparity is even greater when considering extreme poverty—family incomes at a level less than half of the poverty threshold—and is significant when considering children and older persons (O’Hare, 1996). Although some Asian Americans are somewhat better off financially than other minority groups, they still are more than one and a half times more likely than whites to live in poverty. Poverty disproportionately affects minority women and their children (Miranda & Green, 1999). The effects of poverty are compounded by differences in total value of accumulated assets, or total wealth (O’Hare et al., 1991).

Lower socioeconomic status—in terms of income, education and occupation—has been strongly linked to mental illness. It has been known for decades that people in the lowest socioeconomic strata are about two and a half times more likely than those in the highest strata to have a mental disorder (Holzer et al., 1986; Regier et al., 1993). The reasons for the association between lower socioeconomic status and mental illness are not well understood. It may be that a combination of factors in the lives of the poor and greater vulnerability to a variety of stressors leads to some mental disorders, such as depression. Poor women, for example, experience more frequent, threatening, and uncontrollable life events than do members of the population at large (Belle, 1990). It also may be that the impairments associated with mental disorders lead to lower socioeconomic status (McLeod & Kessler, 1990; Dohrenwend, 1992; Regier et al., 1993b).

Cultural identity impacts distinct patterns of beliefs and practices that have implications for the willingness to seek, and the ability to respond to, mental health services (McLeod, 1992). Cultural differences may also influence the likelihood that a person will use mental health services, and if so, which services the person will use (O’Hare, 1996).

Mental Health: An Assertive Education Program?

Can Your Community Afford To Not Have An Assertive Mental Health Education Program?

Let Us Help You Reach Out To Those Who Are At Risk

(914) 948-6699
Providing Quality Services In Culturally Diverse Communities

By Sharon E. Carpinello, RN, PhD
Commissioner
New York State Office of Mental Health

Our culture, the environment in which we were raised and in which we live, is a personal and powerful part of our lives. It forms the prism through which we view the world around us, and helps shape who we are. As providers of mental health services, we all must truly understand and work within the cultural context of people’s lives if we are to provide effective mental health services to “every single one.”

The importance of culture has recently been reinforced in numerous documents and publications, including the Final Report of the President’s New Freedom Commission on Mental Health (2003), Mental Health: A Report of the Surgeon General (1999) and Culture, Race and Ethnicity, a Supplement to Mental Health: A Report of the Surgeon General (2001). One of the goals identified in the New Freedom Commission’s Final Report directly challenges us to eliminate disparities in mental health services in numerous documents and publications, including the Cultural competence is a process whereby knowledge, language-access services are provided for those with limited English language use. However, we recognize that we need to work toward improving the areas of access to services and cultural adaptation of services. Most importantly, we need to document “what works” at the community level to build the science base demonstrating effective practices.

Family Psychoeducation
In Three Diverse Communities

Recognizing this need, Dr. Eric Caine, Laurie Flynn and I submitted a proposal to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in March of 2003. As a result, OMH received a grant totaling nearly $1 million from SAMHSA to create family psychoeducation sites in three culturally diverse communities. This award will support the development of family psychoeducation in communities with large African American, Asian and Hispanic/Latino populations—communities that have typically been underserved in the area of mental health services.

Family psychoeducation is an intervention consistently proven to result in positive outcomes for adults with mental illness. Research has shown that when families are educated about mental illnesses and the impact of illness on individuals, there are better outcomes for recovery. Recipients, family members and providers work together to develop strategies to solve problems, reduce stress, communicate effectively and cope with stigma.

While evidence suggests that the effectiveness of family psychoeducation generalizes to nearly all major cultural populations, there is evidence that cultural language can pose significant barriers to the provision of family psychoeducation, requiring culturally relevant adaptations and further study (Bentelspacher et al., 1996; Guarnaccia & Parra, 1996; Implementation Resource Kit, 2002, p. 32; Lopez et al., 2002; Xiong et al., 1994). In other words, the benefits of family psychoeducation may not be generalizable across all cultures or subgroups within a cultural group (Leffhey, 2002).

Traditionally, low participation rates in families of color in support and education groups are believed to impact on the potential efficacy of family psychoeducation in these groups (Guarnaccia, 1998; Roy Neville, NAMI, personal communication, 2003). It is expected, and has been reported in the literature, that many barriers have unique meanings for diverse populations, e.g., lack of awareness of benefits of family involvement, unfamiliarity with the family psychoeducation intervention, difficulty with self-disclosure, group problem-solving contradicts family hierarchy (Lee, 1997; Lopez et al., 2002; Sue, 1999). This warrants the development of tailored, culturally and linguistically sensitive strategies for family psychoeducation implementation.

The grant’s three project sites are located in New York City, which is richly diverse and provides a natural opportunity for applying culturally specific enhancements to family psychoeducation. According to the 2000 U.S. Census, the metropolitan areas of New York saw large increases in the Hispanic/Latino and Asian American populations from 1990 to 2000. Similarly, a large increase in Africans of Afro-Caribbean and sub-Saharan African ancestry has taken place in the New York City area over the same period.

Concentrating the project in one geographic area will maximize measures to control variability. The intent is to focus on the largest and fastest-growing minority populations. We are working to document “what works” at the community level to build the science base demonstrating effective practices. I am confident that we can improve access to culturally appropriate mental health services. I am committed to providing quality mental health services to “every single one,” and I ask you all to join me in making culture count.
Called JCAHO has new programs intended for mental illness. Dr. Molly Finnerty, Director of the Bureau of Evidence-Based Medicine and Clinical Practice Guidelines New York State Office of Mental Health, informed the managers that health care insurers are demanding that covered treatments be tied to proven researched methods. Dr. Molly Finnerty, Director of the Bureau of Evidence-Based Medicine and Clinical Practice Guidelines New York State Office of Mental Health, informed the managers that health care insurers are demanding that covered treatments be tied to proven researched methods.

Mental Health News Desk

Artist Takes Show On The Road To Help Raise Awareness About Mental Illness

Staff Writer Mental Health News

C happaqua Framing has joined forces with noted artist Susan Weinreich in a bold and unique union to raise awareness of mental illness. Ms. Weinreich will be exhibiting her art in the heart of downtown Chappaqua, New York. All net proceeds from the sale of Weinreich’s art will be donated to the Four Winds Foundation, an educational, non-profit branch of Four Winds Psychiatric Hospital in Katonah, New York.

Weinreich has been affiliated with Four Winds for more than 25 years. First as a patient and later as an employee, lecturer, and most recently as a volunteer, sharing her experience and inspiration of recovery.

Diagnosed with paranoid schizophrenia in her sophomore year at the Rhode Island School of Design, Weinreich credits her success to a broad continuum of treatment, Four Winds Hospital, and a persistent dedication and commitment toward making art.

“I have always felt that without my passion for making art, both before I became ill, as well as during the ten years of hospitalizations and especially during the 25 years of recovery that followed, I might never have made it to this point.” Weinreich insists that there is no mystery to transformation, “whether we are using the tools of a sculptor or our gloved hands in the garden. Our passion, our sense of “making a difference” is what heals us. It is what we as individuals and as humans have always longed for, and along with our ability to communicate and persevere, it is what guides us through growth.” Susan understands that illness, of any kind creates isolation. Isolation from loved ones, isolation from the world around us and eventually, if one retreats deep enough, isolation from ourselves. She feels that the formula for an artist is quite simple. “A picture is worth a thousand words. We have created a universal language and there is an immediate instant contact.” Ms. Weinreich says that she enjoys sharing her experience with others. “I live by the belief that when one door closes, another door opens.” Speaking as an artist is quite simple. “A picture is worth a thousand words. We have created a universal language and there is an immediate instant contact.” Ms. Weinreich says that she enjoys sharing her experience with others. “I live by the belief that when one door closes, another door opens.” Speaking as a patient and later as an employee, lecturer, and most recently as a volunteer, sharing her experience and inspiration of recovery.

Behavioral Management Briefed On Quality Standards And Technology

Staff Writer Mental Health News

St entinel events is a term used in the context of health care quality control that refers to egregious errors that sometimes have tragic results. Dr. Mary Cesare-Murphy, Executive Director of Behavioral Healthcare Accreditation Services at the Joint Commission of Accreditation of Healthcare Organizations (JCAHO), was speaking to 70 behavioral healthcare managers at the recent Annual Management Institute of the Association of Behavioral Healthcare Accreditation Services (ABHAS) held in South Street Seaport in New York City. “We have found,” Cesare-Murphy said, “that sentinel events are most often the result of a failure of communications.” JCAHO has new programs intended to enhance communications between itself and the institutions it surveys. Called Shared Vision-New Pathways, this initiative takes full advantage of modern communications technologies.

Pope Simmons, Chief Advocate in Congress of the National Association of Mental Health News Desk

Behavioral Healthcare Management, spoke on the need to communicate intensely with legislators for fair-funding treatment for behavioral health care.

Matthew Rosenblum called the Healthcare Insurance Portability and Accountability Act (HIPAA) a strategy by the federal government to force health care institutions to adopt electronic data management and communications systems. Mr. Rosenblum is the Chief Operating Officer of the consulting firm CPI Directions of New York. He reviewed pertinent provisions and answered questions about the massive legislation designed to protect the privacy of patient records as they are stored in databases or communicated electronically in the course of care.

Today, modern telecommunications play a vital role in delivering treatment for behavioral health patients. In communities where psychiatrists are not directly accessible, telepsychiatry has been called upon to do the job. Institute speaker Louisa Manfridi, an attorney, described a program she set up in a rural county jail where inmates were provided with “face-to-face” psychiatric sessions via telepsychiatry communications (reciprocal TV monitors) with a university psychiatrist 300 miles away. The advantages and outcomes were significant. Peter Conrad, CSW-R, Director of Green County Community Services, increased availability to psychiatric counseling from zero to services for 300 patients using telepsychiatry communications. Dr. Molly Finnerty, Director of the Bureau of Evidence-Based Medicine and Clinical Practice Guidelines New York State Office of Mental Health, informed the managers that health care insurers are demanding that covered treatments be tied to proven researched methods.

Association of Behavioral Healthcare Management-New York Chapter, President Mark Gustin, a Senior Associate Director at Kings County Hospital in Brooklyn, summed up the conference: “This year’s annual conference provided our members with very practical information that will ultimately benefit patients and families. We learned about the latest research in the field and picked up many practical tips on how others deal with problems that arise everyday in caring for their patients. Ultimately, the conference provides us with the benefit of sitting down and talking with peers that renews our commitment to professionalism as health care managers.”

For information about membership in the Association of Behavioral Healthcare Management, New York Chapter, contact Mark Gustin at 718-245-5674.
According to County Executive Andy Spano, County of Westchester, New York, “Our demographics are rapidly changing according to the 2000 census report,” and added, “I am asking all of our departments to take action and address the needs of our changing consumer groups so that we can better serve our new residents.”

The Department of Community Mental Health is just one department that has begun to develop training curriculum to help employees at the county and in nonprofit agencies.

Christine Reinhard, M.A., M.S., Deputy Commissioner, and Mary DeVivo, CSW, Coordinator of Community Education, have recently developed and presented workshops to help agencies begin to look at how their individual organizations can increase their ability to provide culturally competent services.

“Embracing Diversity—Supervisory Skills for the Frontline Manager,” was presented at the NYSACRA conference at the Sagamore Hotel in Lake George, and at “Your Values, My Values, Our Values,” a conference sponsored by Taconic Innovations in Mount Vernon. Ms. Reinhard said, “Each organization needs to begin to look at how diversity is encouraged within the structure of their organizations, and managers should look for methods to enhance and embrace the diversity which exists. In addition, direct-care staff needs more help to become empowered to handle new cultural challenges they face in the field. Both training and supervision are needed to help our agencies develop better skills to reach out to our broader community.

Ms. DeVivo emphasized how important it is to understand your own cultural history and how to utilize your uniqueness while working with others from other cultures. We are often fearful when working with individuals who are different from ourselves. We don’t want to appear uninformed, so we don’t adequately take the time to find out what we need to know from these individuals. We don’t want to look incompetent and/or vulnerable. This can lead to shying away from difficult issues, which in turn decreases the level of cultural competence in our clinical work. However, with adequate supports in our agencies, we all have the capacity to become more culturally aware and competent.

The workshop focuses on tools and skills needed to help build cultural competence with staff and supervisors within the agency. It outlines the need to understand how different disorders are viewed within the culture that is seeking help. It emphasizes the importance of providing education about the origins and etiologies of different disorders to staff, consumers and families. Lastly, it addresses policies and procedures that are helpful for attracting and retaining talented staff, which in turn will create a richer environment to meet the needs of a diverse consumer population.

Although this workshop begins to address some of the issues that we are facing today in Westchester, we at the county realize, along with many of our colleagues, that we still have a long way to go. We look forward to working and sharing ideas with individuals, agencies, consumers and families in our community in order to improve our capacity to address multicultural issues.

If you would like more information please contact the Westchester County Department of Community Mental Health at (914) 995-4534.
Beam Me Up, Doc
By Joshua Koerner

S cott Miller is the co-founder of the Institute for the Study of Therapeutic Change. Back when he was an intern at a psychiatric hospital, he met a man with a delusion: the patient believed himself to be the Terminator. He was living out the second Terminator movie, part of which is set in a psychiatric hospital. The patient dreamed that he might perpetrate the scene in which the unit psychiatrist, dismissive and contemptuous of Sarah Connor’s story about the robots from the future, gets flung across the room by Sarah’s “delusion.”

This patient had been leading other patients in repeated escape attempts, and the staff’s efforts at rational discussions, and drugging, failed to calm the situation. By the time Miller first talks to him he’s in the quiet room, stripped to his underwear. The situation can’t get much worse, so the senior staff do not think this student can do any damage, and Miller, young and not yet indoctrinated in the ways of the psychiatric establishment, tries something new.

First, he talks to the patient as if he were the Terminator. He doesn’t ques-
tion his “fixed” delusion. Miller then asks him if he is not the Terminator, but really Arnold Schwarzenegger. The pa-
tient smiles and asks, “How did you know?” Miller addresses him as if he’s Arnold, telling him he has accomplished so much since coming to America. And then Miller asks if he’d be willing to attempt a role like nothing he’s played before, a difficult stretch. Would he be willing to play a mental patient? Would he be willing to go to groups, take meds and not attempt to escape? The patient responds, “I can do it.”

And he did: after weeks of deteriorat-
ing, he was released in a matter of days. Miller noted on the radio program, This American Life, and also in the book, The Mummy at the Dining Room Table, that: “We have these notions that psychosis is a biological condition, and talking just really isn’t the thing that helps them, they really need the drugs. In fact, very often people are advised you don’t actu-
ally engage people in conversations about what that looks like, that might perpetu-
ate them. So you want to make sure you are very rational with them, set limits with them, and with some clients that’s going to work. But when you’ve tried that approach and it doesn’t work, you probably need to try something else. And our research actually says that clinici-
ans frequently don’t recognize when a case is failing. That means they persist in doing more of the same thing that hadn’t worked before; either the same class of intervention, or type of intervention. So if a little medication doesn’t work well, then we’ll try a little bit more. If a little confrontations doesn’t work to overcome the client’s denial, well then, by God, we’ll put them in a group where 12 peo-
ple can confront them simultaneously. It’s interesting to me that, in mental health offentimes when there’s a prob-
lem, it’s the clients who end up some-
how blamed.”

Evidence-based practice is the buzz phrase of the moment in the mental health field; it means we ought to be doing what works. But the evidence is that we know what works, that we’ve known for decades, and that we aren’t doing it. Instead, the field has been co-
opted, and corrupted, by the forces of Big Medicine, and has made pharmaceu-
ticals the answer. That’s not an evi-
dence-based approach, as empirically, there’s little to support the notion that mental illness is the result of a “chemical imbalance,” just as there is little evi-
dence that drug therapy is superior to psychotherapy.

What does work? Miller and his col-
leagues state that “using the client’s the-
tory of change to guide choice of tech-
ique and integration of various therapy 
modules” is what works. You can read their evidence in detail on the internet at www.talkingcure.com.

I recall a psychiatric student I met on an inpatient unit. This was my second 
hospitalization, in 1984, but my first at the Big Teaching Hospital. With it’s 
verdant lawns and tennis courts to match its sterility reputation, I cannot blame my 
mother for thinking this was the best for 
her son. How could she have known that the campus culture was one of pseudo-
Freudian detachment: that doctors never 
your glare, settle your dust,” is an excel-
lent non-pharmaceutical recovery tool.

It would have been so much better to have taken what I was interested in, sci-
ence and philosophy, as a basis of a the-
ory of change in which I believed, rather than using one packaged by drug compa-
nies, or conceived by Freud (while he 
was using cocaine).

A footnote: In 1997 the practical ap-
plication of Bell’s Theorem was proven 
with the first teleportation of a photon, a 
unit of light, and then on June 17 of this year the National Institute of Standards 
and Technology, as well as the Quantum 
Teleportation Team at Innsbruck, Aus-
tria, reported the teleportation of whole 
atoms, thus opening the door to quantum 
computing. By using qubits, which have 
four simultaneous possible states rather than the limited on or off state, I’m not as 
swearing questions about that.” But I was 
on the spot; if I made a scene they might not let me go.

But the worst aspect of the whole 
thing was sitting there, answering horri-
ably invasive questions from a total 
stranger, feeling like a bug under a mi-
croscope, getting all choked up and then looking around the room and seeing 
these callow young doctors, and they were 
— my anguish bored them. As terrible as I already felt, their utter 
lack of empathy made it ten times worse.

What did those residents learn that 
day? That you study the disease and 
ignore the person. What did I learn? That 
my feelings weren’t important and that 
doctors aren’t to be trusted.

Years later, I learned on my own 
what a clinician who knew and followed 
the evidence could have taught me: that the Tao Te Ching, which says “Close 
your mouth, block off your senses, blunt 
your glare, settle your dust,” is an excel-
lent non-pharmaceutical recovery tool.

It would have been so much better to have taken what I was interested in, sci-
ence and philosophy, as a basis of a the-
ory of change in which I believed, rather than using one packaged by drug compa-
nies, or conceived by Freud (while he 
was using cocaine).
Barriers To Financing Cultural Competence

By Michael B. Friedman, CSW

Meeting these challenges will take great inventiveness. It will take money. And ultimately it will also require the political will to create a mental health system that is socially just.

How will we finance the creation of a culturally competent mental health system?

Recently I was privileged to moderate a panel on barriers to financing state-of-the-art services for people of color at a wonderful conference organized by the Institute for Community Living in Brooklyn. Tara Sher, from Citizen’s Committee for Children, and Ed Smith from The Coalition of Voluntary Mental Health Agencies, joined me on the panel. Tara focused on children, Ed focused on adults, and I focused on older adults.

I wish I could say that the discussion that took place revealed the answers to the question of how to finance cultural competence. It did not. But it did reveal a great deal about the difficulties that have to be confronted. Here are some of the major themes that emerged.

Financing Cultural Competence

Is A Challenge That Must Be Taken On in the Private Sector As Well As The Public Sector

Lack of insurance coverage and the failure of insurance to provide adequate coverage of mental health conditions and non-traditional services is a major problem for minorities who need mental health services. When we think about cultural minorities, there is a tendency to think first about the inadequacy of public health insurance—for example, the problems of eligibility for Medicaid or of the lack of parity in Child Health Plus and Medicare. But most people of color are working people, who ought to have mental health insurance coverage through work. It is important, of course, to press for extending coverage provided by the public sector; but unless this nation makes universal health coverage, it will also be important to press the private sector to provide adequate mental health insurance coverage.

Funding Structures Are Out Of Alignment With Service Needs And Goals

Funding structures for mental health services are fundamentally out of alignment with the realities of providing good services for cultural minorities. For example, funding for health and mental health services in the United States is built on the expectation that people who need services will go to sites where services are provided. Providers wait for people to come to them rather than reaching out to people in their homes and communities. This approach to service provision creates special problems for cultural minorities because, as Lloyd Hogler has observed, different cultures follow different pathways to help. Funding needs to be structured so that mental health providers can place themselves along these pathways, at sites where people from cultural minorities will naturally turn for help.

In addition, funding sources for mental health services tend to draw from medical models of service, which leave out of account not only the need for outreach into indigenous communities, but also the need for family support, case management, integrated cross-system services and the like.

Fragmentation Of Funding Sources Contributes To The Failure To Provide Integrated Services

People who are poor—and in the United States people of color are disproportionately poor—need to have multiple problems to confront. They are not likely to be just depressed. Adults may also be struggling to hold onto, or to get, jobs; to make rent payments or find housing; to feed and clothe their families; to be available when their children need them; or to protect themselves from domestic violence. Children may be struggling to get by in school, to handle peer pressures that steer them in dangerous directions, to find a bicultural identity, or to survive child abuse. Older adults may have lost touch with family and friends; to have nothing that would give them a sense of satisfaction and meaning; to be home-bound, or to be so financially strapped that they have to choose between food and medications.

Our society responds to people with multiple problems with categorical systems of service, which only addresses one need at a time. As a result it becomes exceedingly difficult to create integrated systems of service, such as school-based services, integrated treatment for people with co-occurring mental and addictive disorders, integrated health and mental health services, etc. It is important, I think, to understand that the bureaucratic obstacles to integrated service result from humane impulses that lead to categorical benefits and not from lack of societal concern or the incompetence of bureaucrats. Fragmentation is rooted in the basic structure of our nation’s systems of health and human services and does not just reflect what is dismissively and simplistically referred to these days as a “silo mentality.”

Additional Funding Is Needed

The claim that we don’t need more money but only restructuring has become increasingly commonplace among public officials trying to figure out how to balance budgets and among advocates trying to persuade public officials that social transformation will reduce costs. The discussion during our panel provided little reason to believe that this is true. How, without additional funding, will we be able to substantially increase the capacity of the service system, make it mobile, and disperse it into indigenous communities? How will we pay for training and education to build clinical and cultural competence? How will we expand research so that it produces findings applicable to cultural minorities?

