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FALL 2004 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 6 NO. 4

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; Center for Mental Health



Services [CMHS], 1998). A constellation of barriers deters ethnic and racial minority group members from seeking treatment, and if individual members of groups succeed in accessing services, their treatment may be inappropriate to meet their needs.

Awareness of the problem dates back to the 1960s and 1970s, with the rise of the civil rights and community mental health movements (Rogler et al., 1987) and with successive waves of immigration from Central America, the Caribbean, and Asia (Takeuchi & 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

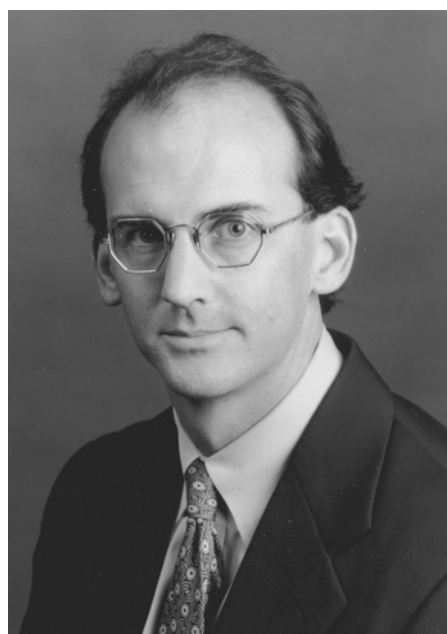
On the third anniversary of the most devastating attack on U.S. soil since Pearl Harbor, it is natural to take stock of our progress in recovery. Research in the community shortly after the attacks found very high rates of PTSD related to the 9/11 attacks in the greater New York area (8-11% of adults) as well as, remarkably, across the U.S. Follow-up studies also confirmed the expectation that the majority of persons with clinically 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 unfortunately this impression can have a basis in reality. A retreat into silent suffering is typically the response.

Although a considerable body of research shows that vulnerability to PTSD is not a reflection on the moral character of a person—in fact, one way of understanding PTSD is as a disorder of enhanced 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 surface, coping well again.

From a public health perspective, PTSD remains a serious and debilitating disorder that largely goes unrecognized and untreated, and PTSD related to 9/11 is no exception. It is for this reason that the NIMH recently funded a treatment study at our center specifically for persons with PTSD related to 9/11. Although we know a great deal about PTSD in general, little is known specifically about treatment of PTSD related to large-scale disasters and terrorist acts. Our pilot data suggest that, indeed, established evidence-based treatments can



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.

It is likely that threats of new attacks will exacerbate 9/11-related symptoms and worsen anxiety and affective disorder symptoms in many. The full impact of ongoing threat and actual exposure in persons with prior traumatization and active or past PTSD symptoms is another 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 because these are different disorders, different populations, or different types of trauma?

One of our patients is a Vietnam veteran. 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

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committee in formation

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and support.

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From The Publisher

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.



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.

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 too 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*.

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Editorial To The Publisher

Cultural and Sub-cultural Influences on Abnormal and Pseudo-abnormal Behaviors

By Joseph A. Deltito, MD

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 steal. Is this fixed belief on the part of the pickpocket a delusion? Perhaps it is a sign of radical narcissism or self-entitlement? Perhaps it merely represents a shared cultural belief, which in no particular way suggests individual psychiatric or personality pathology. Whichever it may be—and it might represent any, all or none of these possibilities—the evaluating psychiatrist would be at a disadvantage in evaluating this patient without knowledge of this particular Gypsy legend.

This interesting example underscores a flamboyant belief of a culture with which many of us may not have regular contact. Yet, as mental health professionals, the patients we evaluate all belong to at least one, and more frequently, multiple cultural and sub cultural groups. Inclusion in such groups may influence someone's behavior, personality and worldview anywhere from slightly to enormously. My own personal experience in evaluating patients has taught me that, most often, cultural influences are profound. Even if they do not precisely generate psychiatric or personality disorders they always influence how patients may present these conditions and behaviors. Mania, psychoses, obsessions, phobias and other psychopathological phe-

nomena have their content inspired by the world in which individuals with these conditions are raised and nurtured. Individuals from Northern European Countries (England, Denmark, Sweden)) who suffer from panic disorder present primarily with concerns and complaints of a cardiac nature. Those suffering from panic disorder in Southern European countries (Spain, France, Italy) and South American countries (Brazil, Colombia) complain more of difficulty breathing and irregularities of pulmonary function. Even mania may present differently in different cultures. For example, in a person raised in an Amish culture signs of mania may be quite subtle when compared to those from other groups. An Amish man who is buying two brightly colored shirts and using mild vulgarity in his speech may be showing just as profound a sign of abnormal behavior as someone else who takes out all their life's savings from the bank to fly to Las Vegas where they gamble for 5 days non-stop with no sleep. While there is no doubt that individual cultures may manifest various psychiatric disorders in different ways, what is more important to a psychiatric evaluator is to understand the shared beliefs and behaviors of given cultures that may otherwise seem to represent individual psychopathology when not understood within their cultural context.

In essence, psychopathology may be overestimated by those evaluators who fail to understand what might be normative behavior in a given culture or subculture. For example, an older Sicilian, Roman Catholic woman may spend hours in prayer to her preferred saint to help her with some urgent plea. Should the saint talk back to her while in prayer, consoling her that all would turn out right, we should not consider her as suffering from auditory hallucinations or in some way as being psychiatrically compromised.

Therefore, what may appear to be abnormal behavior might actually be only pseudo-abnormal behavior (that is normal) when viewed in its cultural context. There has been much attention in this country on so-called "suicide bombers" who are reared in certain Middle Eastern countries. I have oftentimes heard these people referred to as "crazy." I do not believe these people are in any way necessarily suffering from any psychiatric disorder. If their culture instructs them that such behavior is admirable and noble, and justified within a certain religious framework, I see no reason to judge them as having abnormal behaviors influenced by psychiatric disorders. I do see such people as terribly misguided, and it being an offense to humanity that they engage in such activities, but this is not psychopathology. Conversely, should someone aspire to become a "suicide bomber" who is raised as a Southern Baptist in Alabama? As a psychiatrist, I am more suspicious that his desire to do so is part of a psychotic or melancholic view of the world.



Joseph A. Deltito, MD

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 Sopranos* and John Steinbeck's *Cannery Row* can all be good examples of treatises on a given 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 world views 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 groups 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's behaviors. Marines, Franciscans, Crips, Mafiosi, Moonies and Girl Scouts all have shared beliefs and codes of behavior that may seem odd, strange, extreme and peculiar to those not familiar with their groups. They should not be conceptualized as suffering from psychiatric illnesses.

In my opinion, the study of group differences has fallen into a certain societal "disrepute" in recent years under the influence of what I would loosely refer to as "Political Correctness." While the gurus of political correctness may extol the virtues of "Multiculturalism" and "Cultural Diversity" these buzz words represent something far from the traditional scholarly and insightful study of the cultural differences in various groups. Under political correctness, studies of multiculturalism usually refer to an ideology that maintains it is incorrect to think that certain favored groups

might display what could be considered poor behaviors. Are certain ethnic groups more likely than others to deal in criminal activities, beat their wives, be unfaithful, or react with disproportional violence when threatened? We all know the answer is yes, but under the doctrine of "Political Correctness" if one notes that these attributes are statistically more represented in their favored group, then these persons are branded as prejudiced and misinformed. Such thinking inhibits any rational study of these issues, which may then elucidate their origins or suggest public policies that might help remedy what might represent huge societal burdens. Under political correctness, offenders are sent to mandatory cultural sensitivity training which most often-times represents an immersion of "proper think" which does nothing but suggest a homogeneity of mankind which patently does not exist. The true study of individual's culture is very important; the pseudo-study of it is criminal. For a full and interesting examination of how political correctness is harmful to the examination and treatment of patients and the training of health care professionals, I highly recommend to you the excellent book on this topic written by Sally Satel, MD: *PC MD: How political correctness is corrupting medicine*.

"A mental health professional evaluating individuals needs to examine human behaviors within their cultural contexts."

One of the most influential and productive psychiatrists of the 20th century was Professor Gerry 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 international studies of Psychiatric Illnesses and their treatments. More than once, Dr. Klerman told me that if 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 tendencies recognized within each group as normative. A mental health professional evaluating individuals needs to examine human behaviors within their cultural contexts. The study of all these cultures and subcultures is a lifetime exercise. Hopefully, we who evaluate patients are up to the task of this line of study, which is among the richest in which we are engaged.

NEWS

MENTAL HEALTH

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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; Schefler & 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/American Indian/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 & Denner, 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 disabilities (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 also large 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 greater stress 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 imparts distinct patterns of beliefs and practices that have implications for the willingness to seek, and the ability to respond to, mental

see Cultural Issues on page 19

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 achieving each mental health goal. Accordingly, in considering New York’s diverse service population, culture plays a role in system improvement in every area.

The Surgeon General’s Supplemental Report on Culture, Race and Ethnicity in Mental Health reminded us that the recommended treatments are those based on a strong and consistent evidence base and tailored to the age, race, gender and culture of the individual. The Report serves as a reminder that culture counts. It bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have and how much stigma they attach to mental illness.

Cultural competence is a process whereby knowledge, information and data from and about individuals and groups are integrated and transformed into clinical standards, service approaches, techniques and marketing programs that match the individual’s culture, thereby increasing both the quality and appropriateness of health care and health outcomes (King Davis, 1997). In interactions with consumers and family members, we are often reminded there is no quality without cultural competence.

Attention to cultural competence at the state level is critical, given changing demographics in New York State and the nation. Of the 630,000 people served through New York’s public mental health system, approximately 22 percent are under age 18, 22 percent are young adults aged 18-34 years, 30 percent are age 35-49 years, 17 percent are aged 50-64, and nine percent are over age 65. The population is evenly divided between male and female. Forty-nine percent are white non-Hispanic, 25 percent black non-Hispanic, 20 percent Hispanic, 5 percent American Indian, Hawaiian or other Pacific Islander, multiracial or another race, and 1 percent Asian non-Hispanic.

Service use rates are highest among black non-Hispanics (55.81/1000) and those of other and multiple races (53.95). They are lowest among Asian non-Hispanics (7.74) and white non-Hispanics (26.39).

The New York State Office of Mental Health (OMH) is well into its “Winds of Change” campaign to enhance quality through the implementation of evidence-based practices (EBPs) in routine clinical settings. However, it is difficult to promote best practices without specific information to guide adaptation for distinct communities. Tailoring practices requires extensive knowledge of all aspects of the practice and intended outcomes, as well as extensive cultural knowledge of the families, consumers and communities to be served.

OMH is committed to addressing disparities by enhancing service access, supporting tailored and adapted services, and providing opportunities for recovery with peers in peer-led programs. Policies are in place to encourage hiring staff reflective of those served, and to ensure that language-access services are provided for those with limited English language use. However, we recognize that we need to do more—we know we need to improve in the areas of access to services and cultural adaptation of ser-

vices. 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 an awareness that culture and 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 (Lefley, 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 minorities 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 in New York State, and as such, this grant focuses on three populations that are historically underserved and underrepresented in the public mental health system.

Through this grant, we will enhance our ability to develop and implement a culturally relevant and responsive staff-training program and a community-oriented and community-specific engagement process. We will also be able to document culturally tailored approaches and their effectiveness. Part of the excitement with this project is the level of community collaboration and the diversity of the consumers, investigators and researchers involved. Additionally, the documentation of the approaches used will allow for lessons learned to be transferred to other settings.

To date, there has been great cooperation and coordina-

tion between the project staff and the many stakeholders, and the project has been flexible and continually open to dialogue at every step of this process. At key points in development, the core decision-making participants have expanded to include new perspectives. This ongoing process of expanding the dialogue to include those who have cultural knowledge with advisory bodies inclusive of consumers and family members, researchers with both qualitative and quantitative research experience and key community informants, has led to partnerships that continually shape the product.

This grant will allow the three sites to serve, in essence, as “laboratories” for identifying and addressing our limitations to the challenges affecting diverse participation in family psychoeducation elsewhere in New York and the nation. The necessary cultural adaptations and “lessons learned” will inform our implementation efforts in family psychoeducation and other EBPs.

We are taking steps to meet the challenge of demonstrating and documenting effective and emerging practices, and establishing the efficacy across cultural groups. Through this grant, we will work to balance fidelity of a model with tailoring to engage and sustain participation; to build the evidence base of the efficacy of culture-specific interventions; and to include sizable minority populations in treatment studies to demonstrate real-world effectiveness across cultures.

As I look to the future, OMH will continue to be guided by strategies and governing principles to promote wellness and reduce the burden of mental illness. I believe that service delivery that is consumer and family focused, responsive to individual needs and respectful of culture and language, will ultimately have the best opportunity to help people recover from their psychiatric illnesses.

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 services and cultural adaptation of 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.

Family psychoeducation, an evidence-based treatment practice, provides education, support and coping skills to members of an individual's support network with the aim of assisting that individual and his or her family in the recovery process.

New York State
George E. Pataki
Governor

Office of Mental Health
Sharon E. Carpinello, RN, PhD
Commissioner

Funded by:
the Substance Abuse and Mental Health
Services Administration, Center for
Mental Health Services

omh
Office of Mental Health

A grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) is enabling OMH to create family psychoeducation sites for three culturally diverse communities. It will also provide a chance to share the lessons learned in order to improve mental health services across the country.



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

Staff Writer
Mental Health News

Chappaqua 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



"The Kiss" Charcoal on Paper

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



Susan Weinreich

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 she does comes quite naturally—there

have been numerous occasions. Whether she is presenting at Grand Rounds or in an interview over the phone, her desire to inform, instruct and support fills her own needs, as well as those who ask the questions. "Making art as I do does not only benefit the maker." She continues, "what is so precious about creativity is that the artist and the viewer benefit equally. It is rewarding for both in its inspiration and revelation of our tenuous, yet bold, human condition."

"It is my intention to straddle the edge between abstraction and realism. My art is conceived in an emotional attempt to unify chaos and harmony, while simultaneously allowing the viewer a point of entry. I believe that it is in this courageous effort to harness the unpredictable agitation of a boundless nature that we arrive at our fullest capability of human expression and experience. Not only are we able to go the distance, but we have created in its wake our evolution, or at the very least, evidence of our having passed through this state."

