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Out of the Abyss of Anger



Anger: The Choice is Yours By

Harris B. Stratyner, Ph.D., CASAC

Psychologists have been researching and writing about the emotion of anger for many years. There is probably very little that I could add to the discussion. We have all read articles, seen segments on television, heard interviews and discussions on the radio, etc., which explain anger in psychological and physiological terms. These same articles discuss “healthy” versus “unhealthy” forms of anger, view the triggers of anger (i.e., reactions to external events versus internal ruminations), and review the multitude of ways one can deal with anger (e.g., cognitive restructuring, relaxation techniques, developing a sense of hu-

mor, regulating one’s environment, psychotherapy, medication, etc.). So, you have to be wondering why I am writing about anger.

It seems to me that since September 11th, anger, as Emerald Lagasse might say, “has been kicked up a notch.” For the first time in all of our lives we have witnessed terrorism of a monumental proportion in our own backyard. While it is true that we have experienced terrorism in our country before, even at the World Trade Center, we have never seen anything like we have this past fall. Think of the words that have been used since that date to describe our reactions: shock, disbelief, fear, anxiety, uncertainty, insecurity, outrage, and of course, anger.

Now, I have no intention of writing about September 11th -- so if you were anticipating that was the direction I was heading, I can assure you it is not. I mention it because I believe it brought all of our emotions to the edge -- anger being one of them. It was fascinating to me as an observer of human nature, to see how many New Yorkers, in somewhat of an exaggerated manner, went from a period of tremendous love and caring, to a return to rushing around and having that angry edge to them once again. Granted, I am speaking in extreme terms, and am myself a New Yorker through

see *The Choice* on page 8



Anger: A Candid Discussion By

Richard J. Frances, M.D.

Since September 11th many of us have been struggling with a variety of emotional reactions including numbness, pain, bereavement, sadness and anger.

Those of us in the mental health profession sometimes are concerned about analyzing everyone’s anger too easily because it may need to be channeled productively into a war effort, a homeland defense and an appropriate response to terrorism. However, in times of stress and war, anger can also be destructive. Anger can lead to a heightening of crime and substance abuse. Psychiatric patients may especially have difficulty dealing with angry feelings which may

end up being turned against themselves in depression, or can lead to problems with impulse control and end up contributing to legal problems.

Legal and illegal substances are often used to control anger. Some people choose opioids as a drug because it helps push away angry feelings, which has resulted in an increase in opioid addiction in recent years which may have been further effected by events of September 11th. Alcohol may also suppress and facilitate outbursts of anger, and many alcoholics are opioid addicts as well. Those who are addicted to sedative hypnotics are using these drugs as a means of anger management which may very well be ineffective. The other substances of abuse, including use of cocaine and crack, can also contribute to poor impulse control, increased rage attacks, anger and crime.

Fifty percent or more of homicides are drug related. For the most part, psychiatric patients are not at much higher risk for crime than the general population. However, psychiatric patients who abuse substances and have a history of violent behavior can have impulsive outbursts, especially when intoxicated. Sixty percent of patients with schizophrenia have substance problems and 60-80% of patients with bipolar disorder have substance problems.

see *A Candid* on page 10

Inside This Issue Of MENTAL HEALTH NEWS

- Evidenced-Based Practices -- The New Frontier?
- Budget Bomb -- Parity Puzzle -- Sopranos Soliloquy
- Autism - the Challenge and the Hope: A Special Report
- Four Winds Hospital Education Series Supplement

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Mental Health News Advisory Council continued on page 39

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The Editor's Desk

A Better Safety Net

Mental Health Consumers Need Evidence-Based Practices To Ensure Effective Outcomes From Treatment And They Need Help Developing Self-Management Skills To Best Utilize The Care Available To Them

**By Ira Minot, Publisher
Mental Health News**

A major factor in surviving a mental illness involves negotiating the maze of programs and therapeutic interventions which make up the mental health care system. This can often be more difficult for consumers (patients) than the system or the clinician would probably care to acknowledge. However, change is in the wind.

Mental health care in America today relies on a system of promise and peril that evolved from an institutional care model to modern day community mental health, a system based primarily on bringing mental health care into the community.

Current research studies point out that although reforms did occur as a result of the community mental health movement, it has had limited impact on improving the lives of persons with mental illness. Howard H. Goldman, M.D., Ph.D., et al, (*Psychiatric Services*, December 2001, Vol. 52, No. 12) points to the need for mental health care to shift to one of *content and quality of services*, the bulwark of a push for a new mental health system based on *evidenced-based practices*.

Robert E. Drake, M.D., Ph.D., et al, (*Psychiatric Services*, February 2001, Vol. 52, No. 2) defines evidence-based practices as *interventions for which there is scientific evidence consistently showing that they improve client outcomes*.

The time is right for bringing evidenced-based (EVP) practices into our mental health system.

It is undeniable that a system that lacks uniformity in its practices invites harmful outcomes in client care and invites unnecessarily prolonged illness.

Mental health care today is somewhat based on best intentions, historical assumptions and clinical opinion for such critical aspects of client care as diagnosis, therapies, medication selection and course of treatments. The architects of evidence-based

practice theory want to design a new system grounded in scientific research and measured on quality and accountability.

Discrepancies in care and professional judgment can and do occur in treatment. A case in point comes from a consumer who wrote to me the following account.

I went to my doctor for his signature on an application for supported housing. Once filed, it would help me live a little easier on the few dollars a month I receive from my social security disability payment. Instead of understanding my request for his help, he was indignant about signing the form and said I should get a full time job, "get with it" and stop draining the system.

How this made the consumer feel?

I felt betrayed...it was awful. I had been in the hospital for almost an entire year following a major breakdown and was trying to get my life back...but I still needed time and a safety net to keep me from being re-hospitalized. The doctor acted as if he didn't care that I was spending so much money on my meds that I barely had enough to eat each week. He didn't understand that the supported housing would allow me to stretch my budget. I didn't want to challenge my doctor's attitude for fear that I would be seen as crazy or non-compliant. The entire situation had me scared, worried, more depressed and fearful that I was heading for a relapse...all over this simple request for his help.

I received another compelling account from one other consumer which I would like to share with you.

I was in a day program following a recent hospitalization for depression, and I wanted desperately to get my life back...I was highly motivated, but the other patients in the program seemed satisfied to stay where they were and not get better. Because of this, I was seen by the other patients as an outcast and a 'goody-two-shoes.' If I wasn't willing to stay at the same level as the other patients, they didn't want me around and resented my high aspirations. It was very depressing. I felt the staff had the same impression of me and when I went to them pleading to help me move on with my life, they would tell me to 'go back into group and talk about it.' I ended up quitting the program and found a consumer-run drop-in center where I felt respected for who I was. It was there that I got my life back on track, and I'm now back in school finishing my degree in business.



Ira Minot

I find these notes from consumers invaluable in helping me pose the following question: *Don't we deserve A Better Safety Net?*

When a person falls ill to mental illness, they aren't given a road map to understand what has happened, what they should know about their illness, and where the programs and resources available to help them are located. That was why I started *Mental Health News*—to give people that road map.

By the same token, consumers are not given a handbook on what to expect from their treatment, the programs they attend and how interactions between them and their caregivers should be taking place. Such a handbook would be welcomed and highly useful to help consumers *functioning well in their recovery process* to become advocates for their own treatment, care and recovery through a process of *day-to-day self-management*.

This notion is *not* to be confused with Advanced Directives, which have been developed as highly useful directives for consumer care in the event they are unable to make informed decisions on their own.

Helping consumers develop daily self-management and empowerment skills needs to become a mainstream of ongoing treatment and one that is respected, acknowledged and encouraged by providers of services throughout the care giving system.

Could a new evidenced-based system, built on quality and accountability, really be designed and implemented uniformly throughout our entire mental health system?

How would this sweeping reformation take place? Would everybody have to go back to the classroom? Who would be the

"experts" that would decide what facts and practices are really the best? Would consumers be involved in designing the new system? How long would this effort take to implement, *and how would we pay the costs associated with accomplishing this task?*

As it is, funding for mental health is a battlefield right now in New York State due to 9/11 expenditures and curtailment of the Community Reinvestment Fund. However, we must not lose faith that funding cut-backs last forever and let's remember that Reinvestment had great success in providing millions of dollars for innovative and effective community mental health services.

We *must* focus on why we need a better safety net.

We need a better safety net, because people need to respond to treatment much more rapidly than they do now. It should not take years of a person's life spent in programs and on dozens of medications to find the help they need to become productive members of the community again. Both consumers and providers make critical mistakes that often prolong recovery time.

On an even broader level, the facts remain that large numbers of people with mental illness still exist and are not being reached in New York State. We still have many homeless people with mental illness, and people with mental illness continue to live under harsh or unsafe living conditions. In addition, many children and adolescents with significant emotional problems are not receiving the services they need in communities throughout New York State.

Will a new scientific approach to mental health care address these broader concerns as well? I pray they will, and I believe that people throughout the state will be working hard to see that we weave a stronger and more comprehensive safety net.

In that spirit I believe that *Mental Health News* can play an important role in bringing evidenced-based practices information and education to communities throughout New York State.

Should the New York State Office of Mental Health support this idea, *Mental Health News* stands ready to serve.

I would like to thank you all for your participation and support, which fuels our commitment to mental health education. Please continue to E-mail your comments and suggestions.

Best Wishes
Ira Minot, Publisher

Letters to the Editor

Stigma and September 11th

To the Editor:

Since September 11, 2001, everyone's attention has been riveted on the Attack at the World Trade Center and all its implications. We hardly remember what we were concerned about before September 10, and we even question if any of the trivial problems we had in the past are even related to the aftermath of the "incident."

For many years, I have been concerned about doing away with the stigma of mental illness. I try to understand how to create an environment in which the mentally ill are accepted and understood, as valuable, contributing members of society. I try to understand how to use language to include the mentally ill in the life experience of the community, and not use it to alienate and isolate the mentally ill.

Several times since the attack, I have heard or read material in which the behavior of the terrorists was referred to as "crazy" or "mentally ill." For example, on the evening after the Attack, I attended a prayer service for those who were missing. Two of the speakers, who happened to be leaders in the community, referred to the actions of the terrorists as "crazy." I approached one of the speakers, after the program, and explained why I thought it was discriminatory to use a word usually thought to mean "mentally ill," when talking about the terrorists. It gives the impression that there is some similarity between

the typical person who is mentally ill and the terrorist, when the only connection is in the mind of the speaker. The response I got was that I was too sensitive, and there was no problem in using that expression, because "everyone knew what was meant."

Unfortunately, I think, "everyone did know what was meant." What it seemed to mean was that people can give the impression that participating in carefully planned violence and destruction is somehow related to mental illness. I do not remember being taught to diagnose mental illness according to this standard. I am not able to find terrorism in the DSM-IV.

The attack on the World Trade Center has brought together people of good will from every walk of life and every ethnic group. People who are disabled by mental illness feel included in this effort. Mental health services are being expanded to people who have suffered from the disaster. To further erode the stigma of mental illness, let us speak up when anyone uses language which equates terrorism, or even violence, with mental illness. Let us help those with mental disabilities feel more accepted in society by spreading the idea that mental illness is treatable and understandable and does not interfere with a person's ability to be a valuable member of the community.

Pauline L. Kuyler, M.D., F.A.P.A.
Fresh Meadows, New York

Thoughts on Anger

To the Editor:

When I think of anger, I think of several things. I think of the anger I grew up with and the anger generated by my illness -- major depression, bi-polar disorder II. I also think of when my medications aren't right, and I get nasty, irritable, and angry. Generally, I am a good person, but sometimes my illness interferes with my "normalcy," and my mind becomes noisy, unsettled, and not at peace.

Anger turned inward equals depression. The only time I remember feeling life without depression or anger was following Electroconvulsive Therapy (ECT). I was 41, and it was the first time in my life that I felt what I guess the "normal" person has always felt -- nothing. No heavy, dark cloud, no noise, no struggle to feel and stay normal. It was the only time it was not a struggle.

It was wonderful having all my energy (that I usually use for the "struggle") to simply enjoy, to laugh regularly and easily. I never knew what it was to feel this way. My mind was without depression and anger.

Does this mean I think everyone should go for ECT? No. But when necessary, it works; it works well. And it made me realize how stimulating the brain could allow someone to have the potential to feel happy. Because those of us who have low serotonin levels, need a chance to experience good feelings.

If used effectively and cautiously, ECT is an effective treatment for depression. ECT brought me back from the darkness, when medications proved ineffective. Yes, I didn't appreciate losing my memory for nearly a year and a half, but depression can do that on its own.

But ECT gave me, for the first time in my life, the opportunity

Profits over People

To the Editor:

The House Republican denial of the Senate's proposal to eliminate the insurance disparities between those who suffer from mental illness to that of physical illnesses displays their ignorance on the nature of the various afflictions that affect the mentally ill community.

The cost to the individual should override corporate cost. Insurance parity will increase the potential for acclimating society to treating mental illness—as the choice of care and treatment opportunities increases. Productivity gained by addressing mental illness issues would outweigh bottom line corporate cost. The issue should be judged as the benefit to society as a whole, not profits. Should corporate profits supersede family care concerns?

The increased costs required to place mental illness on par with other medical illnesses is certainly out-weighed by the tangible and intangible gains. By not offering increased access to mental illness care, our society continues to lose the potential of people who are lost to illness because intervention is not available. When better care and treatment are available early on,

the losses of a productive employee are held to a minimum. Then there is the destructive loss to the family system and the community at large when access to health care is denied. Should these far reaching repercussions be predicated by a corporation or congressman's worry about the bottom line?

I didn't know values our country was founded on were only based on dollars and cents.

Only those who have mental illness and their families that must endure the pain, hardships and losses imposed by the illness, should be given the final word on passing parity legislation. This is evidenced even more in that both Sens. Wellstone and Domenici, who championed passage of parity legislation both have family members with mental illness.

Let's not wait until others become ill for us to better understand the need for parity legislation to be passed.

Let's not allow the greedy financial needs of an inanimate corporate mentality and bottom line legislative thinking decide the basic rights of individuals and families in pain.

Glenn Slaby
New Rochelle, New York

To the Editor:

Ira, we applaud your extraordinary efforts in providing support, education and advocacy for families of persons with serious mental illness.

NAMI Families and Friends of the
Nathan Kline Institute for Psychiatric Research
"Hope and Recovery Through Research"
Orangeburg, New York 10962 - www.rfmh.org/nki

to feel the way a "normal" person feels. It felt wonderful to laugh, to feel light, to be able to think and see clearly.

Medications are wonderful. when they work, I work. And when they don't work, I get irritable, nasty and angry. I don't feel like a nice person nor am I a nice person when my medication is off. So, since ECT, it has been important to have my medication balanced periodically.

Once the brain chemistry is regulated, talk therapy helps as well. I attended a DBT (dialectic behavior program) that helped a lot. I learned coping skills I never knew existed and had support at least a few hours of my day. Great support!

The skills I learned taught me how to deal with my anger, how to deal with conflict, how to ask for what I wanted or needed --

just to name a few.

I grew up in a family where anger was an outgrowth of alcoholism passed on from past generations. Growing up with anger isn't fun. And if one was to do geneology research of their family, they would probably find it way back there, too. Is it inherited through the genes? Or is it inherited through the emotional cycle being handed down, and down, to what I experienced in my life today. And, will my life repeat the same cycles as those before me? That's a frightening thought. Can I break the cycle?

I know I must continually work at managing my illness on a daily basis, and continue every effort towards recovery and healing.