Political Will

Barriers to financing a culturally competent mental health system will not be easy to overcome. Engaging the private sector, as well as the public sector, requires substantial restructuring of financing mechanisms; and funding for increased service capacity, training and research are all profoundly difficult to achieve. Does the political will exist to take on these challenges? Participants in the ICL conference expressed a fundamental cynicism about our society’s willingness to honestly confront the needs of cultural minorities.

Thus our panel, and the conference overall, ultimately became a call to action, a call to create the political will, without which the challenges of creating and financing a culturally competent mental health system cannot be met.

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The opinions in this article are his own and do not necessarily reflect the positions of The Mental Health Associations.
O n June 16, 2004 the Institute of Community Living held a conference entitled “Bridging the Gap in Mental Health Care: Adapting Best Practices to Communities of Color.” I was privileged to participate on a panel with Michael Friedman and Tara Sher where we presented on the economics of mental health and system delivery for multi-need individuals and families. I focused my comments on the systemic fiscal challenges in financing mental health services for the adult population and the impact these challenges have upon the delivery of evidenced based practice services to racial and ethnic communities of color.

As a start, I wanted to understand some of the data regarding the number of adults who receive mental health services in the United States; and how much money was spent nationally and in New York City by the mental health sector in providing mental health services to the adult population. That information helps to provide an understanding of the fiscal construct and structure of the mental health sector, helps identify the number of people accessing services (the unmet need information is unavailable), and illuminates the cost associated with providing care.

According to the prevalence data provided by the New York City Department of Health and Mental Hygiene, The Surgeon General’s report estimates that in the course of one year about 1 in 5 adults, age 18 and older, experience a psychiatric disorder. Applying that estimate to the 50 million New Yorkers age 21 and older results in approximately 10 million individuals who have a psychiatric disorder. By the end of the year, it is estimated that nearly 2 million of these individuals will experience a serious mental illness. The total cost of mental illness services to the adult population were $4.4 billion dollars. Given the projected future transformation in the racial and ethnic makeup of the US States population, the costs of caring for mental health services may be required in order to achieve successful outcomes in racial and ethnic communities of color.

While the funding streams for public mental health services flow through 5 basic silos – government funded insurance programs (Medicaid/Medicare), state aid, local tax levy dollars, public and private grants, and philanthropy/private fund raising initiatives, state and local governments are the major payers for public mental health services. The main public funding streams that finance mental health services for the adult populations are Medicaid/Medicare, Family Health Plus, and Medicaid managed care. These public programs serve as the “safety net” for the most vulnerable populations.

Medicaid, an entitlement, is the largest payer of mental health services. Because of ever increasing costs associated with service delivery, Federal and State governments are seeking ways to reduce Medicaid spending. This also includes those services which are covered under Medicaid. Medicaid funding goes back to the federal government. Because Medicaid does not fund all mental health services and mental health treatment needs, the delivery and funding of mental health services and treatments are fiscally and programmatically complex and fragmented. As stated in the Surgeon General’s report “Mental Health: A Report of the Surgeon General”

During the past two decades there have been important shifts in what parties have final responsibility for paying for mental health care. The role of direct state funding of mental health care has been reduced, whereas Medicaid funding of mental health care has grown in relative importance. This is in part due to substantial funding offered to the states by the Federal government. One consequence of this shift is that Medicaid programs have been influential in shaping the delivery of mental health care. State and mental health authorities, however, continue to be an important force in making public mental health services policy, working together with State Medicaid programs. Considerable administrative responsibility for mental health services has devolved to local mental health authorities in recent years.

Services and funding are fragmented across programs. Multiple federal, state, and local, service programs with disparate objectives and requirements may finance mental health services and support for a single individual. These services and supports have to be administered on the local level by a provider who has to understand the nuances of effectively coordinating the service delivery and funding to ensure that the consumer has received the totality of services that will aid in his or her recovery. These services and treatments, funded through a combination of various sources – State and local general funds, Medicare, SSI, SSDI, OASIS, Department of Education, TRAF, Juvenile Justice, HUD, Child Welfare, Federal Block grants etc. – creates a financing approach that is at times rich, complex, restrictive, and inconsistent in coverage.

Dr. Michael Hogan, Chair of the President’s New Freedom Commission on Mental Health, has emphasized that “the field has no successful strategy to counter this subtle but dangerous mental health safety net and the increased fragmentation caused by reliance on multiple funding streams …total spending on mental illness has in fact sky rocketed…this spending is not taking place in the treatment system but in the criminal justice system, in the general health care system, because of the impact of depression and other mental disorders on the course and outcomes of physical illness, and in the welfare system.”

The fragmentation of the system has a serious impact on the delivery of mental health services to racial and ethnic minorities and communities of color. Racial and ethnic minority populations are growing, and by 2025 will account for 40% of all Americans. The recent report by the Surgeon General’s Office “Mental Health; Culture, Race and Ethnicity” underscores the disparities in care to racial and ethnic minorities. The disparities, in part, can be attributable to the fragmented system, lack of access to services, and gaps in insurance coverage and the total absence of insurance. Many of the barriers to care also include societal stigma, mistrust/fear of treatment, cultural perspectives regarding health, difference in help-seeking behaviors, language and communications patterns, racism, institutional and personal discrimination.

The mental health service delivery system is also being impacted by new service delivery models that are comprehensive, focusing on evidence-based practices, or evidence based treatment, or state of the art treatment, or promising treatment. These modalities are presenting new challenges to the delivery of mental health services. First, they are very costly and based on controlled research which is generally funded at full cost and provide services that may not be reimbursable under the array of systems that fund mental health services. Some of the services rendered during a research study that show good outcomes may not be reimbursable services when applied in practice by community-based mental health agencies. Research based services, while focused on obtaining good outcomes, often do not consider the impact of the service on the system and the reimbursement of the service. This is not applied in practice, it has been found that the reimbursement and the service delivery model may be at variance and a provider may be subject to exposure when audited.

Additionally, communities of color are generally not included in the research that supports the evidence-based practices. Much of the research is not conducted in multi-lingual, ethnically diverse, densely populated urban centers like New York City.

The implementation of evidence based practices may not necessarily mean that the treatment is “culturally appropriate” and addresses the nuances of effectively treating communities of color and obtaining good outcomes for a particular community.

For example, an evidence-based practice that is being implemented in New York is Assertive Community Treatment (ACT). This treatment requires intensive work in the community involving clinicians and psychiatrists’ visits to the homes of consumers to provide treatment, including the dispensation of drugs and a focus on wellness management. What has proven to be effective is that the research may, in fact, become a barrier to services when applied to communities of color.

With regard to ACT, as an example, the expected outcomes from an evidence-based treatment may not materialize for consumers of color. If the research based treatment can not be fully applied because of culturally inappropri- ate application and other treatments that have not been tested are unreimbursable and/or fall outside of the fragmented funding streams that support mental health services, communities of color and racial and ethnic minorities may not fully benefit from their recovery potential or achieve desired outcomes.

Dr. Alvin F. Poussaint, professor of psychiatry at Harvard University and...
By Spencer Eth, MD
Chairman of the Ethics Committee
American Psychiatric Association

A recent New Yorker cartoon showed a gentleman testifying before a hearing panel. The caption read: “Please pay attention, as the ethics have changed.” Whether or not you find the cartoon humorous, it is true that medical and psychiatric ethics have evolved over the years. However, it is also true that the core ethical principles governing the practice of psychiatry remain in force.

In this article I will first review what is new, and then what is timeless, about psychiatric ethics.

All psychiatrists who are members of the American Psychiatric Association and its local branches are bound by the American Psychiatric Association Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. This code carefully regulates professional behavior and, by so doing, protects patients from harm. It may be reassuring for patients to verify that their psychiatrist is indeed a member of the APA. Every local branch of the APA has an Ethics Committee that reviews complaints of unethical conduct by psychiatrists. These complaints can be investigated, and, if found to be serious, a hearing can be held, in which the psychiatrist must respond to the allegation of a violation of the principles of medical ethics. Although it happens infrequently, psychiatrists have been expelled from the APA for improper behavior toward patients.

The APA recently changed the procedures by which complaints against psychiatrists are handled by local branch ethics committees. The three most significant modifications in procedures involve the addition of an “educational option” to the traditional enforcement process, the imposition of a statute of limitations for ethics complaints, and an alteration in the process of appealing an ethics sanction of reprimand, suspension or expulsion from membership. The goal of the educational option is to permit local branches to resolve complaints in an educational atmosphere that facilitates learning, sensitivity and behavior change rather than stigmatization. It is not intended for allegations of serious ethical infractions.

The APA had never adopted a statute of limitations, recognizing that it may take years for a patient to file an ethics complaint. However, states generally impose time limits on the filing of legal actions, including malpractice lawsuits, in order to exclude cases involving poor memories and lost evidence. Although state statutes tend to be in the 2-3 year time frame, the APA has set a 10-year statute of limitations, except in the case of children when it would begin at adulthood.

The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry is a document that derives from the ancient Greek study of philosophy. In fact, ethics is the specific branch of philosophy that encompasses the analysis of moral value judgments and duties, including the duties of professionals. In the work Crito, Socrates presents a discourse on moral responsibility. Socrates argues that he should not break the state’s laws, though they were unjust, by escaping from his prison death sentence. Instead, he chose to accept his punishment by drinking hemlock. By dying, Socrates proved that ethics should be taken seriously.

Awareness of the importance of ethics declined over the centuries, only to be revived in the aftermath of World War II. A significant but unfortunate factor stimulating interest in medical ethics has been the repeated exposure of unethical experimentation by physicians. Two millennia ago Hippocrates observed, “as to diseases, make a habit of two things—to help, or at least to do no harm.” The tradition of beneficence, doing good, is at the core of the physician’s role in society and the basis for the trust and honor invested in the profession. It was shocking and horrifying to discover that doctors could place their patients in mortal jeopardy.

Initially, it was presumed that unethical experimentation was confined to Nazi physicians. It was later discovered that patients were exploited in places far from the concentration camps. In fact, a shocking revelation involved an experiment sponsored by the United States Public Health Service. This was a study of the natural history of syphilis in African-American men in the rural South. Some of these men continued to be denied effective treatment for syphilis into the 1960’s! The direct result of these revelations was the creation of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and the implementation of a universal system of Institutional Review Boards in hospitals to oversee the protection of human subjects.

The same ethical scrutiny now given to the conduct of research can also serve as a model for the routine treatment of all patients by physicians. For example, a patient ought to be informed of the relevant facts concerning the purpose, procedures, risks, benefits and alternatives of any recommended medical intervention. It may not be easy to determine exactly which risks should be explained to the patient. One standard is the reasonable person rule, which states that all of those risks that a reasonable person would want to know should be explained.

A patient should be allowed to exercise decision-making without coercion. A fundamental value in biomedical ethics is autonomy, or the cardinal principle of respect for persons. Autonomy serves to safeguard the liberty or freedom of an individual to control his or her own body. In fact, psychiatric treatments are designed to enhance autonomy, by empowering patients to choose freely their own course of action by limiting the constraining effects of mental illness.

A patient needs to have the capacity to appreciate the information provided by the physician, or choose another person to offer consent instead. The question of what constitutes capacity to consent is complicated. There should be an ability to understand factual information and to make a reasonable decision. Whether a patient with major mental illness is capable of exercising an acceptable degree of competence requires individual consideration.

Psychiatric ethics has made progress in addressing the never-ending series of moral issues in professional practice. Serious attention to this dimension of mental health care promises to contribute further to the benefit of psychiatrists and patients alike.

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What Is So Untypical About Atypical Antipsychotic Medications?

By Richard H. McCarthy
MD, CM, PhD
A Psychiatrist in Private Practice

Medications that are used to treat depression are usually referred to as antidepressants. Likewise, medications that are used to treat psychosis are usually referred to as antipsychotics. Naming psychiatric medications this way makes it easy to pass multiple choice tests (What medication would you use to treat mania? A. an antidepressant, B. an antipsychotic, C. an antianxiety, D. a tranquillant). But it does nothing to help us understand how these medications work.

Moreover, as previous columns in this column have noted, these “illness-specific names” suggest that these medications are illness specific, which they are not. The best antianxiety medications (the so-called benzodiazepines) come from the class of medications usually referred to as the antipsychotics. Most of the antianxiety agents are actually medications that were developed to treat seizures (not surprisingly they are usually called antiepileptic drugs). As with most drug discoveries in psychiatry, the fact that they also are effective with mania or mood instability was discovered by accident. As we saw in an earlier column, drugs are discovered turns out to be fairly important.

The fact that medications can be used to treat psychosis was discovered entirely by accident. The people that made this discovery were not psychiatrists, but were surgeons and anesthesiologists. They made this discovery because they were looking for something that would help patients have fewer secretions during an operation. The anesthetic that they chose to use was chlorpromazine, sold under the brand name Thorazine®. To everyone’s surprise, psychiatric patients who had surgery for one reason or another, became less psychotic after they received chlorpromazine as a part of their anesthesia. The discoverers wrote a letter to the editor of a journal and reported this. Heinz Lehman, a psychiatrist in Montreal, was the first person to use chlorpromazine with psychiatric patients in North America. He gave chlorpromazine to six consecutive patients admitted to Verdun Hospital in Montreal. At the time, the average length of stay in most psychiatric hospitals was 15 years. All six of the patients who received chlorpromazine were discharged within six months. For those who witnessed this in the early days of psychopharmacology, it was as if God himself had touched each of these people and cured them. Chlorpromazine was smuggled into the United States by families and physicians desperate to alleviate the suffering of patients with psychosis.

One way to develop a new medication is to make small alterations in the compound will be useful in treating illness. One of the first medications that came out of this was imipramine, later sold under the brand name Tofranil®. It turned out that this medication was useless in treating psychosis but did treat depression. Thus, the antidepressants were born.

Another way to discover medications is to look for an easily observable effect that the medication has on animals, and then screen other drugs to see if they too, have the same effect. If they do, they might also be used to treat illness. Chlorpromazine not only treats psychoses it also makes rats stiff, an easily observable effect. Some, but not all, of the other medications that make rats stiff can also treat psychosis. These medications include haloperidol (Haldol®), fluphenazine (Prolixin®), trifluoperazine (Stelazine®), as well as a host of others. Since these medications treat psychosis they are referred to as antipsychotics. Since they can make those who take them stiff, they are also called neuroleptics. Like many words in medicine, the term neuroleptic is a made up word, with Greek roots, that mean ‘to take hold of the brain.’ There are some medications that make rats and people stiff, which do not treat psychosis, but treat something else. Such a drug is metoclopramide (Reglan®) which is used to treat nausea and vomiting. While it is technically a neuroleptic, almost no one refers to it as such. Usually, the term neuroleptic is reserved for medications that make people stiff and treat psychosis.

All neuroleptics are antipsychotics, but not all antipsychotics are neuroleptics. Those medications that are both neuroleptics and antipsychotics are referred to as classical neuroleptics, traditional antipsychotics, antipsychotics or typical antipsychotics. They are typical because they all make people stiff; i.e., they are all neuroleptics. They are typical because all are equally effective, there is no particular reason other than adverse effects, to choose one over another. Likewise, they all share some similar adverse effects, most especially raising the levels of a hormone called prolactin.

All medications that treat psychosis are called antipsychotics, but not all antipsychotics are neuroleptics. In fact, almost none of the newer antipsychotics are. Medications that treat psychosis without causing stiffness are referred to as atypical antipsychotics. All but one of these medications are based, in one way or another, on clozapine (Clozaril®). Along with clozapine, the atypical antipsychotics include risperidone (Risperdal®), olanzapine (Zyprexa®), quetiapine (Seroquel®), ziprasidone (Geodon®) and aripiprazole (Abilify®). The atypical antipsychotics are listed in order of their introduction in the United States. Interestingly, these newer medications are different, atypical, in other ways as well. All of them have been shown to be better than haloperidol in clinical, experimental trials. This is quite different and is one of the reasons that these medications are being used so much today. Here, the term atypical is usually thought of as better. This is frequently but not always, true. Likewise, most of these medications share similar adverse effects. The most serious of these is weight gain and the development of diabetes. (I will discuss these problems in another column.) Two of the above medications differ from the others. Risperidone is the only atypical antipsychotic that also raises prolactin. Moreover, at higher doses it can make people stiff. As with all of the atypical medications, it has been shown to be better than haloperidol. Thus, risperidone shares some characteristics of classical neuroleptics (Prolactin elevation and stiffness at high doses) and some of the characteristics of the atypical (improved efficacy as compared to haloperidol). In a way, risperidone is halfway between the typical and atypical antipsychotics. The other medication that differs from all of the others is aripiprazole. This medication is thought to have a unique mechanism of action. All of the typical antipsychotics block some dopamine receptors; most of the atypicals block some dopamine, but much less so; all of the atypicals block some serotonin receptors. This differential blockade of receptors is thought to be responsible for the medication’s beneficial and adverse effects. Aripiprazole is a bit more complicated. In some situations it acts like a blocker of dopamine, and in other situations it acts like a simulator. This odd pattern of receptor interaction is thought to be responsible for its actions. Moreover, some people argue that just as the chlorpromazine derivatives or neuroleptics were the first generation antipsychotics, and the clozapine derivatives (the so-called atypicals) were the second generation, then aripiprazole, with a very different mode of action, should be thought of as the first of the third generation of antipsychotics.

To sum up, the atypical antipsychotics having been found and developed in a way different from their predecessors (the typicals), work in a different way, have a different set of adverse effects, and have been shown to be more effective than haloperidol in clinical trials. Thus, they are likely to be better in some ways, more effective, and possibly worse in others, adverse effects. The real value is that the atypicals have prompted a new round of drug discovery and development, and have resulted in improved treatment and recovery for many people.
Voluntary and Involuntary Admissions To Acute Care Psychiatric Facilities

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Psychiatric emergencies are unlike any other medical emergency. The typical medical emergency requires immediate surgical or medical intervention, followed by a brief recovery period. In comparison, the typical psychiatric emergency requires acute behavioral intervention, an observation period, titration (increased dosing) of psychiatric medications and stabilization prior to discharge. Confusion and anxiety are common responses when one is admitted to an inpatient psychiatric facility, either unwillingly or in emergent circumstances. The consumer (the patient) should be aware that they have legal rights and obligations when they are involuntarily brought to a hospital for psychiatric care, or present to the hospital voluntarily. In admitting an individual to a psychiatric emergency room or treatment unit, the hospital must follow a strict set of legal guidelines. In New York, the legal statute governing the involuntary hospitalization of individuals believed to be mentally ill is Article 9 of the Mental Hygiene Law (Article 9 hereinafter). Article 9 sets forth the legal requirements for emergency, voluntary and involuntary admissions to a hospital, as well as continuation (commonly called retention) of patients within the hospital voluntarily. In admitting an individual to a psychiatric emergency room or treatment unit, the hospital must follow a strict set of legal guidelines. In New York, the legal statute governing the involuntary hospitalization of individuals believed to be mentally ill is Article 9 of the Mental Hygiene Law (Article 9 hereinafter). Article 9 sets forth the legal requirements for emergency, voluntary and involuntary admissions to a hospital, as well as continuation (commonly called retention) of patients within the hospital voluntarily. In admitting an individual to a psychiatric emergency room or treatment unit, the hospital must follow a strict set of legal guidelines. In New York, the legal statute governing the involuntary hospitalization of individuals believed to be mentally ill is Article 9 of the Mental Hygiene Law (Article 9 hereinafter). Article 9 sets forth the legal requirements for emergency, voluntary and involuntary admissions to a hospital, as well as continuation (commonly called retention) of patients within the hospital voluntarily.

Basically, the terms voluntary, involuntary and emergency relate to the willingness and understanding of an individual to accept care and treatment in a psychiatric facility on a short-term or “acute” basis, and the hospital’s obligation to provide care and treatment. The following is a discussion of the general differences between these various types of admission status.

It should be noted that a hospital, upon a patient’s admission, (regardless of status) must inform the patient in writing of his/her status and rights under Article 9, including the availability of the Mental Hygiene Legal Service (MHLS), the appointed legal counsel for patients in psychiatric facilities.

The Voluntary Admission

Article 9 explicitly encourages voluntary admissions over the involuntary admission by providing that a person requesting admission to a hospital, who is suitable for admission on a voluntary status, shall be admitted only on such a voluntary status. Article 9 states that a hospital may admit as a voluntary patient any suitable person in need of care and treatment, who voluntarily makes written application for admission. The statute defines “in need of care and treatment” broadly as meaning that a person has a mental illness for which in-patient care and treatment in a hospital is appropriate. Under the statute, a person is suitable for admission as a voluntary patient if he/she is notified of and, despite his/her mental illness, has the ability to understand the following three fundamentals regarding his/her admission to the hospital: (1) that the hospital to which he is requesting admission is a hospital for the mentally ill, (2) that he is making an application for admission, and (3) the nature of voluntary status, and the provisions governing release or conversion to involuntary status.

The consumer should be aware that voluntary does not equate to the ability to leave at one’s will. There is a process by which a voluntary patient may seek release from a psychiatric hospital and/or a hospital may seek to retain a voluntary patient against their wishes. Article 9 provides that:

1. If a voluntary patient gives notice in writing to the director of the hospital of the patient’s desire to leave the hospital, the director shall promptly release the patient, provided, however, that if there are reasonable grounds for belief that the patient may be in need of involuntary care and treatment, the director may retain the patient for a period not to exceed seventy-two hours from receipt of such notice. Before the expiration of such seventy-two hour period, the director shall either release the patient or apply to court for an order authorizing the involuntary retention of such patient.