The art show will take place at Chappaqua Framing, One South Greeley Avenue, Chappaqua, New York, Friday, October 22nd from 4:00 p.m. - 8:00 p.m. (rain date: Saturday, October 23rd, 4:00 p.m. - 8:00 p.m.). The show is Free and open to the public. For further information call: (914) 666-2398.

Behavioral Management Briefed On Quality Standards And Technology

Staff Writer
Mental Health News

Sentinel 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 Management-New York Chapter in Poughkeepsie. "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



Mark Gustin and Keynote Speaker Dr. Caesar-Murphy

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 elec-

tronic 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 Manfredi, 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 Konrad CSW-R, Director of Green County Community Services, increased availability to psychiatric counseling from zero to services for 300 patients using telepsychiatry communi-

cations.

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.

MENTAL HEALTH NEWSDESK

Westchester County Department Of Community Mental Health Offers Help To Agencies On Addressing Multi-Cultural Issues

Staff Writer
Mental Health News

According to County Executive, Andy Spano, County of Westchester County, 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



Christine Reinhard, M.A., M.S.

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 and meet the needs of a diverse consumer population.

Although this workshop begins to address some of the issues that we are facing today here 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.

St. Vincent's Receives Healthcare Association Of New York's Top Award

Staff Writer
Mental Health News

St. Vincent's Hospital Westchester has been awarded the 2004 Pinnacle Award for Quality Improvement, presented annually by the Healthcare Association of New York State (HANYs) to recognize significant achievements by hospitals and systems in improving the health and safety of their patients. St. Vincent's Westchester, part of Saint Vincent Catholic Medical Centers (SVC MC), is the first behavioral health hospital to ever win the award.

St. Vincent's Westchester was recognized for a quality improvement program that increased patient safety by decreasing the use of restraints in its inpatient behavioral health programs. To reach the hospital's goal of exceeding national standards in the use of restraints, the medical and nursing staffs collaborated to develop alternative crisis intervention techniques. All staff received training in these crisis intervention techniques and found that they were very effective.

"It is great to see our quality program receive this recognition," said Dr. Dean Harlam, Chair of Quality Improvement for behavioral health services. "The teamwork of our doctors, nurses, and the rest of our staff made this possible, and we are all very proud."

Runners up for the award included North Shore University Hospital at Glen Cove for its program to improve access to health care, and Rochester Heart Institute at Rochester General Hospital for its Zero-Defect Initiative in cardiothoracic surgery.



Jennifer Carter, HANYs Director of Quality and Research Initiatives; HANYs Chairman J. Ronald Gaudreault, who is President and CEO of Huntington Hospital; Dr. Dean Harlam, Chair of Quality Improvement at St. Vincent's Hospital Westchester; Alan Eskenazi, Director of Quality Assurance and Performance Improvement at St. Vincent's Hospital Westchester; and Daniel Sisto, HANYs President.

Dr. Brian Fitzsimmons, Executive Director for SVC MC behavioral health services, said of the award: "This achievement is consistent with our continuing pursuit of excellence in the way we approach all of our patient care. As a specialty facility, we always seek to function not just at the accepted standard of care, but at the highest possible level."

St. Vincent's Westchester is part of Saint Vincent Catholic Medical Centers (SVC MC), one of the New York metropolitan area's most comprehensive health care systems, serving nearly 600,000 people annually. SVC MC was established in 2000 as a result of the merger of Catholic Medical Centers of Brooklyn and Queens, Saint Vincent's Hospital and Medical Center of New York and Sisters of Charity Healthcare in Staten Island. Sponsored by the Roman Catholic Diocese of Brooklyn and Sisters of Charity of New York, SVC MC serves as the academic medical center of New York Medical College in New York City.

The system includes eight hospitals: Mary Immaculate, Queens; St. John's, Queens; St. Joseph's, Queens; St. Mary's, Brooklyn; St. Vincent's, Manhattan; Bayley Seton, Staten Island; St. Vincent's, Staten Island and St. Vincent's, Westchester. Resources include over 3,000 physicians, four skilled nursing facilities, three home care agencies, a hospice and over 60 ambulatory care sites which provide a broad array of medical, psychiatric and substance abuse services. Presently, SVC MC recorded 100,000 inpatient discharges, 1,920,000 outpatient visits, and 524,000 home care visits. Its emergency rooms, which include three Level 1 trauma centers, received 285,000 visits in that same year.

A Voice of Sanity

*A Column by Joshua Koerner
Consumer Advocate and Executive Director,
CHOICE, New Rochelle, New York*



Beam Me Up, Doc

By Joshua Koerner

Scott 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 locked psychiatric unit. I love 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 question his "fixed" delusion. Miller then asks him if he is not the Terminator, but really Arnold Schwarzenegger. The patient 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 deteriorating, 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 actually engage people in conversations about their delusions; that might perpetuate 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 clinicians 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 confrontation doesn't work to overcome the client's denial, well then, by God, we'll put them in a group where 12 people can confront them simultaneously. It's interesting to me that, in mental health oftentimes when there's a problem, it's the clients who end up somehow 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 pharmaceuticals the answer. That's not an evidence-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 evidence that drug therapy is superior to psychotherapy.

What does work? Miller and his colleagues state that "using the client's theory of change to guide choice of technique and integration of various therapy models" 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 its verdant lawns and tennis courts to match its sterling 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 smiled or, if you passed them in the hallway or shared an elevator, would even acknowledge your existence.

I cannot recall anything of the way the resident looked – I may have spent all of half an hour with this man and never saw him again. He never treated me, we just chatted for half an hour shortly after I'd been admitted. He was probably just doing an intake interview, or perhaps had been sent in to observe

me, to see what mania looked like up close. Yet to this day the one thing about him I do remember is his smile, a broad grin of delight that told me he was genuinely interested in what I had to say.

I was trying to explain Bell's Theorem, which states that entangled pairs of electrons will always have spin states that add up zero, even if they are separated by hundreds of miles. Einstein derided this as "spooky action at a distance," but when it came to quantum mechanics, Einstein was wrong.

The young doctor was fascinated; no one had ever told him that anything could travel faster than light, and here it seemed that there was some superluminal signal passing between the particles. What, he wanted to know, did I think that meant? "It means locality fails!" I exclaimed. The whole idea of local causes is wrong; instead there is an implicate order underlying the universe, despite our perceptions of cause and effect, here and there. Where we perceive chaos and disunity there is instead harmony and oneness, a sure sign that God exists.

I hadn't learned such arcane physics principles in a classroom. When I was first hospitalized in 1979, it was a crushing blow. I was out in California at the time, gone there to seek my fame and fortune. When I had to return home at age 24 to live with my mommy, depressed, unable to work and labeled a mental case, I felt completely disgraced. Then I started to read about quantum mechanics, and Buddhism, and it gave me some solace, because they both said that everyone's perception of reality was wrong, and in fundamental ways both agreed with each other.

Now I was back in the hospital, perceiving directly how everything is tied together. It was an amazing, expansive, oceanic feeling: birds and trees and clouds and traffic, they all seemed to mesh together in total synchronicity. And this doctor was really interested in it; he really wanted to hear what I had to say, as though he could learn something from me.

Contrast that with the case conference held in 1986, during my fifth hospitalization. I'd been an inpatient six months, and I was dying to get out. They asked if I would participate in a case conference. They didn't say my discharge depended on it—they didn't have to. My discharge date had been moved back once: they could move it again. I said sure, anything you want.

The case conference was held in a large meeting room. I sat up front while a senior staff doctor interviewed me, and there were thirty or so residents arrayed around us. I remember one was falling asleep, and many of the others appeared bored and restless. I had been told the topic would be my discharge plans, what I learned in the hospital, blah, blah, blah, and I was all set to tell them what I thought they wanted to hear.

And then, without warning, the interviewer starts to ask me about my father. *My dead father*. It was an ambush, and I wanted to say, "Screw you, I'm not answering 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 horribly invasive questions from a total stranger, feeling like a bug under a microscope, getting all choked up and then looking around the room and seeing these callow young doctors, and they were bored—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 sharpness, untie your knots, soften your glare, settle your dust," is an excellent non-pharmaceutical recovery tool.

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

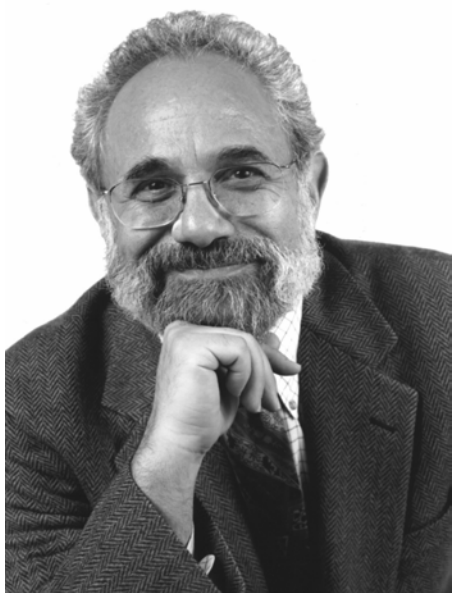
A footnote: In 1997 the practical application of Bell's Theorem was proven with the first teleportation of a photon, a unit of light, and then on June 17 of this year the National Institute of Standards and Technology, as well as the Quantum Teleportation Team at Innsbruck, Austria, reported the teleportation 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 states of bits, the power of computers may one day increase by several orders of magnitude.

That is, unless it's all a delusion.

POINT OF VIEW POINT OF VIEW

Barriers To Financing Cultural Competence

By Michael B. Friedman, CSW



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 health 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 moves to 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 Rogler 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—tend 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 homebound, 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 system 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.

Michael B. Friedman is the Director of the "Center for Policy and Advocacy" of The Mental Health Associations of New York City and Westchester. He can be reached at center@mhaofnyc.org. The opinions in this article are his own and do not necessarily reflect the positions of The Mental Health Associations.

Creating a culturally competent mental health system requires vast efforts:

- To assure access to needed, state-of-the art services
- To organize services in ways which engage, and are effective with, cultural minorities
- To build a culturally competent workforce
- To set research priorities that will result in state-of-the-art practices relevant to cultural minorities, and
- To establish a leadership structure through which minorities can have a strong enough voice to influence the systems through which they are served.

The Coalition Report

The Coalition
of Voluntary
Mental Health
Agencies, Inc.

Bridging the Gaps in Financing Mental Health Services: *Prioritizing the Delivery of Culturally Appropriate Best Practices and Treatment Services to Communities of Color*

By Edward C. Smith, Esq.
General Counsel, The Coalition of
Voluntary Mental Health Agencies

On 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 New York; 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 (1999) 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 NYC adult population, DOHMH estimates that approximately 934,00 New Yorkers ages 18-54 and 321,000 New Yorkers age 55 and older are affected annually. That means that 21% of adults in NYC age 18-54 are affected annually and 19.8% of adults in NYC age 55 and older are affected annually. Further, in terms of utilization, during a survey week in the Fall of 1999, 62,281 adults, or about 1% of all NYC adults, were served in NYC mental health facilities. Forty-five thousand (45,000) of them were adults age 18-54. Almost thirty-six thousand (36,000) of them were identified as seriously and persistently mentally ill.

According to the Surgeon General's report "Mental Health: Culture, Race and Ethnicity," by 2025, it is projected that 40% of adults and 48% of children in the United States will be from racial and ethnic minority groups. The overall rate of mental illness among minorities is similar to the overall rate of 21% across the U.S. population. According to the last year of available data (2002), the total direct costs for treatment services to the adult population were \$4.4 billion

dollars. Given the projected future transformation in the racial and ethnic makeup of the United States population, changes in the financing, delivery, and treatments of 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 places added pressure on States to maximize current Medicaid spending by shifting the States share of Medicaid spending 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 program design has become very 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 supports for a single individual. These services and supports have to be administered on the local level by a provider who has to understand the nuance of coordinating the service delivery and funding to ensure that the consumer has



Edward C. Smith, Esq.

received the totality of services that will aid in his or her recovery. These services and treatments, funded through a combination of several sources -- State and local general funds, Medicare, SSI, SSDI, OASIS, Department of Education, TRANF, 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 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 costly 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 commonly referred to as evidenced 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 juxtaposing the service model with reimbursement methodologies required in practice. When the research is then 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 practice. 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.

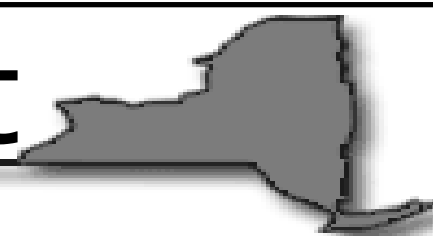
For example, an evidence-based practice that is being implemented in New York is Assertive Community Treatment (ACT). This treatment requires intensive work in the community involving clinician and psychiatrists' visits to the homes of consumers to provide treatment, including the dispensation of drugs and a focus on wellness management. What has proven to be effective according to 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 inappropriate 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 realize their recovery potential or achieve desired outcomes.

Dr. Alvin F. Poussaint, professor of psychiatry at Harvard University and

see Bridging on page 48

The NYSPA Report



Understanding Psychiatric Ethics

By Spencer Eth, MD
Chairman of the Ethics Committee
American Psychiatric Association



Spencer Eth, MD

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 Medical 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 towards 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 in-

volve 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 constricting 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.

Dr. Spencer Eth is Professor of Psychiatry at New York Medical College, and is Medical Director of the Behavioral Health Services at Saint Vincent Catholic Medical Centers of New York.