Jane E. McCarty
Harrison, New York

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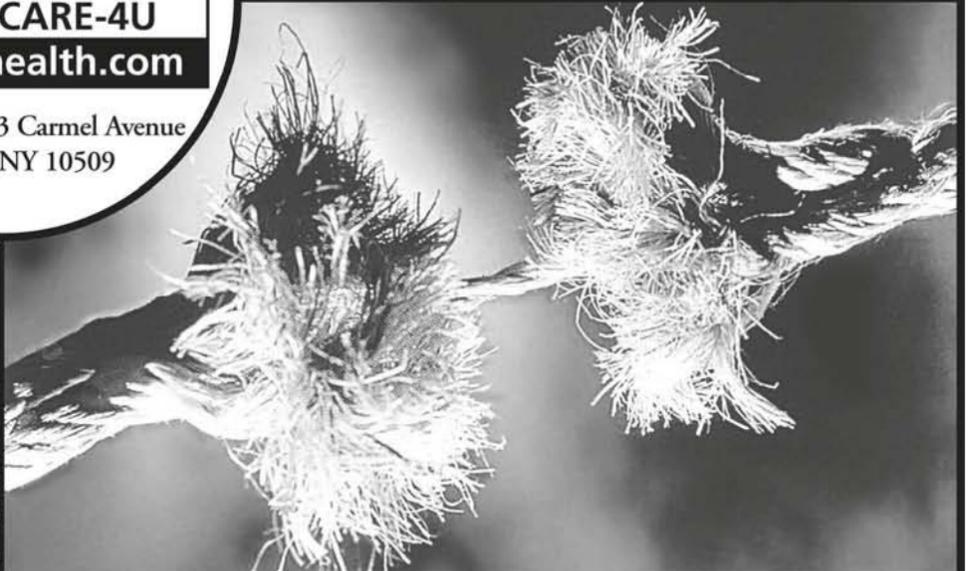
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tnio 9 Point of View

Conscience and Cowards

By **Marty Luster**
New York State Assembly



Marty Luster

If "conscience (meaning reflection) doth make cowards of us all," those who only reflect on their own political security are cowards of the first class. I refer to the display of cowardice by ten Republican members of the House-Senate Conference Com-

mittee on the Labor-Health and Human Services-Education Appropriations bill in Washington on December 18th. The amendment championed in the Senate by Senators Domenici (R-NM) and Wellstone (D-MN). The amendment would have eliminated discriminatory and unequal insurance coverage for mental health services by prohibiting the practice by insurance companies of imposing one set of deductibles, co-payment, days-of-coverage and scope of treatment provisions for those with "physical ailments," and another, more restrictive, set for those who have mental illness. It would have been a giant step toward the elimination of the stigma attached to mental illness and a recognition that many who are mentally ill can be treated and often cured and should be treated no differently than those with broken bones, cancer or other "physical" ailments.

This vote occurred even though 244 members of the House of Representatives had

indicated their support for the amendment by co-sponsoring parity legislation or signing letters urging the inclusion of the Senate amendment in the final appropriations bill. Clearly, the ten House Republicans who scuttled this effort, which enjoys enormous support by the American public, were under great pressure from the House Republican leadership who, in turn, caved in to the demands of the insurance industry and big business. For those who think that there is no difference between the political parties, think again.

After the vote, all that was left standing was a one-year extension of the current ineffectual federal parity legislation that was passed in 1996. Shame on the Republican leadership in the House, and shame on those members who lacked the courage to enact a measure that provides fairness and equity to the 20% of Americans who, at one time or another, will suffer from serious mental illness.

Given the lack of backbone

demonstrated by these members of Congress, it now falls to those states that do not have comprehensive parity legislation in place to enact such measures as soon as possible. In the 2001 legislative session, I introduced the Fair Insurance Treatment Act of 2001 (A.4506). This bill, if enacted into law, will completely eliminate discriminatory insurance coverage for mental health and substance abuse services. It mandates coverage for those illnesses and requires that the coverage be provided on the same basis as coverage for physical ailments. It passed the Assembly in June and is now pending in the Senate, sponsored by Republican Senator John Marchi.

Many of the same bogus arguments that were made to defeat the federal Domenici-Wellstone amendment were also used in Albany during the pendency of the parity bill in the Assembly. We were regaled with claims that the cost of insurance coverage would skyrocket, ultimately

see **Conscience** page 14

Governor's Budget Gives Mental Health Short Shrift

Coalition of Voluntary Mental Health Agencies, New York City



Phillip A. Saperia

Community-based mental health agencies were disappointed to learn today that Governor Pataki's 2002-03 budget proposal did not substantively address the problems besetting the mental health workforce, in-

cluding an annual staff turnover that is as high as 54%.

Last year, the Governor and the Legislature walked away from promises to the mental health sector for 10% Medicaid fee increase and 2.5% cost-of-living-increase. "We feel like we were jilted at the altar," commented Mr. Saperia.

"Throughout the heady years of the 1990s, the mental health sector was told to wait for a better time to get a Medicaid fee increase and cost of living increase that would have begun to redress the years of static reimbursement and growing costs," said Phillip A. Saperia, Executive Director of The Coalition of Voluntary Mental Health Agencies. "Better times have never arrived and this sector is in greater need than ever before. While we support the governor's initiative for increases for hospital workers who also faced high turnover and staffing shortages, mental health workers should not be left out."

"Already, a significant portion of our workforce has been driven

to other jobs. Ironically, these are often in the healthcare sector which pays better salaries. Un-addressed, the persistent and deliberate underfunding of the community mental health system will lead workers to find jobs elsewhere," said Saperia. "This will have a deleterious effect, over the long run, on the quality of care and may limit access to people in need. In the meantime, agencies are forced to increase caseloads for caregivers, decrease time spent with each consumer, and raid contingency funds simply to stay afloat. Studies indicate that 2 of every 3 people who leave their job in mental health programs have been with their agency longer than a year. We are losing the most experienced staff at alarming rates. In mental health, it means discontinuity and disruptions in the healing relationship which is so necessary for recovery."

A model of public-private partnership, the non-profit community mental health sector is largely funded through contracts

with the State. Yet, with the way the budget is structured a flat mental health budget acts as a cut in community mental health services because costs have escalated with annual inflation. State mental health workers, who are contracted to receive a 3% COLA each year, are paid approximately \$10,000 more than their counterparts in the community who have the same job description. For each year that community mental health is left out of the budget, the disparity grows even larger.

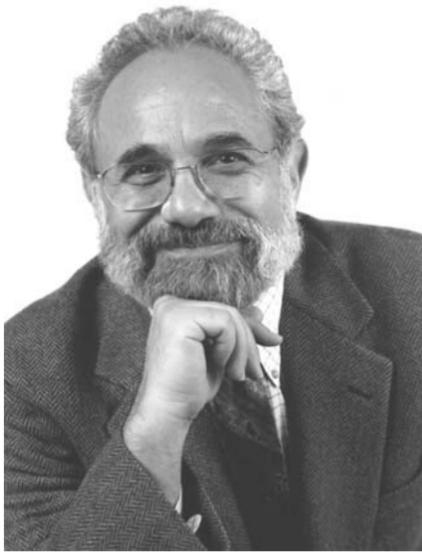
Moreover, this is also a time when community mental health agencies are being asked to do even more as a result of September 11. The crisis counseling services that are funded by FEMA require a stable base from which to operate. Despite a strong commitment to providing these needed services, agencies are finding it difficult because the infrastructure is so badly frayed. "Since 1990," said Saperia, "the Consumer Price Index has risen

see **Short Shrift** page 14

trio Point of View

Coming To Terms With Reality: The New York State Mental Health Budget For 2002-2003

By Michael B. Friedman, CSW



Michael B. Friedman

For over twenty years I have been an advocate for the progressive development of a comprehensive community mental health system. Year after year I have pushed for more housing, more rehabilitation services, more outpatient services, more effective crisis services, and more community supports for adults with severe, long-term mental illnesses and their families. I have also pushed for more community services and better integrated services for children and adolescents with serious emotional disturbances and their families. This year--for the first time--I am not advocating for service expansion. I am advocating only for funding to buttress existing services. Why? Not because new services are no longer needed. They are needed. I am advocating only for funding to support existing services because the failure of the State to provide adequate compensation for workers in community mental health

agencies over the past decade has created a crisis in community mental health.

When wages for entry level workers are lower than work in fast food restaurants, when clients breaking into work for the first time can get more per hour than the people helping them, you know that something is wrong. And the consequence is that turnover in some agencies is over 50% per year. That means that people who need mental health care don't get continuity in their relationships with the people hired to help them, and it means that jobs go vacant for long periods of time. Workers who remain in their jobs have excessive workloads and cannot provide the time and attention their clients need. It is a recipe for disaster, and it cannot be allowed to continue.

Last year the Governor recognized that there is a crisis in community mental health and proposed a multi-year approach to increase funding for community mental health agencies. His proposal called for replacing the Community Mental Health Reinvestment Act, which was originally designed to use savings from reductions in State hospitals to expand services, with a new Reinvestment Act, designed to use those savings to provide increases for community mental health agencies. Because his proposal included a plan to close several state hospitals and to consolidate several state children's psychiatric centers with state psychiatric centers for adults, it was politically unpopular and collapsed in the state legislature. And, because the Senate and the Assembly were unable to agree on an alternative approach, community mental health agencies got no increase--

yet once again--and the Reinvestment Act lapsed on September 30, 2002.

This year the Governor's Budget Request includes funding to increase wages for health care workers--including mental health workers--in general hospitals. It includes funding to increase wages for mental health workers in state facilities. It is important and right that their wages will be raised. But sadly the Governor chose not to request funds for workers in community mental health agencies. "Not enough money during an economic downturn," the Governor maintains. In other words, it's not at the top of his list of priorities this year.

So this is a year for political realism. That means focusing all of our energies on a single priority and joining together to do it. For most of us that priority is wage stabilization--that is, paying people enough so they will take jobs and stay in them.

It is possible to make a case that there is enough money both to buttress the community mental health systems and to expand it. But it seems extremely unlikely this year that the legislature and the Governor would agree to allocate money for both. That is why most of us are pushing to extend the Reinvestment Act and to use the savings from reductions in state hospitals for increases for the existing system rather than for the development of new services.

There is an enticing counter-argument--that there must be new services to meet the needs of the people who will no longer be served as inpatients in state facilities. However, the sad reality is that it has become very difficult to develop new services now because salaries are too low to

attract and retain the necessary staff. Given the fact that there will be some new service development in the coming year as funds for new programs that were frozen last year are released, it is hard to imagine that more development will be feasible until we have addressed the crisis confronting existing community mental health services.

I find these realities very disturbing. As I said at the beginning of this piece, I have devoted most of my professional career to advocating for expansion of community mental health. Further expansion is necessary, and to the very core of me I want to push for it. But I have come to terms with the reality of this year. We must overcome the workforce crisis in community mental health, and it will take all of us focusing exclusively on this one budget issue to get it done. It will take the advocates working together. It will take the Senate and the Assembly forging a common position. It will take the Governor to sign on. We all must put aside our differences this year to get this crisis behind us. Only then will we be able to once again pursue a vision of comprehensive community mental health.

Michael B. Friedman is the public policy consultant for The Mental Health Associations of New York City and Westchester County. The opinions expressed in this essay are his own and do not necessarily reflect the opinions of the Mental Health Associations.

Mental Health News wishes to thank the Mental Health Association of Westchester for sponsoring Mr. Friedman's column.

***Mental Health News Wants To Hear From You
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Anger: The Choice from page 1

and through (and wouldn't have it any other way) but, if you haven't noticed, drivers are honking much faster again when the light changes, and even those old familiar hand gestures have slipped back in. For that matter, it's probably true in all fifty states.

So, metaphorically speaking, is it the world that's spinning a bit faster that causes us to lose our patience and flare up? Have the internet and microwave made us more intolerant of waiting? (What I like to refer to as the "push a button" mentality.) Perhaps we have been saturated by our pagers and cell phones to the extent that our nervous systems are constantly on edge from the anticipatory call or message that beckons us, and anger is the only emotional direction we have to go in.

I guess there really is no turning back the hands of technology. But don't we still have the ability to choose how we respond to things? I know, "stimulus-response," it's beyond our control -- we are merely "operating" according to our environments. But certainly the cognitive therapists have taught us that we can alter our reactions.

What I am arguing for in this article is that anger really comes

down to simply being a choice. Don't we really choose whether or not we will respond to a given situation with anger? Perhaps if we practiced serenity a bit more the choice would be more obvious than automatic. Ah, that word "serenity" -- there lies the rub!

I am sure that those of you who have continued to read on and know that I am involved in working with addicted individuals might have guessed I would bring up serenity. Certainly it is the cornerstone of addiction treatment. But, I believe it is the key to all psychological treatment -- including anger management.

Think for a moment of the "serenity prayer." It is so simplistic in what it instructs, yet it represents an entire philosophy of existence. Let us for just for a moment focus on the three basic aspects of the prayer and for those of you who have difficulty with the use of the word "God" or even the word "prayer," simply view the concepts independently.

First of all, one is instructed to "...accept the things I cannot change." How freeing!!! I cannot change the traffic, so logically why get angry with the traffic? Why not simply accept the traffic and move on mentally and emotionally? Think of all the "traffic" in our heads. We have roadblocks from the past that cause us to ruminate and become an-

gry, yet, we cannot change the past. In the present moment we encounter situations that make us angry, for example, a particular individual, and yet we cannot force others to change, but only change how we react to others. Certainly getting angry because one is anticipating a future event to turn out a certain way is also a futile exercise.

Now let us turn to the second statement: "...the courage to change the things I can." The one thing that we all have the ability to change is ourselves. We can change how we choose to react. However, it does take courage. Think of Ghandi and King. They had the courage to remain calm in the face of torment. This allowed them to influence millions of individuals to think about what they were doing. Would I be naïve to think that they did not feel outrage? Of course I would, but they had the courage and conviction to practice peace. Allow me to tell you as a psychologist, but perhaps, more importantly, as a human being, one must choose to practice being peaceful. It is hard work, but it is well worth the journey.

For those of you who know me personally, you have to be saying at some point, "Come on Harris, you get angry;" Of course I do, I am a human being, but I can tell you that today I am better able to

deal with my anger by realizing the difference between the first and second statements -- which leads us to the last statement: "...the wisdom to know the difference."

Having the wisdom to distinguish between what we cannot change and what we can is the whole secret. This last statement addresses everything I stated in the first paragraph of this article. It allows us to distinguish between "healthy" and "unhealthy" anger, it speaks to what we choose to view as "anger triggers," it allows us the ability to take the time and pause and think, etc., etc.

So, the next time you find yourself stuck in "traffic" of the street or of the mind, think about choosing serenity. In the long run you will feel a great deal better, and so will those around you.

Harris B. Stratyner, Ph.D., CASAC, is a licensed psychologist, and the Director of Addiction/Recovery Services for New York Presbyterian Hospital -- Westchester Division, and the New York United Hospital Medical Center. He is a member of the Commissioner of Westchester County Department of Community Mental Health's Community Services Board, and can be heard weekly on his own popular radio show, "Here's to Your Good Health" on Am 1230, WFAS.



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MENTAL HEALTH



NEWSDESK



Seay New Director of NAMI-NYS



J. David Seay, J.D.

**Staff Writer
Mental Health News**

The board of directors of the National Alliance for the Mentally Ill, New York State (NAMI-NYS) has announced the appointment of J. David Seay, J.D., as Executive Director for the statewide mental health support, education and advocacy organization.