The written notice of the patient’s desire to leave the hospital is commonly referred to as a 72-hour letter because it triggers the hospital’s obligation to either discharge the patient or seek court authorization to retain the patient in involuntary status within seventy-two hours of the patient’s submission of the notice. There are no formal requirements for the notice, other than that it be written by the patient and that it request release from the hospital. The patient may give the notice to any member of the treatment team. Article 9 provides that in the event the hospital applies for a court order to retain a patient who has submitted a 72-hour letter, the hearing must be held within three days of the date the court receives the hospital’s application. In addition, courts have consistently held that for such a commitment to satisfy constitutional due process requirements, the patient must present a real and present threat of substantial harm to himself or others.

The Involuntary Admission

A psychiatric hospital, pursuant to Article 9, may admit and retain as an involuntary patient any person alleged to be mentally ill and in need of involuntary care and treatment upon the certification of two examining physicians, accompanied by an application for the admission of such a person. An admission under this section is often referred to as a 2 PC admission because of the requirements for two physician certificates. This should not be confused with the “emergency admission,” discussed in detail below. The statute explains that the physician’s examinations must be made within ten days prior to admission, they may be conducted jointly, but, that

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that disrupt normal thoughts, speech and causes severe mental disturbances described as a psychosis—a type of illness. While the term schizophrenia literally disease. While the term schizophrenia literally population, schizophrenia is a severe, affecting approximately 1% of the world’s neurochemistry, new/improved treatments and genetic origins. Constance E. neurochemistry, new/improved treatments and genetic origins. Constance E. Lieber has served as president of NAR- SAD since 1989.

Schizophrenia remains one of the most intractable mental illnesses. Aff ecting approximately 1% of the world’s population, schizophrenia is a severe, chronic and often disabling brain disease. While the term schizophrenia literally means “split mind,” it should not be confused with multiple (“split”) personality disorder. It is more accurately described as a psychosis—a type of illness that causes severe mental disturbances that disrupt normal thoughts, speech and behavior. We have seen vast improvements in its treatment over the past thirty years, but we still need to better understand the disease and to find more effective approaches to treatment of this and other psychiatric disorders. Some exciting research now underway promises to advance these goals. The National Alliance for Research on Schizophrenia and Depression (NARSAD) has provided grants to researchers whose fresh, original studies offer new hope for schizophrenia sufferers.

Much study, from many different perspectives, is being done on schizophrenia. The hunt is on for genes responsible for the disease, and for new ways to predict those at risk for development of schizophrenia. While the genetic underpinnings of the disease are being explored, and neuroscience research is underway to understand the underlying aspects of the brain mechanisms and chemistry behind the disorder. To help schizophrenia sufferers to function more independently, other researchers adopt a psychosocial approach and look at ways to improve the quality of a patient’s life. With researchers painstakingly building—block-upon-block—our understanding of human brain development and function, and with ever more powerful technological tools at their disposal, there has never been greater cause for optimism in the fight against serious mental disorders.

Seeking new insights into the genetic underpinnings of schizophrenia, Susan Harley, PhD, a psychologist at the University of California, San Diego (NARSAD 2004 Distinguished Investigator) is studying a unique data resource—the Jerusalem Perinatal Study, based on 92,468 individuals born in Israel from 1964 –1976. Past studies suggest a familial link between schizophrenia and cancer, and Dr. Harlap is investigating cancer incidence in the families of schizophrenia patients by studying data on this cohort. The occurrence of both diseases in one family—especially if also associated with a birth defect—could contribute to the discovery of genes for schizophrenia. Also pursuing the genetic angle, a research team based at the University of Chicago has identified a gene variation on a particular chromosome that raises the risk for both bipolar disorder and schizophrenia.

Although susceptibility to schizophrenia is thought to be primarily genetic, it has been suggested that poor environmental conditions during development could increase an individual’s risk for developing the disorder. Michael J. Meaney, PhD of McGill University (NARSAD 2002 Distinguished Investigator) is looking at whether adversity in early life might alter neural development and elevate risk for pathology later in life. Early, difficult life events often correlate to chronic illness, including depression, anxiety disorders, schizophrenia, and drug abuse. Dr. Meaney and others have proposed that the brain’s chemical reactions to stress early in life actually alter the brain, and affect it permanently in subtle ways. Documenting that these changes occur, and understanding them in detail, can help pave the way for new and better treatments for schizophrenia.

Schizophrenia generally strikes like a bolt out the blue right at the cusp of young adulthood—in the late teens or twenties. Determining who is at risk for developing the disease is critical for early treatment, but has proved elusive and remains the subject of intense study by neuroscientists. Rajaprabhakaran Raja- rethnam, MD of Wayne State University (NARSAD 2004 Young Investigator) joins in this quest by studying the superior temporal gyrus, or STG of the brain, which is an area responsible for language association and thought processes. Studies show that STG is smaller in individuals with schizophrenia and their children, and that the children demonstrate subtle deficiencies in language tests. Dr. Rajarethnam hypothesizes that scanning this area of the brain genetically at-risk adolescents while they listen to spoken language could predict a later onset of schizophrenia.

Is there a link between schizophrenia and intelligence? Considerable evidence suggests that this is so, and recent studies have demonstrated an increased risk of schizophrenia in individuals with high intellectual abilities. Abraham Reichen- berg, PhD of Mount Sinai School of Medicine (NARSAD 2004 Young Investigator) notes that these studies used scholastic achievements and aptitude tests to assess intellect, without looking at the individuals’ neurological and psychological histories. Dr. Reichenberg’s research approach is to compare a cohort of schizophrenia patients with high and low premorbid IQs (assessed by the Wechsler Intelligence Scale for Children), in conjunction with their premorbid neuropsychological profiles. This focused methodology will help us to more precisely understand the link between schizophrenia and intelligence.

Most schizophrenia treatments and research looks at either the “positive,” psychotic symptoms of schizophrenia, including delusions, hallucinations and disorganized thinking, or the disease’s “negative” symptoms, which include emotional flatness, passivity and a lack of pleasure or interest in life. Uniquely, the research being conducted by Joseph Coyle, MD of Harvard University (NARSAD 2004 Distinguished Investigator) has implications for both the pos- itive and negative symptoms. His studies on the brain’s NMDA receptor offer new hope for an expanded understanding of the chemistry underlying schizophrenia’s diverse symptoms. Using this research approach, Ca- tana Brown, PhD of the University of Kansas (NARSAD 2003 Independent Investigator) studies the effectiveness of two different rehabilitation methods on individuals with schizophrenia and schizoaffective disorder. Both schools of thought aim to promote more inde- pendent living; however, one approach emphasizes learning and skill acquisition, while the other seeks to tailor the individual’s environment with assistive devices and other means. Dr. Brown believes that some patients will benefit from one of the approaches, and others from a combination of the two.

Pushing the envelope of innovative schizophrenia treatment, Ralph Hoff- man, MD of Yale University (NARSAD 2003 Independent Investigator) has found Rapid Transcranial Magnetic Stimulation of the brain’s NMDA receptor to be beneficial in treating auditory hallucinations. Fifty to 70% of schizophrenia sufferers “hear voices,” and this symptom is often resis- tent to medications or other treatments. Targeting magnetic brain stimulation has been shown effective in treating depression, and now shows promise for schizophrenia treatment as well. This research will enable us to better understand the physical basis of auditory hallucinations and may lead to non-invasive, nonpharma- cological treatments for this difficult aspect of schizophrenia.

While schizophrenia remains heart- breakingly difficult both for those suffer- ing from it and for the people who love them, there is reason for hope as never before. Research scientists have made enormous strides in understanding the human brain, and treatments have dra- matically improved in only a few short years. Empowered by ever-advancing technology, these dedicated men and women build on the work of others and pave the way for those who follow. With our ongoing encouragement and support, it is they who will usher in the dawn of a new day in the struggle against schizophrenia and other serious mental disorders.
Cultural Issues from page 8

health services. These include coping styles and ties to family and community, discussed below.

Coping Styles

Cultural differences can be reflected in differences in preferred styles of coping with day-to-day problems. Consistent with a cultural emphasis on restraint, certain Asian American groups, for example, encourage a tendency not to dwell on morbid or upsetting thoughts, believing that avoidance of troubling internal events is warranted more than recognition and outward expression (Leong & Lau, 1998). They have little willingness to behave in a fashion that might disrupt social harmony (Uba, 1994). Their emphasis on willpower is similar to the tendency documented among African Americans to minimize the significance of stress and, relatedly, to try to prevail in the face of adversity through increased striving (Broman, 1996). Culturally rooted traditions of religious beliefs and practices carry implications from religious figures.23 Many people of all racial and ethnic backgrounds believe that religion and spirituality favorably impact upon their lives and that well-being, good health, and a sense of commitment or faith are integrally intertwined (Taylor, 1986; Priest, 1991; Bacone, 1994; Pargament, 1997). Religion and spirituality are deemed important because they can provide comfort, joy, pleasure, and meaning to life as well as means to deal with death, suffering, pain, injustice, tragedy, and stressful experiences in the life of an individual or family (Pargament, 1997).

In the family/community-centered perception of mental illness held by Asians and Hispanics, religious organizations are viewed as an enhancement or substitute when the family is unable to cope or assist with the problem (Acosta et al., 1982; Comas-Diaz, 1989; Cook & Timberlake, 1989; Meadows, 1997). Culture also imprints mental health by influencing whether and how individuals experience the discomfort associated with mental illness. When con"veyed by the arts and sanctioned by cultural norms, characteristic modes of expressing suffering are sometimes called "idioms of distress" (Lu et al., 1995). Idioms of distress often reflect values and themes found in the societies in which they originate.

One of the most common idioms of distress is somatization, the expression of mental distress in terms of physical suffering. Somatization occurs widely and is believed to be especially prevalent among persons from a number of ethnic minority backgrounds (Lu et al., 1995). Epidemiological studies have confirmed that there are relatively high rates of somatization among African Americans (Zhang & Snowden, in press). Indeed, somatization resembles an African American folk disorder identified in ethnographic research and is linked to seeking treatment (Snowden, 1998). A number of idioms of distress are well recognized as culture-bound syndromes and have been included in an appendix to DSM-IV. Among culture-bound syndromes found among some Latino psychiatric patients is ataque de nervios, a syndrome of "uncontrollable shouting, crying, trembling, and aggression typically triggered by a stressful event involving family. . . ." (Lu et al., 1995, p. 489). A Japanese culture-bound syndrome has appeared in that country's clinical modification of ICD-10 (WHO International Classification of Diseases, 10th edition, 1993). Taijin kyofusho is an intense fear that one's body or bodily functions give offense to others. Culture-bound syndromes sometimes reflect comprehensive systems of belief, typically emphasizing a need for a balance between opposing forces (e.g., yin/yang, "hot-cold" theory) or the power of supernatural forces (Cheung & Snowden, 1990). Belief in indigenous disorders and adherence to culturally rooted coping practices are more common among older adults and among persons who are less acculturated. It is not well known how applicable DSM-IV diagnostic criteria are to culturally specific symptom expression and culture-bound syndromes.

Family and Community as Resources

Ties to family and community, especially strong in African, Latino, Asian, and Native American communities, are forged by cultural tradition and by the current and historical need to assist arriving immigrants, to provide a sanctuary against discrimination practiced by the larger society, and to provide a sense of belonging and affirming a centrally held cultural or ethnic identity.

Among Mexican-Americans (del Pinal & Singer, 1997) and African Americans (Lee, 1998) relatively high rates of marriage and low rates of divorce, along with a greater tendency to live in extended family households, indicate an orientation toward family. Family solidarity is known to have been involved in explaining relatively low rates among minority groups of placing older people in nursing homes (Short et al., 1994). The relative economic success of Chinese, Japanese, and Korean Americans has been attributed to family and communal bonds of association (Fukuyama, 1995). Community organizations and networks established in the United States include rotating credit associations based on lineage, surname, or see Cultural Issues on page 26.
By J. David Seay, JD
Executive Director, NAMI-NYS

Multicultural Competence: Facing Challenges That Lie Ahead

Multicultural competence is an increasingly important challenge for NAMI-New York State and it is a responsibility we take seriously. Reaching out to all members of a community who are suffering in silence and isolation with a loved one with mental illness is a must for NAMI-NYS as a statewide organization and for our 58 local affiliate organizations all across New York. As mental illness knows no boundary of geography or socioeconomic class, so also is it indifferent to ethnic, racial and cultural distinctions. So it is incumbent upon all of us within NAMI at the local, state and national levels to do whatever we can to make sure that the services we provide—support, education and advocacy—reach into all of our communities. Shortly after I arrived at NAMI-NYS in the fall of 2001, we asked the New York State Office of Mental Health’s multicultural specialist, Cathy Cave, to address a meeting of the NAMI-NYS Board of Directors and Affiliate Presidents on the topic of multicultural sensitivity and outreach. This very productive session resulted in the appointment by NAMI-NYS President Michael Silverberg of a special Multicultural Outreach Task Force to work with and advise NAMI-NYS on issues of multicultural outreach and competence. And at the annual meeting and educational conference in 2002, our twentieth anniversary celebration, Darlene Nipper, director of multicultural and international outreach for national NAMI, spoke in plenary session on “The Importance of Multicultural Outreach for the NAMI Movement.”

Over the two events, the Multicultural Outreach Task Force has been working diligently to seek broad input into NAMI-NYS’s efforts to expand our reach both geographically and multiculturally. Very ably chaired by Aaron Lukrec of NAMI Staten Island and Ruth Levell and Denise Reed of NAMI Harlem, the Task Force meets periodically to learn first-hand from members of various ethnic communities how best to undertake what can often be very delicate and sensitive outreach methods, and to craft a plan that incorporates that understanding and sensitivity. Towards that end, the Task Force is working with NAMI Harlem on a pilot project to test an outreach methodology that would convene local leaders and community board members for the purpose of assessing the unmet needs of the communities they represent. Facilitated discussions and other techniques will be tested to determine the most efficacious ways to reach out to and support ethnic and multicultural groups within the Harlem community. The Task Force is also considering other higher-level, city-wide convening in pursuit of the same goals.

In other developments, NAMI-NYS is very proud of their friends and colleagues at NAMI Westchester for conducting the first NAMI Family-to-Family training program in Spanish. We hope to encourage them to continue this and for other affiliates to offer the course in Spanish and perhaps even other languages as well. For many years, NAMI-NYS has made many of our educational brochures available in a number of foreign languages, including Spanish, Korean, Russian and Greek, and these are distributed widely by our affiliate leaders around the state. NAMI-NYS has also participated in the Somos del Futuro Legislative Conference in Albany in April and several meetings of the Hispanic and Latino community leadership convened by Assemblyman Peter Rivera, chairman of the Assembly’s mental health committee.

In the national level, NAMI National is active in the area of multicultural outreach and support. They have created the Multicultural Action Center (MAC), which “works to focus attention on system reform to ensure access to culturally competent services and treatment for all Americans and to help and support families of color who are dealing with mental illness.”

MAC’s priorities include addressing:

- Disparities in treatment and services
- Lack of Bilingual/ multicultural health professionals
- Higher rates of misdiagnosis, institutionalization and suicide among youth
- Overrepresentation of people of color with mental illnesses in the criminal justice system, and
- Underrepresentation of people of color in research studies and clinical trials

The 2004 NAMI National Convention will feature a symposium entitled "A Latino Mental Health Resource Manual"

Fact sheets providing information about the mental health status of four major communities identified by the Surgeon General (African American, American Indian and Alaska Natives, Asian American, Pacific Islanders and Latinos) and written materials providing information about mental illness, treatment options, recovery and advocacy in Spanish, Chinese, Portuguese and Italian.

And, of course, they produced the Spanish Family-to-Family curriculum, which was described above and introduced in NYS by NAMI Westchester, and which NAMI-NYS hopes to bring to communities throughout the state.

The challenges are real and the responses are heartfelt and well-intentioned at each level within the NAMI movement. It remains to be seen how effective and “evidence-based” our successes will be. However, NAMI-NYS remains dedicated to the goals and opportunities of multicultural competence and outreach and will continue to pursue our action agenda.

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Each physician must execute a separate certificate. Each certificate must include the facts and circumstances forming the basis of the physician’s judgment that the person is mentally ill and that his/her condition is such that he or she needs involuntary care and treatment in a psychiatric hospital. The accompanying application, which must be signed within ten days prior to the admission, may be made by, among others, someone who lives with the mentally ill person, a close relative, the director of a hospital in which the patient is hospitalized, or a qualified psychiatrist who is either supervising the treatment of, or treating such person for, a mental illness in a facility licensed or operated by the office of mental health.

The hospital may retain a patient for up to sixty days from the date of admission or conversion (from voluntary status) to involuntary status. At any point within that period, the hospital has a duty to convert the patient to voluntary status if the patient is suitable and willing to apply for such status. Further, within the sixty-day retention period, the patient, or someone on his/her behalf, may request a court hearing to determine the necessity of continued involuntary retention. The hospital must forward notice of this request to the court forthwith, and the hearing must be set for a date within five days of the court’s receipt of the notice. The result of the hearing can be either the patient’s release or his/her continued retention in the hospital.

If the hospital determines that an involuntary patient is in need of further retention beyond the initial sixty-day period, and the patient is unwilling to remain in the hospital as a voluntary patient, the hospital must apply for a court order, pursuant to Article 9, authorizing continued retention for a period up to six months. The hospital’s application must be made no later than sixty days from the date of the initial involuntary admission or conversion, and the hospital must give written notice of its application to the patient and to MHLIS. The notice must state that a hearing may be requested within five days (excluding Sundays or holidays), and that if a hearing is not requested within that period, the court may issue an order authorizing continued retention without a hearing. A subsequent court order authorizing

see Admissions on page 48
The Impact Of A Cross-cultural Treatment Approach To Mental Health

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m my hope that this article will convey how a cross-cultural approach is a separate modality within itself. It requires a clinician to practice in a multi-dimensional fashion, specific for a population of interest, evolves over time and is rewarding and inspirational to carry out. It is important to emphasize that I am writing this article based on my clinical and educational experience with the treatment of the Hispanic population within the tri-state area.

Implementing a cross-cultural treatment approach means valuing, validating and incorporating culture when treating a population that places significant meaning on their culture of origin. It emphasizes the need for a clinician to become aware of the strengths inherent in that population’s culture which will be valorized throughout the treatment process. To appropriately carry out this approach entails the acknowledgement that a cross-cultural approach is a specialty modality within itself. It requires the clinician to seek adequate supervision, training, consultation and education needed to correctly carry out this much needed intervention. To speak another language, to be able to translate in another language, or to be born in a different country is not sufficient. In other words, being bilingual, is not enough. Being bilingual, by itself, will not supply the appropriate clinical skills needed to carry out specific cultural interventions. It will also not aid in identifying what cultural variables may effect or intensify a client's mental health or substance abuse problems. This modality requires a clinician to go beyond the traditional therapeutic model in which interventions are exclusively carried out within the context of the clinician's office. A cross-cultural approach, on the other hand, requires continuous interfacing with the population of interest's context—the community at large. This requires a commitment by the clinician to travel outside the traditional context into the broader context of the community. Hence, if a clinician is dedicated to this model, he/she understands that assessing an individual and their psychiatric and substance abuse needs requires the use of a multidimensional modality: Assessing psychiatric/substance abuse needs while simultaneously finding out how they are affected by the community at large, as well as how their culture impacts on what is being presented by the individual and/or family. A cross-cultural model in a psychiatric setting is most effectively carried out when implemented by members of a multidisciplinary multicultural team (from different cultural perspectives and backgrounds). In addition, if a clinician using this approach becomes aware of possible barriers that may affect a given population in a multicultural setting, the clinician will outreach to relevant members of the community and advocate at removing the barriers or minimizing factors that contribute to mental health and/or substance abuse problems. For example, if there is a lack of culturally sensitive services for a given population, a clinician using this approach will: 1) Meet with members and providers within the community most relevant to the population of interest (i.e. places of worship, schools, community agencies, etc.) to carry out a needs assessment, as well as provide the needed psychoeducation and interventions geared at increasing services; 2) Advocate to the community leaders at large about the need to improve these services; and, 3) Create interagency collaboration to address the problem rather than to work alone. The significance of a cross-cultural model is based on its impact on populations that are poorly acculturated into American society and frequently face linguistic and cultural barriers. It will most likely, but not exclusively, be implemented with poor and underserved populations who immigrate to the United States to improve their lives and the lives of their families. To effectively carry out this approach entails the clinician to differentiate an individual's psychiatric, substance abuse as well as community needs; and one needs to understand that these needs will evolve over time. For example, many of today's bilingual/bicultural clinicians in the tri-state area were trained, educated, and supervised 15-20 years ago (or more) with a cross-cultural model based on the immigration experiences of the Puerto Rican and Dominican families of the 60's and 70's. These families immigrated usually as "intact families" during the mid-1900's. In 1859, Paul Briquet described hysteria as a polysymptomatic disorder. He was the first clinician to break with the medical tradition that started in Pericles' Ancient Greece, where hysteria was viewed as a disorder that originated from the sexual organs, asserting instead that it was caused by a disease of the brain. Briquet's detailed observations of patients with somatization were adopted in earlier versions of the DSM. A contemporary of Briquet, George Miller Beard, coined the term "neurasthenia" or "nervous exhaustion," in 1869. Neurasthenia has been described since as an illness related to somatization, with cognitive, somatic and affective symptoms, with fatigue, physical weakness and insomnia as the most characteristic symptoms. Although neurasthenia does not have a place in the DSM-IV, it continues to exist in the ICD-10 and in the CCMD (the Chinese Classification of Mental Disorders, as shen jing shazeru). There is a current debate among transcultural psychiatrists and psychologists about the validity of neurasthenia as a distinct diagnosis. Some believe that neurasthenia should be subsumed by a set of broadened criteria for depression, while others feel that it is a distinct diagnostic entity with a natural history separate from that of major depression. Stekel first used the term "somatization" in 1943 to describe a type of polysympotomatic neurosis in which intrapsychic conflicts were symbolically transformed into physical symptoms. Stekel's psychodynamic formulation of somatization was similar to Freud's formulation of hysteria. Called by Lipowski the "borderland between Medicine and Psychiatry," somatization presents an interesting nosological challenge to clinicians. The classification of somatization syndromes has continuously changed over the past four decades. The current perception continues to be that many patients with unexplained physical symptoms do not meet the existing DSM-IV diagnostic criteria and that the DSM criteria are too numerous. Somatization and subsyndromal disorders have a chronic course, usually start in the second decade of life, and present with other comorbid depressive disorders in up to 50% of cases. When somatization coexists with major depression, levels of work and social disability as well as symptom severity are

Somatization: Mind, Body and Culture

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Somatization is a highly prevalent condition characterized by a pattern of multiple physical symptoms that cannot be explained by existing medical illness. Patients who somatize may be unaware that their somatic symptoms could be a manifestation of psychological distress, and resist efforts from clinicians to re-frame their distress as psychiatric symptoms or illness. The frustration created by the disappointment that the patients' physical symptoms cannot be explained by physical examination or laboratory testing, coupled with the patients' lack of psychological insight, leads to dissatisfaction with medical care, frequent medical visits, unnecessary diagnostic procedures, and clinicians' therapeutic nihilism. Compounding this problem is the cumbersome and confusing nosological status of somatization disorders, unfamiliarity with somatization as a cultural idiom of distress, and a paucity of research studies on the phenomenology and treatment of these disorders.