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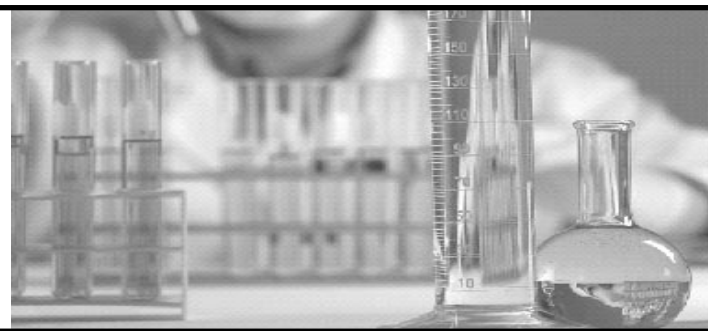
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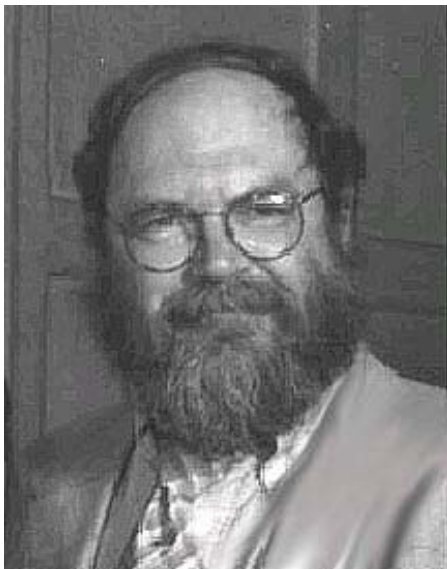
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WORKING WITH MEDICATIONS



What Is So Untypical About Atypical Antipsychotic Medications?

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



Richard H. McCarthy, MD

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 anti-manic.), but it does nothing to help us understand how these medications work. Moreover, as previous columns have noted, these “illness-specific names” suggest that these medications are illness specific, which they are not. The best anti-anxiety medications (the so-called anxiolytics) come from the class of medications usually referred to as the antidepressants. Most of the anti-manic agents are actually medications that were developed to treat seizures (not surprisingly they are usually called antiseizure 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, how drugs are discovered turns out to be fairly important.

The fact that medications can be used to treat psychosis was discovered en-

tirely 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 antihistamine 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 hospital was 15 years. All six of the patients that 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 molecule and then to see if this new 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 psychosis it also makes rats stiff, an easily observable trait. Some, but not all, of the other medications that make rats stiff can also treat psychosis. These medications include haloperidol (Haldol®), fluphenazine (Prolixin®), trifluoperazine (Stealazine®), 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) are 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.

So, 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.

THE MENTAL HEALTH LAWYER



Voluntary and Involuntary Admissions To Acute Care Psychiatric Facilities

By Carolyn Reinach Wolf, Esq.

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 inpatient 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 pursuant to a court order.¹

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



Carolyn Reinach Wolf, Esq.

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 clear that voluntary does not equate to an 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:

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 on 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. (Practically speaking, the hearing is held on the next available court date, as these hearings usually are held one day per week in each county.) The statute also provides that if the court determines that the patient is mentally ill and in need of retention for involuntary care and treatment, the court will issue an order authorizing the involuntary retention of the patient for up to sixty days. Article 9 defines in need of involuntary care and treatment as meaning that a person has a mental illness for which care and treatment as a patient in a hospital is essential

to such a person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment. 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.²

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 certificates 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 requirement 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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The Law Offices of Carolyn Reinach Wolf, P.C.

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The Law Offices of Carolyn Reinach Wolf, P.C. represents more than twenty major medical centers, as well as community hospitals, nursing homes and outpatient clinics, in the New York metropolitan area in the field of mental health litigation, consultation, advocacy, and related disciplines.

In addition, our team of attorneys, with more than forty years combined experience, offers legal representation to families and individuals affected by mental illness. We provide a broad range of legal services and counsel on such matters as: mental health case management and continuity of care; discharge planning; Assisted Outpatient Treatment (Kendra's Law); Mental Health Warrants; Hospital Treatment over Objection and Retentions; Patients' Rights and Guardianships.

Our firm regularly contributes to a number of publications concerned with Mental Health and related Health Care issues and participates in seminars and presentations to professional organizations and community groups.

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The NARSAD Report

The National Alliance for Research on Schizophrenia and Depression

By Constance E. Lieber, President
NARSAD



Constance E. Lieber

Schizophrenia – Frontiers In Understanding and Treatment

The National Alliance for Research on Schizophrenia and Depression (NARSAD) is the largest donor-supported organization in the world devoted exclusively to supporting scientific research on brain and behavior disorders. Since 1987, NARSAD has awarded \$157.3 million in research grants to 1,883 scientists at 321 leading universities, institutions and teaching hospitals in the United States and in 22 other countries. By raising and distributing funds for research on psychiatric brain disorders, the pace has accelerated, resulting in greater knowledge of brain functioning, neurochemistry, new/improved treatments and genetic origins. Constance E. Lieber has served as president of NARSAD since 1989.

Schizophrenia remains one of the most intractable mental illnesses. Affecting 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 conducted on schizophrenia. The hunt is on for genes responsible for the disease, and for new ways to predict those at risk for developing it. Innovative treatment therapies are being explored, and neuroscientific research is underway to expand our understanding 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 targeted living therapies that, when utilized in conjunction with pharmacological treatment, can help 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 Harlap, MB, BS of Columbia University (NARSAD 2004 Distinguished Investigator) is studying a unique data resource—the Jerusalem Perinatal Study, based on 92,408 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 Rajarethinam, 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. Rajarethinam hypothesizes that scanning this area of the brain of 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 Reichenberg, 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 positive and negative symptoms. His studies of the brain's NMDA receptors offer new hope for an expanded understanding of the chemistry underlying schizophrenia's diverse symptoms.

Using a psychosocial approach, Catana 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 independent 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 Hoffman, MD of Yale University (NARSAD 2003 Independent Investigator) has found Rapid Transcranial Magnetic Stimulation (rTMS) to be beneficial in treating auditory hallucinations. Fifty to 70% of schizophrenia sufferers "hear voices," and this symptom is often resistant to medication therapy. Targeted 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, nonpharmacological treatments for this difficult aspect of schizophrenia.

While schizophrenia remains heartbreakingly difficult both for those suffering 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 dramatically 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.

NARSAD RESEARCH

Announces

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Marking the First Time That A Private Philanthropy Has Provided Funds of This Magnitude

For Research In The Field of Mental Health

The effort and dedication of over eighteen thousand NARSAD donors has made it possible to announce the end of NARSAD’s five-year campaign to raise \$100 million for brain research. Constance E. Lieber, NARSAD’s President said, “Our gratitude towards the thousands of supporters who have made this achievement possible is enormous. We are particularly indebted to the many donors who have, year after year, given us their support financially as well as in their communities. NARSAD is still a young organization, and we have demonstrated that we have the basis for major growth. The challenge to improve and save lives through the research which we fund is immense. Our organization is devoted to fulfilling that promise, and as a result of this campaign, it is moving rapidly ahead to meet these long-term goals on behalf of the millions afflicted by severe psychiatric disorders.”

Since the start of the campaign, NARSAD has:

- provided 1,345 research grants at 305 universities and medical centers in the United States and 21 other countries;
- funded research achievements during the campaign which are opening new horizons in brain and behavior treatments and cures;
- funded an unprecedented number of genetic related studies, as well as research in imaging, molecular biology, analysis of brain structure and cognitive functions which has initiated prospective breakthrough results;
- provided funding to investigators who have now been named to head important laboratories and academic research programs, and to others who have received the most distinguished awards in the field;
- achieved broader recognition with the awards of two Nobel Prizes to NARSAD-funded scientists in 2000.

NARSAD’s ANNUAL GALA AWARDS DINNER AND SCIENTIFIC SYMPOSIUM WEEKEND

FRIDAY, OCTOBER 22, AND SATURDAY, OCTOBER 23, 2004

NARSAD will announce the recipients of the most prestigious prizes in psychiatric research at its annual **GALA AWARDS DINNER**, Friday evening, **October 22nd, at The Pierre in New York City**. The NARSAD weekend will also include a **SCIENTIFIC SYMPOSIUM featuring 15 NARSAD Young Investigators** presenting their research in: **BASIC BRAIN SCIENCE (Friday morning)**, **AFFECTIVE DISORDERS (Friday afternoon)**, **SCHIZOPHRENIA (Saturday morning)** at **The Roosevelt Hotel in New York City**.

For more information on these events, please call 1.800.829.8289.

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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 important consequences for willingness to seek mental health services. In many traditional societies, mental health problems can be viewed as spiritual concerns and as occasions to renew one’s commitment to a religious or spiritual system of belief and to engage in prescribed religious or spiritual forms of practice. African Americans (Broman, 1996) and a number of ethnic groups (Lu et al.,

1995), when faced with personal difficulties, have been shown to seek guidance 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 religious commitment or faith are integrally intertwined (Taylor, 1986; Priest, 1991; Bacote, 1994; Pargament, 1997). Religion and spirituality are deemed important because they can provide comfort, joy, pleasure, and meaning to life as well as be 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 conveyed by tradition 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 Asian 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 has been invoked to explain 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

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The NAMI-NYS Corner

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By J. David Seay, JD
 Executive Director, NAMI-NYS



J. David Seay, JD

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."

Since those 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 our friends and colleagues at NAMI Westchester for con-

ducting 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 el 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.

At 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/bicultural mental 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

African Americans: Facing Mental Illness & Experiencing Recovery, September 8, 2004, at the Washington Hilton and Towers Hotel in Washington, D.C. The *Symposium* will address key mental health issues that affect the African American community, highlight major research findings and discuss mental illness and recovery from a family approach. This event will bring together consumers, family members, researchers and providers to share information, tools, ideas and approaches to reach African American families.

NAMI MAC has produced numerous outreach resource materials, including:

- 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, au-

thorizing 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 MHLS. 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

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The Impact Of A Cross-cultural Treatment Approach To Mental Health

By Leo Leiderman, PsyD, ABPP, CGP,
Director of Latino Treatment Services
Saint Vincent’s Hospital Westchester

It is 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; is 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 valued 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 an-



Leo Leiderman, PsyD, ABPP, CGP

other 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 brooder 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 multi-dimensional 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 community one works in, 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 it’s 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”

see *The Impact* on page 53

Somatization: Mind, Body and Culture

By César A. Alfonso, MD
Research Psychiatrist - Hispanic
Treatment Program, NYS Psychiatric
Institute - Columbia University

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.



César A. Alfonso, MD

Historical Antecedents, Nosology
And Phenomenology

Although our current classification systems (DSM-IV and ICD-10) recognize several somatoform disorders, our

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 disorder 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 shuairuo). There is a current debate among transcultural psychiatrists and nosologists 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 “somatization” in 1943 to describe a type of polysymptomatic 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

see *Somatization* on page 40

Embracing Cultural Diversity

By **Margo Benjamin, MD**
Unit Chief, Adolescent Inpatient Unit
Assistant Professor of Psychiatry
NewYork-Presbyterian Hospital
Payne Whitney Westchester

To achieve the dual goal of enabling 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 individual’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 embrace these concepts and adjust our interventions 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 enable individuals to feel at ease with discussion of this issue without fear of re-crimination or judgment. One such technique 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 question 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 care provider about his or her culture. Some examples are:

- What is the ethnic/cultural background 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 individual and his family turn?
- What are cultural food preferences?
- What has the individual’s previous experiences with health care providers 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” cultural diversity, but rather exhibiting true curiosity and openness to learning about the language, music and religious celebrations that define individuals. Ultimately, these elements have an enormous 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 population. For example, we offer a kosher menu to our Jewish patients and are sensitive to providing Sabbath candles and a place of solitude for worship on a weekly basis. We are aware of our Muslim 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 Psychiatrist and head of an Adolescent Inpatient



Margo Benjamin, MD

Unit, I have been involved in the psychiatric care of young people from numerous cultural backgrounds. At any given time our unit may have adolescents whose descendents can be traced to distant parts of the world, yet it takes a relatively short time for most patients to learn the unit rules and form friendships. This process is fostered by the fundamental unit rule that everyone is expected to treat one another with respect. I have found that regardless of language and cultural differences, when mutual respect underlies patient interactions, misunderstandings and miscommunication 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, language, music and food preference may vary greatly. This is generally achieved

through group discussions and, in particular, 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 different cultures is through reading and learning different languages. The multicultural library on our adolescent unit has a collection of books which tell stories about young people from all over the world. These books describe the various stressors that can arise during the adolescent years and address ways in which different cultures interpret and deal with these stressors. We also strive to recognize 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 simple sign phrases, as well as provide information about deaf culture. Deaf patients 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 collection of books that focus on multicultural aspects of health care delivery, with particular emphasis on mental health care. In addition, a Cultural Competence Committee was developed in 2003 “...to foster a culturally and linguistically sensitive collaboration with patients, families and health care providers.”

In summary, acknowledging an individual’s cultural background and understanding how it impacts that patient’s care and compliance to follow up treatment is not only a challenge, but an obligation we have to our patients, and one which I am honored to fulfill.

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Separation, Reunification And Adaptation: The Migratory Process

By Lee Guich, CSW
The Guidance Center

Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant, a toddler or a school child, but throughout his adolescence and his years of maturity as well, and on to old age. From these intimate attachments a person draws his strength and enjoyment of life and, through what he contributes, he gives strength and enjoyment to others. (Bowlby, 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 breast fed him and had given 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. This allows them to grow up in warmer family-oriented environments that result in deeper attachments between children and their parents.) Traditionally, an Hispanic baby is not separated from the mother during the first few years. Therefore, any separation may be experienced by the baby as very stressful. Baby sitters are not known and if necessary, family members like grandmothers may become the substitute caregivers.

Two days after his second birthday his mother divorced his father, and by the time Jose was three years old, she came to the United States to work so that she could give Jose a better life in the future. Jose was left with his maternal grandmother in their small hometown. Jose went around the house looking for his mother for days, weeks and months. Day after day, he could not figure out why his mother, who was his whole life, was not there for him. His grandmother tried very hard to keep Jose's mother's image alive, showing him pictures and always talking to him about her, and about how someday he would be coming to live with her again in the United States. As the years went by, Jose's grandmother was seen by Jose as his mother, as the one who was there when he needed her. "Problems arise when a good attachment is interrupted by the physical unavailability of the attachment figure. The frightened child, dependent on the attachment figure for soothing and protection, becomes overwhelmed and traumatized by the parent's absence.