Mr. Seay, previously an attorney in private practice specializing in exempt organizations, nonprofit corporate law and health care, comes to NAMI-NYS with over 20 years experience in health policy, nonprofit management and governance, education,

advocacy and government relations.

From 1979 to 2000 he was an officer of the United Hospital Fund of New York, a health care philanthropic and research organization, where he served as Vice President, Corporate Secretary, and General Counsel.

He has also served with a large national health insurer and the Executive Office of the President of the United States in Washington, and has served on the boards of directors of numerous local and national nonprofit organizations. He and his wife Anita, and artist, reside in North

Chatham, Columbia County, New York.

NAMI-NYS is a grass-roots, self-help, support and advocacy organization dedicated to improving the lives of all people who are affected by mental illness. It strives to enable all individuals with a mental illness and their families to live the best life possible. There are over 50 NAMI-NYS affiliates across New York state, working together to provide support groups, promote better treatment and support services, and advocate for research into the causes and treatments of mental illnesses.

Luster Announces Retirement

**Staff Writer
Mental Health News**

Assemblyman Marty Luster (D-125th) today announced his intention to retire from the Assembly at the end of his current term in December 2002. Luster, a 14-year veteran of the Assembly, said his decision to not seek reelection came largely from a desire to have more time to spend with his family, including two grandchildren, as well as an interest in pursuing other avenues of involvement in political and civic affairs. Luster also recently accepted an appointment as a

Visiting Professor at Cornell University's Department of Government for the fall semester.

In 1988, Luster was the first Democrat in 75 years to be elected to represent the 125th District. This followed a 5-year tenure as Ulysses Town Supervisor.

"Serving in public office for 19 years has been the highest honor of my life," said Luster. "I thank my constituents, supporters, staff, and above all, my family, for their encouragement and help throughout this time. It has been an extraordinary privilege to serve the people of the 125th Dis-

trict. My experience has confirmed my feeling that public service is an honorable and worthwhile calling and that Oliver Wendell Holmes was right when he said:

"As life is action and passion, it is required of a man that he share in the passion and action of his times, at the peril of being judged not to have lived."

In the Assembly, Luster, an unabashed liberal, authored hundreds of bills, 150 of which have been signed into law including: the creation of the Assembly Standing Committee on Libraries, of which he was the first Chair;

1997 welfare reform efforts, legislative reform efforts in 2000, Legislation benefiting migrant laborers, and new laws establishing residential hospices, life-care communities.

According to NYAPRS Director Harvey Rosenthal: "Marty has been a champion during his tenure for the promotion of the recovery, rehabilitation and rights of New Yorkers with psychiatric disabilities" sentiments shared throughout the mental health community.

Joining Luster at his announcement was Barbara Luster, his wife of 38 years.

Federal Court Decision on Mental Illness

**NAMI E-News
February 28, 2002 Vol. 02-57**

Arlington, VA-The U.S. District Court for the District of Columbia has opened a breach in the artificial wall that has long separated coverage of physical and mental illnesses in insurance policies.

In *Fitts v. Federal National Mortgage Association* (Civil Action 98-00617), Judge Harold H. Kennedy ruled on February 26, 2002 that Fannie Mae and Unum Life Insurance Company of America (Unum) improperly classified an employee's bipolar disorder (manic depression) as a mental rather than physical illness, which subjected her to a 24-

month limit in benefits.

"The decision has symbolic importance in the ongoing Congressional debate over parity for mental illnesses in health insurance," said Ron Honberg, legal director of the National Alliance for the Mentally Ill (NAMI). "It will have a practical impact on precisely how the industry drafts long-term disability insurance contracts in the future. It also is another step toward ending discrimination based on myths and stigma."

"What is most important is that the court weighed science-based factors in reaching its decision. Mental illnesses are brain disorders. They have fundamentally physical causes. Insurance

companies cannot arbitrarily ignore the reality of the mind-body connection," Honberg said.

The court's decision turned on an interpretation of an ambiguous definition of mental illness in Unum's contract with Fannie Mae. Noting that "courts are split over whether ailments like bipolar disorder fall within the definition of mental illness contained in employee benefits plans," Judge Kennedy identified "three basic approaches" which have focused on symptoms, causes or treatments.

The court found both cause-based and symptom-based approaches to be "intuitively appealing" and reasonable, but observed that advances in science

make public perceptions of mental illness an evolving concept. There is no hard, fast rule to govern the definition.

In the case of Jane Fitts, an attorney who began work for Fannie Mae in 1982 and was diagnosed with bipolar disorder in 1995.

"The court declared that the dispute was not over facts, but definitions," Honberg said. "In the 21st Century, there is better understanding of the physical nature of mental illness. It's not just scientists who understand this, but also, increasingly, the average person. This decision is a reflection of that reality."

The Price We Pay For Our Anger

**By Barbara Mazer-Turtenwald
Co-Occurring Disorders Coordinator,
New York-Presbyterian Hospital,
Westchester Division**

Anger is one of the basic human emotions. Most people have developed, through trial and error, effective coping skills to deal with their anger. Occasionally, we all get "stuck" in our anger, but we muddle through it somehow. As a mental health provider, I have been involved in treating a disproportionate amount of people who cannot effectively deal with their anger.

Mental illness carries a stigma, as does alcoholism/drug addiction. Both of these diseases are characterized by an inability to tolerate stress and by the development of maladaptive coping skills. At the very least these skills are ineffective; in the extreme they can be lethal (e.g. alcoholism).

Depending on the source of statistics, it is estimated that between 40-60% of individuals with a mental illness suffer a

co-occurring disorder, i.e. substance abuse. As a substance abuse counselor and the co-occurring disorders coordinator at NYPH, my gut instinct tells me that these figures are probably higher.

So why is anger a topic of importance from a mental health perspective? It is important because it is often the nutritional source which feeds the stress response in our bodies. Unrelieved stress acts like a physical, mental and spiritual cancer. For people who suffer from chemical addiction the solution is immediate -- get high! What price do these individuals, their families, their friends and their employers pay? A very high price, often ending in institutionalization, incarceration or death. It has been estimated that for every alcoholic at least five other people are directly affected by his/her disease -- hence the term "family disease."

Drug use (alcohol is a drug, too) masks anger, numbs anger, temporarily relieves anger, but it does not get rid of the anger. Therefore, the stress contin-

ues and a cycle of dependence may develop. Can a person "get rid of anger"? The answer is: "Yes," with the right coping skills.

Anger is a normal human emotion, which can serve many purposes in our psyches. The problems arise when our anger or our coping skills become self-destructive. Alcoholism is self-destructive. Drug abuse is self-destructive regardless of whether the drugs of abuse are prescribed or illicit.

The things that make me and the rest of the human race angry could fill a book. The starting point for dealing with any problem must be identifying that there is a problem. Addiction and other mental illnesses often start out slowly with few signs or symptoms. The slowness of this progression often leads the inflicted to rationalize other reasons for their behaviors. This is a defense mechanism. Rationalization defends our minds, our sense of self, from being labeled with the stigma of addiction and/or the stigma of mental illness.

It strikes me that stigma and peer pressure are creations of our own minds. If I hurt, how can I stop the pain permanently? Treatment. The signs of early stage alcoholism are numerous and vary from person to person. For simplicity sake let me just say that if you think you "may" have a problem with alcohol or drugs -- you probably do. Share your concerns with someone...anyone, and seek professional help.

In the aftermath of our National Tragedy on September 11, 2001, I fear that there will be many people who will needlessly suffer because of their inability to cope effectively with their rage ("anger" seems too mild a word to express the feelings for that abomination).

Addiction and other mental illnesses are highly treatable today and with ongoing research we are constantly improving modes of treatment. I hope this article has you thinking about the coping strategies that you use and has you reassessing what role pride takes in your choices.

Anger: A Candid from page 1

It is likely to be the patient with psychosis who has an additional substance problem and is in a paranoid state that is likely to strike out in a violent way.

Another aspect of the problem of violence that affects everyone today is the enormous amount of violence that youths are exposed to in film, TV and even on the news. This American culture of violence may have a particular effect on that segment of the population who tend to either have vulnerability to anxiety, or have impulse control problems.

One area of special concern is teenage violence and suicidal behavior.

We have seen a 3 to 4 fold increase in teenage suicide over the last 30 years, and we have also seen children and young adults who are increasingly liable to be carrying guns and committing violent acts. Episodes such as Columbine can have an epidemic impact as children with violent fantasies may copy things that they see happen on the news. Inadequate national efforts in the area of gun control and inadequate efforts at violence prevention is a national tragedy. In addition, relatively little research on the nature of violent behavior is done. Whenever anyone attempts to study violence, they are sometimes stigmatized because societal concerns that the study be done fairly and that results are accurate.

One significant debate regarding violent behavior is whether the intoxicated person is person-

ally responsible for their violent acts, or whether Addiction is a brain disease which should therefore relinquish the person from responsibility for what they do.

In the United States our legal system emphasizes that everyone is responsible for acts they commit even while intoxicated, unless there is no intent and they meet criteria for being criminally insane—criteria which are held to a rigorous standard when substance abuse is also involved. Most courts will hold someone guilty for acts committed while using alcohol and drugs. In fact, though addiction is as Alan Leshner of the National Institute of Drug Abuse says, a brain disease, it is a disease where there is a voracious component to use substances that may lead to further increase and impulsivity and violent acts.

It is my feeling that once someone knows they have a diagnosis of addiction, they should be held *more* responsible for their acts then at just a point in time where they may not be aware of how affected their behavior is by substances of abuse. This knowledge could be used in a wise way in sentencing. For example, the person who has a first DWI, has a strong family history of addiction, is in a high drinking environment and did not know that they had a problem, should be treated differently from the person who's been through 4 rehabs and has had 3 DWI's and is now charged with manslaughter.

Anger may be manifested as a dimension across many different

diagnostic entities. In depression, we often see anger turned against the self. In addiction, anger may often be suppressed and released by the use of substances. A dilemma often results where the person may be using substances to try to manage their anger only to further worsen their condition and less control of their anger in the long run.

In psychiatric illness such as psychotic conditions, the patient may misperceive events around them in a paranoid way, which can lead to defensive anger and sometimes violence. For example, an innocent friend's gesture may be taken in some delusional way as an attempt to hurt the patient, and the patient may react in an angry or belligerent manner which seems uncalled for. Various psychiatric medications may help patients with psychiatric problems better cope with or deal with angry feelings. SSRI's, antidepressants may help a depressed person who is chronically struggling with angry and depressed thoughts to not being as troubled by certain negative aspects of their lives. Atypical antipsychotic agents are helpful in reducing paranoia, increasing impulse control and management for schizophrenic patients. Bipolar patients who are stable on lithium or anticonvulsive medications are much better able to manage their impulses and anger. Similarly, patients who are taking Revia or Antabuse to help treat their alcoholism may also indirectly manage their anger better.

Patients with borderline per-

sonality disorder may also be impulsive and commit aggressive acts either directed at others or themselves. They may burn themselves with cigarettes or cut themselves and they may also be destructive of other's property at times. Patients with obsessive-compulsive disorder are constantly torn between their anger and their fear and have difficulty managing both emotions and tend to displace this into hand-washing, rechecking things, and a general high level of anxiety.

The anger management which is most dangerous is that which occurs in patients with sociopathic personalities who are truly likely to commit criminal acts when they are feeling angry, entitled or upset.

Richard J. Frances, M.D., is President & Medical Director of Silver Hill Hospital in New Canaan, Connecticut. He was formerly chairman of the Dept. of Psychiatry at Hackensack University Medical Center and professor of clinical psychiatry at the University of Medicine and Dentistry of New Jersey, New Jersey Medical School. He is an international expert on addiction psychiatry, and has published over 175 articles, books, and reports, including co-editing The Clinical Textbook of Addictive Disorders. He is also the founding president of the American Academy of Addiction Psychiatry.

To learn more about Dr. Richard J. Frances and the care and programs available at Silver Hill Hospital, in New Canaan, Connecticut, visit their website at www.silverhillhospital.com.

Finding a Balance in Therapeutic Relationships

By **Steve Miccio, Executive Director, PEOPLE, Inc.**



Steve Miccio

How are people supposed to recover or stay well while therapists and psychiatrists continue to drive them crazy?

We had a friend at our agency that came in daily and volunteered his services any way he could. He was full of energy and life! We'll call him "Bob." He had been shut in his house for about three years and was very depressed and lost after his wife had died of cancer. Bob was so devastated and missed her so much that he just could not cope with the world outside.

He was subsequently taken out of his house and hospitalized for quite a while until he showed signs of recovery. Once he was out of the hospital, he contacted us and was intrigued with our mission at PEOPLE, Inc. We accepted him for who he was and we listened to him each and every day. He would talk for hours about his wife and their life together. Before Bob became depressed, he and his wife did charity work in New York City. We are fortunate that he brought that charity to our organization. However, we consistently witnessed the pain inside of him as to how he missed his wife so much. There were days when he wouldn't come to the office because he was feeling so down. It

was a feeling we could all relate to in the office. We may or may not have felt the exact intensity that Bob felt, but we definitely could relate to the feeling of loneliness and sadness. We introduced him to advocacy and self help and naturally, he jumped right into the work. We accepted his occasional absences and would keep in touch through personal visits to see if there was anything that we could offer him. Bob would either accept our company and support or he wouldn't. We respected his wishes.

Bob's biggest problem was that whenever he saw his therapist and he was having a bad moment, day or week, the therapist immediately became alarmed and offered more medication, increased therapy, crisis housing or even hospitalization. This was irritating to Bob, so he would "act" happy and behave how he perceived the therapist would expect a "normal" or recovered person to act while visiting his therapist and then go back into isolation until next time. Or, Bob would charge into my office and complain about this very subject. He would say, "Don't they (therapists) know that everyone can have a bad day sometimes and that it isn't necessarily a mental illness?"

Bob would talk about how little his therapist really knew him. You must understand that Bob was a very energetic, open and honest man and did not harbor any secrets that I know of. It was not difficult to get to know Bob if you just took the time to listen. Bob would always comment on how he felt he was on an assembly line at his therapist as evidenced by the large amount of people that were always in the waiting area. Bob could see the anxiety and frustration on his therapists face often. He believed that she was very overworked.

In defense of therapists, there is often limited time to see so many patients in a day and I

would tell Bob that the clinic he attends is very busy. I should also mention that there are many amazing consumer friendly therapists that do take the time to get to know their patients. However, this is a concern that we see consistently when talking to our peers. We have found others having the same problem with their therapists when they felt sad or happy on a particular day. They consistently state that they are afraid at times to tell the Dr. or therapist what they are feeling for fear of some form of forced treatment.

Is it a learned behavior from their therapist or Dr.? Is it so ingrained in people that if they begin to exhibit an emotion which in many cases is very appropriate, they actually begin to believe that they are getting sick and they believe they may need to increase, change or decrease their medication? Or, visit their therapist more often? Or, go into the hospital? How can recovery be possible if people are not empowered to feel "normal" emotions?

How can Dr.'s and therapists insure safety while taking a dignified risk that a patient is just having a bad day and that it is not their illness talking?

There is no easy answer to this. I don't claim to have the perfect answer, but we do need to get to know each other in a healthier manner. That's easy to say, but does everyone have the luxury of time to get to know each other? Ask any case manager, therapist or Dr. Most have very large caseloads and find it difficult to spend the kind of time two people need to really get to know each other.