Modern understanding of somatization traces back to the mid-19th century. In 1859, Paul Briquet described hysteria as a polysymptomatic disorder. He was the first clinician to break with the medical tradition that started in Pericles' Ancient Greece, where hysteria was viewed as a disorder that originated from the sexual organs, asserting instead that it was caused by a disease of the brain. Briquet's detailed observations of patients with somatization were adopted in earlier versions of the DSM. A contemporary of Briquet, George Miller Beard, coined the term "neurasthenia" or "nervous exhaustion," in 1869. Neurasthenia has been described since as an illness related to somatization, with cognitive, somatic and affective symptoms, with fatigue, physical weakness and insomnia as the most characteristic symptoms. Although neurasthenia does not have a place in the DSM-IV, it continues to exist in the ICD-10 and in the CCMD (the Chinese Classification of Mental Disorders, as shen jing shazeru). There is a current debate among transcultural psychiatrists and psychologists about the validity of neurasthenia as a distinct diagnosis. Some believe that neurasthenia should be subsumed by a set of broadened criteria for depression, while others
Embracing Cultural Diversity

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to achieve the dual goal of ena-
bl ing an individual to cope
with the psychosocial stressors
inherent in today’s society,
while at the same time respecting the
unique cultural aspects of that individ-
ual’s life, is an ongoing challenge we
face as mental health practitioners. To
this end, we must recognize our own as
well as the individual’s capacity to em-
brace these concepts and adjust our in-
terventions to meet that challenge on a
continual basis.

While it may not be possible to fully
learn about all of the cultures that exist,
it is essential that we embrace them by
utilizing tools and techniques which en-
able individuals to feel at ease with dis-
cussion of this issue without fear of re-
crimination or judgment. One such tech-
nique is encouraging patients and their
families to include a “cultural narrative”
as part of the initial assessment. This
can be done with an open-ended ques-
tion such as “What are some of the
things that you think would be important
for me to understand about your cultural/
religious/ethnic background?” Another
way to approach this discussion would
be to ask a series of direct questions that
allow the patient to inform the health
health care provider about his or her culture.
Some examples are:
• What is the ethnic/cultural back-
ground of the individual?
• What is the meaning of illness in the
individual’s family?
• What languages are used/preferred?
• When confronted with illness or
other crises, to whom does the indi-
vidual and his family turn?
• What are cultural food preferences?
• What has the individual’s previous
experiences with health care provid-
ers been like in the past?

When working with culturally diverse
populations, one cannot allow prejudice
caused by past societal influences, which
can neither be directly changed nor
erased from our collective memories, to
open and infect old wounds. Indeed, the
challenge is not simply “tolerating” cul-
tural diversity, but rather exhibiting true
curiosity and openness to learning about
the language, music and religious cele-
brations that define individuals. Ulti-
mately, these elements have an enor-
mous impact on the development of an
alliance and compliance to the treatment
recommendations being made.

The manner in which we face and
accept this challenge is a potent indicator
of how successful we will be in facing
the larger challenge of treating mental
illness with a culturally diverse popula-
tion. For example, we offer a kosher menu
to our Jewish patients and are sen-
tive to providing Sabbath candles and a
place of solitude for worship on a
weekly basis. We are aware of our Mus-
lim patients’ observance of Ramadan and
offer to accommodate their menu plans
to allow for the period of fasting before
sundown. In addition, efforts are made
to understand cultural differences that
exist among persons of African descent,
including mainland Africans, African
Americans and West Indians. Although
they share common ancestral roots, there
is a rich cultural diversity between and
within each of these groups.

As a Child and Adolescent Psychia-
trist and head of an Adolescent Inpatient
Unit, I have been involved in the psychi-
atri c care of young people from numer-
ous cultural backgrounds. At any given
time our unit may have adolescents
whose descendents can be traced to dis-
tant parts of the world, yet it takes a rela-
tively short time for most patients to
learn the unit rules and form friendships.
This process is fostered by the funda-
mental unit rule that everyone is ex-
pected to treat one another with respect.
I have found that regardless of language
and cultural differences, when mutual
respect underlies patient interactions,
misunderstandings and misconstruc-
tions can usually be quickly resolved.
This is facilitated by a willingness on
the part of the adolescents to understand
one another’s background, enabling them
to feel comfortable that “the other” is not
so very different from themselves, even
though their cultural background, lan-
guage, music and food preference may
vary greatly. This is generally achieved
through group discussions and, in par-
ticular, during the weekly community
meeting. We have also found that during
family meetings, participants appreciate
being given the opportunity to tell their
unique story of how the young person in
their family became ill and how it is
viewed in the context of their culture.

Other ways one can learn about dif-
ferent cultures is through reading and
learning different languages. The multi-
cultural library on our adolescent unit
has a collection of books which tell sto-
ries about young people from all over
the world. These books describe the various
stressors that can arise during the adoles-
cent years and address ways in which
different cultures interpret and deal with
these stressors. We also strive to recog-
nize the language and cultural needs of
our deaf and hard of hearing population.
When deaf adolescents are admitted to
our unit, members of the hospital’s Deaf
and Hard of Hearing Program are readily
available to teach staff and patients sim-
ple sign phrases, as well as provide in-
formation about deaf culture. Deaf pa-
tients have also been asked by their peers
to teach sign language during supervised
group sessions.

On a larger scale, our hospital’s
medical library has a substantial collec-
tion of books that focus on multicultural
aspects of health care delivery, with par-
ticular emphasis on mental health care.
In addition, a Cultural Competence
Committee was developed in 2003 “…to
foster a culturally and linguistically sen-
sitive collaboration with patients, fami-
lies and health care providers.”

In summary, acknowledging an indi-
vidual’s cultural background and under-
standing how it impacts that patient’s
care and compliance to follow up treat-
ment is not only a challenge, but an obli-
gation we have to our patients, and one
which I am honored to fulfill.

Mental Health News

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In the United States, Jose's mother worked very hard, often doing two jobs, and sent money back to the family every month. She made sure that he was happy and loved or that he has done something wrong.” (James, 1994).

In the Guidance Center

Immature attachments to other human beings are the hub around which a person’s life revolves. When he is an infant, a toddler or a school child, but throughout his adolescence and his years of maturation as well and on to old age. From these immature attachments a person draws his strength and enjoyment of life and, through what he contributes, he gives strength and enjoyment to others. (Bowby, 1980)

The following case study identifies the stresses of separation, reunification and adaptation that Jose, (not real name) an immigrant child, has had to deal with in his short 14 years of life. Like Jose, the majority of the Hispanic immigrant children that we have had come through our clinics have very similar stories to tell.

Jose is a good looking 14-year-old adolescent. For the first two years of life, Jose had been inseparable from his mother and father while living in their small town in Central America. He had been raised since infancy by his mother, who had breastfed and bathed him, and had taken him plenty of body contact and a high level of affectionate response, therefore developing a strong attachment bond. Jose always slept with his mother and father. (It is quite common for Hispanic children to sleep with their parents until the age of 5 years). Jose had been interrupted by the unavailability of the attachment figure. The frightened child, dependent on the attachment figure, becomes overdistressed when this need for comforting and reassurance have been interrupted by the physical unavailability of the attachment figure. When this happens, the mission of the primary attachment person as protector: “Everything will be okay. I’ll take care of you, set limits and keep you safe.” As provider: “I’m the source of food, love, shelter, excitement, soothing and play.” And as guide: “This is how the world works” is no longer provided (James, B. 1994).

Jose finds the school experience very difficult. He faces discrimination and hostility from the native-born Hispanic and American children. Jose, along with five other Hispanic students formed a subgroup because they were not accepted by the other students. In the subgroup, they were going to fight a group of students that were not accepting of them. Jose was referred to a school-based counseling program where he started to come to a weekly group conducted by a bilingual/bicultural certified social worker, where half of the children were newly arrived immigrants like himself, and the other half of the group was made up of students that were either born here or had migrated several years ago. Through this program, Jose was able to bond with students he would not have been able to meet on his own because they would not have accepted him. One of several experiences he had in the group was to tell his story about how he got to the U.S. All of the newly arrived students traced their immigration experience, some telling their stories of walking across the border into the desert, etc. By the end of the eight weeks they spent together, the students who were born here had a much better appreciation, understanding and acceptance of the newly arrived students.

Jose’s mother had never been inside the school. She felt intimidated because her English was not that good. School-based programs that reach out to such mothers are encouraging and empowering Hispanic mothers so that they can learn to navigate the American school system. Schools, often in collaboration with community-based organizations, are continually working on developing realistic models to get the parents involved. The main problem is that the majority of immigrant parents do not have the flexibility to attend meetings at the school because they often work long hours or more than one job. It is difficult for these parents to help their children with homework, for example, because they lack English language skills, the homework may be too complex and they may not be able to afford computers, etc. It is not possible for some of the parents to read to their young children, again they may not know English and sometimes because

The Guidance Center

By Lee Guich, CSW

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Can You Recognize A Problem With Your Child’s Mental Health As Well?

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THE GUIDANCE CENTER

You Know, You Recognize This Warning Sign, And You Take Action.
Reaching The Latino Older Adult

By Debra Del Toro-Phillips, CSW
The MHA of Westchester

The buzz everywhere these days is how rapidly the nation is aging, and how do we go about meeting the needs of such a diverse aging population. Perhaps I am feeling the buzz more than others, since I work with older adults, and experience the diverse issues so often confronted by Latino seniors. I frequently find myself assisting Latino elders with adjusting to their environment. Learning a new language, becoming part of a new community and becoming familiar with new systems can be an overwhelming task for anyone. Older adults, conditioned to certain cultural values and traditions, can find this challenge almost insurmountable. Such changes and adaptations often cause added stresses, affecting the older person’s physical and mental health. Despite this, many Latino older adults are reluctant to accept professional mental health assistance.

In the Mental Health Association of Westchester County’s program, Caminando Juntos (Stepping Together), personal outreach strategies appear to work best in getting the Latino elders to accept mental health services. Once a connection is made, they respond appreciatively to our bicultural-linguistic staff. We believe this acceptance is indicative of the comfort they feel at being served by someone who speaks their language and understands their needs.

Once a person accepts our services, we need to assess their mental health needs. This is not always easy. Cultural issues can complicate matters. For instance, Latino elders may be reluctant to accept mental health treatment for fear of being considered “loco” (crazy) by their families and friends. Or, since they tend to experience mental distress in the form of somatic symptoms, and depressed mood and anxiety in the context of feeling nervous “nervios” or “susto” (fright), it is difficult to get them to accept treatment. Instead, they are likely to seek the support and counsel of family and friends, rather than professional mental health assistance.

In getting the Latino elder to accept mental health services, usually several visits are required before they agree to accept treatment. As the assessment process evolves, we work on developing a trusting relationship, and at the same time, we take the opportunity to provide education about mental health issues. The combination of trust and education can often lead the way to acceptance of mental health services and assistance.

Depression and anxiety are the most common mental illnesses amongst the Latino elders served in our program. The new cultural changes they must adapt to, the isolation from others who speak their language and share their culture, physical disabilities, limited social outlets, caregiving for grandchildren, unemployment, crowded living conditions, and all the losses experienced, are all contributors to depression and anxiety. Only when mental problems have reached a level where functioning is affected or a crisis occurs will Latino elders and their families seek mental health treatment. The provision of education and increased awareness of mental illnesses is essential in combating the stigma mental illness holds in the Latino community.

At Caminando Juntos, our focus is to reach the Latino elder and provide clinical treatment services. Home visits are a standard service and essential to our outreach efforts. Our experiences reveal the best way to reach the Latino elder is through person-to-person outreach, spending the necessary time in the engagement process while developing a trusting relationship, and in the meantime, providing education about mental illness and information on community resources, which will provide them with the assistance and support needed.

For more information about Caminando Juntos, call Debra Del Toro-Phillips, CSW, MHA of Westchester County, 914-345-5900, ext. 290

Free Mental Health Services Available Through CREW Program

The Mental Health Association of Westchester is providing free mental health counseling and services to anyone who worked or volunteered at the September 11th WTC site and who may experiencing difficulties with work, family life, relationships and substance abuse. Family members may qualify for these services, as well. The Program is called CREW: “The Center for Responders and Emergency Workers” and it is a collaboration of the Mental Health Association of Westchester and Putnam Family and Community Services.

For information, please call (914) 666-2021
Cultural Issues from page 19

region of origin. These organizations and networks facilitate the startup of small businesses.

There is evidence of an African American tradition of voluntary organizations and clubs often having political, economic, and social functions and affiliation with religious organizations (Milburn & Bowman, 1991). African Americans and other racial and ethnic minority groups have drawn upon an extended family tradition in which material and emotional resources are brought to bear from a number of linked households. According to this literature, there is “(a) a high degree of geographical propinquity; (b) a strong sense of family and familial obligation; (c) fluidity of household boundaries, with greater willingness to absorb relatives, both real and fictive, adult and minor, if need arises; (d) frequent interaction with relatives; (e) frequent extended family get-togethers for special occasions and holidays; and (f) a system of mutual aid” (Hatchett & Jackson, 1993, p. 92).

Families play an important role in providing support to individuals with mental health problems. A strong sense of family loyalty means that, despite feelings of stigma and shame, families are an early and important source of assistance in efforts to cope, and that minority families may expect to continue to be involved in the treatment of a mentally ill member (Uba, 1994). Among Mexican American families, researchers have found lower levels of expressed emotion and lower levels of relapse (Karno et al., 1987). Other investigators have demonstrated an association between family warmth and a reduced likelihood of relapse (Lopez et al., in press).

Epidemiology And Utilization Of Services

One of the best ways to identify whether a minority group has problems accessing mental health services is to examine their utilization of services in relation to their need for services. As noted previously, a limitation of contemporary mental health knowledge is the lack of standard measures of “need for treatment” and culturally appropri- ate assessment tools. Minority group members’ needs, as measured indirectly by their prevalence of mental illness in relation to the U.S. population, should be proportional to their utilization, as measured by their representation in the treatment population. These comparisons turn out to be exceedingly compli- cated by inadequate understanding of the prevalence of mental disorders among minority groups in the United States. Nationwide studies conducted many years ago overlooked institutional populations, which are disproportionately represented by minority groups. Treatment utilization information on minority groups in relation to whites is more plentiful, yet a clear understand- ing of health-seeking behavior in vari- ous cultures is lacking. The following paragraphs reveal that disparities abound in treatment utiliza- tion: some minority groups are under- represented in the outpatient treatment population while, at the same time, overrepresented in the inpatient popula- tion. Possible explanations for the dif- ferences in utilization are discussed in a later section.

African Americans

The prevalence of mental disorders is estimated to be higher among African Americans than among whites (Regier et al., 1993a). This difference does not appear to be due to intrinsic differences between the races; rather, it appears to be due to socioeconomic differences. When socioeconomic factors are taken into account, this difference disappears. That is, the socioeconomic status-adjusted rates of mental disorder among African Americans turn out to be the same as those of whites. In other words, it is the lower socioeconomic status of African Americans that places them at higher risk for mental disorders (Regier et al., 1993a).

African Americans are underrepre- sented in some outpatient treatment populations, but overrepresented in public inpatient psychiatric care in rela- tion to whites (Snowden & Cheung, 1990; Snowden, in press-b). Their underrepresentation in outpatient treatment varies according to setting, type of provider, and source of payment. The racial gap between African Ameri- cans and whites in utilization is small- est, if not nonexistent, in community- based programs and in treatment fi- nanced by public sources, especially Medicaid (Snowden, 1998) and among older people (Padgett et al., 1995). The underrepresentation is largest in pri- vately financed care, especially individ- ual outpatient practices, paid for either by fee-for-service arrangements or managed care. As a result, underrepre- sentation in the outpatient setting oc- curs more among working and middle- class African Americans, who are pri- vately insured, than among the poor. This suggests that socioeconomic standing alone cannot explain the prob- lem of underutilization (Snowden, 1998).

African Americans are, as noted previously, overrepresented in inpatient psychiatric care (Snowden, in press-b). Their rate of utilization of psychiatric inpatient care is about double that of whites (Snowden & Cheung, 1990). This difference is even higher than would be expected on the basis of prevalence estimates. Overrepre- sentation is found in hospitals of all types except private psychiatric hospitals. While difficult to explain definitively, the problem of overrepresentation in psychiatric hospitals appears to be rooted in poverty, attitudes about seek- ing help, and a lack of community sup- port than in clinician bias in diagnosis and overt racism, which also have been implicated (Snowden, in press-b). This line of reasoning points that poverty, disinclination to seek help, lack of health and mental health services deemed appropriate, responsiveness, as well as community support, are major...
Pediatric Mania: A Developmental Subtype of Bipolar Disorder?

By Joseph Biederman, M.D.

Despite ongoing controversy, the view that pediatric mania is rare or nonexistent has been increasingly challenged not only by case reports, but also by systematic research. This research strongly suggests that pediatric mania may not be rare, but that it may be difficult to diagnose. Since children with mania are likely to become adults with bipolar disorder, the recognition and characterization of childhood-onset mania may help identify a meaningful developmental subtype of bipolar disorder worthy of further investigation. The major difficulties that complicate the diagnosis of pediatric mania include: 1) its pattern of comorbidity may be unique by adult standards, especially its overlap with attention-deficit/hyperactivity disorder, aggression, and conduct disorder; 2) its overlap with substance use disorders; 3) its association with trauma and adversity; and 4) its response to treatment is atypical by adult standards.

Introduction

Over the last twenty years, the view that mania in children is extremely rare or nonexistent has been increasingly challenged by many case reports and series. Despite continued debate and controversy over the validity of the diagnosis of mania in children, there is a growing consensus that many seriously disturbed children are afflicted with severe affective dysregulation and high levels of agitation, aggression, and dyscontrol that pose severe diagnostic and therapeutic challenges to the practicing community. These children have received increased clinical and scientific attention, as evidenced in the scheduling of two National Institute of Mental Health workshops on bipolar disorder in children and adolescents, and in exhaustive reviews that have supported the validity of the disorder in youth.

The Atypicality of Pediatric Mania

The atypicality (by adult standards) of the clinical picture of childhood mania has long been recognized. Mania in children is seldom characterized by euphoric mood, rather, the most common mood disturbance is severe irritability, with “affectionate storms,” or prolonged and aggressive temper outbursts. The type of irritability observed in mania of children is very severe, persistent, and often violent, and often includes threatening, agitating, or attacking behavior towards family members, other children, adults, and teachers. In between outbursts, these children are described as persistently irritable or angry in mood leading to a frequent diagnosis of conduct disorder. Aggressive symptoms may be the primary reason for the high rate of psychiatric hospitalization noted in manic children.

In addition to the predominant abnormal mood in pediatric mania, its natural course is also atypical, as compared with the natural course of adult mania. The course of pediatric mania tends to be chronic and continuous rather than episodic and acute.

Comorbidity with ADHD

A leading source of diagnostic confusion in childhood mania is its symptomatic overlap with ADHD. Although ADHD has a much earlier onset than pediatric mania, the symptomatic and syndromic overlap between pediatric mania and ADHD raises a fundamental question: do children presenting with symptoms suggestive of mania and ADHD have ADHD, mania, or both? One method to address these uncertainties has been to examine the transmission of comorbid disorders in families. If ADHD and mania are associated due to shared familial etiologic factors, then family studies should find mania in families of ADHD patients and ADHD in families of manic patients. Studies that examined rates of ADHD (or ADD with hyperactivity) among the offspring of adults with bipolar disorder all found higher rates of ADHD among these children, as compared with control subjects. One problem facing studies of ADHD and mania is that these disorders share diagnostic criteria.

Comorbidity with Conduct Disorder

Like ADHD, Conduct Disorder (CD) is also strongly associated with pediatric mania. This has been seen separately in studies of children with CD, ADHD, and mania. In fact, the comorbid presence of CD heralded a more complicated course of mania, with 42% of hospitalized youths with mania having comorbid CD. In investigating the overlap between mania and CD in a consecutive sample of referred youth, and in a sample of ADHD subjects to clarify its prevalence and correlations, a striking similarity was found in the features of mania regardless of comorbid CD. Additionally, the age of onset of mania was similar in subjects with or without comorbid CD. In both groups, mania presented with a predominantly irritable mood and a chronic course, and was mixed with symptoms of major depression.

Comorbidity with Anxiety Disorders

Although anxiety is frequently overlooked in studies of mania, pediatric studies of youth with panic disorder and youth with mania document an important and bi-directional overlap between anxiety and mania.