A child's sense of time is such that the feeling of terror accompanying the loss can seem unending, and the feeling cannot be assuaged because the source of soothing is not there. The meaning of the parent's absence to the child can be that he is not loved or that he has done something wrong." (James, 1994).

In the United States, Jose's mother worked very hard, often doing two jobs, and sent money back to the family every month. She sent pictures of herself so that Jose would not forget her, and sent gifts at Christmas and his birthday. She called Jose and spoke to him on special occasions in her effort to keep her image as his mother alive. She had only been able to go back and visit him once when he was five years old.

One year ago, at age 13, Jose was able to get his immigration papers so that he could travel to the U.S and be reunited with his mother. At this point in his life, 10 years after being left by his mother, Jose's fate was to relive the separation traumas; the first one when his father left at the time his mother divorced him, then when his mother immigrated, and now, when he had to leave his grandmother who, to him, had become "his mother."

Immigration is one of the most stressful events a family can undergo. Immigrants must learn new cultural expectations and a new language. They are stripped of many of their significant relationships, including family members, friends and community relations. (Falicov, C.J. 1998).

Once in the United States, Jose felt very lonely and sad. He no longer knew this person he called mother. He missed his grandmother terribly. He ached to see his friends from back home. He couldn't even communicate outside the house as he had no knowledge of the English language. Learning a new language can be seriously impaired by posttraumatic cognitive difficulties, anxiety and depression (Barudy, J. 1989). He finds that his life is a struggle every day when he wakes up. In addition to these difficulties, Jose's mother had a significant other living in the house—the father of a half sister he had never met. Jose felt anger towards his mother for having "abandoned" him in the first place. For Jose, reunification with his mother has been a very painful and disorienting ordeal. For him, the absence of his mother created a lack of trust. His father left him, his mother left him, and now his grandmother is far away. He is afraid to form a close bond with his mother again, fearing that she may leave once more. His mother, who feels rejected by Jose's withdrawal and rage, often has no idea how to deal with his behavior. She finds it difficult to express the internal distress she is suffering. She feels depressed and unhappy, and the only way she is expressing her distress is through somatic symptoms. In the Latino culture, expressions of distress such as back-aches, difficulty sleeping, headaches, etc., are acceptable because they are "outside of her control." There is a social stigma associated with words like depression and mental health problems (Katon et al. 1984).

Data derived from the Longitudinal Immigration Student Adaptation (LISA) study, conducted at the Harvard Graduate School of Education, reveals that 85 percent of the youth underwent separation from one or both parents for periods from six months to more than ten years. (Suarez-Orozco et al, 2002). Separation of children from their parents in the majority of Hispanic families is routinely part of the migratory process. The majority of children that I have treated from grammar

school, middle school and high school are part of this 85 percent of children who have experienced separations from their primary attachment. Satisfaction of the needs for comforting and reassurance have been interrupted by the unavailability of their primary attachment. 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 who you are and who I am. 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

see Separation on page 51

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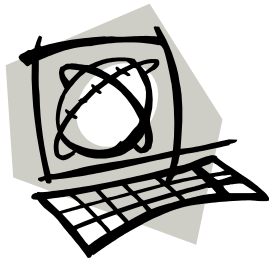


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Reaching The Latino Older Adult

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 elderly 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 bilingual-bicultural staff. We believe this acceptance is indicative of the comfort they feel at being serviced 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

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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 appropriate 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 complicated 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 understanding of health-seeking behavior in various cultures is lacking.

The following paragraphs reveal that disparities abound in treatment utiliza-

tion: some minority groups are underrepresented in the outpatient treatment population while, at the same time, overrepresented in the inpatient population. Possible explanations for the differences 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 underrepresented in some outpatient treatment populations, but overrepresented in public inpatient psychiatric care in relation 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 Americans and whites in utilization is smallest, if not nonexistent, in community-based programs and in treatment financed by public sources, especially Medicaid (Snowden, 1998) and among older people (Padgett et al., 1995). The underrepresentation is largest in privately financed care, especially individual outpatient practice, paid for either by fee-for-service arrangements or managed care. As a result, underrepresentation in the outpatient setting occurs more among working and middle-class African Americans, who are privately insured, than among the poor. This suggests that socioeconomic standing alone cannot explain the problem of underutilization (Snowden, 1998).

African Americans are, as noted above, 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. Overrepresentation is found in hospitals of all types except private psychiatric hospitals. While difficult to explain definitively, the problem of overrepresentation in psychiatric hospitals appears more rooted in poverty, attitudes about seeking help, and a lack of community support than in clinician bias in diagnosis and overt racism, which also have been implicated (Snowden, in press-b). This line of reasoning posits that poverty, disinclination to seek help, lack of health and mental health services deemed appropriate, responsiveness, as well as community support, are major

see Cultural Issues on page 50



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Pediatric Mania: A Developmental Subtype of Bipolar Disorder?

By Joseph Biederman, Eric Mick,
Stephen V. Faraone, Thomas Spencer,
Timothy E. Wilens, and Janet Wozniak

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 "affective storms," or prolonged and aggressive temper outbursts. The type of irritability observed in manic children is very severe, persistent, and often violent, and often includes threatening 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 thus 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 syndromatic 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 transmis-



Joseph Biederman, M.D.

sion 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 systemic 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

see Mania on page 30

Four Winds Hospital is the leading provider of Child and Adolescent Mental Health services in the Northeast. In addition to Child and Adolescent Services, Four Winds also provides comprehensive Inpatient and Outpatient mental health services for Adults, including psychiatric and dual diagnosis treatment.

FOUR WINDS HOSPITAL

Community and Professional Education Programs

OCTOBER

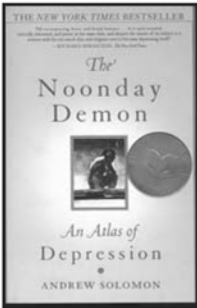
Community Service • Thursday, October 7th • 2:00 - 4:00 pm

“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”

Andrew Solomon Award-Winning Author of *The Noontday Demon: An Atlas of Depression*; writer for *The New York Times Magazine*, and *The New Yorker* (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 neither 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 conspires.
- 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, 272 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 any child care worker, school officials, doctors, nurses, dentists, podiatrists, EMTs, etc. A State Education Department certificate of completion will be given at the end of the class.

Fee: \$45.00 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 (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

These programs will be of interest to: physicians, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

Grand Rounds • Friday, October 15th • 9:30 - 11:00 am

“Women Confronting Retirement:
A Non-Traditional Guide”

Marilyn Ogus Katz, Dean of Studies Emerita, Sarah Lawrence College. Consultant, Bank Street College of Education. Author and Editor. Contributor to *Women Confronting Retirement: A Non-Traditional Guide*, Rutgers University Press, 2003.

The generation of women considering retirement today fought hard to be taken seriously as professionals. Influenced by the women's movement, they found an identity in their work, helped support families and made significant contributions to society. Dean Katz, a contributor to a recent book on women and retirement, will explore the emotional and personal issues these women must confront as they struggle with the losses of identity, structure and community.

- Participants will understand the unique role work played in the lives of educated and socially conscious women who entered the work force in the Sixties and Seventies, influenced by the women's and civil rights movements.
- Participants will learn the specific emotional and psychological issues these women confront as they consider retirement or actually retire, and how these issues complicate the aging process.
- Participants will discover successful strategies retired women used to adapt to and reflect upon this new stage in their lives.

Fee: \$20.00 payable to the Four Winds Foundation, a not-for-profit organization
1.5 CME Credits Available

SAVE THE DATE!

Nursing Career Day

Tuesday, October 26th • 4:00 - 7:00 pm

Experience Four Winds firsthand
during this informal event.



Join a team that uses a multi-disciplinary approach to treatment.

Your Voice Will Make a Difference!

Refreshments, Tours, an Opportunity to Meet with Nursing Leadership
Competitive Salaries/Benefits
RSVP by October 19th at 1-800-546-1754 ext. 2413

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 strength-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

Safety First, Interpretations Later: An Attachment Paradigm for Psychotherapy with the Self-Harming Patient

By Sharon Klayman Farber, Ph.D.

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 Shakespearean 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 relationship formed between patient and 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 roughly divided into three phases, which have considerable overlap: stabilization and trust; trauma work; and the last, mourning, resolution, reconsolidation, and reconnection.

When patients 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 in patients who had not harmed 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 the patient is more stabilized.

Because the expression of emotions, especially anger, is so concrete, impulsive, body-focused, and destructive, 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 themselves 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 to see what there is from the past that the patient is superimposing upon the relationship with the therapist. And the therapist must be willing to examine herself to see what buttons the patient is pushing that evoke the therapist's own reactivity and difficult 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



Sharon Klayman Farber, Ph.D.

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 determined fight to hold onto the symptoms. Despite how apparently destructive the symptoms are, they perform several powerful psychological functions, as I described in *Mental Health News* Fall 2003. Self-harm, paradoxically, is both the patient's worst enemy and also her best friend. So for many, losing their symptoms is like losing their best friend. For others, it is equivalent to losing their best defense against a descent into psychosis or suicide. All defenses must be treated with respect and care, even when those defenses are potentially life-threatening symptoms. By focusing on eliminating symptoms, therapists can actually make the patient worse.

The therapist should evaluate the self-harm behavior according to several axes, which will suggest points for immediate intervention: the potential lethality of the behavior, the frequency or repetitiveness, chronicity, the directness of the harm, the extent to which the behaviors are compulsive, impulsive or both, the extent to which the behavior is accept-

able (i.e., how ego-alien or ego-syntonic it is), the level of consciousness that accompanies the act, the degree to which the intent is suicidal, sadistic, or masochistic, and the multiple psychic functions served by the behavior.

The first axis, the lethality of the self-harm behavior, is most critical. The therapist should engage the patient in considering how he can make his self-harm behavior less dangerous, so that it is safe for him to be treated at whatever level of care you are treating him-- outpatient, inpatient, day hospital, etc. The therapist will have to rely on his powers of observation, the information he gets from the patient and/or family, which may or may not be reliable, and quite possibly, a medical evaluation. In the case of patients with eating disorders, the exam should be done by a physician with special expertise in doing such evaluations and appropriate understanding of the problem. To assess the lethality 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 indication 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; superficial 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 thought or sequence of events and thoughts that serves either to trigger the self-harm or forms some sort of ritual leading up to it? Generally the more bizarre 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 substance abuse 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 solitary 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 to the patient in event of a crisis or emergency, and establish certain boundaries. It is the patient's responsibility to keep her appointments, pay for the treatment, and care for herself well enough so that the treatment is possible.

see Safety First on page 30

FOUR WINDS HOSPITAL *Community and Professional Education Programs...Continued*

NOVEMBER

Grand Rounds • Friday, November 5th • 9:30 - 11:00 am
“*Latino Mental Health Update*”

Belisa Vranich, Psy.D., Clinical Psychologist, Private Practice, New York City
Jorge R. Petit, M.D., Associate Clinical Professor, Mount Sinai School of Medicine

Authors of the first self help book for Latino families on depression *The Seven Beliefs/Las Siete Creencias*, Drs. Jorge Petit and Belisa Vranich present “Latino Mental Health Update.” Participants will learn about specific mental health issues in the Latino community—diagnosis, evaluations, and management. The presentation will cover the impact of latino cultural and traditional attributes, their impact on mental health and the evidence/research conducted on this topic. Additionally, they will discuss psychopharmacological and psychotherapeutic interventions for this community as well as novel educational initiatives.

- Participants will learn about specific mental health issues in the Latino community.
- Participants will learn about cultural and systemic barriers to treatment.
- Participants will learn about novel treatment approaches and cultural sensitivity.

Fee: \$15.00 payable to Four Winds Hospital
1.5 CME Credits Available

Grand Rounds • Friday, November 19th • 9:30 - 11:00 am
“*Preserving a Beautiful Mind: An International Approach to Early Detection of Serious Mental Illness*”

Scott W. Woods, M.D., Associate Professor, Yale University School of Medicine

This presentation will explain the course of serious mental illness with emphasis on the early phase. Material will be presented to help the audience recognize behaviors of concern and specific symptoms that are the early warning signs of serious mental illness in adolescents and young adults. The research supporting this work, both here and abroad, and ethical implications of early intervention will be discussed.

- Participants will learn to identify behaviors of concern and early warning signs of serious mental illness in adolescents and young adults.
- Participants will become familiar with research supporting early intervention in serious mental illness both here and abroad.
- Participants will understand the importance and ethical implications of the early identification and treatment of serious mental illness.

Fee: \$15.00 payable to Four Winds Hospital
1.5 CME Credits Available

DECEMBER

Grand Rounds • Friday, December 3rd • 9:30 - 11:00 am
“*The Body/Mind Connection: Rewiring Neural Pathways Through Simple Exercises*”

Judy Swallow, MA, TEP, CRS, Senior Pychodramatist, Four Winds Hospital;
Co-Director of the Hudson Valley Psychodrama Institute

Judy Swallow a certified Rubenfeld Synergy(R) practitioner and teacher (Rubenfeld Synergy(R) combines the Feldenkrais Method, the Alexander Technique, Gestalt Therapy, and Ericksonian Hypnosis), will discuss how our life histories create habitual tensions and postures, emotionally and physically. In a safe and inquiring atmosphere, we can notice what seems “normal” and stretch our choice of possibilities into more flexibility and ease. This lecture will include experiential learning.

- Participants will learn somatic ways to work with habitual attitudes.
- Participants will learn psychophysical methods for helping fearful and defended clients create a sense of safety.
- Participants will learn the concepts of “normal” and “habitual”, and how we can extend it into both mental and physical possibilities for more healthy choices.

Fee: \$15.00 payable to Four Winds Hospital
1.5 CME Credits Available

Mania from page 27

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

dren 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 incapacitation that is highly suggestive of mania. Clarifying the diagnoses of these very ill children would have substantial clinical implications.