It does not mean that we shouldn't try. Therapists and psychiatrists and case managers need to become more educated in the social aspect of working with individuals. They need to take the time to understand and relate to people so that they do not jump the gun in creating a clinical

crisis for someone. Therapists and psychiatrists and case managers also need to learn more about complimentary therapies that teach individuals how to cope and survive in recovery. Most people know what works well for their own recovery. They just need to be heard.

Getting back to "Bob," we often discussed how we can go about teaching someone how to self advocate and demand services that focus on that persons own recovery without ending up being forced into a hospital or having a mobile team come to their door because the therapist has a feeling something is wrong with him/her.

Bob didn't always have good days. He continued to miss his wife and was afraid to stay at home because of what his case manager or therapist might think, Bob came to our drop-in center and hang out. That should be okay! Mental illness isn't always about reaching out. Sometimes we just need to be left alone, however, in the mental health system; self isolation can often be viewed as a bad thing.

We need to teach and learn from one another. Therapists and psychiatrists and case managers need to become advocates for recovery and understand us better. We need to learn from therapists and psychiatrists and case managers as to what they need to help them do their job better. If we don't have open dialogue and if we can't communicate in a safe environment, we will continue to be scrutinized, stigmatized and controlled by the system. And we have all seen how that worked over the past hundred years.

PEOPLE, Inc. is a consumer run organization, that provides advocacy services to people with mental illness. Services include vocational case management, supported housing, outreach and education. Offices are located in Poughkeepsie and Kingston, NY, reach them at (845) 452-2728.

Resources on The
Subject of Anger

Websites

- The Committee for Children Website: www.cfchildren.org
- National Coalition Against Domestic Violence Website: www.ncadv.org
- Anger and Aggression Website: www.mentalhelp.net/psyhelp/chap7/
 - PTSD & Anger: www.zoloft.com
- American Psychological Association - Controlling Anger: www.apa.org/pubinfo/anger.html

Books

Wherever You Go There You Are: by Jon Kabat-Zinn

Real Magic: by Dr. Wayne Dyer

The Role of Advance Directives In Ensuring The Power of Self-Determination

By Dawn Casey
Central New York Regional
Educator, NYAPRS Advance Di-
rectives Training Project

Tremendous feelings of powerlessness, helplessness, or lack of control are among the most debilitating consequences of seeking help for a psychiatric disability. All too often, well-meaning providers may seem to function as "pseudo-parents," engaging in decision making about the treatment of those they serve without taking into consideration their own wishes, choices, and preferences. Sadly, this approach often results in people's loss of faith in their own judgment, and a resultant loss of confidence, motivation and hope. People in need come to look at mental health professionals as experts on what is best for their treatment and their lives, when really, the best expertise usually lies within themselves.

The research is clear: taking control of one's own treatment leads to increased recovery outcomes. Dr. Courtenay Harding's landmark study on treatment outcomes 25 years after individuals were released from Maine and Vermont state hospitals showed that even in the most extreme cases of persons never expected to leave an institutional setting, healing and recovery can—and did—happen, despite the beliefs and stigmatization of general society. Persons given the ability to be engaged in their own treatment planning and care were found to make significant advances in their own recovery, in contrast with those not granted such autonomy in choice making.

Persons afforded the opportunity to set goals for themselves, make choices, garner skills, and accept supports—but not crutches—in the community were found to have achieved significant recovery outcomes including having substantial relationships, living independently, working, decreased use of medication and

fewer symptoms.

The value and right of individuals to select health care of their own choosing is underscored under New York State law. For example, providers of mental (and physical) health services are required to afford their clients the opportunity to give informed consent to treatments that providers wish to offer them. Informed consent occurs when consumers are properly informed about the nature of the proposed treatment, including its benefits, risks and alternatives.

Consumers need to remember that they have the right to accept or refuse treatment. Given what they learn in speaking with their treatment providers, each individual has the opportunity—and the given right—to make the decision about whether they wish to engage in that treatment or not. Asking questions, making sure they fully understand, doing independent research to learn additional information about the proposed treatment, and asking others who may be knowledgeable about the treatment are key elements in decision making about what the best care for you may be.

A powerful tool in ensuring that an individual's health care choices are followed, even during times of difficulty, is an advance directive.

An advance directive is a type of written or verbal instruction about health care to be followed if a person is determined to be incapable of making decisions regarding her/his physical or mental health treatment. Advance directives are prepared when a person is deemed competent and can set forth instructions to be followed during periods of time when the person may be considered to lack the capacity to make medical treatment decisions.

There are three types of advance directives: the Health Care Proxy, in which an agent is appointed to represent the principal's wishes in times of incapacity;

the Living Will, where wishes, choices, and preferences can be made known in writing, and Do Not Resuscitate (DNR) Orders, prescribed by physicians in end-of-life situations.

Most people recognize advance directives as being used primarily for "end of life" decisions, such as specifying the wishes of individuals to be withdrawn from life supports when there is no longer any reasonable hope of survival. In recent years, however, advance directives have been recognized as being helpful in empowering individuals suffering from psychiatric disabilities to communicate treatment preferences in advance of periods of incapacity.

In New York State, a health care proxy is the only legally recognized means of protection of treatment choice that is available. If a person is unable to create a health care proxy, perhaps because they have not found a satisfactory agent to appoint, they may make their choices and preferences known in a written document known as a living will. In New York State, we do not have Living Will law in the same way we have Health Care Proxy law. However, courts in New York have honored Living Wills that have established a person's wishes by "clear and convincing" evidence.

In the living will document, the principal states specifically his wishes for the health care treatment he wants or does not want to receive. This is another way that choice can be relayed to treatment providers at times of incapacity.

When an individual is found by their physician to be incapable of making treatment decisions, providers of health services must take into account the contents of their advance directive, therefore bringing the capability of having a voice and choice in treatment possible even when a person is not capable of speaking for himself or herself. Every consumer of mental health services, espe-

cially those who may be most vulnerable to the threat of forced or involuntary treatment, should consider creating an advance directive.

Advance directives have many benefits: they ensure that a person's wishes regarding health care treatment are known during periods of incapacity so that they may be honored to the greatest extent possible. They invite consumers confidence that their knowledge of what works for them in time of crisis (and in general) will be respected and utilized.

In the case of the health care proxy document, conflict and confusion in families about who makes treatment decisions is reduced. And finally, the documents ensure that consumers can still be seen as the experts on their care, even during potential incapacity.

A wise man once said, "If you don't know you have a right, you don't have a right." As citizens, as members of a community, even as human beings we are afforded numerous rights—but if we don't know what these rights are, how can we ever achieve what we are entitled to?

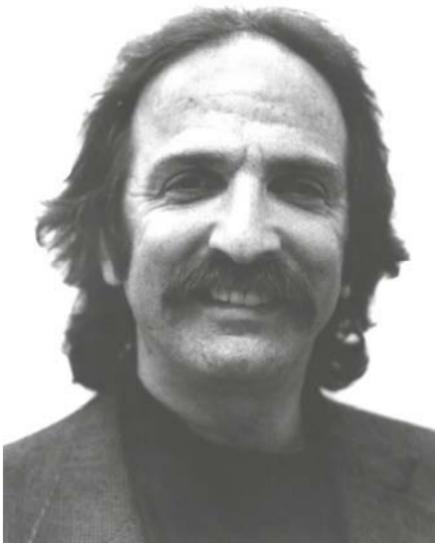
To ensure that New Yorkers are adequately informed about their rights under advance directives, the NYS Office of Mental Health funds several training initiatives. The New York Association of Psychiatric Rehabilitation Services operates an Advance Directives Training Project aimed at educating service providers about their use. OMH Commissioner James Stone has urged all provider agencies and programs to schedule such a training. Call NYAPRS at 518-436-0008 for more details.

OMH also has funds for an Advance Directives Training Program for consumers/survivors that should be operational soon. Interested? Call OMH's Bureau of Recipient Affairs at 518-473-6579 to learn more.

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Details On Page 30

The Trend Towards Evidence-Based Practices: Will It Promote Recovery For New Yorkers With Psychiatric Disabilities?

By Harvey Rosenthal
Executive Director, NYAPRS
New York Association of Psychiatric Rehabilitation Services



In recent years, national and state mental health agencies and organizations have come to make the use of 'evidence-based practices' one of their top priorities in the delivery of services to Americans with psychiatric disabilities.

Evidence-based practices, which are considered to be services and supports that have been consistently proven by research to help people in their recovery, have been the theme of several major recent studies, conferences and funding initiatives. As such, their use represents a major national and state trend that will effect all of the stakeholders in our mental health service community, from consumers/survivors to family members, from service providers to state and local mental health agencies.

So, what is this trend towards evidence-based practices about...and what implications can it have for proponents of recovery, rehabilitation and rights for New Yorkers with psychiatric disabilities?

From 1992-8, the National Institute of Mental Health funded a study, implemented by the Patient Outcomes Research Team (PORT), to develop and distribute recommendations for the treatment of schizophrenia based on 'existing scientific evidence.' One

of the strongest findings of the PORT study was, as Principal Investigator Dr. Anthony Lehman noted, that less than half of all Americans receiving treatment for a diagnosis of schizophrenia received what research had shown to be the proper doses of psychiatric medications with the right mix of 'appropriate psychosocial interventions,' which they considered at the time to include employment supports and case management services.

In 1999, the U.S. Surgeon General's report on mental health further emphasized the great gap that existed between the kind of care the research found to be most effective...and the kind of care that most Americans received, concluding that "services and programs based on scientific advances in treatment are not routinely available" to meet the needs of individuals with psychiatric disabilities.

Subsequently, prominent national researchers like Dr. Robert Drake have focused national attention on 6 particular evidence-based treatments, citing that "...research strongly supports:

- the use of specific medications prescribed in specific ways as well as the use of psychosocial interventions such as
- supported employment,
- various approaches to illness self-management,
- family psycho-education,
- case management based on the principles of assertive community treatment, and
- substance abuse treatment that is integrated with mental health treatment."

(I've adapted this quote into a bulleted format to highlight the 6 practices).

Over the past year, the NYS Office of Mental Health has sought to put evidence-based practices on the front burner here in New York, highlighted by a special 'Best Practices Conference' it hosted last June in Brooklyn and a new special 'Winds of Change' presentation it will be rolling out this across the

state this year.

OMH has highlighted what is being called the 'quality chasm,' urging us to look at instances where some services are being overused, underused or misused and calling on service providers to shift their practices to high-light consumer-centered, timely, effective and efficient approaches.

While most groups have well appreciated the notion that the services people with psychiatric disabilities receive should be the best ones possible and ones with clear evidence to back up their effectiveness, the trend towards evidence-based practices has raised a number of provocative questions from the recovery and rehabilitation community.

Dr. William Anthony, the nation's leading proponent of psychiatric rehabilitation, has pointed out that evidence-based practice research to date has not focused enough on "recovery-related process and outcomes (e.g., having choices, feeling respected, positive changes in meaningful work, self esteem, empowerment, etc.)." Anthony has urged that "the concept of evidence-based practice must be broadened to include 'encouraging and promising but not yet confirming' evidence-based practices."

For example, a number of groups here in New York and across the country have advocated for the inclusion of increasingly popular and effective self-help approaches. In that spirit, peer support services proponent Shery Mead M.S.W. has pressed for the inclusion of "research that is grounded in the outcomes of...alternative (peer support) practices," adding that "it is crucial that we teach and practice approaches that allow us to put...(these) values into action."

NYAPRS has been encouraged by the NYS Office of Mental Health's responsiveness to these concerns. Recently, OMH has issued its priority list of evidence-based practices for adults that have added:

- self-help and peer support services and
- post-traumatic stress disorder treatment

to the 6 evidence-based practices already endorsed above.

Further, OMH has supported the restructuring of the 'illness self-management' practice into

- wellness self-management education (featuring a strong emphasis on approaches that teach individuals to develop their own personalized recovery plan featuring a number of self-help and 'alternative' approaches, like Mary Ellen Copeland's Wellness Recovery Action Plan.

What's next? Look for the following over the next few months:

- OMH staff will be featuring the 'Winds of Change' presentation at a number of forums across the state.
- NYAPRS in conjunction with PEOPLE, Inc. will be hosting a broad number of regional and local presentations on the call for quality and the nature and use of evidence-based practices.
- The Mental Health Empowerment Project will be featuring workshops on EBPs in each of their upcoming spring regional conferences.
- The NYS Council for Community Behavioral Healthcare will feature a track on evidence-based practices at its upcoming June conference.

And this year's NYAPRS 20th Annual Conference will feature both an 'exemplary services' track and a special September 10 Institute Day program, "Making the Case for Peer Support Services as an Evidence-based Practice," that will feature national figures like Dr. Edward Knight, Dr. Daniel Fisher, Joseph Rogers, Larry Belcher, Dr. Jean Campbell, Dr. Jean Dumont, Shery Mead and Laura Prescott.

NYAPRS is a statewide coalition dedicated to promoting the recovery, rehabilitation and rights of New Yorkers with psychiatric disabilities. For further information, please contact us at (518) 436-0008 or E-mail us at NYAPRS@aol.com.

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Short Shrift from page 6

by more than 39%; at the same time, the community mental health system has received aggregate increases of less than 4%. This is a road to bankruptcy of a crucial social safety net. Agencies cannot continue to operate under these circumstances, let alone continue to provide vital services."

The Governor's budget also failed to reinstate the landmark Community Reinvestment Act which funneled savings from closed state psychiatric beds into the community mental health sector. Passed in 1993, this legislation has funded more than \$200m in new programs. Part of its appeal is that it costs the State no additional dollars; rather it redeploys the same dollars to a community setting that

is more efficient and better able to help consumers reach their full potential in their own communities where they live.

Because Reinvestment expired in September, the community mental health sector stands to lose \$9.2m in the current fiscal year alone. By failing to continue Reinvestment in the out years, community mental health stands to lose millions more.

"The recent funding for hospital and other health care workers is evidence of what we can do when we all work together to solve an important problem," said Saperia. "High staff turnover, zooming caseloads and quality work environments in community mental health agencies are clearly a problem of the same or greater magnitude, and should garner the same attention and prompt resolution."

Every Month Is Mental Health Month At Mental Health News !

Conscience from page 6

resulting in fewer people being able to afford insurance altogether. This claim is nothing but a scare tactic by the insurance industry and is belied by all objective proof. Maryland, Minnesota, North Carolina and Texas have all enacted parity legislation. Maryland experienced an initial increase and then a subsequent reduction to pre-parity levels. In Minnesota, one of the large insurance providers reported that the requirement would add only 26 cents to the monthly premiums paid by the 460,000 people enrolled with the company. After implementation of mental health parity for all North Carolina state employees, the state experienced a reduction in the per member/per month cost of mental health services over a five year period by more than 32%. Similarly, Texas experienced a more than 50% drop in per person/per month costs when they enacted parity for state employees.

A New York-specific study was commissioned and Price WaterhouseCoopers has issued a preliminary report on the estimated cost of enacting this law. It reveals an estimate of \$1.26 per insured person per month – highly affordable and far from the doomsday projections of the insurance industry.

One dollar and twenty-six cents in additional premium per month is a very modest cost when contrasted with the costs associated with undiagnosed and

untreated mental illness and substance abuse, which can cause or contribute to accidents, job turnover, inter-personal conflict, disability, workers compensation, involvement with the criminal justice system, disrupted lives and families, and increased dependency on public resources. With mental health and substance abuse services readily available to all insured individuals, such ailments can be diagnosed and treated earlier, thus placing fewer burdens on public resources, business and individuals themselves.