Pediatric Mania and Trauma

Although it has long been suspected that mania in children may be the result of trauma, and associations between trauma and mania have been reported in adults, there has been relatively limited systematic research of this issue. However, elevated lifetime rates of mania among adult and adolescent subjects with posttraumatic stress disorder (PTSD), have been found. A strong association between manic-depressive illness and PTSD in adult subjects did not determine if mania was primary or secondary to the trauma. This report further suggested that behavior problems including stealing, lying, truancy, vandalism, running away, fighting, misbehavior at school, early sexual experience, substance abuse, school expulsion or suspension, academic underachievement, and delinquency before age 15 predicted later PTSD.

Since juvenile mania is commonly associated with extreme violence and severe behavioral dysregulation, as well as

see Mania on page 30
COMMUNITY AND PROFESSIONAL EDUCATION PROGRAMS

OCTOBER

Community Service • Thursday, October 7th • 2:00 - 4:00 pm

“National Depression Screening Day”
Free Depression Screening for Children, Adolescents and Adults

Take advantage of this free program designed to educate the public about depression. The screening process will include a written “self-test,” a consultation with a mental health professional, and an educational presentation (screening is modified for children). For information, or to schedule a confidential appointment, please call 1-800-546-1754 ext. 2413. Free of Charge • Open to the Public

Grand Rounds • Friday, October 8th • 9:30 - 11:30 am

“Anatomy of Melancholy”

“When you are depressed, the past and the future are absorbed entirely by the present, as in the world of a three-year-old. You will never remember feeling better, nor imagine that you will feel better. Being upset, even profoundly upset, is a temporal experience, whereas depression is atemporal. Depression means that you have no point of view. All I wanted was for it to stop, but I could not say what “it” was.”

- Participants should understand the concomitant suffering and fear that accompany depressive illness.
- Participants should understand that vulnerability to depression need not be entirely genetic, the environment also counts.
- Participants should understand that the shifting self reaches beyond medication and therapy to conquer depression, but the opposite of depression is not happiness, it is vitality.

Fee: $25.00 payable to the Four Winds Foundation, a not-for-profit organization
Location: Northern Westchester Center for the Arts, 372 North Bedford Rd., Mt. Kisco, NY - For directions call 1-914-241-6922
2.0 CME Credits Available

Special Training • Thursday, October 14th • 2:00 - 4:30 pm

“Child Abuse Identification and Reporting”
Valerie Saltz, C.S.W., Four Winds Hospital

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include all child care workers, school officials, doctors, nurses, dentists, podiatrists, MDs, etc. A State Education Department certificate of completion will be given at the end of the class.

Fee: $15.00 payable to the Four Winds Foundation, a not-for-profit organization

Albert Einstein College of Medicine designates this continuing medical education activity for a maximum of 2.0 Category 1 credits towards the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACME to provide continuing medical education for physicians. These programs will be of interest to: physicians, psychologists, nurse practitioners, social workers, mental health providers, EAPs, education professionals, school counselors, IEPs and consumers.

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Grand Rounds • Friday, October 29th • 9:30 - 11:30 am

“Working with Unmotivated, Angry Youth: Strategies for Fostering Cooperation, Hope and Resilience”
Robert Brooks, Ph.D., Faculty, Harvard Medical School

Angry, unmotivated youth are a challenge to both professionals and parents. This presentation will examine a strengths-based approach for working with these challenging youngsters. Strategies to promote motivation, self-discipline, self-esteem, hope, and resilience will be described.

- Participants will learn the importance of empathy in understanding and responding more effectively to at-risk youth together with exercises to foster empathy.
- Participants will learn factors that contribute to anger and resistance in children and adolescents.
- Participants will learn strategies rooted in a strength-based model for nurturing cooperation, hope and resilience in angry youngsters.

Fee: $20.00 payable to the Four Winds Foundation, a not-for-profit organization
2.0 CME Credits Available
When patients harm themselves, whether it be through disordered eating, self-mutilation, or compulsively getting themselves tattooed or pierced, their bodies speak of trauma. It can be the trauma of physical or sexual abuse, witnessing violence, early traumatic separations, childhood medical or surgical procedures, or the cumulative effect of parental indifference or neglect. When the body speaks, there are two key questions to ponder: What is the body saying? To whom is the body speaking? To know what we have experienced in our lives, we must take it in, metabolize, and integrate it. This does not happen with traumatic experiences as they are more likely to be dissociated and stored in the body, ready to be discharged through the action of self-harm. To help patients progress from the immediate intensity of bodily experience to a verbal, thinking mode, they must develop the ability to speak of their traumatic experience in a way that metabolizes and integrates it. The development of a healing narrative—the Shakespearian injunction to "give sorrow words"—is the key task of psychotherapy with all patients. This can occur once a safe and secure attachment to a therapist develops, something that does not happen easily. In fact, it is a safe and secure attachment to a therapist that is the foundation for all treatment, whether that treatment is psychodynamic, cognitive-behavioral, or systemic.

Phase-Oriented Treatment

It is the significant interactions between patient and therapist that ultimately lead to structural changes in the patient's personality, and so it is these interactions that are emphasized. Treatment is a phase-oriented process divided into three phases, which have considerable overlap: stabilization and trust, symptom management, and resolution, reconsolidation, and reconnection.

Patients who have stored traumatic memories in their bodies, symptoms including self-harm symptoms, may get worse as delayed or recovered memories emerge. Any combination of PTSD symptoms such as intrusive thoughts, memories, flashbacks, or nightmares may appear, or dissociation, somatization, and affect dysregulation. Self-harm may appear to be efforts to harm themselves before, or may get considerably worse. So therapists must be cautioned against rushing in to explore the trauma before a sense of real trust in the therapist has been established and before any intervention is more stabilized. Because the expression of emotions, especially anger, is so concrete, impulsive, and disturbing, treatment should aim at helping these patients to develop a capacity for taming their aggression and impulsiveness, developing a greater capacity for affect tolerance and containment, and a greater ability to use words symbolically. The course of treatment is usually a long, hard road with many detours, regressions, and plateaus. Progress is often followed by a regressive move backward, and the patient-therapist relationship can become quite stormy. When self-harming patients regress or experience anxiety in treatment, their first line of defense will be to do what they have always done when they feel bad, and that is to harm themselves.

Safety First

Treatment can take a long time and tremendous emotional energy on the part of both patient and therapist. Before the patient can come to care for himself and develop a reflective mind, he must feel cared for and protected and know that his well-being is paramount in the mind of the therapist. The cardinal rule in working with traumatized patients is that their safety always comes first, meaning both the patient’s physical safety as well as a sense of emotional safety in the relationship with the therapist.

The therapeutic alliance, sometimes called the working alliance, is the means by which therapist and patient work together toward the same end. Self-harming patients, who are used to finding situations in relationships with people who treat them poorly or abusively, often enter therapy immediately distrustful of the therapist. This is a major obstacle to the development of a therapeutic alliance, which can become the major focus of treatment.

When strong feelings from the past take over the present patient-therapist relationship, patient-therapist interactions must be looked at to see just what feelings and scenarios from the past either patient or therapist or both are bringing to the table. That is, the therapist should help the patient to examine stormy interactions as they occur or after they have happened. Often the therapist is superimposing upon the relationship with the therapist. And the therapist must always know her or himself to see what buttons the patient is pushing that evoke the therapist’s own reactions and past experiences.

Therapists treating self-harming patients should expect intense feelings to be evoked, and should not expect themselves to maintain neutral feelings. Some degree of supervision or consultation, individually or in a group, is needed for the therapist to maintain a sense of safety, security, and perspective in conducting the treatment. That is, the therapist will need supportive and caring relationships to trusted colleagues or supervisors.

As the relationship develops and the patient becomes more receptive to accepting help from the therapist, such as a referral for a medication evaluation or other medical help, the relationship can serve as a bridge to new and healthier relationships in the real world. This is a time when patients are more receptive to accepting help from the therapist in learning ways to modulate the states of extreme anxiety. One way is for the therapist to make herself available at such times by phone or for emergency sessions. As the patient begins to experience the therapist as someone who really can be there for him when needed, there is less need to turn toward his own body for relief of anxiety. Another way is for the therapist to teach the patient specific behavioral techniques that make the body feel alive by stimulating circulation (exercise, massage), so that they do not have to turn to self-harm to make their dissociated selves come alive.

Symptom management, an essential part of the treatment, is quite different from eliminating symptoms. If the therapist does not understand how symptoms function, and regards them as managed care does, as bad things to be eliminated as soon as possible, this immediately creates a fear of the therapist and a deterrent to the patient’s ability to allow himself to express his feelings and scenarios from the past. Despite how apparently destructive the symptoms are, they perform several powerful functions for the patient. The symptoms are, for example, it is the therapist's responsibility to keep her awareness of the behavior, the clinician will need to know how severe and out of control it is. The rapidity of weight loss, the severity of purging (number of purging strategies and frequency of purging), the severity of self-mutilation, and alcohol or drug-related medical damage are indicators of severity. If the self-harm has spiraled upward in frequency and severity, this is an indicator that an addictive-like cycle is already established and out of control. For example, episodes of bingeing and purging twice a week is less dangerous than seven or eight episodes a day in which each binge is followed by several purges; superficially controlled cutting is less dangerous than deep jagged cuts.

The therapist must know how they harm themselves and in what context. Is there a certain kind of occurrence or sequence of events or thoughts that serves either to trigger the self-harm or forms some sort of ritual to it? Generally, if the body is bazaar the rituals are, the closer the patient may be to primary process thinking or psychosis. The self-harm that occurs within groups can be far more dangerous because there is a contagious competitive factor, because the self-harm is more likely to be involved as well, and in the case of cutting, because they are more likely to share cutting instruments. Most self-harm occurs in solitarity but the clinician should never assume it. Ask.

The therapeutic relationship becomes more of a partnership with each partner having certain responsibilities. For example, it is the therapist’s responsibility to set aside time for the patient, to be there, listen attentively, make himself available between sessions twice a week to the patient in event of a crisis or emergency, and establish certain boundaries. It is the therapist’s responsibility to set boundaries, pay for the treatment, and care for herself well enough so that the treatment is possible.
Mania from page 27

as hypersexuality, mania in children could either be a reaction to, or a risk factor for trauma exposure. When trauma- 


tized children present with severe irritability and mood lability, there may be a tendency by clinicians to attribute these symptoms to having experienced a trauma. To the contrary, longitudinal research suggests the opposite: mania may be an antecedent risk factor for later trauma and not represent a reaction to the trauma.

Summary

The explosive developments in the neurosciences, neurobiology, genetics and neuroimaging, will undoubtedly help advance the understanding of this complex and crippling disorder, particularly its relationship to ADHD, CD, and other psychotic and nonpsychotic neuropsychiatric disorders. It is hoped that such advances can shed light on the etiology and underlying pathophysiology, including the identification of dysfunctional brain circuits that may underlie pediatric mania. For example, an emerging literature on the subject has identified genetic markers associated with bipolar features in children with velocardiofacial syndrome. More imaging research is needed to document the neuroanatomic underpinnings associated with pediatric mania. These scientific approaches can also be used in the identification of anatomic variations in unaffected relatives of youth with bipolar disorder.

The symptomatic overlap and co-occurrence of mania with ADHD has produced debate as to whether these children have ADHD, mania, or both. Despite this debate, many clinicians recognize that a substantial minority of children suffer from an extraordinarily severe form of psychopathology associated with extreme irritability, violence, and inca- pacitation that is highly suggestive of mania. Clarifying the diagnoses of these very ill children would have substantial clinical implications. This literature indicates that mania can be identified in a substantial number of referred children using systematic assessment methodology. Thus, this disorder may not be as rare as previously considered. Children with mania frequently demonstrate an atypical picture by adult standards, with a chronic course, severely irritable mood, and a mixed picture with depressive and manic symptoms co-occurring. Most children with childhood-onset mania may also have other conditions which requires additional treatment. Initial clinical evidence suggests that atypical neuroleptics may play a unique therapeutic role in the management of such youth. The high levels of comorbidity with other disorders is common, further requiring the cautious use of a combined pharmacotherapy approach. More research is needed to build a scientific foundation for the notion that pediatric mania is a unique developmental subtype of bipolar disorder.

Four Winds Hospital Note: (This article is a highly abridged version of the original article by these distinguished researchers with many references not noted here. For a complete copy, please see the copyrighted version of 2000 Society of Biological Psychiatry, Biological Psychiatry, 48:458-466).

Safety First from page 29

When sufficiently stable, the work of deconditioning traumatic memories and responses can begin, which further stabi-

lizes the patient. Then the healing narra- 


tive can begin, as the patient can begin to integrate the traumatic experiences. And over time, as the therapist serves as a bridge to relationships in the outside world, the patient can come to see herself as more than a victim, more than a survi-

vor of trauma, but as a complex human being in the great chain of humanity who no longer needs to define herself by her pain and suffering.

Sharon Klayman Farber, Ph.D. is a Board Certified Diplomate in clinical social work in private practice of psychotherapy with children and adolescents in Hastings-on-Hudson, NY. She is the founder of Westchester Eating Disorders Consultation Services. Dr. Farber is a Fellow at the Cape Cod Institute and the author of “When the Body is the Target: Self-Harm, Pain, and Traumatic Attach-

ments” (Aronson 2000,2002.) Dr. Farber offers individual and group consultation and in-service training to mental health professionals who treat self-harming pa-

tients and hopes to develop a supportive network of such therapists. She can be reached at 914-478-1924 or at www.Drsharonfarber.com.

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All of the Grand Rounds, Special Trainings and Events will be held at the Four Winds Hospital Conference Center unless otherwise noted.

Due to limited seating, registration is limited to the first 100 paid registrants. Certificates of Attendance will be awarded at the conclusion of each program, can be used for continuing education credits in various disciplines. Check with your certifying agency for information on how to submit Certificates of Attendance for Continuing Education Credits in your field of expertise.

For those requiring special services, please call no later than two weeks prior to the conference date so that the appropriate arrangements can be made.
t doesn’t seem like five years has passed, but in the fall of 1999 the first issue of Mental Health News was published. The idea to start Mental Health News followed my own ten-year and life-threatening battle with depression. In the wake of this horrific experience, the idea to provide “a road-map to recovery” for others with mental illness came to light.

Had a publication like Mental Health News been available to me during my illness, I firmly believe that my ordeal would not have had such tragic consequences. Our greatest challenge is to continue to grow—because I know that, as you read this, there are people with a serious mental illness who feel so hopeless they will try to take their own life—and many will succeed.

The good news is that we are working hard to raise the funds necessary to expand our distribution of free copies to more and more communities. Thanks to your ongoing support, and the efforts of our wonderful Board of Directors, we are succeeding.

One exciting new project we are working on is the upcoming launch of Salud Mental, a bilingual (Spanish) version of Mental Health News that will reach out to the Latino community.

You have inspired us to continue to pursue and broaden our mission, and have helped us to raise the bar and redefine how the mental health community delivers mental health education. Our progress would not have been possible without the many award-winning writers, the agencies who provide their expertise in the understanding and treatment of mental illness and providing display ads that direct readers to the help available to them in their community, and finally, to the tireless efforts of mental health advocates and policymakers who continually keep us focused on the critical issues. Here are some of the important stories we have covered over the past five years.

Thanks for the memories!!

Fall 1999
Agenda 2000: Leaders Speak Out On What Our Priorities Should Be

Winter 2000
Surgeon General Releases Groundbreaking Mental Illness Report

Spring/Summer 2000
The Crisis of Suicide in America: It’s A Matter of Life And Death

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When Mind and Body Collide: Understanding Eating Disorders

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Celebrating Our 5th Anniversary
By Ira H. Minot, CSW Founder and Publisher

In The News At The Office Of Mental Health News

This Fall Issue Marks Our Fifth Year In Print

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When The Mind Causes Pain New Video Available

Susan, a 40 year-old school-teacher, was suffering from daily headaches, pains in the back of her neck, shoulders, and chronic feelings of tension and sleepless nights. After a number of diagnostic tests and a thorough examination, Susan’s physician informed her that there were no physical problems indicated in her X-rays, blood tests or her MRI. Yet Susan’s pain was very real. To her surprise, her doctor informed her that the physical pain and discomfort she was experiencing were symptoms of depression.

“When the doctor told me that I was depressed, I was very surprised. I had no idea that physical pain and depression were linked,” said Susan.

Susan is one of several people who tell their stories of how painful physical symptoms were disrupting their lives in a video entitled, When the Mind Causes Pain. The video was produced by Freedom From Fear, a non-profit mental illness advocacy organization. Freedom From Fear began its focus on pain and depression with a survey to explore the impact of physical symptoms on an individual’s work, social life and family life.

The survey, conducted last May, revealed that almost 90 percent of the participants believe that depression or anxiety could cause painful physical symptoms. Also, 50 percent of the participants who were diagnosed with arthritis, migraines, diabetes and other medical conditions that have painful symptoms reported that on days when they felt anxious or depressed their pain was more severe.

“Mary Guardino, Executive Director and Founder of Freedom From Fear, states that, “Among patients with depression, 80 percent (four out of five) first present to their doctors exclusively with physical symptoms. The most common are: joint and back pain, fatigue, insomnia, dizziness and headaches. In fact, patients with painful physical symptoms are three times as likely to experience high depressive symptoms.” Chronic pain affects more than 40 million Americans each year. Depression affects more than 19 million. The numbers are staggering. The cost in human suffering is immeasurable. Yet there are safe, effective treatments available and people can improve their quality of life even if they are experiencing painful symptoms. A feeling of well being is a joint effort of the mind and body working together.

If you are experiencing physical symptoms and you feel that your mood and emotional state are being affected, help is available. Call toll free 1-888-442-2022 to access a mental health professional in your area for free mental health screening. To learn more about “When the Mind Causes Pain,” visit freedomfromfear.org. If you wish to purchase “When the Mind Causes Pain” and related materials, send $25.00 to Freedom From Fear, 308 Seaview Avenue, Staten Island, NY 10305.

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PAGE 32  MENTAL HEALTH NEWS ~ FALL 2004
A recent series of major reports beginning with the Surgeon General’s report on Mental Health in 1999, the Institute of Medicine’s “Crossing the Quality Chasm,” and most recently the President’s New Freedom Commission’s 2003 report reflect that minority communities are less likely to access care. The beliefs and history of diverse cultural groups may have an enormous impact on whether consumers access and adhere to care. They are often poorly accommodated within the existing system. According to the studies, there is a distinct need for fundamental changes in the delivery of mental health care in America. In response to these reports and what is being seen firsthand by mental health professionals, a groundbreaking conference was held understanding how the mental health system can better serve communities of color was the theme of a recent full-day conference entitled “Bridging the Gap in Mental Health Care: Adapting Best Practices to Communities of Color.” The conference was organized by the Institute for Community Living, Inc. (ICL), a not-for-profit agency serving individuals and consumers from dozens of agencies and universities addressed over 300 mental health practitioners, consumers, family members, policymakers and researchers.

The Mental Health News
New York City Section

Institute For Community Living Convenes Conference To Address Multiculturalism

By Linda Nagel, Vice President
Institute for Community Living’s Child & Family Services

Ocean House Operators Plead Guilty To Stealing $2 Million
DA Morgenthau Thanks NYS Agencies For Their Assistance

Office of the District Attorney
New York County

Manhattan District Attorney Robert M. Morgenthau announced today a guilty plea from two individuals and an affiliated company for stealing more than $2 million in a financial fraud stemming from their management of a not-for-profit adult home for residents with mental disabilities.

Today's pleas involve the financial transactions and operation of Ocean House Center, Inc. (“Ocean House”), a not-for-profit adult facility located in Far Rockaway, Queens. SHERMAN TAUB, a disbarred lawyer who is an officer and de facto operator of Ocean House, and his son JUDAH (“Jay”) TAUB, is the president of Ocean House. SHERMAN TAUB and his company International Mortgage Servicing Company entered pleas of guilty to Grand Larceny in the First Degree, a Class B Felony and the New York State Department of Tax and Finance; today's pleas are the result of that investigation.

Ocean House is a 125-bed facility licensed by the New York State Department of Health to provide room, board and assistance to adults with mental disabilities. Ocean House receives approximately $1.4 million per year from the Social Security Administration on behalf of its residents to pay for their accommodations.

Prior to its incarnation as Ocean House, the same facility was known as HI-LI Manor Home For The Aged (“HI-LI Manor”), an adult home that was run by SHERMAN TAUB’s brother-in-law, Zyskind. HI-LI Manor was the subject of a 1990 CQC investigation which resulted in the prosecution and conviction of Zyskind in the Eastern District of New York for bank fraud and theft of residents’ funds. Zyskind eventually declared bankruptcy and defaulted on HI-LI Manor’s two existing mortgages, one for $1.2 million and the other for $450,000.

The investigation revealed that after Zyskind defaulted on the two mortgages, his brother-in-law, SHERMAN TAUB, secretly arranged to purchase the mortgages at a steep discount by using a nominee to make it appear that a disinterested third party was the purchaser. Through his nominee, TAUB purchased the mortgages for $400,000 and thereby effectively took control over the facility, which was subsequently reorganized as the not-for-profit Ocean House. SHERMAN TAUB installed his son, JAY TAUB, as Ocean House’s president. Although JAY TAUB was the nominal president, the investigation revealed that SHERMAN TAUB maintained control over the facility.

The keynote speaker was Alvin Poussaint, MD, noted psychiatrist and professor at Harvard University and director of the Media Center at the Judge Baker Children’s Center in Boston. Dr. Poussaint explored historical and cultural influences on African-American attitudes toward psychiatry and illuminated ways in which mental health providers may express racism and how it may exist intrinsically within the system.