The emerging 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 ADHD, 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 nation 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 stabilizes the patient. Then the healing narrative 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 survivor 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 adults in Hastings-on-Hudson, NY. She is the founder of Westchester Eating Disorders Consultation Services. Dr. Farber is on the faculty at the Cape Cod Institute and the author of “When the Body is the Target: Self-Harm, Pain, and Traumatic Attachments” (Aronson 2000,2002.) Dr. Farber offers individual and group consultation and in-service training to mental health professionals who treat self-harming patients and hopes to develop a supportive network of such therapists. She can be reached at 914-478-1924 or at www.Drsharonfarber.com.

Registration is Required for All Programs.
Please Call 1-800-546-1754 ext. 2413

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, awarded at the completion of each program, can be used for continuing education credits in various disciplines. Check with your credentialing 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.

In The News At The Office Of Mental Health News

This Fall Issue Marks Our Fifth Year In Print

Celebrating Our 5th Anniversary

By Ira H. Minot, CSW
Founder and Publisher

It 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 policy-makers 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*

Fall 2000

The Miracle That Is NARSAD

Winter 2001

*When Mind and Body Collide:
Understanding Eating Disorders*

Spring 2001

*Fears, Phobias And Panic Attacks:
Understanding Anxiety Disorders*

Summer 2001

*400 Million Suffer:
U.N. Calls For Global Strategy To
Address Mental Health Crisis*

Fall 2001

*Understanding And Treating
Posttraumatic Stress Disorders*

Winter 2002

*Healing Hearts and Minds
In the Wake Of The 9/11 Disaster*

Spring 2002

*Out of The Abyss of Anger
How Are We Doing After 9/11?*

Summer 2002

*Anxiety and Depression
35 Million Affected in the U.S. Annually
Salute to "Freedom from Fear"*

Fall 2002

*Mental Health News Salutes The
Mental Health Association Movement*

Winter 2003

*Mental Health News Salutes NAMI
The National Alliance
For The Mentally Ill*

Spring 2003

*Housing For People
With Mental Illness*

Summer 2003

*Employment For People
With Mental Illness*

Fall 2003

*Depression In
Children And Adolescents*

Winter 2004

*Understanding And
Coping With Suicide*

Spring 2004

*Eating Disorders:
Body and Mind In Conflict*

Summer 2004

*Sleep Disorders:
Why Millions of Us Are Suffering*

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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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New York State Office of Mental Health
Keynote Speaker

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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

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 with mental and developmental disabilities, and the Brooklyn Borough President's Office.

During the conference, professionals and consumers from dozens of agencies and universities addressed over 300 mental health practitioners, consumers, family members, policymakers and researchers.



Alvin F. Poussaint, MD

Keynote Speaker
Alvin F. Poussaint, MD

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 the field. In order to truly be culturally competent, one must be sensitive to the differences

see Conference on page 46

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.

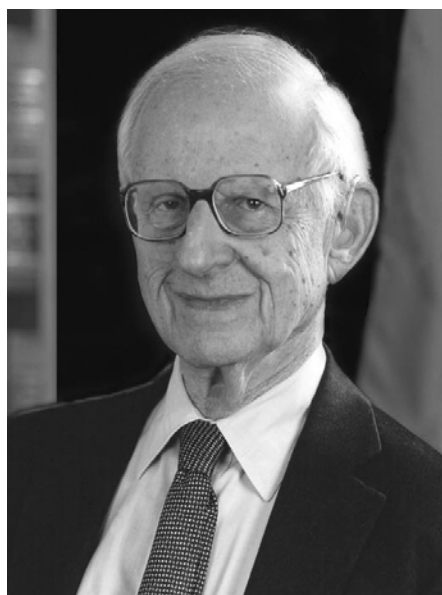
Today's pleas involve the financial transactions and operation of Ocean House Center, Inc. ("Ocean House"), a not-for-profit adult facility located in Far Rockaway, Queens. SHERMAN TAUB, a disbarred lawyer who is an officer and de facto operator of Ocean House, and his son JUDAH ("Jay") TAUB, is the 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 JUDAH TAUB pled guilty to Offering a False Instrument for Filing, a Class A misdemeanor.

SHERMAN and JUDAH TAUB and International Mortgage Servicing Com-

pany, will be sentenced on November 15, 2004 in front of Justice James Yates. SHERMAN TAUB will be sentenced to 1 to 3 years in prison. JUDAH TAUB will be sentenced to 3 years of probation. The defendants, SHERMAN TAUB and IMSC will pay restitution in the amount of \$1,650,000 to the New York State Attorney General's Office. They are also required to file amended local, state and federal tax returns for the years 1998 through 2002.

The investigation resulting in today's pleas began when the State of New York Commission on Quality Care for the Mentally Disabled ("CQC") audited Ocean House because of complaints about poor care and conditions at the facility. The CQC issued a report detailing its findings in October 2001, including a description of questionable financial transactions relating to Ocean House's mortgages. The CQC referred the financial aspects of its findings to the District Attorney's Office which undertook a joint investigation with the CQC 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



Robert M. Morgenthau

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, Beryl Zyskind. HI-LI Manor was itself 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.

see Operators on page 46



the mental health association
of new york city, inc.

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



Giselle Stolper

Attitudes toward mental illness, and how a disorder should be treated once the symptoms emerge, are as plentiful and varied as the many cultures that characterize New York City. There is much evidence available regarding 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 Disparities 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. Interestingly, 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 percent 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 incomes 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 report, *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 populations. 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 perceptions 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 programs, which revolve around LifeNet, the MHA of NYC's crisis, information and referral hotline, heightens 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 hotline 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 (1-877-990-8585).

It was crucial to build awareness of the hotlines within the communities. Our outreach needed to utilize what Dr. Lloyd Rogler, founder of the Hispanic Research Center at Fordham University, termed "help-seeking pathways," if we were to improve access to services effectively. Unless we promoted 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, non-traditional 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 articles, conduct mental health screenings at high schools and senior centers, participate on the boards of community organizations, and staff tables at neighborhood fairs to distribute literature and answer questions. The effort has paid off. Calls to AYUDESE and Asian LifeNet continue to climb, currently averaging 300 per month for each hotline.

The 9/11 Attacks And Multicultural Populations

Over the past three years the aftermath of the 9/11 attacks crystallized our challenge in reaching out to multiple populations. For many Latinos, their loss of a job meant they no longer had money to send to their families back home. Many Chinatown residents shut down their businesses when tourism declined. These economic stresses compounded the severe trauma these individuals may have experienced on the day of the attacks.

The traditional obstacles that hinder many from seeking help emerged as major barriers. People who lacked proper immigration documentation feared deportation if they came forward. Others internalized their experiences, which might have included injury, loss of income, loss of loved ones who perished, or even reliving horrible memories of terror that many immigrants experienced in their country of origin. Calls to the LifeNet hotline reflected increasing symptoms of anxiety and post traumatic stress disorder, as well as reports of growing substance abuse and domestic violence.

Over the past three years the MHA of NYC, in tandem with The Septem-

ber 11th Fund and the American Red Cross, have promoted the **9/11 Mental Health and Substance Abuse Program**, which provides financial assistance to people who were directly affected by the attacks. Residents and employees who lived and worked in the downtown area are eligible to enroll. Latino and Asian populations were an underrepresented population among enrollees, until we mobilized an active outreach effort at the grassroots level and in the press.

Last September our organizations held a press conference on the steps of City Hall to promote the mental health program to the Latino community. Councilwoman Margarita Lopez, capitalizing on her role as a community leader, shared her own personal experience and her need to seek help in the wake of the attacks. Calls to AYUDESE hit an all-time high for weeks after the conference.

In November, media personality Lisa Ling, host of *National Geographic Ultimate Explorer*, endorsed the mental health benefit at a press conference held at an elementary school in Chinatown. Councilman John Liu sent a delegate to lend his support as well. As with AYUDESE, calls to Asian LifeNet peaked within 24 hours of the media event.

Our experience repeatedly demonstrates that targeted education and outreach efforts, conducted in partnership with the guides, leaders and organizations that touch the lives of New York's diverse communities, are essential to heightened awareness and access to mental health services. LifeNet augments these efforts by providing mental health professionals who speak the languages, and understand the cultural sensitivities, of New York's many populations. Combined, the MHA of NYC gives members of the community a vital resource they can use to help themselves and their loved ones grow stronger and healthier. And that makes New York stronger.

If you would like to learn more about our educational programs about mental health, or to promote The 9/11 Mental Health and Substance Abuse Program, for your community or organization please call the Mental Health Association of New York City at 212-614-6300.

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FEGS Helps The Latino Community In Central Islip, New York

By Maria Romero
Program Manager

Resistance to seeking mental health services is very prevalent within the Hispanic/Latino population. This population often views mental health treatment as an extreme alternative for people who are “locos,” as insane. In their native countries, people are often first treated through the informal systems like Santeria—home remedies or assistance from the priest or pastor. If the informal systems fail, they are hospitalized and treated in psychiatric wards. This frequently leads to stigmatization of the individual and their family.

During the later part of the 1990s and early 2000, the influx of Hispanic/Latino immigrants into the USA increased tremendously. The census of 2000 indicates that the Hispanic/Latino population is now the largest minority in the U.S. Hispanic/Latino people are very diverse. They come from many different nationalities located in South America, Central America, North America, Europe and the Caribbean Islands. Some people enter the U.S. with a visitor’s visa that allows

them to stay for a period of time as tourists. A large number cross the borders of Mexico using a guide (“Coyote”) who transports them through the Mexican desert, across the Rio Grande and across the border into the U.S. A great number of people suffer horrible traumas during this ordeal. Women and children are exposed to physical and sexual abuse. Some people die of starvation. Later on, as a result of this trauma, many will experience symptoms of posttraumatic stress disorder (PTSD), depression, anxiety and other psychiatric disorders.

Once the Hispanic/Latino immigrant arrives in the U.S., the most important priority is to find a job to support himself/herself and the families left behind. Many buy false social security numbers to be able to find a job. There is no time to attend school to learn English. Language barriers and differences in customs and culture create problems for immigrants, leading to tremendous stress. The fear of being reported to the Immigration and Naturalization Services (INS), now under the Department of Homeland Security, causes immigrants to be distrustful of services that require personal information. Hoping to avoid discovery and deportation, many become

almost invisible.

Survival often requires working a full-time job and one or two part-time jobs. Health/mental health problems are usually ignored or postponed for later. If a Hispanic/Latino person does seek medical care, the language barrier can often lead to misdiagnosis and thus, improper or inadequate care.

Hispanic/Latino clients frequently do not seek mental health treatment voluntarily. Many are referred to mental health clinics by hospitals after they have been hospitalized due to serious psychiatric illness. Some are referred by local Family Health Centers. A few get referred by their primary care physicians (PCP). A considerable number are referred by Child Protective Services (CPS) and are court mandated to treatment.

The Hispanic/Latino client often enters mental health treatment with a tremendous amount of resistance and mistrust. They are afraid to disclose information about themselves, believing it will be used against them. This creates a barrier to forming a trusting, therapeutic relationship with the clinician, even when the clinician is bilingual/bicultural. During intake, symptoms may be minimized or withheld to avoid giving the

appearance of being crazy (“locos”). Instead of viewing the mental health professionals as allies, there to assist them, they are often seen as potentially dangerous authority figures, prying into their private lives. Many eventually drop out of treatment despite having serious mental health problems.

In order to overcome the barriers to treatment, The FEGS Counseling Center in Central Islip provides the following services in a safe, non-judgmental atmosphere for clients:

Bilingual/Bicultural personnel

Our staff are sensitive to immigration issues: Our clinicians are fully aware of immigration laws and procedures needed for individuals to achieve legal permanency in their new country, an important component in developing the trust needed in a therapeutic relationship.

- An intake process that includes forms in Spanish
- Reassurance that treatment will be provided to them regardless of their legal status
- Family involvement in treatment

see FEGS Helps on page 50

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 Bukharian Jews.

The culture shock for these new Americans was profound, as it was for so many émigré 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 is when 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 Anna 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 Bukharian Jews added other impediments that kept troubled individuals from seeking treatment. Most of the Bukharian 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 difficulty with tasks as simple as using public telephones, so daily activities and the search for a job to support their family 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 anxiety, depression and a lack of self-confidence. Pursuing treatment for men-

tal illness posed a stigma unlike the one known to us in the United States. Seeking help in their former country was not something of which they could even conceive. Clients worried about being seen in a clinic, as it could jeopardize their standing in the community and prevent their children from marrying.

Engaging this émigré population was clearly not an easy task. The journey began with acknowledging that we could only do this job with a culturally competent staff that could empathize with the issues of emotionally troubled, new Americans in order to assist them in achieving their goals. Clearly, the first thing we did was to hire licensed staff that came from the many regions of the former Soviet Union.

We reached out to many secular and rabbinical leaders in the community to encourage their constituents and congregations to pursue needed treatment. We ensured the community that all counseling sessions were held in strictest confidence. Yet it was not until the first few consumers experienced a major change in their lives, and then told others, that the barriers began to break down.

The story of Rosa (not her real name) illustrates how we overcame many of these impediments. Rosa, a mother of three, recently immigrated to the United States, and came to us complaining of depression and constant anxiety. She could not identify the reason for these feelings. In her initial assessment, the therapist found that a good part of Rosa’s distress 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 able 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 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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Diversity, Multiculturalism And Antiracism In Human Service Organizations: Can We All Get Along?

By Benjamin Kohl, CSW, Director
Multicultural Practice and Research
JBFCFS

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, diversity is generally used to draw respectful attention to differences in social identity. The word became popular when new positive language that recognized dimensions of human difference such as race, gender, ethnicity, age, class, sexual orientation, mental and physical ability and faith tradition was needed to counter negatively tinged language regarding affirmative action laws and other prohibitions against discrimination. When definitions hinge on values, a second problem can develop in which the multiple uses of a term blur its meaning. 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 (NASW) notes that, "Now there are, of course, standards of cultural competence and cultural competence has been part of our Code of Ethics since 1996, but there is still a question. The expectation is, now that we have worked on this issue for quite a while, leaders now want to see the roots of the issue. And all the other discussions—about diversity, cultural competency, multiculturalism—are not getting to it."

For organizations that provide mental health services, getting to the roots of the issue can be difficult for a number of reasons. The thickening pluralism of this nation often means that both an organization's workforce and consumers are 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-



Benjamin Kohl, CSW

ers adopt to address problems related to racism and other forms of social inequity are usually linked to an organization's history, service traditions and mission.