As stated earlier, the Fair Insurance Treatment Act of 2001 has already passed the State Assembly. With the failure of the effort to have parity legislation enacted at the national level, it is imperative that the New York Senate hear from mental health consumers, their supporters and families, providers of such services and the rest of us who, in all likelihood will, in our lifetimes, directly or indirectly, be affected by mental illness and substance abuse.

2002 must be the year that New York State enacts meaningful parity legislation, and it must be the year that we, as a nation, hold politically responsible those who so shamefully traded the welfare of 20% of the American population for the desires of the insurance industry giants.

Luster chairs the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities.



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Let's All Stop Bullying: The ABC Way

By Joel Haber, Ph.D.

Every one of us with school-aged children has heard the term, or even experienced the emotional pain that comes with incidents of bullying and teasing. Unfortunately, bullying / teasing are facts of life that occur daily for some children with serious deleterious effects. Any teacher can tell you that these kinds of problems lead to disruptions in learning and social/emotional consequences that are difficult to manage. Estimates of bullying are scary. Almost all children know that bullying occurs in their schools. Fifty percent of children and more believe that bullying occurs a lot. In the USA, between 20% and 50% of students report frequent and regular bullying. It is believed that in every classroom approximately 10% of children live with terrible fear of bullying. Developmentally, bullying escalates from elementary school through 9th grade and then gradually decreases.

When we talk about bullying we need to understand the term. A child is seen as bullied when he/she is exposed repeatedly and over time to negative actions on the part of one or more kids. The "bully" behavior is seen as aggressive, goes on over time, and occurs in a relationship that is imbalanced in strength or power. Bullies, therefore, use their power to hurt or gain attention over someone who is weaker. Therein, lies the problem. Bullies need a target that is weaker, so they can test out their power.



Joel Haber, Ph.D.

Bullying, therefore, can encompass a range of hurtful behavior. Direct bullying is easy to identify. A child who is hit, kicked, pushed, shoved or has lunch money taken away are all examples of direct bullying. Indirect bullying is harder to see initially, but in no way any less painful. These examples include: ignoring or excluding a child, telling lies or spreading rumors, trying to get other kids to dislike a child, and malicious teasing when a child cannot defend him/herself. Girls bully almost as much as boys do, but it is usually indirect.

Did we ever wonder who these bullies are and why they do what they do? Our old understanding of a bully was that they were the awkward, uncomfortable, big, insecure kid who defended their insecurity by aggression. What we know now is that they are aggressive and intimidating because getting other people to do

what they want increases their status and self-esteem. They are generally more aggressive and intimidating, and have little remorse for others. They lack skills in caring, empathy and cooperation. Bullies are not the kids with less than average intelligence. They can be very smart and socially skilled. They have learned to be intimidating and use that power to further themselves. Bullies do not hurt others in front of adults like teachers or the principal. They know who has the power. They do their damage in unstructured and unsupervised situations like the playground, or school bus, when they are less likely to be caught. Most importantly, parents of bullies usually support their child's aggressiveness toward others.

Victims on the other hand, can be vulnerable in some way. They may be nice, passive, anxious, or lack self-confidence. The bully senses that these kids are not able to easily defend themselves, and target them. These children may not have the social skills needed to defend themselves from an aggressor. Victims are not necessarily different in appearance. They are different in their psychosocial abilities to defend themselves.

In addition to the bullies and victims, there are also the majority of children who are not victimized. These children frequently have good interpersonal relationship skills. They typically do not insist on their own way and justify disagreements. They know how to compromise, apologize and negotiate well. It is this

"silent majority" of children that can actually be very helpful in stopping the bully problem.

How do we know when our child is bullied or involved in a bully incident? The most important thing we can do is ask the questions to address these issues. For example, we want to ask our children if they are bullied or teased in school, or if they have been involved in any bullying towards others. It is important to ask your child if they always have someone to eat with during lunch, or a friend to play with during free periods. Ask your child if they ever feel left out or feel picked on for any reason. Sometimes, a change in behavior or disinterest in school, or a report of lunch money being missing in school can be an alert to a potential problem. If you notice a problem, or suspect a problem, it is important to ask your child how they want you to intervene or provide help. However, it is important to stay cool and not overreact when your child shares this information with you. An overreaction removes the safety in reporting that our children need to feel when he/she shares this information with you. You want to ensure that your child's report of a problem is not seen as causing them more stress than it already has.

The response to a bully problem needs to be multifaceted. In fact, bully problems that continue and are not dealt with comprehensively can grow into far greater problems. My clinical

see *Stop Bullying* on page 18

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. In the Spring and Fall of each year, Four Winds presents it's Community and Professional Education Program Lecture Series. Enlisting speakers who have an expertise on a myriad of mental health topics, these Grand Rounds, Community Lectures, and Special Events are provided as a resource for continuing education. Reprinted here are excerpts from presentations given by three of the speakers in the Fall of 2001.

Four Winds Hospital - Spring 2002

Community and Professional Education Programs

APRIL

Grand Rounds

Friday, April 5th • 9:30 - 11:00 am

Temperament – Linked Anger Management: Theoretical and Treatment Perspectives

Norman Brier, Ph.D., Director, Adolescent Division, Children's Evaluation and Treatment Center and Clinical Professor of Pediatrics and Psychiatry, Albert Einstein College of Medicine, Bronx, NY; Private Practice, Bedford, NY

Drawing on the current literature, Dr. Brier will discuss the key factors that contribute to emotional regulation problems in older youngsters and adolescents with a history of "difficult child" behaviors and will review the treatment strategies that have proven to be most efficacious with this population.

Fee: \$10.00 payable to Four Winds Hospital

Save the Date!

Wednesday, April 17th • 4:00 - 7:00 pm

Nursing Career Day

Experience Four Winds firsthand during this informal event. Refreshments, Tours, an Opportunity to Meet with Nursing Leadership Competitive Salaries/Benefits

RSVP by Friday, April 12th • 914-763-8151, Ext. 2413

A Special Community Program

Friday, April 19th • 9:30 - 11:00 am

Assessment and Intervention in Children's Grief

Grace Christ, D.S.W., Associate Professor at Columbia University School of Social Work, New York City, NY

Dr. Christ will discuss how development impacts a child's response to grief and loss. Grieving is often affected by the context of the loss: whether it was anticipated, sudden, or traumatic. The death of a loved one, separation from friends and family, including foster care arrangements, and traumatic events such as the crisis of September 11th, and its impact on children, will be discussed.

Fee: \$20.00 payable to the Four Winds Foundation, a non-profit organization

Location: Northern Westchester Center for the Arts, 272 North Bedford Road, Mt. Kisco, NY 10549

Registration required: Please call 1-800-546-1754, ext. 2413

Conference Space Generously Donated by the Northern Westchester Center for the Arts

Conference

Tuesday, April 30th • 10:00 am - 1:00 pm

Treating Troubled Children and Their Families: A Brief Integrative Approach

Ellen F. Wachtel, J.D., Ph.D., noted Author and Lecturer

Dr. Wachtel will present a method of working with young children and their families to bridge the gap between child and family approaches. This workshop is designed to teach individual and family therapists, as well as school counselors and psychologists, how to provide help to young children by working with both the family and child in short-term, active therapy.

Fee: \$25.00 payable to Four Winds Hospital

Books will be available for sale. Location: Hillside Manor, 240 Blvd., Route 32, Kingston, NY. Registration Required: Please call 1-800-546-1754, ext. 2413 Co-sponsored by Ulster County Mental Health, Astor Home for Children, Inc. and Four Winds Hospitals in Westchester and Saratoga

MAY

May is Mental Health Month

Wednesday, May 1st • 1:00 - 4:00 pm

National Anxiety Disorders Screening Day

A program for consumers designed to provide an anonymous screening and educational information about anxiety and depressive illnesses. For information, or to schedule an appointment, please call 1-800-546-1754, ext. 2413. Free of charge.

A Special Program for Children's Mental Health Week

Thursday, May 2nd • 2:00 - 4:30 pm

Child Abuse Identification and Reporting

Joanna Landau, Ph.D., Psychiatric Nurse Practitioner, Adult Service, Four Winds Hospital

This course is required by all licensed professionals involved in reporting child abuse and neglect. A State Education Department certificate of completion will be given at the end of the class.

Fee: \$40.00 payable to the Four Winds Foundation, a non-profit organization

Grand Rounds

Friday, May 3rd • 9:30 - 11:00 am

Dialectical Behavioral Therapy: Achieving a Balance Between Acceptance and Change in the Treatment of Borderline Personality Disorder

Patricia Trainor, Ph.D., Private Practice, Mt. Kisco, NY

Drawing on a blend of traditional cognitive behavioral therapies and elements of Zen philosophy, DBT offers a fresh, compassionate approach in the treatment of Borderline Personality Disorder. Dr. Trainor will present a theoretical overview and offer pragmatic strategies for effectively managing difficult behaviors.

Fee: \$10.00 payable to Four Winds Hospital

Save the Date!

Thursday, May 16th • 8:15 am - 3:30 pm

The 23rd Annual Child and Adolescent Workgroup Conference

Co-sponsored by Rockland Unified Services, Child and Adolescent Workgroup, Four Winds Hospital, BOCES, SETRIC and the Mental Health Association of Rockland County. Location: Stony Point Conference Center, Stony Point, NY

For information and to register, please call Eileen Finn at (845) 364-3705.

Grand Rounds

Friday, May 17th • 10:00 - 11:30 am

The Use of Art in Healing the Silent Screams

Bobbie Kaufman, MPS, ATR-BC., Director, South Fork Mental Health Programs for the Family Service League of Long Island

This presentation will offer the audience the opportunity to learn to 'read' the messages presented in the drawings of survivors of childhood sexual abuse. Ms. Kaufman will review a series of survivor's drawings and will point out how the impact of sexual abuse is reflected in each. The collaborative use of verbal and art therapy will be explored. Attendees are invited to bring in client's artwork so that possible interventions which might be helpful in the survivor's healing journey can be discussed.

Fee: \$25.00 payable to the Four Winds Foundation, a non-profit organization

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

Due to limited seating, registration is limited to the first 120 paid registrants. 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.

For Registration and Information Please Call us at
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ADHD: Attention Deficit Hyperactivity Disorder

By Eugene M. Kornhaber, M.D., Board Certified Adult, Adolescent and Child Psychiatrist

ADHD is a neurobiological disorder. Simply put, it is physically, not emotionally based. ADHD has nothing to do with motivation, parenting, etc. It is a clearly diagnosable, and treatable, medical condition.



Eugene M. Kornhaber, M.D.

Discussion:

There is no test for ADHD. It remains a clinical diagnosis, as is true with depression, Alzheimer's, etc. While rating scales and other tests are helpful, they only confirm the presence, or absence of symptoms. For example, there are at least eight causes of short attention span, only one of which is ADHD.

Additionally, there is no such thing as borderline ADHD. That would be like being borderline pregnant. You either are ADHD or you're not. ADHD symptoms can, however, be present on a spectrum of mild to severe. In fact, ADHD symptoms are not abnormal, but an extreme of normal. For example, all of us, at some point in time, have a short attention span.

It is crucial to understand that ADHD is a disorder of inhibition. "He can't start doing what he's supposed to do because he can't stop doing what he's not supposed to do."

Children with ADHD also have selective attention spans. This means they can pay attention for hours to things that interest them, (e.g. Nintendo), but have more difficulty than average maintaining concentration on things of less interest. Attention is selective as the ADHD brain is a sleepy brain. Hence, these children need to be constantly stimulated. They love excitement, danger, and activity, as the sleepy brain needs a constant wakeup call. A child with a sleepy brain, in a classroom with 'boring' schoolwork, may become fidgety, talkative, and a general nuisance. Likewise, the daydreaming ADHD student may 'zone out' at various times and, thereby, be subject to gaps in learning.

ADHD individuals, even with significant learning disabilities, tend to have higher IQ's than the average population. In fact, although ADHD is present before age seven, it may not become symptomatic until high school, or even college. This is because ADHD children tend to possess wonderful auditory memories. They can remember things in class, and get good grades, in spite of very little effort and doing minimal homework. Eventually, however, their auditory memories cannot cope with material that is becoming more and more complex and, as a consequence, a formally good student starts to falter.

Types of ADHD:

There are four types of ADHD:

Predominantly hyperactive/impulsive: fidgety, overactive, on the go, talks excessively, Curious George, into everything, etc. Gender Ratio: 9 boys to 1 girl.

Predominantly inattentive: spacey, day-dreamy, confused, in a fog, low activity level, loving child, not a behavior problem, disorganized, forgetful, etc. Gender Ratio: 1 boy to 1 girl

Combined type: (combination of hyperactive/impulsive and inattentive types)

Adult ADHD: 25% of those having ADHD as children carry it into adulthood. Crucial to diagnosis is the presence of ADHD as a child, along with current symptoms such as impulsivity, disorganization, high activity level, inability to sit still for long periods of time, short fuse, etc.

Diagnosis:

As the diagnosis is medically based, it is best made by a medical doctor. This requires about two to three hours and must include a careful detailed history as well as both neurological and psychiatric exams. As symptoms may mimic those of other disorders, it is crucial to differentiate between them and ADHD. Likewise, there is a high frequency of ADHD coexisting with other disorders such as depression, anxiety, and learning disabilities. It is important that these disorders be acknowledged and properly treated.

Treatment:

Treatment should be multimodal, encompassing all aspects of the child, and clearly focus on the child's strengths. Medication should not be considered a "last resort." It is, frequently, the cornerstone of treatment. Just as diabetes is a chemically based disorder, so is ADHD. To not give medication, when warranted, is, in some ways, like withholding insulin from a diabetic.

The primary medication used with ADHD are stimulants. Their history is long, safe and effective (Dexedrine, 1937 and Ritalin, 1957.) Both have no long-term side effects. They are the most studied medications in pediatric literature. The main side effect from the medications is not to use them when they are indicated. Many untreated ADHD individuals resort to marijuana and alcohol to self-medicate and, thereby, embark on a path of self-destruction.

One of the key elements of treatment is preventing damage to self-esteem. This can be achieved through early inter-

vention (kindergarten through second grade). However, it is never too late to treat ADHD. My oldest ADHD patient is 78 years old.

ADHD is an eminently treatable disorder. I have been honored, and gratified, to work with this population for twenty-six years. They are truly special people. It is important to help them find their own unique areas of giftedness.

Dr. Kornhaber is a Board Certified Adult, Adolescent and Child Psychiatrist in Private Practice in Mount Kisco, New York. He can be reached by calling 914-241-0682

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- 24 hour crisis intervention
- Flexible full or half-day scheduling
- Weekly multi-family group
- On-site school
- 5 days a week (9:00 am - 3:00 pm)



Adult Partial Hospitalization Program

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Child Psychopharmacology In The Emergency Room

By Robert Catenaccio, M.D.
Assistant Clinical Professor
of Psychiatry, Albert Einstein College
of Medicine

Since every kind of problem finds its way into the emergency room, let us, in order to provide some focus for our discussion, limit our enquiry to the most common problems which might plausibly be responsive to medication. Of course, the usual caveats apply: medication works best in the context of ongoing treatment relationship including other modalities; medication compliance and the adjustment of dosage require a treatment alliance with both parent and child; and the doctor must be an educator rather than simply a technician, working to sharpen the awareness and articulation of symptoms, to flesh out a diagnosis which is meaningful in ordinary language, and to create a modest and realistic set of expectations, of risks and benefits.