In a word of caution, Dr. Poussaint urged mental health professionals to be careful in assessing individuals—based upon accepted norms within in the field. In order to truly be culturally competent, one must be sensitive to the differences.
Forging New Pathways To Mental Health For New York’s Diverse Populations

By Giselle Stolper, Executive Director The Mental Health Association Of New York City

A ttitudes toward mental ill-

ness, and how a disorder should be treated once the symptoms emerge, are as plentiful and varied as the many cul-
tures that characterize New York City. There is much evidence available re-
garding the extent to which different populations attach stigma to mental illness, which treatments they believe will work best, and how they may even define mental illness in the first place. However, access to quality mental health treatment should be the same for all New Yorkers across cultures, locations, and economic levels. That’s where the Mental Health Association of New York City works to make a difference.

New York City has the greatest diversity of any other city in the United States. The Department of Health and Mental Hygiene’s (DOHMH) recent report, Health Dis-
pairities in New York City, indicates that more than one-third of New Yorkers were born outside the United States, as compared to 11 percent of the entire nation’s population. Interest-
ingly, nearly four out of five Asians living in New York City were born on non-US soil. While the city’s cultural diversity is rich, the dollars don’t spread as evenly. DOHMH reports the wealthiest twenty percent of New Yorkers enjoy 50 per-
cent of the city’s income. Disparities in wealth make themselves known in higher rates of AIDs, obesity, heart disease, asthma, colon cancer, and low birth weight babies among poorer populations. Lower-income families, especially those with household in-
comes under $25,000, are two to six times more likely to report problems of serious emotional distress than their wealthier counterparts.

In 2001 the Surgeon General’s re-
port, Mental Health: Culture, Race and Ethnicity, underscored the importance of “cultural competence” in the design and provision of mental health services among the nation’s diverse popula-
tions. The report emphasized the need to help underserved populations find appropriate services, and then provide treatment in a way that is responsive to their values, cultural beliefs and per-
ceptions of mental illness.

Public Education To Reach Underserved Populations

One of the ways the MHA of NYC responds to this issue is through public education and outreach. These pro-
grams, which revolve around LifeNet, the MHA of NYC’s crisis, information and referral line, heighten awareness of signs and symptoms mental illnesses and gives people a place to call, 24/7, where they can find referrals to services. The English language hot-
line was founded in 1996. Though we had multi-lingual professionals on staff, we learned quickly that LifeNet would increase its effectiveness if we offered a dedicated phone number and culturally attuned staff for Latino and Asian populations. In 1998, we added 1-877-AYUDESE and subsequently, Asian LifeNet (1-877-990-8385).

It was crucial to build awareness of the hotlines within the communities. Our outreach needed to utilize what Dr. Lloyd Roger, founder of the His-
panic Research Center at Fordham University, termed “help-seeking path-
ways”, if we were to improve access to services effectively. Unless we pro-
moted the LifeNet hotlines along the existing pathways, the people we needed to reach would never know about us.

The MHA of NYC recruited mental health professionals who conduct grassroots outreach within the city’s many Latino and Asian communities to promote mental health awareness and knowledge about LifeNet. They have created linkages to neighborhood guides and influencers: community and spiritual leaders, religious groups, general practitioners, and mental health care providers, civic groups, mental health agencies serving the community, local hospital emergency rooms, and even the local pharmacists. Building these linkages helps reduce the stigma of seeking help and equips community leaders with knowledge they can share.

Our LifeNet outreach professionals give presentations and seminars on mental illness, publish papers and arti-
cles, conduct mental health screenings at high schools and senior centers, par-
ticipate on the boards of community organizations, and staff tables at neighborhood fairs to distribute litera-
ture and answer questions. The effort has paid off. Calls to AYUDESE and Asian LifeNet continue to climb, cur-
rently averaging 300 per month for each hotline.

The 9/11 Attacks And Multicultural Populations

Over the past three years the after-

...
Help is Just a Phone Call Away

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Latino LifeNet: 1-877-AYUDESE
Coming To America: FEGS Faces A Cultural Challenge

By Joyce Kevelson, F.E.G.S.
Assistant Vice President, Queens

Trying to help émigrés acculturate, while dealing with the added burden of mental health problems, is a constant challenge in the changing demographics of New York. For individuals from the former Soviet Union, coming to America posed its own set of cultural challenges. Some 15 years ago, the area of Rego Park, in Central Queens, experienced a major influx of émigrés from the former Soviet Union, especially Bukharan Jews.

The culture shock for these new Americans was profound, as it was for so many émigrés communities. While many seemed to be experiencing family distress, personal emotional problems, or more profound problems that they and family members brought to this country, few sought the needed help. For those people, the problems do not get better and interfere with their ability to learn the language, get a job and recover from medical and/or mental illness. This was a professional help is needed. The F.E.G.S staff at our Rego Park and Brooklyn Counseling Centers specialize in working with individuals to adjust to a new society and a new culture.

The stigma of receiving mental health services precluded many of these new Americans from seeking treatment. As Amina Sakharova, a supervisor at the F.E.G.S Rego Park Clinic, points out, in the former Soviet Union, “all doors were closed” to individuals who were treated for mental illness. This affected the entire family and often meant living in constant fear, ostracized from their community. Adult children were unable to find a spouse, get a job, or enroll in a skills-training program, and were often prevented from travel. Rehabilitation was a foreign concept, and there were no traditional career pathways for individuals who wanted to pursue employment. Employment is critical in working with these individuals; our therapists have to ensure that linkages to all community resources are part and parcel of the treatment process.

The culture and history of the Bukharan Jews was added other impediments that kept troubled individuals from seeking treatment. Most of the Bukharan Jews came from rural areas and had trouble negotiating the metropolitan transportation system. Social worker Galina Iskhakov reported that, in addition to the language barrier, many of her clients had difficulties with tasks as simple as using public telephones, so daily activities and the search for a job to support their families were clearly difficult.

Moreover, many of these clients came from the smaller republics of Uzbekistan, Tajikistan, or Turkmenistan. These areas border on Afghanistan, with its strong Muslim influence. A male-dominated family system rendered many women second-class citizens and stripped them of any voice in family decisions. For most women, this led to difficulty related to her relationship with her husband. However, knowing this male-dominated culture, the therapist could not address this issue early in treatment. Treatment had to be shaped to accommodate cultural differences.

The therapist met with Rosa and carefully helped her to see how the American culture was different from her previous life. During that period, the therapist met with the husband, but at a different time and day from Rosa. At first, he could not see that maltreatment of his wife was a problem. It seemed that a brief cooling off period was in order for this very volatile situation. Rosa took her kids and stayed with family for a few weeks. Once Rosa felt safe, she was better to acknowledge the triggers for her anxiety and depression. She was able to see that she had rights and began to develop greater self-confidence. Her husband missed his family and became even more amenable to understanding that there are consequences in the US for his behavior.

Over time, the therapist was able to link Rosa with ESL and skills-training classes, where she learned accounting and ultimately got a job. The couple united and began to spread the word, as did other “courageous pioneers,” that seeking treatment can greatly improve your life. They understood that confidentiality is respected, which assisted others to apply for treatment. Since then, F.E.G.S has helped thousands of émigrés become independent and find a better life.
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committee in formation
The ongoing racial and ethnic diversification of New York City and the rest of the nation, combined with the endurance of inadequate minority mental health care, suggests the need for consensus on what constitutes a diverse, culturally competent and antiracist human service organization. Yet many discussions and initiatives about this topic are derailed or neglected. One reason for this difficulty is the shifting relationship between multicultural values and language. For example, multiculturalism can signify a dimension of human diversity, such as race, an aspect of discrimination, or even an ethical principle. This lack of definitional precision is often compensated for by the development of additional terms that can become interchangeable. So, cultural competency, which relates to the helping professions’ struggle to name an ideal of practice with diverse clients, is frequently abandoned for cultural sensitivity, cultural responsiveness, or culturally diverse practice.

To be fair, during the past generation, mental health professionals have worked hard to define language and standards of practice. Robert Schachter, Executive Director of the New York City Chapter of the National Association of Social Workers, notes, “We’ve been aware of issues of discrimination. We are talking about is that we are living in a multicultural society. The word ‘multicultural’ has become part of the everyday vocabulary, especially among social work professionals.”

Indeed JBFCS, which has a 110-year history and serves 65,000 New Yorkers annually through 185 programs, is an excellent example of an organization that has actively advanced a commitment towards multiculturalism and antiracism. Joan Adams, CSW, Director of the agency’s Youth Counseling League, and long time teacher and consultant on issues of diversity in mental health speaks to the changes at JBFCS. “When I started teaching the In-service course 12 years ago, I tended to rely more on outside speakers. As the face of the organization diversified and I focused on social identity exercises, it was possible just to have people talk about their own identities, their experiences, staff relations and live clinical material. There are now social workers from the major racial and ethnic groups in NYC—Latinos, African American, Jewish, Caribbean, Asian and Whites—so it became easy to let the class speak for itself.”

Mary Pender Greene, Chief of Social Work Service and Director of Group Treatment for JBFCS and immediate past president of New York City Chapter of NASW, is cautiously optimistic. She notes, “What is encouraging now is that over the past two years in New York City, we are in a unique position.”

Although diversity may be increasingly diverse, while their core values, funding sources and internal structures may remain unchanged. While a diversifying client base often provides the impetus for better multicultural practice, the approaches that lead-
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or to establish the criteria as to what you want the outcomes to be. Initiatives around diversity initially meant hiring more people of color and reducing the amount of compliance issues. As consultants, we feel that is insufficient, because the hiring of people does not necessarily address the issues of attitudes in the workplace or the fairness to employees who are part of this workforce. It does not address the way the organization then becomes the mechanism, or vehicle, through which policies and practices ensure that the delivery of services is done in a cultural competency way.” This perspective is echoed by David Billings who notes that “the real undoing of racism is about how we can work it in our profession—how do we create critical mass that begins to have our professions and our organizations, model the equity that we say needs to happen?”

Clearly these issues are complex; and one problem may be in how we conceptualize them as a linear process. That is, an organization first diversifies, then develops culturally competent best practices, and finally commits to structural change that reflects an incorporation of a power analysis of systemic racism. Dr. Franklin cautions, “the fallacy in the antiracism paradigm is the belief that transforming individual attitudes and beliefs will necessarily translate into better practices. And will necessarily, through better practices, also translate into better institutional policies. You are dealing with two different domains as such. You are dealing with antiracism—the domain of individual values and beliefs. You are dealing with multicultural competency—the domain of best practices; and diversity—the domain of composition of staff and, presumably, the fairness of employment practices. It is important to keep those distinctions in front of us so that we do not assume that one necessarily presumes change in the other as you attain one.”

Robert Schachter expresses a similar concern shared by most organizations that commit to this process. “Because there are those that have not engaged the issues as an ongoing process, there are different levels of where we are in terms of deepening the discussion. There are many people who have avoided or not felt the need to address the issues. So we have to start where people are. We have to be mindful of how hard it is—and how difficult and frightening the discussion can be—and we need to be patient despite the urgency.”

The challenge then becomes how to sustain a dialogue across all three dimensions, when people enter the discussion with individual beliefs and values and attitudes towards others, and they need to work towards best practices, and they need to work towards policies and procedures that essentially support that.” David Billings emphasizes that the stakes are high. “I feel the very integrity of the field is dependent on mental health professionals understanding the long legacy and manifestations of racism in this country. I think that to not understand racism when the overwhelming voices from people of color are that this is something that they deal with on a daily basis is to render us irrelevant at best, and at worst is very damaging.”

The answer to the question asked by the title of this article is “We must all get along.” What makes us effective as mental health professionals is the same thing that makes us effective as people. It is the application of human understanding to the values of social justice. Benjamin Kohl, CSW, is Director of Multicultural Practice and Research & Program Director of Southern Brooklyn Family Services for the Jewish Board of Family and Children’s Services. He is an adjunct faculty member at New York University School of Social Work, where he is finishing his doctorate.
somatization from page 21

significantly elevated relative to levels observed in depression alone. The association between depression and somatization merits further scrutiny.

Epidemiology And Health Care Utilization

Prevalence rates of incapacitating somatization range from 4.4% to 12% in the general U.S. population. These rates are much higher in clinical settings. In primary care studies, the prevalence of somatization ranges from 18% to 25%. Our current data (Hispanic Treatment Program/New York State Psychiatric Institute) shows that in a primary care sample of Latino patients in the Washington Heights community of New York City (N=1058), 23% presented with a high index of multiple unexplained physical symptoms. The majority of our patients are recent immigrants from the Caribbean (Dominican Republic) and other Central and South American countries.

There is a vast body of literature that supports the association between medical service use and psychiatric diagnoses. It has been estimated that up to one-third of primary care visits could be attributed to psychiatric disorders. Data supports a positive association between unexplained physical symptoms and the use of health services. Patients with somatization disorder use outpatient medical services three times as often as patients without somatization and ten times more than the general population. When compared to psychologically healthy individuals, patients with somatization disorder have three times as many hospitalizations and surgeries than depressed patients without somatization.

Etiology And Biopsychosocial Correlates

Although the etiology of somatization disorder is unknown, several predisposing factors have been found to be important determinants in its pathogenesis. Engel’s biopsychosocial illness model can be helpful in understanding the multifactorial origin of somatization disorders, where physiological, pathological and psychological variables may interact resulting in patients experiencing complex bodily sensations that cannot be attributed to known medical illness.

Biological factors associated with somatization disorder include dysfunction in attention processes and negative affectivity. When internal sensory and external environmental cues compete for an individual’s attention, insufficient filtering of irrelevant bodily stimuli might result in increased bodily sensations and complaints of somatic symptoms. This dysfunction of attention could be explained by reduced corticofugal inhibition of afferent bodily stimuli in somatosensory areas such as the diencephalon and the brainstem. Hypersensitivity of the limbic system towards bodily stimuli could also be etiologically related to somatization. Negative affectivity, a construct similar to neuroticism and pessimism, is related to higher levels of perceived distress. Negative affectivity correlates with a state of hypervigilance that makes individuals more attentive to subtle sensations in their bodies. Increased activation of inhibitory centers in the septum and the hippocampus could result in such state of hypervigilance and amplification of somatic sensations.

Early childhood trauma, in particular childhood illness and sexual abuse, are considered risk factors for somatization disorder. Individuals with somatization disorder report serious and multiple childhood illnesses more than medically ill subjects without somatization disorder. Morrison compared patients with somatization disorder to depressed subjects, and found that 55% of somatizers and 16% of depressed patients reported childhood sexual abuse. They further reported in patients with chronic pelvic pain and irritable bowel syndrome. Stuart and colleagues reported that patients with somatization disorder have a heightened awareness of their own bodily sensations and a mistrust of medical providers. They found that patients with somatization disorder were more sensitized to bodily sensations and were more likely to attribute to bodily sensations than healthy controls. They also found that patients with somatization disorder had a lower threshold for experiencing bodily sensations.

Psychodynamic theories postulate that repressed intrapsychic or interpersonal conflicts can be symbolically transformed into physical symptoms. Self-psychology theory proposes that the threatened disintegration of the self can cause extraoedinary anxiety and somatization becomes a defense against feelings of fragmentation or emptiness. Alexithymia is a concept that describes an individual’s inability to verbally express emotions. Alexithymia positively correlates with hypochondriasis and somatization disorder. Balint’s anxiety reaction occurs when a psychoanalyst working with the medically ill led to his observations that traumatic early life development could lead patients to amplify non-specific distress into complaints of multiple somatic symptoms. Barsky further developed this concept and coined the term somatopsychiatric amplification. In somatoanalytic amplification, stimuli and peripheral sensations undergo cortical elaboration and magnification. Cognitive theory emphasizes the importance of patients’ distortions of benign physical sensations and the attribution of such sensations to pathological processes. Misattribution could be based on cognitive schemes formed from early illness experience. The negative cognitions about physical sensations can be of the magnitude of catastrophic thinking, leading to even higher levels of arousal and reinforcing maladaptive behavior.

Pharmacologic And Psychosocial Treatments

Clinicians should be aware that patients with somatization syndromes attain symptomatic relief with tricyclic antidepressants, serotonin reuptake inhibitors and mood stabilizers. Our group is presently conducting a trial of lamotrigine, a mood stabilizer with antidepressant and anxiolytic properties, for Latino patients with somatization and comorbid depression.

There are a small number of rigorously designed controlled studies testing the effectiveness of psychotherapeutic interventions for somatization disorders. Studies of supportive psychotherapy and liaison interventions with primary care providers show a reduction in health care utilization and in somatic symptoms, but no change in measures of psychological distress. Studies testing the efficacy of brief-dynamic psychotherapy show overall improvement, but have only been conducted in patients with unexplained gastrointestinal symptoms. Over the last decade, a series of CBT studies were conducted for the treatment of somatic symptom-specific disorders and functional somatic syndromes. These studies paved the way for the development of a manualized CBT treatment that was piloted and is currently being tested by Escobar and colleagues in a large controlled study.

The efficacy of CBT for somatization disorder needs to be further studied in diverse settings. A study should be made against antidepressant medication, other psychotherapies and a placebo-control group.

Transcultural Aspects Of Somatization

As stated by Kleinman, culture influences all psychiatric diagnoses. In Puerto Rico, somatization disorder is as prevalent in women as it is in men, while in the U.S. the sex ratio approximates 10:1. This difference in prevalence may reflect that cultural factors may influence how this disorder presents in different populations. Culture-bound somatoform disorders have been described, mainly to emphasize that the type and frequency of somatic, depressive and anxiety symptoms differ depending on the population studied. While Western neuropsychiatric approximates phenomenologically to Chinese shen jing shuairuo, Japanese shinkeishitsu, Korean hwabyung, and kanmo - ashakpantha in India, subtle but perhaps important differences among these disorders or “idioms of distress” need to be clarified by ethnographers and cultural researchers. Little is known about the relationship between somatization, immigration and acculturation. Escobar’s multivariate data from a study completed in a California primary care setting made possible a comparison of somatization in Anglo-Americans, U.S. born Latinos, and Latino immigrants. He analyzed their data to figure what proportion of immigrants, U.S. born Latinos, and Anglo-Americans presented with “discrete somatization” (somatization disorder) and “non-discrete” somatization with other psychiatric comorbid disorders. There was a significant difference in Latino (Mexican and Central American) patients, with “discrete” somatization than did either U.S. born non-Latinos (all white) or U.S. born Latinos. One interpretation of this finding is that somatization emerges as a prominent idiom of distress for Latinos upon their arrival to the U.S. but becomes less so as they become acculturated. The so-called “psychosomatization” is a phenomenon of the “new” American culture. It may seem reasonable to conclude that while newcomers somatize, those acculturating to the U.S. mainstream may learn to psychologize their distress. The generalization that acculturation is positively correlated with co-morbid somatization and negatively correlated with discrete somatization needs to be further studied in patients of diverse national origins.
Veteran educator and school administrator, Armand F. Fabbri, has been named Headmaster of Seton Academy, located on the 25-acre campus of Hall-Brooke Behavioral Health Services, located at 47 Long Lots Road, in Westport, Connecticut.

In announcing the appointment, Stephen P. Fahey, President and Chief Executive Officer of Hall-Brooke, noted that Fabbri recently retired after 42 years of service as Executive Officer of Hall-Brooke, noted Stephen P. Fahey, President and Chief Executive Officer of Hall-Brooke.

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What a positive statement these members made by their presence and support of their PNP agency! They are all volunteers, and span the diverse talents evident in a community. They are people from the business, communication, educational, government, health care, human resource, legal, spiritual, and so many other sectors of a community. Their skills are generously applied in the course of being a member of a board of directors. Their PNP agency is a nonprofit corporation and must be effectively managed as with any business. Their skills help this to happen.

What I continue to find most impressive about these board members is not only the skills they use to help their PNP. Yes, these are important. But what is most admirable is that they are exercising their responsibility as private citizens. In the words of the late Supreme Court Justice Louis D. Brandeis, “The most important office [is] that of private citizen.” As private citizens in their community, they understand and value the role their agencies play, in concert with dedicated state employee partners, in contributing to outcomes such as the following for Connecticut’s youngsters, adults and families:

- Promoting health and life skills so youngsters and young adults regularly attend and fully participate in academic experiences rather than being diverted by bullying, family stresses, early use of substances and the effects of mental illness;
- Delivering accessible, quality services in emergency department and other acute-care hospital settings, with appropriate follow-up care in the community;
- Providing good prevention, outpatient, residential and other recovery-oriented services so that persons not only learn to manage their illness but also to rejoin their community, have the highest quality of life possible, and contribute to economic growth by being in school, having a job and a decent place to live;
- Decreasing fiscal and other demands on local social service and public safety entities related to domestic violence, child abuse, and other incidents/violations of the early identification or prevention of mental illness/substance use disorders;

These board members know that a focus on mental health and substance use must be part of the health care and fiscal agenda of every community. It’s a good investment. A hearty THANK YOU for their dedication and for exercising the role of private citizen!

Comments are always welcome at Thomas.Kirk@po.state.ct.us

Citizen from page 41

For a healthy mind and body, Norwalk Hospital’s Department of Psychiatry offers expert staff and services to the diverse talents evident in a community. They are people from the business, communication, educational, government, health care, human resource, legal, spiritual, and so many other sectors of a community. Their skills are generously applied in the course of being a member of a board of directors. Their PNP agency is a nonprofit corporation and must be effectively managed as with any business. Their skills help this to happen.

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Love Defines Latino Experience at Hall-Brooke Center

By Jo Fox, Public Relations

Hall-Brooke Behavioral Health Services

In our Latino program, “It’s really love that defines the treatment experience,” muses Beatrice Chodosh, LPC, Program Coordinator of the Hall-Brooke Center in Bridgeport, Connecticut.

Love was identified as the quintessential characteristic of the program and its participants near the end of an interview of staff members who were asked to discuss “cross-cultural issues and their impact on mental health.”

Patients were described as having a cultural affinity toward helping and nurturing within a group. “They care about each other,” Chodosh notes, “in a deep and personal way. When some of the usual participants are absent from a group session, our patients don’t like it.” Where is everybody? They ask.