Paul Levine, Associate Executive Vice President of Jewish Board and Family and Children's Services (JBFCFS) and Board member of the Council of Family and Child Care Agencies (COFCCA), notes that "this agency is rooted in the interests of the Jewish community in New York, and we have long been aware of issues of discrimination. For many members of the Jewish community, this awareness of hurt, threat and discrimination predates American racism. Nevertheless, there is no competition for who has been most hurt by discrimination. We are not naïve that skin color is an issue; and we are not willing to say that all forms of discrimination are equal. At different times there are different levels of vulnerability for different people. For Jews and African Americans there is a shared understanding that comes from origins that were equally brutal. We both survived attempts to annihilate us."

The relationship between the history of an organization and its commitment to service is significant. Sheldon Gelman, Dean of Wurzweiler School of Social Work at Yeshiva University, relates how "diversity was important from the beginning in maintaining the school's mission. We wanted to create not just a school of social work, not just a Jewish school of social work, but a school open to all and one that could utilize the life experience of Jews who had acculturated in this country. So we feel that it is part of the profession's mission to learn more about the strengths of different groups and how to best work with those strengths." Similarly, Paul Levine emphasizes, "we have made some major efforts to increase understanding and fairness and to build opportunity for our staff and our clients. Both these issues—fairness and opportunity—come out of service. They come out of our role as a provider. We

are not here to right the wrongs of the world, but we must be aware of the world's wrongs as we help people overcome obstacles."

Defining how an organization's identity provides the context for services is a critical part of the process of becoming antiracist. David Billings is a core trainer for the People's Institute for Survival and Beyond, a decades-old national collective of organizers and educators whose "Undoing Racism" workshops have been offered with increasing frequency over the past two years in New York City. In discussing the challenges mental health agencies face in the 21st century, Billings notes that, "the first step for an organization is to do a lot of work as a collective around, 'what is our world view?' What set of principles under girds our understanding of what constitutes normality and mental health? And then to look at that worldview and say, 'how does this approach to our work demonstrate an understanding of the race construct?' In other words, how does our world view and understanding as mental health practitioners speak to the lives and realities of people of color in this country?"

In further explaining the antiracism perspective Billings states, "The challenge is that most social service agencies do not root their work in a power analysis and rather do it from a needs assessment standpoint; and while needs assessments are certainly good and point us in the direction of services, we want to do that in a context of a power arrangement. What groups like the People's Institute are talking about is that we are living in a race-constructed society that has had institutional support and cultural nurturing that has been many generations in the making. And so we are often unaware of how this country is systemically structured on the basis of race, and that our institutions still manifest that racial prejudice. It is not a conscious thing necessarily, but we can see it in the results of where we have an overwhelming white professional class in this country, in really any of the professions, and increasingly our constituents are people of color, and to some extent other poor people."

Of course, not every agency providing mental health services is grappling with diversity, cultural competency and antiracism. Paul Levine notes, "A hundred years ago Jews created entire organizations to meet the needs of their communities. Today we are an organization in the mainstream—we see all New Yorkers as deserving care. Smaller organizations that primarily focus on the needs of a single community do not have the same struggle with the issue of diversity. Because of our size and our history we are in a unique position."

Indeed JBFCFS, 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 JBFCFS. "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—Latino, 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 JBFCFS and immediate past president of New York City Chapter of NASW, is cautiously optimistic. She notes, "What is encouraging now is that conversations about race and racism are starting to happen at different levels of social work service delivery. They are emerging at the leadership level where policy is determined. They are happening more in supervision where worker self-care and professional development is encouraged. And they are more often happening during the treatment hour where the lives of the people we serve are of course most affected. However, in order for there to be lasting change in the profession, we must sustain these conversations on all levels, beginning with the leadership, encouraged in supervision and mandated in treatment. We also should be mindful of the unrealistic expectation that there will be a comfortable, harmonious atmosphere. As diverse voices explore certain truths and biases around the human condition, we should expect a degree of discord and confusion; and we can anticipate that there will be a desire to let the conversations fade into the background."

What, then, does it mean for a social service organization to be in the process of diversification, enhancing its clinicians' cultural competency, and striving towards an antiracist perspective? Anderson J. Franklin, PhD, is a professor and former director of the Clinical Psychology Program at the City College and Graduate Center of The City University of New York. With his partner Nancy Boyd Franklin, PhD, he currently holds a two-year appointment to the JBFCFS Saul Z. Cohen Chair in Child and Family Mental Health, which supports nationally recognized leaders in mental health as scholars-in-residence. In discussing the relationship between diversity, cultural competency and antiracism, Dr. Franklin stresses, "When you get to a nonprofit organization like JBFCFS, the bottom line becomes a little different than in the private sector. It becomes much more difficult to quantify

see Get Along on page 39



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UJA Federation
of New York

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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—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 different perspectives. A.J. Franklin cautions that no single approach is sufficient, "for organizations to change, they need to work with the individuals' 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.

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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 patients with depression, 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. Similar findings have been reported in patients with chronic pelvic pain and irritable bowel syndrome. Stuart and Noyes are currently investigating their hypothesis that somatization is an interpersonal behavior originating from anxious and maladaptive early life attachments.

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 extraordinary 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 experience as a psychoanalyst working with the medically ill led to his observa-

tions 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 somatosensory amplification. In somatosensory 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 schemas 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 analgesic 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 changes 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 (Irritable Bowel Syndrome). 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.

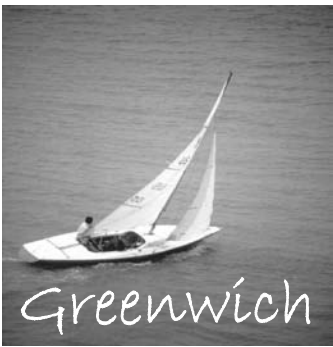
The efficacy of CBT for somatization disorder needs to be further studied in diverse settings, and should be tested against antidepressant medication, other

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 neurasthenia approximates phenomenologically to Chinese shen jing shuairuo, Yoruba Ode Ori, Japanese shinkeishitsu, Korean hwa-byung, and kamzori - ashaktapanna 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 multiethnic 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 without co-morbidity) vs. somatization with other psychiatric comorbid disorders. There was a significant relationship in that more Mexican and Central American immigrants had "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 to a more "psychologically minded" 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.



Mental Health News

The Connecticut Section

Hartford BRIDGEPORT **Stamford** Kent New London

Former Superintendent Named Seton Academy Head

Staff Writer
Mental Health News

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 in the field of education, the last 11 as Superintendent of Schools and Director of the Office of Education for the Diocese of Bridgeport.

In these roles, he was responsible for administration of 33 elementary schools and five high schools in Fairfield County, which collectively educate approximately 12,000 students each year. He was in charge of more than one thousand teachers and administrators. While he was Superintendent, St. Cath-



Armand F. Fabbri

erine Academy in Bridgeport, the only Catholic special education school in Connecticut, was opened.

“Armand Fabbri is well-known and highly respected among the administra-

tors and leaders in education from throughout the region,” Fahey noted. “He brings a wealth of experience to the operation of Seton Academy, which will facilitate achievement of the school’s special mission.”

Seton Academy’s programs combine comprehensive mental health and academic services for students in grades six through 12 who, because of emotional or behavioral difficulties, have unsuccessful school experiences. At Seton, the emotional and social needs of each student are addressed in small, therapeutically-oriented classes and individual and group therapy sessions. The goal is to make possible the reintegration of a student into his or her community school.

Fabbri began his career in 1962 as an English teacher at Notre Dame High School in Fairfield. He subsequently was named English Department Chairman. He also served as Librarian, Debate Moderator, Athletic Director, and coached hockey, baseball, football and basketball. In 1970, he was appointed Assistant Principal and, in 1983, he was appointed Principal.

He has served on the Board of Trustees of Sacred Heart University in Fairfield, and is presently a trustee of St. Vincent’s College in Bridgeport. He holds a BA in English, an MA in Education, and a State Administrator’s Certification, all from Fairfield University. He and his wife, Mary Ann, live in West Haven, and have two children and five grandchildren.

Seton Academy, formerly known as Hall-Brooke School, is part of Hall-Brooke’s integrated continuum of supportive services for children, adolescents and adults with behavioral disorders and/or substance-abuse problems. Hall-Brooke is a wholly-owned subsidiary of St. Vincent’s Health Services of Bridgeport, and is affiliated with the Department of Psychiatry of Columbia University’s College of Physicians and Surgeons.

Referrals to Seton Academy can be made by the student’s school guidance and placement team, or by parents, in association with the team. For further information, call Seton Academy, 203-221-8841.

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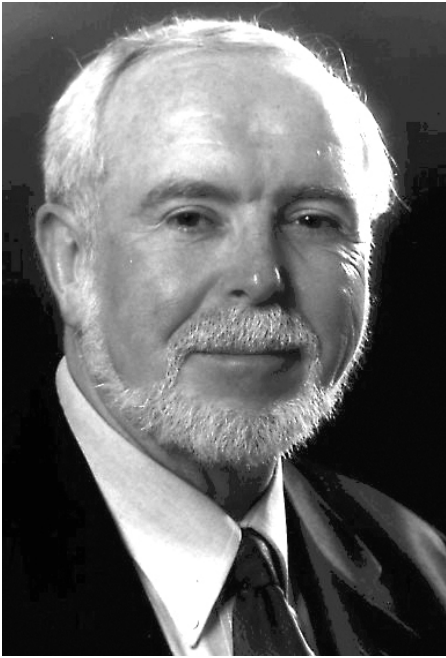
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committee in formation

Private Citizen: A Role Well Played

Thomas A. Kirk, Jr., PhD
Commissioner, DMHAS
Connecticut Department of Mental
Health and Addiction Services




Thomas A. Kirk, Jr., PhD

Mental health and substance use affect the health status, educational achievement, social service and public safety demands, and the economic status of every one of the 169 towns and cities in Connecticut. Thus, increasing the quality of life of a community is greatly enhanced when its citizens share their time and talent to improve mental health, prevent substance abuse, and support the recovery of individuals and families who experience these health care conditions.

Approximately 300 Connecticut citizens recently participated in one of five regional meetings hosted by DMHAS, and led by myself and Deputy Commissioner Arthur Evans. Their attendance was a response to our invitation to the boards of directors of DMHAS-funded private nonprofit (PNP) agencies throughout Connecticut to meet for a few hours in the evening. Representatives of boards from over 100 PNP agencies participated in sessions held in Hartford, Norwalk, Norwich, Wallingford and Waterbury.

see Citizen on page 42




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Silver Hill Hospital Names New CFO

Staff Writer
Mental Health News



Ruurd G. Leegstra, JD, CPA

Ruurd G. Leegstra, JD, CPA, of Greenwich, has been named Chief Financial Officer of Silver Hill Hospital, the private, not-for-profit psychiatric hospital located in New Canaan, Connecticut.

Mr. Leegstra holds a BA degree from Duke University and a doctorate in law from St. John's University Law School, where he was publications editor of the Law Review. Prior to his retirement in 2000, he had a 30-year career in the financial and accounting world, serving as a Partner in both Coopers & Lybrand and Price Waterhouse. Mr. Leegstra joined the Board of Directors of Silver Hill Hospital in April, 2003, serving as Chair of the Board's Planning and Finance Committee. He was appointed to the position of CFO in July, 2004.

Dr. Sigurd Ackerman, President and Medical Director of Silver Hill Hospital, said, "We are extremely fortunate to have a CFO with Mr. Leegstra's impressive financial experience and commitment to the future of Silver Hill Hospital."

Leegstra welcomes his new role "as part of the team to help make Silver Hill the best hospital it can be," saying, "During the year I served on the board, I realized what a wonderful place Silver Hill is, and developed a better understanding of what the hospital needs to move forward in the 21st century. My

strategic outlook is to make the financial process, policies and flow of information support management in making the proper operational decisions so the hospital is successful."

Silver Hill Hospital provides a full range of services for adults and adolescents, from acute care and inpatient to transitional living programs. For further information, call 800-899-4455 or visit us at: www@silverhillhospital.org.

Citizen from page 41

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 good and 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 how 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 traffic accidents/violations by 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

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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.”

Theirs is a culture of the family, or the group. It is a culture of “us” or “we,” not of the solitary, independent, self-absorbed person celebrated by mainstream Americans as the norm in the “me generation,” center staff members explained.

Because of this, Chodosh and other staffers 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,” she 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 in the water, with the closeness Latinos seem to need for a healthy existence.”

Because of the machismo character of Latino society, women find it more difficult to seek help for sexual abuse. “There are tremendous cultural barriers to surmount when a girl is abused by her father,” Chodosh explains. “If the culture says ‘father 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 an alien 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.

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 have to be careful that we don’t miss an actual physical problem,” Chodosh says.

Many clients come from rural backgrounds 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 artwork shows how much they miss their former homes,” he explains.

The room in which we sit has walls filled with artwork of brilliant, tropical colors, and the exuberant flora and fauna of memory.

“Our patients do beautiful work,” he said, hauling out some attractive shell-covered boxes, examples of works-in-progress in the art therapy program. “They are really creative. They can make something beautiful out of the most ordinary materials,” he noted with obvious appreciation.

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. Just knowing the language is not enough, explains Vanessa Santiago, LCSW, Treatment Coordinator, who is a native of Puerto Rico. A patient who said she heard voices at night was originally thought to be possibly schizophrenic, but the deeper communication and cross-cultural awareness available at the Center made it possible to learn that the patient actually had upstairs neighbors who were noisy at night.

Love is often expressed through extreme generosity of patients toward each other. Treatment Coordinator Yasmin Perez, MS, related a story of a patient who had “graduated” from treatment for a serious mental illness to being able to have his own apartment. His fellow patients organized an effort to furnish the place for him. “They bought everything, from kitchenwares to furniture. How they did it, we’ll never really know, because all of them have so little.”