What distinguishes emergency room psychiatry from routine practice is, sometimes, severity, sometimes the suddenness with which difficulties have developed, and, most of the time, the appalling incompleteness of the information available to the clinician. Certainly, then, it is best to do as little as possible, so as to do no harm; much of the time it is simply the holding function of the emergency room which provides the treatment. If a child already has a psychiatrist, and if time and conversation have, by defusing the crisis, made it safe for the patient to wait until the next outpatient appointment, it is most responsible to defer to the more knowledgeable clinician. But many cases fall into the zone where it is not possible to discharge the child without having first made a medication decision, and yet where actually admitting the child to a hospital would be undesirable or impractical.

For the sake of vividness we will imagine such a case, the most typical of all those boys, mostly, who are escorted into our emergency room. This boy, whom I shall call John/Juan/Jovann, or J

for short, was sent via ambulance by the school for an aggressive tantrum, beginning over a trifling argument with a peer, escalating as the teacher scolded both boys, and ending up with the school security staff and the assistant principal restraining J, as he bit, punched, kicked and was apparently heading for the window.

The background is as follows: J is ten years old, in a special education placement for the past three years, for language delays and explosiveness. He has had four similar incidents this school year, and one or two in previous years. He has many milder tantrums at home – according to his mother, who has just arrived from home shepherding three smaller ones. He generally resists limits, is moody and easily frustrated, and has been too rough with his little brother; two weeks ago, in fact, he had grabbed a kitchen knife in a fit of rage. The biological father has never been involved, and is currently incarcerated; a stepfather has been out of the home for over a year.

J. had been in foster care for six months when he was five, because of some combination of domestic violence and maternal substance use; and, when he was eight, he had stayed with a great-aunt for a few months because his mother couldn't handle him. Two brief episodes of treatment had petered out, once because of a move, once because his mother felt that he was better: he has never been on medication, and his mother doesn't know what condition J has. Maybe if he could talk his feelings out, she suggests, he could get to the bottom of things – is it sadness over missing his father?

J. himself, however, is quite clear about what the problem is: the teacher is mean and unfair, the other kids start trouble with him, his mother favors his brother, and if he doesn't get GameBoy Advance he will kill himself!

Since essentially all cases that come into the E.R. sound like this, how can we possibly come up with a set of rational medication choices? With time and many shrill demands pressing upon us,

what few questions would be most helpful to ask? Well, treatment must await some diagnosis, however imperfect, and the process of diagnosis here comes down to focusing on the differences between A.D.H.D., mood disorders, anxiety disorders, and subtle presentations of psychosis. While a thorough discussion of the differential diagnosis would be beyond the scope of this talk, a brief review may be helpful.

A.D.H.D. is extremely common, often missed, and frequently can be masked by oppositionalism. It can be part of a more diffuse picture of brain damage in severe learning disabilities or retardation. In intelligent children, the impulsivity is often, in the history, more prominent than the distractibility, since they can fade in and out and still get the job done. In the emergency room itself, unlike oppositional children, who respond to the long waits, the boredom and the inertness of the environment by first rebelling and then complying, children with A.D.H.D. progressively disorganize, exposing the organic roots of the condition.

The good news here is that psychostimulants are clearly effective, easily explained, and safe enough to begin in the emergency room, although dosages will have to be adjusted later. If a child is old or large enough, it makes sense to start with a long-acting preparation, and simply skip the visits to the school nurse altogether, thereby gaining in privacy as well as convenience.

Making a convincing diagnosis of a mood disorder is a bit harder, certainly if the presenting problem is as we have sketched out above. There is a ubiquity of tragic loss in the lives of our children; often it is hard to distinguish treatable depression from the lingering character effects of emotional deprivation. Still, if all criteria are met, we make the diagnosis and try an SSRI; often especially in young teens, there is chronic ruminative worry underlying the defensiveness, and this can get remarkably better in a week or two. The only danger is in worsening an unrecognized bipolar disorder.

Bipolar disorder in children is a hot topic, but definitive studies are hard to come by. Family history, aggressiveness, grandiosity, paranoia, wide swings in mood and energy level, and marked instability of sleep-wake cycles are prime symptoms to look for. Lithium is not a medicine we can use in our setting, but valproate (Depakote) is – we then expect liver function tests as part of the routine follow-up. But increasingly we are trying Gabapentin (Neurontin), which is generally very well tolerated, unlike valproate, which almost always makes people tired and hungry. Both medications are reasonably effective for aggressive outbursts, even when a firm diagnosis of bipolar disorder is not possible.

Finally, a word about psychosis, which of course is not a disease entity, but a general term related both to specific symptoms, like hallucinations and delusions, and to a global assessment of functioning. In a population of impulsive, over stimulated, often cognitively impaired children, some types of hallucinations or near hallucinations are very common: visions of movie monsters at bedtime, a voice urging destructive action when frustration mounts. In younger children, we rarely medicate such symptoms. If disturbed modes of thinking or perceiving lead to action, however, or to chronic anxiety and depression, then a very low dose of one of the newer atypical antipsychotics can be helpful. The parent deserves a good talk about risks and benefits, including drowsiness, weight gain and, rarely tardive dyskinesia. In addition, caretakers and clinicians alike should be aware of an unfortunate tendency in our field to continue such medications indefinitely, perhaps out of fear of unmasking the psychosis. Yet here, unlike the case in adult schizophrenia, we are often dealing with errors in processing which brain development alone will ultimately correct.

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Stop Bullying from page 15

work in this area led to the creation of a comprehensive program, "A Better Community: The ABC Program; Skills for Caring, Cooperation and Conflict Resolution". The ABC Program was designed for school systems interested in reducing the bully problem. No one person can solve bullying alone! In fact, a parent or a teacher working alone is no match for children who don't have the skills to manage their behavior. The only way to effectively deal with these problems is to enlist all school personnel in training, education, skill development and effective management techniques to deal with bullies and their victims. All of us want safe schools and healthy learning environments. A community approach to the bully problem, which

includes parents, teachers, teacher-aides and students, is the effective way to manage and reduce bullying.

A community approach means that school administration, teachers, teacher-aides, school personnel, children and parents all understand the dynamics of bullying and what constitutes an effective response. The ABC Program provides the training and language that is developmentally appropriate. This provides all of us with ways to talk about and deal with bullying/teasing. Parental involvement in training provides ways to identify and deal with their children if a problem is identified and helps parents feel empowered in their reporting/management of bully incidents to the school in ways that will provide resolution.

Children deal with bullies/teasing

when they learn skills to help each other in the classroom, feel safe in using these skills, and know that their actions to help each other will work. We all can make a difference by becoming a "majority voice" in our schools and having a clear, consistent approach to reduce bullying. A comprehensive approach lets the real ABC's take place.

Dr. Joel D. Haber has been a Clinical Psychologist since 1983. He is a co-owner and Clinical Director of Prime Care Psychiatric & Behavioral Health Services, a multidisciplinary group mental health practice in White Plains, New York. In addition, in private practice, he specializes in treatment of adults and families. Dr. Haber is extensively published and has recently completed a book tour promoting his newest publication, Primary Care Meets Mental

Health: Tools for the 21st Century.

Dr. Haber has served as a Consultant to the New York State Office of Domestic Violence as a trainer of health professionals in the detection and treatment of Domestic Violence. Dr. Haber's work has also focused on ways to enlighten people on the effects of violence in families, and the management of "bullying problems in school systems". Within this domain he has developed "The ABC Program: A Better Community; Skills for Caring, Cooperation and Conflict Resolution". The ABC Program is a school-based/community anti-bullying program that teaches children how to help each other reduce bullying and teasing.

Dr. Haber can be reached at (914) 686-6891, ext. 23. He can be faxed at (914) 682-7518.

Ticket to Work & The Economics of Recovery

By Donald M. Fitch, M.S.
Executive Director, The Center
for Career Freedom



Don Fitch

According to the Social Security Administration, 19,418 disabled beneficiaries of SSI and SSDI, 18-64 years old, residing in Westchester County will receive a "Ticket-to-Work and Self-Sufficiency" Voucher in the next several months. In NYS about 614,000 persons with disabilities will receive it. Distribution in Westchester began on February 11th.

The "Ticket" is SSA's latest effort to encourage persons with psychiatric or physical disabilities to return to work.

SSA estimates that fewer than 1% of SSI or SSDI beneficiaries leave the disability rolls and return to work. If only one-half of one percent ceased receiving benefits as a result of returning to work, the savings to the Social Security Trust Fund would be over three and a half billion dollars over the work life of these individuals.

In addition to encouraging recipients to leave SSI/SSDI for competitive employment and self-sufficiency, other purposes of the Ticket Program are to:

- Increase beneficiary choice in obtaining rehabilitation services, and to
- Remove barriers that require people with disabilities to choose between health care coverage and work.

Importantly, for the first time ever, the recipient will have a choice in deciding who they want to assist them in obtaining employment and other support services. They will no longer be mandated to utilize VESID, New York State Education Department's Vocational and Educational Services for Individuals with Disabilities.

Other benefits to the recipient for leaving SSI/SSDI and returning to competitive employment include:

- Extended Medicare coverage from the current 4 years to 8 ½ years
- No Medical Continuing Disability Review for 5 years during employment
- Access to benefits planning to ease the transition to self-sufficiency.

A booklet which accompanies the Ticket to Work instructs recipients to call MAXIMUS at 1-866-968-7842 to learn where they can obtain vocational services. To learn even more about ticket to work, you should visit www.yourtickettowork.com or www.ssa.gov/work.

Currently there are four

choices for persons with psychiatric disabilities in Westchester; VESID, The Center for Career Freedom, Human Development Services of Westchester (HDSW), and the Mental Health Association of Riverdale.

The Ticket is a milestone on the road to recovery and we applaud the efforts of the advocates, caregivers and legislators who brought it to fruition. However, had it not been for the heroic efforts of Harvey Rosenthal of NYAPRS who, along with others, chained themselves to Governor Pataki's office to urge passage of the Medicaid Buy-In initiative, the ticket could not fulfill its promise.

Currently, SSI/Medicaid beneficiaries who attempt to work their way off of SSI to self-sustaining competitive employment are penalized because SSI takes one-half of all earnings over \$85./mo. This and the Medicaid spend-down requirement together wipe out most of what they earn. Dollar wise, these have been the major barrier to re-entry into the workforce.

On January 23rd, the NYS Assembly and Senate passed the Medicaid Buy-In legislation, a landmark opportunity which allows disabled people to earn up to \$45,500/year and still receive Medicaid coverage (at a cost of \$1,260/year in premiums). If it is signed into law and funded, the program would begin in April 2003 giving people a year to prepare, train and test the waters with part-time employment.

While this is certainly good news, major hurdles still exist; rent takes .30 of every \$1.00, (Sec. 8/Shelter Plus), and food

stamps are minimal (\$10/mo) for persons in supported housing. For example, a person who wants to go back to work and earn \$400/mo. keeps only \$6 out of the \$400.

Hopefully, the next milestone will enable SSI recipients to transition to full time employment by providing a higher earnings threshold, at least at the poverty level.

SSDI beneficiaries who want to go back to work and earn \$400/mo. maintain an almost 2:1 economic advantage over SSI beneficiaries. According to SSA's "Red Book on Employment Support", SSDI beneficiaries can earn up to \$780./mo and still retain their disability status and income. For example, the average consumer at our Center receives 800/mo in Social Security Disability. If they went back to work and earned \$750, their total monthly income would be \$1550 with a net gain of \$280. This does not include on going prescription drug costs which can run \$150-\$400+/mo. (These are deductible).

To address the consumer/survivor's response to these changes The Center recently initiated a survey among SSI and SSDI beneficiaries to quantify the impact of future earnings on benefits and the desire to return to work. Results will be reported in a future issue of Mental Health News.

It is the responsibility of every caregiver to understand and communicate the realities of the *economics of recovery* to all consumers/survivors who want to return to work and especially to the Ticket-holders.



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The Sopranos: Violence, Psychiatry and the Mob

By Joseph Deltito M.D., Clinical Professor of Psychiatry and Behavioral Science, New York Medical College, Consultation Practice: Greenwich, CT



Joseph Deltito M.D.

To some people "Anna Karenina" will always remain no more than a novel about an unfortunate train accident and "Moby Dick" will endure solely as a story of an elaborate fishing expedition gone tragically wrong. Should you fall into this category you will most likely regard the "Sopranos" as nothing more than another mob story about the violent lives of a group of Italian-American gangsters. Should you possess certain sensibilities, you may even see this weekly TV drama as anti-Italian, perpetuating disturbing ethnic stereotypes. For those who look at their Drama from a deeper level there is nothing neither stereotypical nor anti-Italian to be found here. This popular TV show parallels a classic Greek tragedy in its portrayal of its main character and "Hero," Tony Soprano. As the series' main character, he is arguably depicted as the most psychologically complete and complex character ever portrayed on an American TV series. He is a most sympathetic character to millions of Americans due to his mixture of fragility and power. While being the powerful "Capo di tutti Capi" of the North Jersey mob, he nevertheless suffers from any of the frailties most of us recognize in ourselves. Tony who loyally protects those he loves may appeal to viewers as the prototypical best friend most of us crave. Remember the utterances of that other most famous mob boss, Don Vito Corleone, of the "Godfather" -- if Tony Soprano was your friend "your enemies would certainly become his enemies" and few people would bother you. He is therefore an

attractive character many of us might want in our lives.

Much of the storyline in the "Sopranos" is revealed in the interaction of Tony with Dr. Melfi, his psychoanalytically oriented psychotherapist. Tony suffers from Post Traumatic Stress Disorder, panic attacks, ambivalent feelings about the violence he dispatches to his enemies, and the multiple wounds inflicted upon him by a mother with a primitive personality disorder (who even conspired to have him assassinated). He is haunted by the belief that he was destined to live this and only this life, and that perhaps even his son is similarly genetically injured so that he can only expect to have a life and the future full violence. Tony strives to balance his own brand of power and force with his sense of duty to protect and to provide for his family and friends; a burden that weighs heavily upon him. Tony therefore is a complex man dealing with threatening and burdensome decisions. He tries to cope with the aid of Psychotherapy and better himself in the process.

Dr. Melfi, his psychiatrist, blends some practical counseling served up with psychoanalytically oriented interpretations about Tony's worldview and behaviors. She also dispenses a somewhat unsophisticated brand of pharmacotherapy. As such, I believe she actually portrays a rather credible rendition of what a psychiatrist may represent in a general office psychiatric practice. Dr. Melfi is humanized through the depiction of her own frailties and confusions. She deals with personal fears generated by knowing the confidences of a man, the knowledge of which may prove personally dangerous to her. Despite her fear, ambivalence and inconvenience (at one point she needs to go into hiding) she persists in her role as Tony's therapist. At some point during the therapy Dr. Melfi is violently raped by an unknown assailant, whose identity is later discovered. She nobly fails to disclose this to Tony as she and everyone American knows he would feel obligated to eliminate this man himself. In not sharing this information with Tony she subjugates her own thirst for violence and revenge to the greater good of not shifting the nature of her psychotherapeutic relationship with Tony, thus enabling him to continue his psychotherapy with her.