There is a culture of the family, or the group. It is a culture of “us” or “we,” out of the solitary, independent, self-absorbed person celebrated by mainstream Americans as the norm in the “me generation.”

Because of this, Chodosh and other staff members noted, group sessions are highly successful. When someone relates their problems, the others in the group surround them with caring and concern. It is a natural Latino response, Chodosh says, noting the elemental difference between Latinos and mainstream patients. “I had a general, non-Latino practice in the past, and it was like ‘pulling teeth’ to get those patients to open up.

“Here, group sessions open the flood gates and we have to sort through a great rush of emotion to determine exact cause and effect. We are inundated with a wealth of clues,” Chodosh says, noting that “Latinos are very verbal. But, because of their connectedness, no one tries to steal the spotlight. They make sure that everyone in a group can speak. They take the initiative to make that happen.”

The center’s patients usually come from dysfunctional families. In a culture where the family is so important, this dysfunctionality has an intensely negative property, which exacerbates a patient’s trauma. “The Center provides them with the ‘healthy family,’ they and their culture honor and expect,” Chodosh says. “Here, they are like fish swimming together ‘fathether air is always right,’ who can she blame but herself? Emotional trauma from such abuse sometimes exists for many years (and does great damage) before it is revealed and dealt with.”

Although the present patient roster is almost evenly split between men and women, staff members noted that there are usually more female patients. Machismo is also seen as the reason for the Latino male’s hesitancy to seek help. Since the Latino man is expected to be in control, he may insist “I’m not crazy,” even when seeking help, staff members recall.

The majority of participants in the Center’s Latino program are from Puerto Rico and often from impoverished backgrounds. They came to the United States, Chodosh explains, looking for opportunities. Instead, they find themselves in isolation and frustration are components of the stress that exists at a high level throughout the Latino community, she says.

One notable aspect in the treatment of mental health in the Latino community, staff members explained, is the “somatization” of problems. Extreme stress often manifests as pain somewhere in the body. “We are aware of this tendency among Latino patients, but to be careful that we don’t miss an actual physical problem,” Chodosh says.

Many clients come from rural back-grounds and are desperately homesick for open fields, green mountains and the horse in their backyard, notes Tony Fusco, LPC, Treatment Coordinator for Expressive Arts.

Often, they live in substandard housing, in concrete deserts without a flower or blossoming tree in view. “Their art-work shows how much they miss their former environment, unable to break out into the mainstream and to access the legendary ‘opportunities.’ The sense of isolation, anxiety and frustration are components of the stress that exists at a high level throughout the Latino community, she says.

The center is bi-lingual, but prides itself on being bicultural as well. Cultural awareness brings the ability to relate on the level of life experiences. It is not what you say, but how you say it. "Our patients do beautiful work," he said, hanging out some attractive sell-covered boxes, examples of works-in-progress in the art therapy program.

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In June 2001, Hall-Brooke Behavioral Health Services opened a new 58,000 square foot, residential style treatment center on its beautiful 24-acre main campus in Connecticut.

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Hall-Brooke has provided comprehensive behavioral health and chemical dependency programs for 104 years. It offers a full range of inpatient and outpatient treatment programs for children, adolescents and adults. It has the only inpatient facility for children in the region. The Hall-Brooke School for day students is also located on the campus.
and similarities within each of us and do not rely on generalities. He also expressed regret to the deeply ingrained mistrust of the medical community, mental health providers should also be cognizant of the “legacy of slavery and racism,” when working with communities of color.

Workshops Targeted Different Areas of Interest: Through eight “breakout” workshops, the conference explored the subtle and overt ways in which racism works, the conference explored the relationships in which racism, when working with communities of color.

NYS Mental Health Experts Lay Groundwork for Conference

Following the welcoming remarks by Peter Campanelli, ICL President and CEO, and Yvonne Graham, RN, MPH, JD, Deputy Borough President of Brooklyn, New York, the New York Women’s Health Association and Sharon Cappinello, PhD, Commissioner, of the New York State Office of Mental Health, presented a workshop which included initiatives to disseminate evidence-based practices with the recognition that treatment models should be tailored to culturally and ethnically diverse consumer.

Lloyd Sederer, MD, Executive Deputy Commissioner for Mental Hygiene, NYC Department of Health and Mental Hygiene, presented the latest results of his department’s annual Community Health Survey, highlighting analyses of vulnerable populations, including race and ethnic subgroups. Among the findings were that Hispanics report a relatively higher incidence of emotional distress in the prior 30 days, yet are not as likely to White as access services; Whites are the least likely to seek counseling, yet are less likely than other groups to access medication; and Blacks report the highest barriers to accessing services. Dr. Sederer detailed the Department’s quality improvement program, Improving Programs through Interorganizational Collaboration (IMPACT), under which city-sponsored mental health and child mental health programs will evaluate consumers’ perceptions of care—a strong factor in consumers’ adherence with treatment. With technical assistance from the City, these agencies will make improvements in their cultural competence, their identification of substance abuse problems and their identification of mental health needs among children with mental retardation.

Staff Training, Support, and Self-Awareness: Issues of Race and Culture

Moderated by Dorothy Farley, Vice President, Social Services, Community Healthcare Network, with panelists, Leonora Reid-Rowe, Director, Cultural Competence and Diversity Initiatives for Coordinated Care Services, Inc. and Antonio M. Young, Consultant, Capital Management Systems, the workshop identified the need to translate science to practice in a culturally competent way, reflecting the communities in which services are provided through cultural training; agency assessments in cultural competence; development of competency standards and credentialing (including federal guidelines); documentation of tracking and monitoring translation and target training to all staff (including line staff, supervisors, administrators and Boards of Directors). Legislators and policy makers should be accountable to ensure a higher-level commitment to culturally competent services, clear data collection from the community, innovation, a systemic and strategic plan in cultural competence and a means to translate policy and procedure to practice.

The consensus of the workshop participants was that staff training, support, and self-awareness around issues of race and culture are crucial in a best practices model. These concerns should be at the forefront of any debate that attempts to bridge the gap in community-based mental health services.

Best Practices in Family Reunification and Preservation

Joanne Nicholson, PhD, University of Massachusetts Medical School, was moderating the workshop that focused on the challenges and rewards of successfully reuniting mentally ill parents and their children in the view of points of Kate Biebel, University of Massachusetts Medical School researcher, Ann Ioms-Williams, Esq, Special Counsel and Associate Commissioner, NYS’s Administration for Children’s Services, Francesa McCray, a substance abuse counselor and parent with mental illness and Jennies Warrington, Consultant, ICL’s Emerson-Davis Family Program.

Points that emerged included the need for intervention with the mentally ill as for other adults, the mental health system too often ignores parental rights and that agencies should draw on the strengths of communities of color—including the church, the neighbors, and other supports—rather than bolstering families against the effects of substance abuse, mental illness, and domestic violence, reducing the risk of placement and improving the chances of successful reunification where placement has occurred.

Ms. McCray described her successful struggle to reunite with her three children after a history of alcohol abuse and a psychotic break. She spoke of the fear and mistrust of “the system” that is so prevalent among parents involved with staff and family issues.

Operators from page 33

Taking a plea today, SHERMAN TAUB admitted that he stole more than a million dollars from Ocean House through the use of fraudulently inflated mortgages for himself and his company INTERNATIONAL MORTGAGE SERVICING COMPANY (IMSC). The investigation revealed that after purchasing the HI-LI Manor mortgages for $400,000 through the nominee, the mortgages were transferred to IMSC, which was created for the sole purpose of receiving and accepting payments on these mortgages. SHERMAN TAUB directed that Ocean House make mortgage pre-payments to his company, rather than spend the money on improving the facility. In this manner, TAUB increased the amount of money he siphoned from Ocean House to himself. In essence, TAUB encumbered Ocean House with fraudulently inflated mortgages to generate profits for himself and his facility through the company he controlled, rather than use the funds to improve the Ocean House facility. The investigation revealed, for example, that from 1995 to 1999, IMSC received more than $2.2 million in mortgage payments from Ocean House, of which at least $1.5 million was remitted directly from IMSC to SHERMAN TAUB.

In addition to the mortgage-related fraud, the indictment also charges construction-related fraud. Because SHERMAN TAUB directed that a substantial portion of Ocean House funds be used for the payment of mortgages held by him, Ocean House had to obtain another loan bank for $1.4 million to finance the renovation of the facility. The indictment charges that during the course of the renovation, forged bills of lading for the construction company were inflated to increase the amount paid to the construction company beyond the worth of the work actually done at Ocean House. The money paid as a result of the inflated invoices was used by the construction company to finance extensive renovations at JAY TAUB’s home, including the renovation of bathrooms and the installation of a new kitchen, totaling in excess of $135,000.

Assistant District Attorney Deborah Hickey and Rackets Deputy Bureau Chief Ellen Nachtigall Biben prosecuted the case under the supervision of Rack- en Bureau Chief Patrick Dugan, Assis- tant District Attorneys Eric Seidel, Gilda Marani, former Assistant District Attor- ney Timothy Zirkel, Rackets Bureau Supervising Financial Investigator John Tampa and District Attorney’s Investiga- tor Louis Bausa also participated in the case.

Mr. Morgenthau thanked the follow- ing agencies and individuals for their assistance in this case: Commission on Quality Care for the Mentally Disabled: Commission Chair Gary OBrien, Walter E. Saurack, Director of the COC’s Fiscal Investigation/Cost Effectiveness Bureau, and Kate Rutnik, CPA, and Michael J. Kester and review specialists Betty Jane Chara and Jerry T. Monstrey; New York State De- partment of Taxation and Finance: Commis- sioner Arthur Roth, Deputy Com- missioner Peter Farrell and Auditor Brian Galaneau; New York City De- partment of Investigation: Commis- sioner Rose Gill Hearn, Deputy Inspec- tor General Maureen Thomas, Deputy Chief Investigative Auditor Joan Russ- sell-Benjamin and Special Investigator Jeffery Dokimaclosco; U. S. Attorney’s Office for the Eastern District: Special Prosecutions Bureau Deputy Chief Daniel Alonso and General Crimes Bu- reau Acting Chief Ilenne Jaroslovitz; Attor- ney General Elliot Spitzer; New York State Department of Health Commis- sioner Antonia Novello; New York City Department of Finance Commissioner Martha E. Stark.

Grande Larceny in the First Degree is a Class B Felony which is punishable by up to 25 years in prison. Grand Larceny in the Second Degree is a class C felony which is punishable by up to 15 years in prison. False Use of an Instrument of Writing in the First Degree are class E felonies which are punishable by up to 4 years in prison.

Defendant Information:
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http://www.manhattanda.org/whatsnew/ index.htm

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Understanding the Mental Health Needs of Recent Immigrants

The newly immigrated child finds him/herself in a new and very intimidat-ing environment—away from the social support of extended family and communi-ty that was so important in the absence of a parent back home. They are often left key children—children who are often left at home alone by the parent who is working two or more jobs. That child may likely develop feelings of be-trayal and abandonment. When the child tries to express these feelings, the gen-eration gap is widened as the parent feels the child is spoiled, weak, and unappre-ciative. It would be a challenge for any child to express appropriate behaviors for taking care of the very ill son. She underlined the importance of understanding the ins and outs of vari-ous systems serving children—such as outpatient and residential mental health, special education, and early intervention.

One recommendation was to access and involve parent advocates to assist fami-lies stymied by multiple problems. Par-ticipants left the workshop with an in-creased sense of hope and knowledge about how to access resources, supports, and concrete services within the mental health community.

Moderator Montalvo, Program Coordinator and Parent Advocate, ICL’s Family Sup-port Program in East New York, and Namiertos, Parent Advocate, Families Together, drew from their own unique backgrounds of raising children with special needs and advocating for parents with similar experiences.

Forging Connections Between Faith-Based and Mental Health Communities

Moderated by Dee Warr-Moody, PhD, Vanndaight Passge for Cen-tral Brooklyn Teens, this workshop dis-cussed how faith communities and the faith-based community is often called upon to seek justice, offer compassion and hospitality and engage in reconciling ministry with persons with mental illnesses as well as others in our society. The faith-based community there is in a unique position to be the bridge between clinical settings and life in the home community and to offer support to people with mental illness.

Understanding that a partnership be-tween faith-based and mental health communities could be a powerful vehicle to promote the understanding of serious and life-threatening mental illness in ministry with persons and their families affected by this illness, panelists Rev. Dr. Cheryl G. Anthony, Judah International Center, and John L. Bolling, MD, The Mandala-Cen-ter, and Miriam Ray Shelton, Latino Institute for Pastoral Care shared recom-mendations to both the faith-based com-munity and mental health systems.

Suggestions include, for faith-based communities, avoid the implication that it a person can “get things right with God...” recognize the need for spiritual healing without focusing on the “cure,” encourage pastoral care and churches to learn more about mental illness, encourage individuals to work with their strengths and help them set realistic goals, become a resource for information and referral for mental health assistance and provide space for clientele, services, support groups or drop-in centers.

For mental health providers: accept interaction between race and religion and religious and mental health systems to ob-serve differences and enhance treatment and help them set realistic goals, become a resource for information and referral for mental health assistance and provide space for clientele, services, support groups or drop-in centers.

This workshop focused on the chal-lenges of implementing the Assertive Community Treatment (ACT) in poor urban communities of color. ACT pro-vides clinical treatment outside the office setting, in the consumer’s home environ-ment through the use of a multi-disciplinary team (social worker/team leader, family specialist, vocational spe-cialist, psychiatrist, RN, LPN, substance abuse specialist and peer counselor).

Moderator Gary Clark, Pathways to Housing and ACT Training Institute, and panelists Anna-Marie Louison, MSW, CASES, Fedner Joseph, MSW, Volun-teer of America, and Mark Kowal, State Office of Mental Health identified the need for the government to partner with agencies to create funding models and service delivery expectations that meet the needs of New York City and programs to take into account the shortage of affordable housing and the safety of staff going alone into clients’ homes to provide services.

Closing Panel of Moderators Identifies Gaps and Barriers: Recommendations

The conference concluded with a panel discussion on communities of color, moderators, moderated by Lavern Miller, Esq., Director, Community Ac-cess’ Howie the Harp Peer Advocacy Center. Each panelist reported back from his or her workshop on common issues he/she addressed such as community approach, cultural, professional, and legislative change. Despite the variety of workshop topics and perspec-tives, there was a striking concordance of views on the four areas discussed.

Understanding and improving con-sumers’ perceptions of mental health services. Relationship-building at the start of treatment and the importance of taking into account clients’ cultural perceptions and misconceptions from the very first con-tact is vital. Panelists recommended that state and city mental health agencies re-evaluate the regulations, which require that clients answer many highly personal questions at the first visit – a procedure likely to alienate and discourage many consumers. The practitioner should be aware of the trust of the mental health system is com-mon among people of color. Clients who are not self-referred will approach treatment with a more guarded or mis-trustful attitude than those who self-refer. Identifying and reducing barriers to service access for people of color: In addition to a lack of service availabil-ity in many neighborhoods, there is a scarcity of bilingual mental health work-ers available for immigrant consumers. Weaknesses in insurance coverage pre-sent many obstacles to treatment for working poor, consumers with Medicare and illegal immigrants. Those with pri-vate insurance find their mental health coverage is limited to clinic-based and in-patient only – providing no reimbur-sement for community-based services which may be the most suitable and cul-turally appropriate. Bias and insensiti-vity among providers is another barrier and many of the federal and local man-dates for cultural competency training are not funded.

Addressing consumers’ interrelated material, spiritual, and mental health needs: Many consumers of color have pressing material problems – from immigration to housing, from childcare to adequate nutrition – that must take precedence over mental health care and are the trigger for much emotional dis-order. Many health agencies should do more to attend to these needs by provid-ing childcare, immigration counseling to assist with entitlements, providing food in their facilities and should reach out into the community to partner actively with them.

Determining how science-based ap-proaches can be adapted to incorporate the preferences and needs of people of color: Panelists spoke of the paradoxes of models of treatment developed far from consumers of color, whose proven effectiveness in their original setting may not translate at all into different settings. At the same time, effective, locally developed models of treatment, which have evolved within communities of color and have been tailored to their par-ticular preferences and needs, may not have empirical support, and may lack of effectiveness, but only due to a lack of research. Panel members called for a “two-way street,” with input and exchange between local providers and mental health researchers, to develop, adapt, and develop an evidence base for models of care that are most best suited to di-verse communities.

The Institute for Community Living extends its sincere gratitude to all who helped us look at how New York’s men-tal health system should best serve its diverse multicultural community.

We would also like to thank Michael Blady, Elizabeth Clee, Christina Muns-feld, Ben Sher, Baraka Smith, Sharon Serravento, Paula Tarant Rives, Wofry and DeMcxia Woeen-Irrazzy, who also contributed to the writing of this article.
experiencing a marked exacerbation after
losing a loved one on 9/11. Among
those who had slept 4 hours per night, and he said he preferred this way of life because he liked to “know what was going on” around him. This is
what being hypervigilant is like. In fact, he
expressed concern that treating his
insomnia would put him in danger by
diminish his ability to stay on guard for
trouble.

After 9/11 from page 1

conducted retention may be for a period
of not more than one year. After that,
each patient review board may be for
a period of up to two years.

The Emergency Admissions

Article 9 authorizes emergency
admissions to a psychiatric facility for
a period not to exceed fifteen days if a
staff physician, usually an emergency
room physician, examines the patient
and finds that he/she has a mental illness
for which immediate observation, care
and treatment is needed. This is an
urgent situation established by
Article 9, which Critical Incident Stress
Debriefing, despite its sound theoretical
base, does not reduce risk for subsequent
PTSD and may sometimes worsen out-
come. Although much more research is
needed, one core concept in this litera-
ture that has practical applications is that
of “relative risk appraisal.” We make
risk assessments in our daily lives, often
without reflection, that can be easily
biased by experience or traumatic events.
In the year 2000, 665 million people
used domestic air travel; in 2001,
this dropped by 15% to 622 million due
to a precipitate decline after the attacks.
The risk of death in airline travel is
about 1 in 7 million; the risk of death on
an air trip to a coast-down fire is about
greater (1 in 14,000). And yet for months
after 9/11, frightened travelers chose
the illusion of safety behind the wheel of a
car over the much safer real-
ity of air travel.

Personal safety is a major concern for
most urban communities now. A guid-

Principle 1. This article does not cover admissions
with the Mental Hygiene Law, Article 81
issues relating to inpatient psychiatric treatment, the laws governing this area
apply to all patients, whether they are
those governed by other statutes, such
tions leading to recovery and
ple or others as manifested by threats of or attempts at suicide or seri-
ses relating to inpatient psychiatric treatment, the laws governing this area
apply to all patients, whether they are
those governed by other statutes, such
of goals leading to recovery and
successful psychological outcomes, including the
development of PTSD. Avoidance can lead
into an ever-constricting downward spiral of disability, resulting in
isolation, unemployment, and an experi-
ence of oneself as frightened and vulner-
able. In the context of ongoing threat, nor-
mal fear may still lead to maladaptive
behavior. It is critical to appreciate the
opportunity to make conscious decisions
that exists in the gap between fear and
fear motivated action.

We believe that mental health
and medical professionals, in addition
to screening for and treating PTSD, will
have a role to play in assessing the need
over the coming months to help patients whose lives are
unnecessarily constricted by dispro-
portional fear and exaggerated risk
appraisal. In other words, the opportunity
to promote resilience in our community
is two-fold: treating patients who are
suffering, and promoting active and ef-
fective coping in others before they be-
come destitute by excesses below 200% of
the poverty line. Similar to fragmenta-
tion of resources and services, social and
political policy has inadequately ad-
ressed the issue of ensuring continuity of
care and improving access to care for
these vulnerable adult populations
struggling to survive with day-to-day social
challenges and maintain emotional
stability.

I am in agreement with Dr. Hogan
when he said that “managers and policy
makers in mental health must commit
to promote resilience in our community
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The Orange County New York Multi-Cultural Task Force, is made up of direct practitioners, supervisors, directors, and peer advocates working in our local mental hygiene agencies. This Task Force came together and developed a group called the Task Force Training Team (TFTT) in 2001.

This followed a three-day Conference in which Task Force members were trained by Fusion Partnership Inc in multi-cultural diversity and awareness. The training team is made up of 8 to 10 members; some participate in every training that the Task Force conducts; some training team slots are rotational among several Task Force members.

The TFTT instructs direct practitioners and supervisors who work in our local Mental Hygiene agencies. The training curriculum is based on the Diversity Awareness Conference that was presented to the Task Force by Fusion Partnership in 2001. The purpose is to teach basic and meaningful concepts in multicultural diversity awareness and to conduct exercises that establish creative thinking in those subject areas.

The TFTT has conducted a number of day-long Diversity Conferences, since 2001. The intent is to train 50 to 60 different practitioners in each conference—until most practitioners and supervisors are trained to understand multicultural diversity awareness.

Multi Cultural Competency Work Sessions With Executive Directors

The Multi-Cultural Task Force has begun a series of work sessions with Executive Directors of our local Mental Hygiene agencies. The purpose of these sessions is to develop actual multicultural statements to be used in official agency documents including: agency plans, policies, and procedures. These Statements are to conceptualize both concrete and broad ideas intended to strengthen and bring multicultural competency to the agency work environment, recruitment and retention of staff (diversity), general operations, and the delivery of services.

The overall goal is to have every agency (or at least those agencies who participate in the work sessions) have multicultural statements in their official documents which will guide specific actions to make the agency more competent in multicultural issues. Once the statements are in place, the Task Force will work with Executive Directors to implement the action(s) as outlined in the statements.