Latino Program Staff (front row l to r): Yasmin Perez, MS, Treatment Coordinator, Beatrice Chodosh, LPC, Program Coordinator, and Vanessa Santiago, LCSW, Treatment Coordinator. Back Row l to r: Ivette Sotomayor, Department Secretary, Dr. Vanja Kondey, Hall-Brooke Staff Psychiatrist, and Tony Fusco, LPC, Treatment Coordinator and Director of Expressive Arts.

Hall-Brooke’s Bi-lingual Bridgeport Center Serves Latino Community

The Greater Bridgeport area has a large Latino population that is rapidly expanding. Bilingual mental health services are scarce in the community and most Latinos who suffer from mental illness struggle to obtain psychiatric treatment.

Hall-Brooke Behavioral Health Services has been offering bilingual mental health services to the Latino population of Greater Bridgeport since 1997 at its Bridgeport Center, 2400 Main Street. It is currently the only agency in the area with specialized Latino Partial Hospital and Intensive Outpatient Programs.

The Partial Hospital (Abriendo Caminos) is designed to treat patients who present with acute and severe psychiatric symptoms. These patients can benefit from a highly structured and supportive milieu where their symptoms can be closely monitored. Abriendo Caminos includes group therapy, individual therapy and medication management, all provided by a caring bilingual staff. The program meets Monday through Friday from 11 a.m. to 3:30 p.m. Lunch and coffee are provided.

When patient’s symptoms have stabilized but continue to require treatment, they are referred to the Intensive Outpatient Program (Cruzando Puentes.) This

program also provides group therapy, individual therapy and medication management. Cruzando Puentes meets several days per week from 9 a.m. to Noon.

The bilingual staff at Hall-Brooke’s Center in Bridgeport includes a psychiatrist and state licensed clinicians. The programs provided are culturally sensitive to the many needs of the Latino community.



Entrance to Hall-Brooke’s Center at Bridgeport, Connecticut



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.

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Health Services



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College of Physicians and Surgeons
Department of Psychiatry

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and similarities within each of us and not rely on generalities. He also explained that due 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 and cultural bias interfere with access to quality care; the unique strengths, needs, and preferences of diverse consumers; the limitations of conventional treatment models and prevailing payment structure in meeting their needs; and the progress being made on several fronts in adapting and delivering care to 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 and founder of the Caribbean Women’s Health Association and Sharon Carpinello, PhD, Commissioner, of the New York State Office of Mental Health (OMH), pointed out that cultural race and class differences have more of an impact on mental health delivery than on health delivery because of the centrality of relationship in mental health treatment. She also detailed her agency’s response to the challenges presented by the reports of the Surgeon General, the Institute of Medicine and the President’s New Freedom Commission, which included initiatives to disseminate evidence-based practices with the recognition that treatment models should be tailored to culturally and ethnically diverse consumers.

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 variations among different neighborhoods and cultural subgroups. Among the findings were that Hispanics report a relatively high rate of emotional distress in the prior 30 days, yet are not as likely as Whites to access services; Whites are the most 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 and Communities Together (IMPACT), under which city-sponsored mental health and child mental retardation 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-Rose, 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 clear competency standards and credentialing (including federal guidelines); documentation to track and monitor training; 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 providing 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 moderator to this workshop that focused on the challenges and rewards of successfully reuniting mentally ill parents with their children. It featured the viewpoints of Kate Biebel, University of Massachusetts Medical School researcher, Ann Isom-Williams, Esq, Special Counsel and Associate Commissioner, NYC’s Administration for Children’s Services, Francetta McCray, a substance abuse counselor and parent with mental illness and Dennies Wharton, Director, ICL’s Emerson-Davis Family Program.

Points that emerged included that while parenting is as meaningful for the mentally ill as for other adults, the mental health system too often ignores parenting in the lives of its consumers and that agencies should draw on the strengths of communities of color -- including the church, neighbors, and other supports – thereby 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

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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 then inflated the mortgages to more than \$4 million and, using Ocean House funds, made mortgage payments to IMSC. In addition, TAUB also directed that Ocean House make mortgage prepayments 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 family 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 bank loan for \$1.4 million to finance the renovation of the facility. The indictment charges that during the course of the renovation, invoices from 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 Rackets Bureau Chief Patrick Dugan. Assistant District Attorneys Eric Seidel, Gilda Mariani, former Assistant District Attorney Timothy Zirkel, Rackets Bureau Supervising Financial Investigator John Tampa and District Attorney's Investigator Louis Bauza also participated in the case.

Mr. Morgenthau thanked the following agencies and individuals for their assistance in this case: Commission on Quality Care for the Mentally Disabled: Commission Chair Gary O'Brien, Walter E. Saurack, Director of the CQC's Fiscal Investigation/Cost Effectiveness Bureau, principal investigators Richard M. Cicero, CPA and John J. Rybaltowski, CFE, senior investigators Raymond J. Rutnik, CPA and Michael J. Kester and review specialists Betty Jane Chura and Jerry T. Montrym; New York State Department of Taxation and Finance: Commissioner Arthur Roth, Deputy Commissioner Peter Farrell and Auditor Brian Galarneau; New York City Department of Investigation: Commissioner Rose Gill Hearn, Deputy Inspector General Maureen Thomas, Deputy Chief Investigative Auditor Joan Russell-Benjamin and Special Investigator Jeffrey Dolcimascolo; U. S. Attorney's Office for the Eastern District: Special Prosecutions Bureau Deputy Chief Daniel Alonso and General Crimes Bureau Acting Chief Ilene Jaroslaw; Attorney General Eliot Spitzer; New York State Department of Health Commissioner Antonia Novello; New York City Department of Finance Commissioner Martha E. Stark.

Grand 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. Falsifying Business Records in the First Degree, Offering False Instruments for Filing and Scheme to Defraud in the First Degree are class E felonies which are punishable by up to 4 years in prison.

Defendant Information:

SHERMAN TAUB, 8/12/44
135-34 78th Drive, Flushing, New York

JUDAH (JAY) TAUB, 7/7/68
59 Causeway, Lawrence, New York

International Mortgage Servicing Corp.
59 Causeway Lawrence, New York

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child welfare and of her gradual return of trust thanks to her supportive housing program. She has ‘graduated’ from Emerson-Davis Family Program. Emerson-Davis is one of only 18 programs for mentally ill parents in the country, and one of three in NYS. The range of supports provided at Emerson-Davis is invaluable through the intense and difficult adjustment process that occurs when children are returned to their parents after years of growing up in another home.

Understanding and Addressing the Mental Health Needs of Recent Immigrants

The newly immigrated child finds him/herself in a new and very intimidating environment—away from the social support of extended family and community that was so important in the absence of a parent back home. They are often latch 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 betrayal and abandonment. When the child tries to express these feelings, the generation gap is widened as the parent feels the child is spoiled, weak, and unappreciative. It would be a challenge for any child to cope with such strong emotional issues and a strong culture shock simultaneously. As symptoms of various disorders begin to manifest, misdiagnosis, lack of treatment or culturally insensitive practitioners compound the problems.

Moderator Pamela Yew-Schwartz, PhD, NY Coalition for Asian-American Mental Health, and panelists Martine François-Cesaire, ACSW, Caribbean Community Mental Health Program at Kingsbrook Jewish Medical Center, and Rosa Brambleweed, CSW, Queens Child Guidance Center, made several suggestions to practitioners, including:

- Emphasize family reunification by acknowledging that immigration is stressful to the family bond.
- The practitioner should be aware of the cultural stigma towards mental illness.
- Special care should be taken to really listen empathetically to the client and be open to their wisdom, acknowledging that the “expert” can learn too.

Translating EBT Research into Action:
A Targeted Family Intervention
to Keep Youth on Track

Through the experience of an evidence-based, school-based family intervention for at-risk adolescents, Professors Brenna Hafer Bry, PhD, and Nancy Boyd Franklin, PhD, of the Graduate School of Applied and Professional Psychology at Rutgers University, noted that evidence-based treatments are “for people who want help,” whereas many people of communities of color served by urban community mental health centers are mandated to treatment, where they experience profound social isolation and powerlessness and are struggling with

poverty and concrete needs.

Until providers recognize this schism, evidence-based treatments, regardless of their efficacy in the university laboratory, will not be successful in the “real world.” The panelists recommended assessing differences in clinic retention rates among cultural groups, and addressing those differences if found and changing the intake processes to allow the clinician time to understand the family from a person-centered perspective before launching into standard clinic procedures and regulatory mandates.

Empowering the Parents of Children with Mental Health Needs

Moderator Iren Valentine, MS Ed., Psy.D. and panelists Karen Gormandy, Anthony Montalvo, and Nilda Torres offered resources for parents raising children with mental illness, who often feel pressured and stressed. Dr. Valentine presented the Mental Health Association’s Coordinated Children’s Service Initiative (CCSI), a program designed to provide families with a voice in planning and coordinating care among multiple providers.

Ms. Gormandy, a board member of NAMI-NYC Metro, described her personal experiences navigating the educational and mental health systems to obtain adequate services for her mentally ill son. She underlined the importance of understanding the ins and outs of various 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 families stymied by multiple problems. Participants left the workshop with an increased sense of hope and knowledge about how to access resources, supports, and concrete services within the mental health community.

Mr. Montalvo, Program Coordinator and Parent Advocate, ICL’s Family Support Program in East New York, and Nilda Torres, 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, Vanguard Safe Passage for Central Brooklyn Teens, this workshop discussed how within communities of color, 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 need. The religious community therefore 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 between faith-based and mental health communities could be a powerful vehicle to promote the understanding of serious mental illness and be in ministry with persons and their families affected by this illness, panelists Rev. Dr. Cheryl G. Anthony, Judah International Center,

John L. Bolling, MD, The Mandala Center, and Miriam Ray Shelton, Latino Institute for Pastoral Care shared recommendations to both the faith-based communities and mental health providers.

Suggestions include, for faith-based communities, avoid the implication that if a person can “get things right with God...,” recognize the need for spiritual healing without focusing on the “cure,” encourage pastors 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 clinical services, support groups or drop-in centers.

For mental health providers: accept that interaction between race and attitudes greatly affects an individual’s decision to seek mental health care, understand that stigma and distrust may lead people of color to minimize symptoms and increase reliance on social support and informal care networks and focus efforts on building coalitions between providers of health/mental health services and faith communities as equals.

Translating EBT Research into Action:
Urban Implementation of the ACT Model

This workshop focused on the challenges of implementing the Assertive Community Treatment (ACT) in poor urban communities of color. ACT provides clinical treatment outside the office setting, in the consumer’s home environment through the use of a multidisciplinary team (social worker/team leader, family specialist, vocational specialist, psychiatrist, RN, LPN, substance abuse specialist and peer counselor). Moderator Gary Clark, Pathways to Housing and ACT Training Institute, and panelists Ann-Marie Louison, MSW, CASES, Fedner Joseph, MSW, Volunteers of America and Mark Iskowitz, 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 for 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 among the workshop moderators, moderated by Lavern Miller, Esq., Director, Community Access’ Howie the Harp Peer Advocacy Center. Each panelist reported back from his or her workshop on common issues to be addressed in an agenda for regulatory and legislative change. Despite the variety of workshop topics and perspectives, there was a striking concordance of views on the four areas discussed:

Understanding and improving consumers’ perceptions of mental health services. Relationship-building at the start of treatment and the importance of taking into account clients’ cultural ways and perceptions from the very first contact is vital. Panelists recommended that state and city mental health agencies re-

evaluate their regulations, which require that clients answer many highly personal questions at the first visit – a procedure likely to alienate and discourage many consumers. Panelists agreed that mistrust of the mental health system is common among people of color. Clients who are not self-referred will approach treatment with a more guarded or mistrustful attitude than those who self-refer. Identifying and reducing barriers to service access for people of color:

In addition to a lack of service availability in many neighborhoods, there is a scarcity of bilingual mental health workers available for immigrant consumers. Weaknesses in insurance coverage present many obstacles to treatment for working poor, consumers with Medicare and illegal immigrants. Those with private insurance find their mental health coverage is limited to clinic-based and inpatient only – providing no reimbursement for community-based services which may be the most suitable and culturally appropriate. Bias and insensitivity among providers is another barrier and many of the federal and local mandates for cultural competency training are not funded.

Addressing consumers’ interrelated material, spiritual, health 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 distress. Mental health agencies should do more to attend to these needs by providing childcare, immigration counseling and other entitlements services within their facilities and should reach out into the community to partner actively with houses of worship.

Determining how science-based approaches can be adapted to incorporate the preferences and needs of people of color: Panelists spoke of the paradox of models of treatment developed far from communities 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 in communities of color and have been tailored to their particular preferences and needs, may not have empirical support -- not because of 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 treatment best suited to diverse communities.

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

We would also like to thank Michael Blady, Elizabeth Cleek, Christina Mansfield, Ben Sher, Baraka Smith, Sharon Sorrentino, Paula Tarant Rivers, Matt Wofsy and DeMecia Wooten-Irizarry who also contributed to the writing of this article.

After 9/11 from page 1

experiencing a marked exacerbation after losing a loved one on 9/11. Among other symptoms, he only 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 diminishing his ability to stay on guard for trouble.

Four to eight weeks after 9/11, approximately 25% of persons living below 110th St in Manhattan reported the symptom of insomnia. If insomnia is in fact a manifestation of psychological vigilance, and if the government is recommending that we stay vigilant for further attacks, how is a mental health professional to respond?

For most of us in the New York area, the challenge of living without unnecessary fear and constriction in the context of ongoing threat is not just a new dilemma that we must address with our patients. The recent, highly specific threats to civilian targets have ramifications for everyone, including mental health professionals. This brings critical

research deficiencies into sharp relief. We know a great deal about vulnerability factors that increase risk for PTSD; we know almost nothing about ways to reduce such risks in individuals, and even less about promoting resilience in individuals and communities.

This is an urgent research question, and the many lists of “coping strategies” one finds on websites and in the literature are no more than well meaning efforts to glean helpful, common sense principles from experience. Many of these strategies could indeed be true and helpful; others might be incorrect or even harmful. A good cautionary tale is the finding, widely publicized since 9/11, that Critical Incident Stress Debriefing, despite its sound theoretical base, does not reduce risk for subsequent PTSD and may sometimes worsen outcome.