This brings me to the core issue I wish to explore in this article. Should a life full of violence, in itself, be considered a feature of psychiatric disease or personality pathology? I believe the in-

formed answer to this question is that it may or may not! The practicing therapist should be cautioned not to automatically view it as such. Who is pathologically violent and who is essentially defending his country, tribe, family or self oftentimes has more to do with the person making the judgments than the individual perpetrating apparently violent acts. One man's terrorist is another man's freedom fighter. Violence in certain sub-cultures, as in organized crime families or East Los Angeles gangs, may say little about the presence of neither personality nor psychiatric dysfunction in their individual members. One could certainly argue that such violence may be "evil" but it may not be "crazy" in any real sense of the word as it represents a shared worldview of a cohesive subgroup. In such groups murder to protect the whole or to enact revenge may be a socially expected duty on the part of its members.

Back to Tony Soprano! He maintains to Dr Melfi that the violent acts he commits are morally acceptable and not a sign of being psychiatrically ill because he is "like a soldier in a war". This is logically congruent with a strong ethic within the mob not to injure "civilians," the word used to describe those not directly involved in mob activities. In addition there is a strong code regarding who deserves extermination and who does not. Micheal Corleone in the "Godfather" makes the argument to his then girlfriend that senators and governors are involved in crimes and murder and that therefore what his father does is just "business." David Chase, the creator of the "Sopranos," illustrates many members of society as pervasively corrupt in their approach to their fellow man. These include otherwise well regarded politicians, college administrators, college students, Black activist-preachers and others. The resounding message is that many people are corrupt; Tony is just another businessman playing a dangerous game by a fixed set of rules.

Psychiatric diagnoses and evaluations are not meant to be made in a reductionistic fashion: patient shows X, it must mean Y. In the age of Managed Care and HMO erosions of reasoned and comprehensive psychiatric evaluations such reductionism is rampant. Any good psychotherapist knows that they must evaluate a patient within their ethnic, religious, cultural and sub-cultural context. It is not delusional for a Christian to firmly believe that a virgin could give birth to a

child, nor is it a sign of psychopathology that a Buddhist monk might set himself on fire to protest an unjust war. We generally applaud members of our Armed Forces for using deadly force to repel our enemies; we do not think of them individually as suffering from blood thirst and anti-social behavior.

As a psychiatrist, often involve the forensic cases and debate, I marvel at many of my colleagues who continue to describe violent gang members as antisocial sociopaths, without any regard for anyone in society when many of their crimes are motivated by an intense loyalty to their fellow gang members. I'm not suggesting we legally give Mafiosi or members of gangs, like the Crypts, a pass, just that their violence may very well in no way represent individual psychiatric nor personality disease.

Some would argue that mankind, itself, is inherently violent. The full anthropological record does not support this position as there are distinct societies where war and personal violence seems to not exist, as may be found in some Inuit cultures. There is great evidence that humankind is easily corruptible through misguided authority. The message of the horrors of the Holocaust in Nazi Germany is not that there was a violent bloodthirsty society who killed so many Jews, Gypsies and other perceived "Undesirables" but that otherwise psychologically normal people were convinced to participate (or look the other way) in its occurrence because the dominant authority deemed it proper to do so.

Tony Soprano is part classic Greek tragic figure, part everyman, who lives in a world which trades in violence. He psychologically struggles with his participation in such a world. He is a man who tries to do the best he can, while trying to comprehend a better life for himself and his family. He lives a life according to a well-defined code of ethics and behaviors.

Tony psychologically struggles with the thought that he's a slave to destiny and fate and cannot make any change in the future of his life. I would like to think that with the help of Dr. Melfi Tony can come to a better peace within his world and learn how to give personal direction to his future. He's not condemned by genetic constitution or personal development to suffer the inability to change the direction of his life. Psychotherapy is not about "insight" but it is about "positive adaptive change based on insight;" this is the essence of "this thing of ours," we Psychiatrists.

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Close relatives of individuals with Borderline Personality Disorder (BPD) often report feeling bewildered and inadequately prepared in relating to and helping their family members. Working with several patients and their families, Dr. Perry Hoffman of New York-Presbyterian Hospital, Westchester Division, has co-founded the National Education Alliance for Borderline Personality Disorder (NEA-BPD). The organization is hosting a conference, to be held at Columbia University on October 19 and 20, 2002, which will provide an opportunity for families and BPD professionals to share information and learn from each other.

Further information is available on the Web at www.borderlinepersonalitydisorder.com; by e-mail at neabpd@aol.com; or by phone at (914) 835-9011.

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Specialized Treatments For Personality Disorders Offered at New York-Presbyterian Hospital, Westchester

Staff Writer
Mental Health News

Beginning in the 1970s under the leadership of Otto Kernberg, MD—internationally recognized as an expert in the field of personality disorders—New York-Presbyterian Hospital in White Plains has been in the vanguard of researching and developing specialized treatments for people suffering from the symptoms and behaviors associated with these mental illnesses.

Personality disorders are characterized by mood instability and difficulties in interpersonal relationships, self-image and behavior. This group of conditions is more prevalent than either schizophrenia or bipolar disorder, afflicting approximately 15% of the general population of the United States. The most common is borderline personality disorder (BPD), which affects mainly young women and involves a high rate of self-injury, as well as suicide attempts and completed suicide. Other symptoms include impulsive behaviors such as unsafe sex, overspending, and unstable, unpredictable mood fluctuations, including inappropriate, intense anger. This symptom picture is often complicated by substance abuse, eating disorders and mood disorders. All of these behaviors increase the likelihood of lost relationships and jobs.

Despite the severity of BPD and related personality disorders, effective treatments have evolved in recent years that are making it possible for patients to recover from the debilitating effects of these conditions. These treatments are grouped into two separate approaches: dialectical behavior therapy, based on cognitive behavioral strategies, and psychodynamic psychotherapy, based on psychodynamic strategies. Both are available at the Westchester Division.

Dialectical Behavior Therapy

Perry D. Hoffman, PhD, is Coordinator of the Dialectical Behavior Therapy Day Treatment Program, which focuses on behavioral change in creating and enhancing one's quality of life. Dialectical Behavior Therapy (DBT), a form of cognitive therapy, emphasizes a balance of accepting, in the moment, what can't be changed, and using problem-solving skills to make changes where possible. Patients are expected to make a commitment to life while acquiring adaptive coping strategies to effectively manage emotions. The therapeutic staff, all of whom

have undergone intensive training by certified DBT trainers, include Dale Terelli, RT; Randee P. Levitt, MS, RN; Carol S. Sandak, ACSW; and Jeremy Stone, PhD. Psychiatric coverage and pharmacology are provided by Ruth Lubleski, MD and Katherine Grunes, MD.

Formulated in the 1970s by Dr. Marsha M. Linehan, a researcher and clinical psychologist, DBT is a manualized, semi-structured therapy where treatment goals are organized hierarchically, with the top priority the reduction of parasuicidal and life-threatening behaviors. "If a patient has engaged in self-injury, the session will focus on this behavior and will be spent doing a detailed behavioral analysis," says Dr. Hoffman. Other goals include reducing or eliminating behaviors that interfere with therapy; decreasing behaviors that hinder or destroy quality of life while increasing those that enhance life; learning emotional, relationship and problem-solving skills; and reducing suffering by addressing the sources of emotional pain.

Participation in the DBT Day Treatment Program varies from several weeks to several months, with patients attending the program for three hours a day, five days a week. The multidisciplinary treatment team provides ongoing comprehensive evaluations, skills training and psychotherapy groups, individual psychotherapy, multifamily therapy, and psychiatric medications, when needed. Controlled clinical research has documented the effectiveness of DBT in reducing parasuicidal behaviors and length of inpatient hospitalization and in improving social adjustment. For further information, please contact Dr. Hoffman at (914) 997-8628.

Psychodynamic Approaches

Another approach to personality disorders, psychodynamic psychotherapy, focuses on the importance of the therapeutic relationship in eliciting the motivations of patients who engage in self-destructive behaviors, and helping them to substitute more successful behaviors. "Psychodynamic psychotherapy is effective to the degree that it helps patients understand their own motivations in maintaining problematic behaviors and encourages changes in these behaviors through the use of the relationship with the therapist," says Catherine Haran, PsyD. Personality Disorders Clinic staff in addition to Dr. Haran are Sonia

Kulchicky, MD, Sheila Cherico, MSW, William Deal, PhD, and Joan Jablow, CNS, NP.

Two related but distinct forms of psychodynamic psychotherapy are offered at the clinic. Transference Focused Psychotherapy (TFP) was developed by Dr. Otto Kernberg and his colleagues at the Westchester Division. The treatment consists of twice-weekly individual psychotherapy, in which a specific treatment contract between the therapist and the patient is drawn up at the beginning of therapy. The contract is directed at the suppression of problematic behaviors outside the session hours. This suppression, combined with the interpretation of "equivalent" behaviors within the session, serves to increase development of insight into the evolution of the circumstances which led to problematic behaviors, and thereby offers the possibility of control over them. The ultimate aim of TFP is to bring about change in the patient's personality structure.

Supportive Psychodynamic Psychotherapy (SPP), developed by Drs. Ann Appelbaum and Monica Carsky and their colleagues, usually involves one individual session per week. Using techniques such as reframing, education, modeling, emphasizing strengths and encouraging health-promoting behaviors to increase adaptive functioning, the therapist pays attention to maintaining an appropriately positive relationship between patient and therapist. Difficulty tolerating "negative" feelings such as anger is often the precursor of impulsive acts, and the supportive therapist helps the patient increase his or her capacity to tolerate feelings without having to act impulsively. As with DBT, all psychodynamic psychotherapeutic approaches use psychopharmacological interventions where appropriate.

For further information about these specialized psychodynamic psychotherapies, contact Dr. Catherine Haran, (914) 997-5840; or Sheila Cherico, MSW, (914) 997-5746.

Personality Disorders Institute

The Personality Disorders Institute at the Westchester Division, under the direction of Drs. Otto Kernberg and John Clarkin, has conducted research into the treatment of people with personality disorders for many years. Currently engaged in an ongoing comparison study of the effectiveness of the most up-to-date treat-

ment approaches (DBT, TFP, SPP), the Institute is offering a one-year course of treatment free of charge to those who meet the criteria for admission. Information about the Personality Disorders Institute is available at info@borderlinedisorders.com; or by phone at (914) 997-5906. For information about the study, contact Nina Huza, (914) 997-5906.



Borderline patients suffer from a dominance of negative affects: anxiety, rage, guilt, depression, irritability, fear. . . . These affects may reflect neurobiological disparities and/or severely traumatic experiences in their early years. The effects of these negative affects are chronic disturbances in these patients' relations with significant others, and with themselves—what is called identity disturbance or identity diffusion. Various psychopharmacological treatments may reduce these negative affects and help the patients to achieve a more effective equilibrium. In the long run, however, specialized psychotherapeutic treatments such as DBT or TFP may be more effective in achieving lasting improvements, particularly in some cases where TFP may bring about fundamental personality changes that resolve the identity diffusion.

Otto F. Kernberg, M.D.

Otto F. Kernberg, M.D., is Director of the Personality Disorders Institute at New York-Presbyterian Hospital, Westchester Division and Professor of Psychiatry, Weill Medical College of Cornell University.

Parenting The Angry Child

By Stephanie Speer, MA
 Coordinator of Community Education
 Mental Health Association in
 Dutchess County, Inc.

As the Coordinator of Community Education at the Mental Health Association in Dutchess County, I have recently developed a six session skill-building series for parents who have children who are easily frustrated, chronically inflexible and explosive. For the past six years, I have been facilitating a popular and effective skill-building series "Managing Defiant Behavior" created by Russell A. Barkley, Ph.D. Although this nine-session program series has proven to be useful and beneficial for the majority of participating families, I noticed that for certain parents this program did not appear to be helpful for their children who in some instances were extremely volatile, aggressive or destructive.

I began to investigate ways in which I could help parents to better understand and address the emotional content that motivated and manifested within their child's behaviors and reactions to

life situations. The Managing Defiant Behavior course, like most behavior management approaches, did not sufficiently focus upon the emotional content of a child's experience but instead relied upon rewards and punishments as the primary approach for managing behaviors. When I came upon the work of Ross W. Greene, Ph.D., author of *The Explosive Child*, child psychologist and researcher at Massachusetts General Hospital and Harvard Medical School, I discovered an alternative approach that specifically focused upon preventing and managing explosions in children who are easily frustrated and chronically inflexible.

Dr. Greene has created a practical and systematic approach designed to help parents and providers manage, cope and help the children who are easily frustrated and inflexible. These children often make life extraordinarily challenging and frustrating for themselves, parents, siblings, teachers, other adults and peers. Many of these children are diagnosed with disorders such as oppositional defiant, at-

tention deficit, Tourette's, depression, bipolar, obsessive compulsive, learning disabilities or Asperger's. Dr. Greene goes beyond the diagnosis and provides tools and skills designed to:

- reduce hostility and antagonism between the child and adults
- anticipate situations in which the child is most likely to explode
- create an environment in which explosions are less likely to occur
- focus less on reward and punishment and more on communication and collaborative problem-solving
- help the child develop self-regulation and thinking skills to be more flexible and handle frustration more adaptively

Although the work of Ross W. Greene, Ph.D. is readily available in his book *The Explosive Child*, I have chosen to create and provide a skill-building series for parents that would provide in-

struction, guidance and support. A parenting skill-building series serves to provide information, education and instruction in the context of a safe, supportive and structured environment. As a member of the group, parents soon discover they are not alone. Participants receive ongoing support, understanding and guidance not only from the instructor but from the participants as well. The specific time set aside for each class, away from the children and the demands of daily living, helps to focus attention, concentrate efforts, reinforce skills and gain the strength to continue. This program is not a quick fix or a simple recipe but rather an in-depth exploration and individualized approach to helping parents help their child to reduce and better handle frustrations, prevent and diminish intense emotional outbursts and aggressive behaviors.

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JBFCS Center for Trauma Program Innovation Expands Key Element in Trauma Treatment Response

By Caroline Peacock, Hunter College School of Social Work Intern



Robert Abramovitz, M.D.

The World Trade Center disaster required New York City Mental Health agencies to rapidly mobilize their services and created an unprecedented demand for clinicians that possessed a sophisticated understanding of the traumatizing effects of disaster. The necessity to respond in this manner taxed every agency's capacity. However, according to Dr. Abramovitz, chief psychiatrist at the Jewish Board of Family and Children's Services (JBFCS) and founder and director of its Center for Trauma Program Innovation, "JBFCS was able to mount a robust response thanks to aggressive planning in trauma-focused programs at our agency over the past six years."

In 1998, JBFCS launched the Center for Trauma Program Innovation (CPTI), the result of a unique gift that created the Saul Z. Cohen Chair in Child and Family Mental Health. The mission of CTPI is to create appropriate services for JBFCS programs interested in establishing a trauma treatment capability, as well as enhancing the trauma resources in the community. The CPTI addresses clinical needs, trauma training, community collaboration, program development and research within and outside the agency.

This allowed JBFCS to begin the necessary trauma-related work described herein immediately on 9/11. Fortunately, the CTPI will be able to continue to provide services made necessary by the aftermath of 9/11 and the continuing state of danger that has ensued and be able to sustain this effort for years to come. As a result of generous philanthropic gifts and the award of an NIMH grant, JBFCS is expanding the Center. The NIMH grant was obtained through a close collaboration between the CTPI and the Mount Sinai School of Medicine's Child Trauma Program and aims to build a true academic-community partnership to foster clinical and evaluation projects.

With the help of the current Cohen Chair, the CTPI will provide trauma-related resources to the agency and community as it expects an increase in the number of people suffering from PTSD. The agency plans to create a continuum of services through development in a

variety of interrelated areas.