This initiative is being done on a voluntary basis with regard to the agencies' participation. However, all agencies are invited and are being strongly encouraged by the Orange County Department of Mental Health, in collaboration with the Multi Cultural Task Force. All agencies are kept apprised of ongoing activities through summaries and agendas of each completed work session. Agency Executive Directors are instructed to come to sessions whether they missed the last, some, or all the previous ones. Therefore, all directors will know where we are with new initiatives and the progress each participating agency is making. As part of our work in the sessions, we develop, review, and fine tune actual statements. We discuss, identify, and attempt to resolve or alleviate obstacles and challenges to implementation and achievement. In addition, we encourage agencies to support and assist one another, while acknowledging that actual statements will be developed and implemented by each agency according to its own decisions, circumstances, and needs. Part of this mutual support and assistance is to encourage agencies and directors to contact each other in between work sessions.

The Work Sessions are being scheduled every 3 months during the statement development and writing phase. When we get into implementation of the Statements, the plan is to meet two to three times per year. To date we have completed two work sessions in Phase One. In the third session (early fall, 2004) we will begin to develop the first statements for participating agencies.

Bridging from page 48

making an impact on these outcomes” so that each individual can reach his or her maximum level of employment, self care, interpersonal relationships, and community participation... researchers and funders of research must speedily move beyond the evidence that increasingly counts is the evidence that treatment works for consumers in real-world settings.” Research and the funding that supports evidence based practice must begin to incorporate the social and cultural dynamics that exist in communities of color.

Advocates, stakeholders, and policy makers in all the disciplines that fund mental health services must also commit to a partnership that bridges the financing system to "real-world settings" research, and that bridges the financing system to treatments that are culturally sensitive and appropriate. In order to achieve successful outcomes in a society where communities of color will represent 46% of the population, we should make this commitment an immediate priority.

In closing, the former Surgeon General, Dr. David Satcher clearly stated the vision that we, as a society, need to champion when he said that “because State and local governments have primary oversight of public mental health spending, they have a clear and important role in assuring equal access to high quality mental health services for racial and ethnic minorities. Just as important, we need to redouble our efforts to support communities, especially consumers, families, and community leaders, in welcoming and demanding effective treatment for all.”

When it is easy for minorities to seek and use treatment, our vision of eliminating mental health disparities becomes a reality.9
Gabriella is a 24-year-old Hispanic woman referred to treatment by a local Family Health Center. Gabby came from a community who have similar experiences and problems. We teach new, culturally specific symptom expression and communication skills in Spanish and in English. Gabby was devastated by having her child removed from her. The baby was placed in foster care. Gabby was Devastated by Having Her Child Removed from Her. The Baby Was Placed in Foster Care. Gabby was Devastated by Having Her Child Removed from Her. The Baby Was Placed in Foster Care.

Cultural Issues from page 26

Asian Americans/Pacific Islanders

The prevalence of mental illness among Asian Americans is difficult to determine because of methodological limitations (i.e., population sampling). Although some studies suggest higher rates of mental illness, there are wide variations across different groups of Asian Americans (Takeuchi & Uchida, 1996). It is not well known how applicable DSM-IV diagnostic criteria are to culturally specific symptom expression and communication of PTSD. With respect to treatment-seeking behavior, Asian Americans are distinguished by extremely low levels at which specialty treatment is sought for mental health problems (Leong & Lau, 1998). Asian Americans have proven less likely than whites, African Americans, and Hispanic Americans to seek care. One national sample revealed that Asian Americans were only a quarter as likely as whites, and half as likely as African Americans and Hispanic Americans, to have sought outpatient treatment (Snowden, in press-a). Asian Americans/Pacific Islanders are less likely than whites to be psychiatric inpatients (Snowden & Cheung, 1998). The reasons for the underutilization of services include the stigma and loss of face over mental health problems, limited English proficiency among some Asian immigrants, different cultural explanations for the problems, and the inability to find culturally competent services. These phenomena are more pronounced for recent immigrants (Sue et al., 1994).

Hispanic Americans

Several epidemiological studies revealed few differences between Hispanic Americans and whites in lifetime rates of mental illness (Robins & Regier, 1991; Vega & Kolody, 1998). A recent study of Mexican Americans in Fresno, California, found that Mexican Americans born in the United States had rates of mental disorders similar to those of other U.S. citizens, whereas immigrants born in Mexico had lower rates (Vega et al., 1998a). A large study conducted in Puerto Rico reported similar rates of mental disorders among residents of that island, compared with those of citizens of the mainland United States (Canino et al., 1987).

Although rates of mental illness may be similar to whites in general, the prevalence of particular mental health problems, the manifestation of symptoms, and help-seeking behaviors within Hispanic subgroups need attention and further research. For instance, the prevalence of depressive symptomatology is higher in Hispanic women (46%) than in whites (almost 20%), yet, the known risk factors do not totally explain the gender difference (Vega et al., 1998a; Zautun- gui et al., 1998). Several studies indicate that Puerto Rican and Mexican American women with depressive symptomatology are more likely to seek mental health services and overrepresented in general medical services (Hough et al., 1991; Duran, 1995; Jimenez et al., 1997).

Native Americans

American Indians/Alaska Natives have, like Asian Americans and Pacific Islanders, been studied in few epidemiological surveys of mental health and mental disorders. The indications are that depression is a significant problem in many American Indian/Alaska Native communities (Nelson et al., 1992). One study of a Northwest Indian village found rates of DSM-III-R affective disorder that were notably higher than rates reported from national epidemiological studies (Kintz et al., 1992). Alcohol abuse and dependence appear also to be especially problematic, occurring at much higher rates of occurrence than in any other population group. Relat- edly, suicide occurs at alarmingly high rates (Indian Health Services). Among Native American veterans, post-traumatic stress disorder has been identified as especially prevalent in relation to whites (Manson, 1998). In terms of patterns of utilization, Native Americans are more likely to seek psychiatric inpatient care in relation to whites, with the exception of private psychiatric hospitals (Snowden & Cheung, 1998; Snowden, in press-b). Barriers To The Receipt of Treatment

The underrepresentation in outpatient treatment of racial and ethnic minority groups appears to be the result of cultural differences as well as financial, organizational, and diagnostic factors. The service system has not been designed to respond to the cultural and linguistic needs present in many racial and ethnic minorities. What is unresolved are the relative contribution and significance of each factor for distinct minority groups.

Help-Seeking Behavior

Among adults, the evidence is consider- able that persons from minority backgrounds are less likely than are whites to seek outpatient treatment in the specialty mental health sector (Sussman et al., 1987; Gallo et al., 1995; Leong & Lau, 1998; Snowden, 1998; Vega et al., 1998a; 1998b; Zhuang et al., 1998). This is not the case for emergence department care, from which Af- rican Americans are more likely than whites to seek care for mental health problems, as noted above. Language. see Cultural Issues on page 51

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FEGS Helps from page 36

• Psychiatric evaluations performed in Spanish
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• Parenting Skills classes in Spanish

When necessary, we connect clients to local advocacy services that will help them to find support for their various needs, including educational and legal. Knowing that the therapist understands the complexity of their lives and concerns helps clients feel that they can talk about behavior, emotional issues and psychiatric symptoms.

The Parenting Skills class offered in Spanish has proven to be a very successful part of our outreach to and service to the Hispanic/Latino population. This component helps individuals learn about the Child Protective Services laws, acceptable U.S. childrearing practices, and connects them with other parents in their community who have similar experiences and problems. We teach new, more effective skills that will help their children to have a better life than the one they had.

Gabriella is a 24-year-old Hispanic female referred to treatment by a local Family Health Center. Gabby came from El Salvador with a group of people, crossing the borders following a “Coyote” (guide). She was coming here to reunite with her boyfriend, who had arrived in New York a couple of years before. During the ordeal, she was raped by the Coyote; as a result, she became pregnant. When Gabby learned about the pregnancy, she disclosed to her boy- friend that she had been raped. She was very afraid of seeking prenatal care services. She approached a Family Health Clinic late during the pregnancy. Acute symptoms of PTSD were present, and when she tried to strangle herself with a rope, she was found by a public health nurse who referred her to FEGS.

When she gave birth, Child Protective Services removed the child from Gabby. The baby was placed in foster care. Gabby was devastated by having her child removed from her. The court mandated her to Parenting Skills classes. Gabby started Parenting Skills classes and she completed the series. She then started individual therapy and was maintained on a medication regime for awhile. Her clinician connected her with a bilingual bicultural lawyer, who helped the client with the legal process of regaining full custody of her child. Gabby found a steady full-time job, was able to secure housing, and completed treatment. Her child was returned to her. Our Parenting Skills group also helped Gabby to find other young parents in her community who she could relate to. Mental health treatment is not frightening or stigmatizing for Gabby or her family anymore. Providing services by culturally compe- tent staff has created a safe, non-threatening environment accessible to the Hispanic/Latino population on Long Island who have long been underserved.

Mental Health Association of Rockland County

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like economic and accessibility differ- ences, can play an important role in why people from other cultures do not seek treatment (Hunt, 1984; Comas-Diaz, 1989; Cook & Timberlake, 1989; Tay- lor, 1989).

Mistrust

The reasons why racial and ethnic minority groups are less apt to seek help appear to be best studied among African Americans. By comparison with whites, African Americans are more likely to give the following reasons for not seeking professional help in the face of depression: lack of time, fear of hospitali- zation, and fear of treatment (Sussman et al., 1987). Mistrust among African Americans may stem from their experiences of segregation, racism, and dis- crimination (Primm et al., 1996; Priest, 1991). African Americans have experi- enced racial slights in their contacts with the mental health system, called “microinsults” by Pierce (1992). Some of these concerns are justified on the basis of research, cited below, revealing clinician bias in overdiagnosis of schizo- phrenia and underdiagnosis of depres- sion among African Americans. Lack of trust is likely to operate among other minority groups, according to research about their attitudes toward government-operated institutions rather than toward mental health treatment per se. This is particularly pronounced for immigrant families with relatives who may be undocumented, and hence they are less likely to trust authorities for fear of being reported and having the family member deported. People from El Salvador and Argentina who have experi- enced imprisonment or watched the gov- ernment murder family members and engage in other atrocities may have an especially strong mistrust of any govern- mental authority (Garcia & Rodriguez, 1989). Within the Asian community, previous refugee experiences of groups such as Vietnamese, Indochinese, and Cambodian immigrants parallel those experienced by Salvadoran and Argen- tine immigrants. They, too, experienced imprisonment, death of family members or friends, physical abuse, and assault, as well as new stresses upon arriving in the United States (Cook & Timberlake, 1989; Mollica, 1989).

American Indians’ past experience in this country also included a lack of trust of government. Those living on Indian reservations are particularly fearful of sharing any information with white cli- nicians employed by the government. As with African Americans, the historical relationship of forced control, segrega- tion, racism, and discrimination has af- fected their ability to trust a white major- ity population (Herring, 1994; Thompson, 1997).

Stigma

The stigma of mental illness is an- other factor preventing African Ameri- cans from seeking treatment, but not at a rate significantly different from that of whites. Both African American and white groups report that embarrassment hinders them from seeking treatment (Sussman et al., 1987). In general, Afri- can Americans tend to deny the threat of mental illness and strive to overcome mental health problems through self- reliance and determination (Snowden, 1998). Stigma, denial, and self-reliance are likely explanations why other minor- ity groups do not seek treatment, but their contribution has not been evaluated empirically, owing in part to the diffi- culty of conducting this type of research. One of the few studies of African Ameri- cans identified the barriers of stigma, suspiciousness, and a lack of awareness about the availability of services (Uba, 1994). Cultural factors tend to encour- age the use of family, traditional healers, and informal sources of care rather than treatment-seeking behavior, as noted earlier.

Cost

Cost is yet another factor discourag- ing utilization of mental health services (Chapter 6). Minority persons are less likely to have health insurance, but this factor alone may have little bearing on access. Public sources of insurance and publicly supported treatment programs fill some of the gap. Even among working class and middle- class African Americans who have med- icate health insurance, there is underrep- resentation of African Americans in outpatient treatment (Snowden, 1998). Yet studies focusing only on poor women, most of whom were members of minority groups, have found a lack of insurance to be barriers to treat- ment (Miranda & Green, 1999). The discourse in the mental health literature suggests that much research remains to be performed on the relative importance of cost, cultural and organizational barriers, and poverty and income limitations across the spectrum of racial and ethnic minority groups.

Clinician Bias

Advocates and experts alike have asserted that bias in clinician judgment is one of the reasons for overutilization of inpatient treatment by African Ameri- cans. Bias in clinician judgment is thought to be reflected in overdiagnosis or misdiagnosis of mental disorders. Since diagnosis is heavily reliant on behavioral signs and patients’ reporting of the symptoms, rather than on labora- tory tests, clinician judgment plays an enormous role in the diagnosis of mental disorders. The strongest evidence of clinician bias is apparent for African Americans with schizophrenia and de- pression. Several studies have found that African Americans were more likely than were whites to be diagnosed with schizophrenia, yet less likely to be diag- nosed with depression (Snowden & Cheong, 1990; Hu et al., 1991; Lawson et al., 1994). In addition to problems of overdiag- nosis or misdiagnosis, there may well be a problem of underdiagnosis among minority groups, such as Asian Ameri- cans, who are seen as “problems-free” (Takeuchi & Uehara, 1996). The pres- ence and extent of this type of clinician bias is one of the reasons for overutilization of inpatient treatment by African Ameri- cans. Bias in clinician judgment is thought to be reflected in overdiagnosis or misdiagnosis of mental disorders. Since diagnosis is heavily reliant on behavioral signs and patients’ reporting of the symptoms, rather than on labora- tory tests, clinician judgment plays an enormous role in the diagnosis of mental disorders. The strongest evidence of clinician bias is apparent for African Americans with schizophrenia and de- pression. Several studies have found that African Americans were more likely than were whites to be diagnosed with schizophrenia, yet less likely to be diag- nosed with depression (Snowden & Cheong, 1990; Hu et al., 1991; Lawson et al., 1994). In addition to problems of overdiag- nosis or misdiagnosis, there may well be a problem of underdiagnosis among minority groups, such as Asian Ameri- cans, who are seen as “problems-free” (Takeuchi & Uehara, 1996). The pres- ence and extent of this type of clinician

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their own education in their own language may be very limited. Jose and a great number of Hispanic immigrant children are deeply affected by the immigration process. They are psychologically scarred because of all the losses and separations they have to deal with in their very young lives.

Bilingual/bicultural certified social worker in the grammar school environ- ment talks about her experience with immi- grant students as follows: “Almost all the students I see come from Hispanic backgrounds, and many of the ones that are referred to me suffer from Adjustment Disorders. Either they just arrived in this country and are struggling with new norms and a language they don’t understand, or they are just being reunited with parents they hardly know. In many cases they have been left behind, raised by grandpar- ents whom they miss. Depression is very common in these children, and one of the symptoms is anger; they will display poor self-control and aggressive behavior. In the classrooms, the teachers teach them how to behave. In sessions, I try to vali- date their frustrations and pain and allow them to recognize and express their feel- ings through games and art. I try to make them feel loved and safe. When they start to adjust to the system, I work with them in groups. These groups teach them social skills, self-control, communication and self-esteem. Again, instead of repeating rules that they already know, I have them interact and share their experiences. I work in a holistic approach by having as much feedback as possible from the teachers concerning their behavior in the classroom and the progress they are mak- ing. I try to keep in contact with the par- ents and with a bilingual/bicultural case manager who has won their trust and ap- preciation.”

Since 1990, about a million new immi- grants per year have come to the U.S., and one in five children in the United States is the child of an immigrant. There are over 100 languages in the New York Public Schools, of which the five top languages are Spanish, Chinese, Vietnamese, Korean and Tagalog. Nearly 80 percent are of color. Nearly half of the school children in New York City schools come from immi- grant-headed households. Family separa- tion from both parents during immigration for Central American children is 80 per- cent. (Harvard Longitudinal Immigrant Student Adaptation Study.)

With statistics as mentioned above, and with numerous stories similar to Jose’s, it is essential that we provide culturally sen- sitive health care. We need to prevent as many high school dropouts as possible, and to prevent so many children from fal- ling through the cracks. These are the children that are going to be our future. Our communities need to be better edu- cated to understand the immigrants and the struggles they are going through, because the United States will continue to be a country of immigrants.

Ms. Guich, is a program director at the Guidance Center, Inc., whose staff in- cludes bilingual and bicultural supports staff, clinicians and psychiatrists, serving a population ranging from preschoolers to people in their golden years. School- based programs are emphasized to help to address the complex needs of newly immi- granting youth. The case example above draws from the many cases serviced at the clinic, and in the schools and although it may have elements that conform to specific situations, such similarities are coinci- dental and reflective of the common issues faced by immigrant families.
cultural biases are not known and need to be investigated.

Improving Treatment For Minority Groups

The previous paragraphs have documented underutilization of treatment, less help-seeking behavior, inappropriate diagnosis, and other problems that have beset racial and ethnic minority groups with respect to mental health treatment. This kind of evidence has fueled the widespread perception of mental health treatment as being uninviting, inappropriate, or not as effective for minority groups as for whites. The Schizophrenia Patient Outcome Research Team demonstrated that African Americans were less likely than others to have received treatment that conformed to recommended practices (Lehman & Steinwachs, 1998). Inferior treatment outcomes are widely assumed but are difficult to prove, especially because of sampling, questionnaire, and other design issues, as well as problems in studying patients who drop out of treatment after one session or who otherwise terminate prematurely. In a classic study, 50 percent of African Americans vs. 30 percent of whites dropped out of treatment early (Sue & McKinney, 1975). However, the disparity in dropout rates may have abated more recently (O’Sullivan et al., 1989; Snowden et al., 1989). One of the few studies of clinical outcomes, a pre-post study, found that African Americans fared more poorly than did other minority groups treated as outpatients in the Los Angeles area (Sue et al., 1991). Earlier studies from the 1970s and 1980s had given inconsistent results (Sue et al., 1991).

Ethnopsychopharmacology

There is mounting awareness that ethnic and cultural influences can alter an individual’s responses to medications (pharmacotherapies). The relatively new field of ethnopsychopharmacology investigates cultural variations and differences that influence the effectiveness of pharmacotherapies used in the mental health field. These differences are both genetic and psychosocial in nature. They range from genetic variations in drug metabolism to cultural practices that affect diet, medication adherence, placebo effect, and simultaneous use of traditional and alternative healing methods (such as medicinal plants and herbs) may result in interactions with prescribed pharmacotherapies. The result could be greater side effects and enhanced or reduced effectiveness of the pharmacotherapy, depending on the agents involved and their concentrations (Lin et al., 1997). Greater awareness of ethnopsychopharmacology is expected to improve treatment effectiveness for racial and ethnic minorities. More research is needed on this topic across racial and ethnic groups.
(the whole family immigrates together) into the protective ghettos of urban communities, and still do today. This greatly contrasts with what a clinician experiences today when treating immigrants from Mexico, Central America and South America. Those families symbolize how a more fragmented immigration pattern has emerged. Parents from Latin American countries immigrate first, and send for their children, who do not immigrate at times until years later. It is not uncommon to hear of stories in which parents meet their children at airports with pictures in hand so that they can recognize one another. The effects of this prolonged separation on the family is devastating. At times, children who are left behind in their native country are neglected and abused by the families who were asked to take care of them. Other times parents feel paralyzed to address the guilt they feel for leaving their children behind. They also tend to be uncertain on how to parent or discipline children they have been separated from for so many years. At times, children act out rather than express their resentments for being left behind. This leads to an awkwardness and heavy silence once families are united. The separation and unification affects all family members and contributes to acculturation, mental health and substance abuse problems.

In order to appreciate the relevance of the cross-cultural approach it is important to briefly review its history within the mental health field. Since the 1960's a focus has been placed on the appropriateness of culturally sensitive mental health services for low-income minority populations. The pioneers of this approach believed that if sociocultural and cultural differences were ignored, the clinician's effectiveness with that population of interest could be minimized. Without awareness of the ethnic context and belief systems, when providing a multicultural and bicultural approach with culturally relevant modalities (i.e. bilingual/bicultural family and group psychotherapies) can reduce problems with attrition and underutilization; it can increase engagement and treatment effectiveness, as well as reduce the stigma many times associated with mental health services by Latinos.

It is important to be aware, there may be negative ramifications in highlighting cultural and contextual characteristics of a particular group of people. It may lead to stereotyping or induce prejudice against that particular group. The review of the literature and the understanding of cultural and contextual characteristics of any specific ethnic group is complex. Hispanics, for example, are not homogeneous. Many are divided between two nations, vary in their use of Spanish and/or English language dominance, and have extended families with Spanish, Black and/or Indian heritage. In fact it is not uncommon today to be treating a couple, family or members of the same community who have different national and ethnic identities, and distinct values and belief systems. When providing a cross-cultural model, the use of generalizations to describe a population is restricted.

To summarize, the importance and impact that a cross-cultural model has when working with those populations is enormous, invaluable, and rewarding. It involves working with a multicultural and multidisciplinary psychiatric and/or substance abuse team; as well as many community leaders and activists all of whom are dedicated to improving the lives of individuals, populations and communities from which these people reside. Many of these providers are inspirational with their dedication, commitment, and sacrifices towards the underserved populations. Many have admirable value systems that one frequently encounters when involved in community activism. Finally, it is a model that parallels with one of the greatest changes occurring in the United States today; the dramatic increase in certain minority populations within this country.

A native Argentine, Dr. Leiderman is a New York State licensed psychologist, a diplomat with a specialty board certification in Clinical Psychology and is nationally certified as a group psychotherapist. He is the director of the Latino Treatment Service at Saint Vincent Catholic Medical Center in Westchester County. The program is comprised of a multicultural multidisciplinary team providing bilingual/bicultural mental health and substance abuse treatment. He serves on several boards and committees geared at improving mental health services within the metropolitan area, especially as related to the psychiatric treatment of Hispanics. He frequently lectures with the tri-state area, has taught, supervised, and consulted many clinicians on culturally sensitive treatment approaches. He has a private practice in Westchester County and New York City.
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