Although much more research is needed, one core concept in this literature that has practical implications 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 precipitous decline after the attacks. The risk of death in airline travel is about 1 in 7 million; the risk of death on a coast-to-coast drive is about 500 times 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 reality of air travel.

Personal safety is a major concern for most urban communities now. A guiding principle for making such decisions is that one should carefully and consciously make a rational assessment of the actual risks involved in a given situation before deciding to change one’s behavior. Research clearly shows that avoidance is strongly associated with pathological outcomes, including the development of PTSD. Avoidance can lead into an ever-constricting downward spiral of disability, resulting in social isolation, unemployment, and an experience of oneself as frightened and vulnerable.

In the context of ongoing threat, normal 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 many opportunities over the coming months to help patients whose lives are unnecessarily constricted by disproportionate 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 effective coping in others before they become debilitated by fear.

Patients can be referred to the Trauma Studies and Services program at (212) 543-5454.

Dr. Marshall is Director of Trauma Studies and Services at the New York State Psychiatric Institute, and Associate Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons. Dr. Neria is Associate Clinical Professor of Medical Psychology, Columbia University College of Physicians and Surgeons and School of Public Health. They are Co-Directors of the Center for the Study of Trauma and Resilience at the New York State Psychiatric Institute and Columbia University.

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keynote speaker at the ICL conference, noted that many African Americans receiving mental health services resist having psychiatrists (and possibly clinicians as well who are viewed as being part of the same system) come to their homes and might refuse to open the door. He said that many African American recipients of mental health services view such a visit as an attempt to institutionalize them and they won’t risk opening a door to a psychiatrist or clinician. Further, African American consumers, in addition to historical experiences like the Tuskegee experiment, view the dispensation of drugs as a rejection of more traditional clinical therapies which they believe are better for them and, therefore, they resist psychotropic therapy. African Americans and other racial and ethnic minorities also seek traditional heal-

ers and alternative medicine practitioners as the first to be consulted when facing a mental health crisis. Dr. Poussaint has stated in his book “Lay My Burden Down: Suicide and the Mental Health Crisis Among African-Americans,” that “we tend to dismiss a lot of these cultural practices as quackery, further alienating the patient or in fact not understanding the patient.”

Communities of color, therefore, are faced with multiple difficulties in accessing adequate, affordable and culturally appropriate mental health treatments and services. As previously discussed, these difficulties include fragmented funding streams, evidence-based practices (that do not account for the nuanced differences in presented in racially and ethnically diverse urban environments) and disparity in insurance coverage. But in addition to these systemic problems, these communities must also struggle to

deal with social issues such as gaps in employment or fluctuations in working hours that also result in intermittent health coverage and access to care.

According to a report by the Commonwealth Fund in March 2002, entitled “Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans,” nearly half of all Hispanics were without health care in the United States in 2002. During that same period one out of three African Americans and one out of five of Asian Americans were without health care in the United States in 2002. Gaps in insurance coverage or no insurance coverage impacts access to services, continuity and quality of care, and strains the effectiveness of care for long term achievements of goals leading to recovery and successful mental health outcomes. According to another recent report by the Commonwealth Fund entitled “Unequal

Access: Insurance Instability Among Low-Income Workers and Minorities,” nearly three-fourths of Hispanics with incomes below 200% of the poverty line were uninsured during full-time employment over a four-year period. About 70% of African Americans and 72% of Hispanics who were uninsured for 13 or more months had incomes below 200% of the poverty line. Similar to fragmentation of resources and services, social and political policy has inadequately addressed 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 health and stability.

I am in agreement with Dr. Hogan when he said that “managers and policy makers in mental health must commit to

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continued retention may be for a period of not more than one year. After that, each subsequent court order may be for a period of up to two years.

The Emergency Admissions

Article 9 authorizes emergency admissions to a psychiatric hospital 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 in a hospital is appropriate, and which is likely to result in serious harm to himself or others, provided the staff physician’s finding is confirmed within forty-eight hours by another examining physician who must be a member of the hospital’s psychiatric staff. According to the statute, likely to result

in serious harm means that there is a substantial risk of physical harm to himself [or] other persons as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. If the patient does not agree to be retained as a voluntary patient, he/she may be retained beyond the initial fifteen-day period only by continuing the admission as an involuntary patient pursuant to the provisions of Article 9 discussed above.

Conclusion

The New York State Legislature, in drafting Article 9, sought to institute a system of checks and balances relating to the care and treatment of individuals who voluntarily seek care in acute psychiatric facilities, or who are brought for

care against their wishes. Because of the complex constitutional and clinical issues relating to inpatient psychiatric treatment, the laws governing this area are quite dense and often may be too much for the lay consumer to digest.

The consumer should, upon admission to any psychiatric facility, request (if they have not already received one) a notice of their status and rights. If he/she is not satisfied with the explanation given in this notice, or after inquiring of the medical staff, then the consumer should ask to speak to an attorney from the Mental Hygiene Legal Service. I am confident that these measures, and a general understanding of Article 9, will help to lessen the frustration, confusion and anxiety relating to the legality of your admission to the hospital.

The Law Firm of Carolyn Reinach Wolf, PC, specializes in legal representation and consultation in the fields of Mental Health and Elder Law, to fami-

lies, individuals, hospitals, skilled nursing facilities, out-patient centers, mental health professionals and other attorneys. Our attorneys have extensive experience with the Mental Hygiene Law, Article 81 Guardianship; civil and criminal litigation and negotiation specific to Mental Health issues.

1. This article does not cover admissions and transfers from a Comprehensive Psychiatric Emergency Program (CPEP) or those governed by other statutes, such as the Criminal Procedure Law.
2. The phrase, real and present threat of substantial harm to himself or others, is the most frequently litigated issue in a hearing to determine whether or not a patient should be released from a hospital. Because of the volume and breadth of the cases and commentary on this issue it will not be addressed at length in this article.

Orange County Promotes Multicultural Initiatives Through County Task Force

By Frank LaRosa, CSW, Director Mental Health Program Services
Orange County Department of Mental Health, Chairperson, Multi-Cultural Task Force

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 multicultural 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 (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.

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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 studies that cannot be generalized... 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 40% 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."

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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 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 boyfriend 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 FECS.

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 in foster care. 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 competent staff has created a safe, non-threatening environment accessible to the Hispanic/Latino population on Long Island who have long been underserved.

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contributors to delays by African Americans in seeking treatment until symptoms become so severe that they warrant inpatient care.

Finally, African Americans are more likely than whites to use the emergency room for mental health problems (Snowden, in press-a). Their overreliance on emergency care for mental health problems is an extension of their overreliance on emergency care for other health problems. The practice of using the emergency room for routine care is generally attributed to a lack of health care providers in the community willing to offer routine treatment to people without insurance (Snowden, in press-a).

Asian Americans/Pacific Islanders

The prevalence of mental illness among Asian Americans is difficult to determine for methodological reasons (i.e., population sampling). Although some studies suggest higher rates of mental illness, there is wide variance across different groups of Asian Americans (Takeuchi & Uehara, 1996).

It is not well known how applicable DSM-IV diagnostic criteria are to culturally specific symptom expression and culture-bound syndromes. 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, 1990). 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 County, 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 men (almost 20%); yet, the known risk factors do not totally explain the gender difference (Vega et al., 1998a; Zunzunegui et al., 1998). Several studies indicate that Puerto Rican and Mexican American women with depressive symptomatology are underrepresented in mental health services and overrepresented in general medical services (Hough et al., 1987; Sue et al., 1991, 1994; 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 (Kinzie et al., 1992). Alcohol abuse and dependence appear also to be especially problematic, occurring at perhaps twice the rate of occurrence found in any other population group. Relatedly, suicide occurs at alarmingly high levels. (Indian Health Service, 1997). 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 overrepresented in psychiatric inpatient care in relation to whites, with the exception of private psychiatric hospitals (Snowden & Cheung, 1990; 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 presented by 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 considerable 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; Zhang et al., 1998). This is not the case for emergency department care, from which African Americans are more likely than whites to seek care for mental health problems, as noted above. Language,

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like economic and accessibility differences, can play an important role in why people from other cultures do not seek treatment (Hunt, 1984; Comas-Diaz, 1989; Cook & Timberlake, 1989; Taylor, 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 hospitalization, and fear of treatment (Sussman et al., 1987). Mistrust among African Americans may stem from their experiences of segregation, racism, and discrimination (Primm et al., 1996; Priest, 1991). African Americans have experienced racist 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 schizophrenia and underdiagnosis of depression 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 experienced imprisonment or watched the government murder family members and engage in other atrocities may have an especially strong mistrust of any governmental 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 Argentine 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 imparted lack of trust of government. Those living on Indian reservations are particularly fearful of sharing any information with white clinicians employed by the government. As with African Americans, the historical relationship of forced control, segregation, racism, and discrimination has affected their ability to trust a white majority population (Herring, 1994; Thompson, 1997).

Stigma

The stigma of mental illness is another factor preventing African Americans 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, African 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 minority groups do not seek treatment, but their contribution has not been evaluated empirically, owing in part to the difficulty of conducting this type of research. One of the few studies of Asian Americans identified the barriers of stigma, suspiciousness, and a lack of awareness about the availability of services (Uba, 1994). Cultural factors tend to encourage 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 discouraging utilization of mental health services (Chapter 6). Minority persons are less likely than whites to have private 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 private health insurance, there is underrepresentation 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 cost and lack of insurance to be barriers to treatment (Miranda & Green, 1999). The discrepancies in findings suggest 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 and 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 Americans. 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 laboratory 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 depression. Several studies found that African Americans were more likely than were whites to be diagnosed with schizophrenia, yet less likely to be diagnosed with depression (Snowden & Cheung, 1990; Hu et al., 1991; Lawson et al., 1994).

In addition to problems of overdiagnosis or misdiagnosis, there may well be a problem of underdiagnosis among minority groups, such as Asian Americans, who are seen as “problem-free” (Takeuchi & Uehara, 1996). The presence 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.


A bilingual/bicultural certified social worker in the grammar school environment talks about her experience with immigrant 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 grandparents 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 validate their frustrations and pain and allow them to recognize and express their feelings 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 their teachers concerning their behavior in the classroom and the progress they are making. I try to keep in contact with the parents and with a bilingual/bicultural case

manager who has won their trust and appreciation.”

Since 1990, about a million new immigrants 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 immigrant-headed households. Family separation from both parents during immigration for Central American children is 80 percent. (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 sensitive health care. We need to prevent as many high school dropouts as possible, and to prevent so many children from falling through the cracks. These are the children that are going to be our future. Our communities need to be better educated 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 includes bilingual and bicultural support 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 immigrating 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 coincidental and reflective of the common issues faced by immigrant families.



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bias 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 Asian 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-versus post-treatment 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 (Lin et al., 1997). Just a few examples are provided to illustrate ethnic and racial differences.

Pharmacotherapies given by mouth usually enter the circulation after absorption from the stomach. From the circulation they are distributed throughout the body (including the brain for psychoactive drugs) and then metabolized, usually in the liver, before they are cleared and eliminated from the

body (Brody, 1994). The rate of metabolism affects the amount of the drug in the circulation. A slow rate of metabolism leaves more drug in the circulation. Too much drug in the circulation typically leads to heightened side effects. A fast rate of metabolism, on the other hand, leaves less drug in the circulation. Too little drug in the circulation reduces its effectiveness.

There is wide racial and ethnic variation in drug metabolism. This is due to genetic variations in drug-metabolizing enzymes (which are responsible for breaking down drugs in the liver). These genetic variations alter the activity of several drug-metabolizing enzymes. Each drug-metabolizing enzyme normally breaks down not just one type of pharmacotherapy, but usually several types. Since most of the ethnic variation comes in the form of inactivation or reduction in activity in the enzymes, the result is higher amounts of medication in the blood, triggering untoward side effects.

For example, 33 percent of African Americans and 37 percent of Asians are slow metabolizers of several antipsychotic medications and antidepressants (such as tricyclic antidepressants and selective serotonin reuptake inhibitors) (Lin et al., 1997). This awareness should lead to more cautious prescribing practices, which usually entail starting patients at lower doses in the beginning of treatment. Unfortunately, just the opposite typically had been the case with African American patients and antipsychotic drugs. Clinicians in psychiatric emergency services prescribed more oral doses and more injections of antipsychotic medications to African American patients (Segel et al., 1996). The combination of slow metabolism and overmedication of antipsychotic drugs in African Americans can yield very uncomfortable extrapyramidal side effects (Lin et al., 1997). These are the kinds of experiences that likely contribute to the mistrust of mental health services reported among African Americans (Sussman et al., 1987).

Psychosocial factors also can play an important role in ethnic variation. Compliance with dosing may be hindered by communication difficulties; side effects can be misinterpreted or carry different connotations; some groups may be more responsive to placebo treatment; and reliance on psychoactive 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 Impact from page 21

(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 of clients, clinicians working with minorities could misunderstand and carry out incorrect decisions and/or treatment interventions. For example, the sex roles that are clearly demarcated within some Hispanic families are looked down upon by many clinicians who usually come from a middle-class and feminist upbringing (values from the White American culture). The implication in treatment would be a condescending attitude toward the Hispanic family's value. Without the necessary education, training, research, and/or supervision, a clinician will rely exclusively on their clinical skills and approaches rather than using a cross-cultural approach or understanding of individuals and/or families. For example, when treating Hispanics a clinician would exclude vital issues such

as the central value of the family, sex role differences, the process of acculturation, factors related to immigration, issues affecting those who experience poverty, and important intergenerational differences.

In addition to providing the extra dimension of better understanding one's population of interest, one of the most important contributions of a cross-cultural model is that it reduces a major difficulty one encounters when treating minorities: High drop out rates and underutilization by minorities to psychiatric and substance abuse treatments. In the case of Hispanics, clinicians commonly face resistance. In fact in the review of literature on Hispanics it has been consistently reported that they will tend to have higher attrition rates, higher underutilization rates than any other ethnic group with similar socioeconomic status. Research has also highlighted how the contribution of using a culturally sensitive 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 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 value 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 these 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

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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 diplomate 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 in 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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