To address the unique impact of 9/11, the CTPI is developing a new traumatic grief module within its pre-existing Loss and Bereavement Program for Children and Adolescents. This program's highly experienced clinicians provide group services to children and adolescents who have lost a parent. The groups for children run concurrently with groups for the surviving caregiver. In response to 9/11, the Loss and Bereavement Program will be offering a traumatic bereavement group beginning in March for children who lost a parent and their parents who lost a spouse in the attacks. Preschool and toddler programs are a priority for the CTPI, as many families with small children lost a parent in the World Trade Center. This is just one of many ways that the CTPI is responding to the needs of the community since 9/11.

Jewish community outreach and support groups will be enhanced through the Jewish Healing Center, one of the agency's programs which is already providing ongoing bereavement groups and trauma counseling. Trauma treatment specialty services will be developed within the agency's 14 mental health clinics to prepare for the onset of many people seeking trauma-related services. Crisis and disaster intervention programs will be developed to prepare the agency and the CTPI for any future disasters, or small-scale crises in the community. The area of secondary trauma resources will be enhanced in anticipation of the needs of our clinicians. The CTPI became part of the Partnership For Recovery in the New York City schools by building upon its Youth Counseling League's pre-existing on-site school-based program at Stuyvesant High School. This is a disaster recovery program which began with the specific intention of serving the five high schools in lower Manhattan that were evacuated on 9/11; it has now expanded to provide services for the entire school system. Finally, the agency will provide public education on trauma-related subjects with the intention of informing the community on what to expect in the aftermath of a large-scale disaster.

All of these new programs represent an expansion of work begun directly following the attack on the World Trade Center. The CTPI immediately began distributing information on trauma and disaster, and its effects on children and adults, to clinicians and staff. According to Dr. Abramovitz "we did that because we knew that psycho-education and resources that supported active coping were critical to counteracting the acute effects of exposure to such an overwhelming event." Understanding that in the immediacy of disasters of this magnitude a person can experience either a great deal of distress and arousal, or extensive denial and numbing, the CTPI stressed interventions that re-establish safety and emphasized

interventions aimed at stabilizing affect dysregulation and counteracting dissociation. These included teaching relaxation and grounding techniques and self-care activities.

In response to the attacks, JBFCS established seven drop-in centers at its clinics to provide services free of charge to those affected by the event. A crisis hotline was established to provide referrals to individuals in need. Various JBFCS mental health professionals also provided counseling for individuals and groups at companies and community centers throughout the city. They received rapid intensive training from Dr. Claude Chemtob and various CTPI staff including Dr. Abramovitz, Dr. Paula Panzer and Libbe Madsen. These efforts addressed more than 3,000 individuals and 200 companies. In addition to this work, clinicians continued to respond to the needs of their established clients, many of whom were re-traumatized by the events of 9/11.

One month after 9/11, the CTPI conducted a survey of all agency clients to determine the level of exposure to the attacks. As research indicates, people exposed to traumatic events often do not acknowledge the trauma until months or years after. The data indicated that JBFCS clients were not experiencing a

great deal of these symptoms, which was to be expected just one month after the event. Now, at the five-month anniversary, another round of surveys will be distributed to determine the amount of new and established clients who are experiencing trauma-related symptoms as a result of 9/11, as the number has probably grown. As many JBFCS clients have been previously exposed to trauma in their lifetimes, this increases the probability of re-traumatization.

As previously mentioned, the CTPI accomplished many of these goals with the help of experts in trauma work who have been appointed to the Saul Z. Cohen Chair in Child and Family Mental Health. The Chair has focused on enhancing JBFCS' trauma competence. Its recipients have included Dr. Bessel van der Kolk, Director of the Trauma Center, Allston, MA; Dr. Sandra Bloom, Director of Creative Alternatives, Philadelphia, PA; and currently, Dr. Claude Chemtob, Director of Child Trauma Program, CATCH, at Mount Sinai School of Medicine in New York.

Before the creation of the CTPI, Dr. Bessel van der Kolk, a renowned expert on post-traumatic stress disorder from Harvard University, was appointed the

see *JBFCS Expands* on page 29



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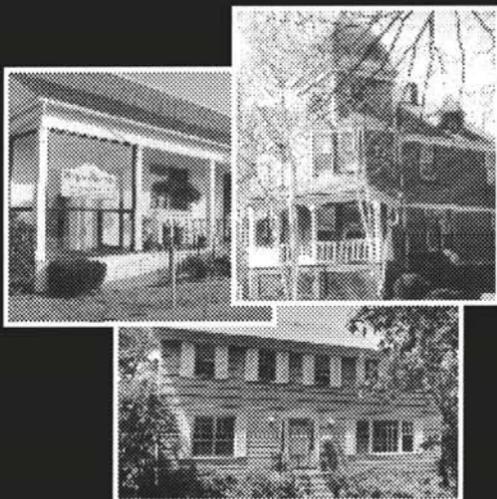
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Autism - the Challenge and the Hope

Staff Writer
Mental Health News

Catherine Johnson remembers thinking about the future of her first child -- one filled with great promise.

But a few years after her oldest son, Jimmy, was born, he was diagnosed with autism and it seemed that the world -- and her family's future -- had ended. Johnson, of Irvington, N.Y., compares the pain of that realization to the pain of childbirth -- only mental.

"I thought my life, and his life, was over," she recalled. "It was devastating, and also very confusing because my child was not dead, but my dream of what his life would be was never the same."

Autism is a complex brain disorder that often inhibits a person's ability to communicate, respond to their surroundings, or form relationships with others. Few disorders are as devastating to a child and his or her family. An estimated 500,000 people in the country are living with some form of autism.

Autism is considered a spectrum disorder because symptoms and severity vary widely from individual to individual. Autism spectrum disorders occur in as many as one in every 500 births, making it the third most common developmental disability, after cerebral palsy and mental retardation. Currently, there are no biological markers, specific medical treatment or cure for autism. It is a disability that often requires lifelong supervision and care.

Johnson and her husband, Edward, accepted that their son had autism, but also adopted a fierce commitment to provide him with a happy, healthy life -- no matter what.

Maintaining that commitment would not be easy.

Despite Jimmy's occasionally difficult behavior, they took him out to restaurants, on airplanes and to visit with friends. They did not allow Jimmy to run wild, which meant constant physical struggles that became more intense as he grew older.

"A child should not be a tragedy," she said. "Children with autism, or any disorder, deserve parents that are very proud of them and what they can accomplish."

Having a child with autism presents many challenges. Having more than one is even more challenging.

The family welcomed twins when Jimmy was seven. Experts told the Johnsons that they had never seen a family with more than one case of autism -- until Andrew and Christopher were born.

Like his older brother, Andrew was diagnosed with autism by the age of two. But unlike Jimmy, he had different behavior challenges. Andrew did not act wildly, but was totally non-verbal and detached. Andrew's twin brother, Christopher, does not have autism.

Johnson estimates that it took her and her husband about two years to "mourn" each diagnosis of autism and reemerge, stronger than before.

That strength was tested when behavior experts told the Johnsons that their oldest son would likely have to be placed in a home -- away from his family. It was

an option the family flatly rejected.

The Johnsons instead talked to Jimmy's doctor about various medical interventions to treat autism, some patients have benefited from select medicines.

Jimmy's psychiatrist suggested that Jimmy take a tranquilizer and as a result the boy was transformed. About a year later, Jimmy started acting out again, but began taking another prescription to help him sleep. The family doctor suspected Jimmy was misbehaving because he was exhausted. As he started sleeping regularly, his behavior improved again. It was the right combination for Jimmy, who is now approaching 15. Today, he attends high school and is on-track to have a full, rewarding life.

Like his older brother, Andrew also has made progress through a strong educational program and prescribed medications. He came out of his shell and started to interact with others after his third birthday, when he started taking an antidepressant, commonly used to treat some symptoms of autism.

Today, Andrew engages in pretend play, makes good eye contact and is a very outgoing and warm boy. Although he still does not speak, he is teaching himself how to read, and has a wonderful personality.

Johnson said it is vital for parents of children with autism and other disorders to remember to focus on the positive things about their children's life that make them special.

"People with autism often times have many special, hyper-specific skills, which may be useful in the workplace," said Johnson. "We have to recognize these special talents and see how they can help people with autism have a brighter future."

In addition to immersing herself in learning about autism, Johnson became an active volunteer for the National Alliance for Autism Research (NAAR), the first non-profit organization in the US dedicated to advancing biomedical research that seeks to find the causes, prevention, treatment and cure for autism spectrum disorders.

She served several years on NAAR's Board of Trustees and as editor of the organization's autism research newsletter, NAARRATIVE. Johnson is currently helping to organize the first WALK F.A.R. for NAAR autism walkathon in the Westchester/Fairfield community. The event takes place Sunday, June 2 at Manhattanville College in Purchase, NY.

Autism Symptoms & Treatment

Autism was first identified by Dr. Leo Kanner more than 50 years ago, and is typically diagnosed by the age of three.

Some symptoms of autism spectrum disorders mirror those associated with other mental conditions, such as clinical depression and obsessive-compulsive disorder. Common symptoms include mood swings and intense, repetitive behavior.

In addition, some pharmacological treatments commonly used to treat clinical depression are also used to treat autis-

tic symptoms. Selective Serotonin Reuptake Inhibitors (SSRI) are commonly used to treat joint attention and help control mood swings and temper in some individuals with autism and those diagnosed with clinical depression.

Autism: Symptoms

Symptoms of autism spectrum disorders include delays or abnormal development in social interaction and language. Although normal in appearance, children with autism are often withdrawn within their own world and are unable to communicate normally, relate to others or learn to understand the infinite nuances of human interaction. Children with autism are typically unable to participate in imaginative play and may engage in odd behaviors and rituals and are commonly resistant to change.

A baby might show early warning signs of autism if he or she: Does not babble or coo by 12 months; Does not gesture, wave or grasp by 12 months; Does not speak single words by 16 months; Does not speak two-word phrases on their own by two years; Has any loss of any language or social skills at any age.

Autism: Treatment & Interventions

Early interventions, especially those beginning before the age of three, have provided the most promising improvements. However, any delay in diagnosis can reduce the effectiveness of early treatments.

According to the National Institute of Child Health & Human Development, some treatments providing hope to many families of children with autism include: Individualized Education Programs, which involve a wide variety of interventions and are designed to help individuals with autism overcome specific problems.

Comprehensive Treatment Programs range from specific learning methods to reaching specific developmental goals. Typically, children need to be in this type of program between 15 - 40 hours each week for two or more years to benefit from the therapy.

Applied Behavior Analysis focuses on reducing specific behaviors and teaching new skills. Recently, these programs have included interventions used prior to or following problematic behavior as well as treatments useful during problematic behavior. These interventions seek to reduce the chances that certain situations will trigger problematic behavior.

Positive Behavioral Interventions & Support attempts to increase positive behavior and decrease problematic behavior by focusing on the interactions that individuals with autism have with their environment and their learning processes.

Pharmacological treatments can help improve behavior or relieve some symptoms of autism. Medications are used to target a specific behavior such as self-injurious, aggressive or compulsive behaviors that may allow the individual to focus on other things such as learning.

When considering treatment options, it is important that patients with autism be evaluated for co-morbid, potentially treatable conditions, such as seizures, aller-

gies, gastrointestinal problems, or sleep disorder. The information in this article is meant to be general and not to be considered medical advice. Please consult your family physician, neurologist or psychiatrist before deciding on any treatments for autism spectrum disorders.

Autism Resource List

Autism Resources - www.autism-info.org ; **Autism Society of America** - www.autism-society.org ; **Families for Early Autism Treatment** - www.feat.org ; **National Institute of Child Health & Human Development** - www.nichd.nih.gov/autism ; **National Institute of Mental Health** - www.nimh.nih.gov ; **National Center on Birth Defects & Developmental Disabilities** - www.cdc.gov/ncbddd/dd ; **National Alliance for Autism Research** - www.naar.org ; **New York Families for Autistic Children** - www.nyfac.org ; **Westchester (N.Y.) Parent Link** - www.westchesterparentlink.org ; **Westchester Institute for Human Development** - www.nymc.edu/wihd

Making a Difference

Interested in making a difference? It is as easy as taking a walk. WALK F.A.R. for NAAR, the National Alliance for Autism Research's signature fundraising and autism awareness event, is coming to the Westchester/Fairfield community for the first time on Sunday, June 2 at Manhattanville College in Purchase, NY. Proceeds from this event benefit will help NAAR further advance autism research. For more information, please call (203) 862-9447 or visit www.autismwalk.org.

Walk F.A.R. for NAAR is held annually in numerous communities across the United States.

Established in 1994, the National Alliance for Autism Research (NAAR) is the first national non-profit organization in the country dedicated to funding and accelerating biomedical research for autism spectrum disorders. The organization was established by parents of children with autism who were concerned about the limited amount of funding for autism research. Last year alone, NAAR committed more than \$3 million in grants for biomedical research projects worldwide that seek to find the causes, prevention, effective treatments and, ultimately, cure for autism spectrum disorders. Additionally, NAAR was instrumental in establishing the Autism Tissue Program, the first parent-led brain tissue donation program for autism research.

NAAR has achieved many milestones in its brief history, but much more must be done. Despite a national interest in autism and high prevalence, autism research remains one of the lowest funded areas of research by both private and public sources. Support for NAAR enables it to continue funding autism research that will one day find the causes, preventions and treatments, and a cure for autism and related disorders.

For information on supporting autism research and becoming a NAAR donor, please call 1-888-777-NAAR or visit their website at www.NAAR.org.



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JBFCS Expands from page 25

first Cohen Chair to address the treatment needs of traumatized populations. Through his work in enhancing the trauma resources at JBFCS, the CTPI was created in 1998. This group brings together JBFCS' core group of trauma experts who have continued to elaborate on the work of the Cohen Chair in the agency and community. The second appointed chair, Dr. Sandra Bloom, introduced the Sanctuary Model to the agency. This was implemented in residential programs to create a safe community for potentially violent adolescents who had been exposed to traumatic events. Additionally, the Sanctuary Model was implemented at one of our shelters for battered women. The model also addresses the "secondary" trauma experienced by staff working with these populations. The Sanctuary Model will expand at domestic violence shelters and youth residential programs.

The most recently appointed Cohen Chair, Dr. Claude Chemtob, is an expert in disaster mental health. He has been internationally recognized for his work with children in post-disaster situations, and has served as a consultant to a Presidential Commission established by the French Republic to develop a national response system to disasters. His appointment (made prior to 9/11) has been exceptionally helpful in assisting the CTPI to create a response to the attacks on the World Trade Center.

The newly expanded CTPI intends to respond to the current needs of those affected by the World Trade Center attack and build a long term capacity to offer sophisticated trauma services through the development of unique programs and initiatives. Thus, JBFCS will also be able to address the many other forms of interpersonal and community violence that have traumatized large numbers of JBFCS clients.

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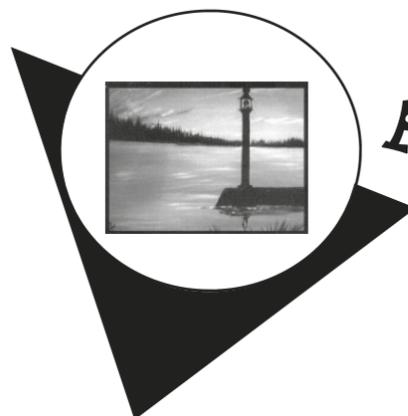
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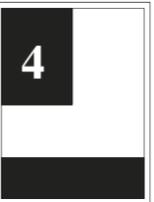
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