WEB VERSION

THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

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New Challenges for NYSPA

by Jim Nininger, M.D.

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On July 14, 1998, the APA Task Force on Strategic Planning presented its report and recommendations to the APA Board of Trustees for the restructuring and streamlining of the governance of the APA, including the Board of Trustees and the APA Assembly. The Task Force's recommendations for restructuring the Assembly include several recommendations that, if implemented, would result in significant changes in our New York State District Branch and NYSPA functioning.

As outlined in the report of our Area II Trustee, Herbert Peyser, M.D., published in this Bulletin, the Task Force recommendations would significantly reduce representation from New York State in the Assembly, eliminate DB deputy representatives for those states (including New York with more than one representative), convert the APA Assembly into an organizations of state societies, convert the New York State district branches into chapters of the newly created state society, eliminate APA funding for Area Council spring and fall meetings and combine district branch dues into the APA dues process.

Although these proposals are recommendations and have not been adopted by the APA Board of Trustees or the APA Assembly, they nevertheless represent a serious challenge to our state district branches and our state association. Dale Walker, M.D., as Chair of the APA Task Force and the others members of the Task Force and Work Groups have taken great care to solicit input from as many members as possible in developing recommendations. As Dale himself has emphasized, there must be full discussion by the Assembly on these issues before any of the Assembly related items are voted on by the APA Board of Trustees. In their present form, I do not believe that the proposals for restructuring our district branches and state society will be acceptable to our members.

However, all APA components must address the need to streamline APA governance and reduce costs. Regarding the need to control costs and membership dues increases, New York State has already achieved significant results. I am pleased to report that the NYSPA Executive Committee has authorized no NYSPA dues increase for 1999. *With no dues increase for 1999, NYSPA will have maintained dues at the same level for nine years!* I do not believe that any other component of the APA can match this record of fiscal restraint. (Of course, we cannot guarantee that we never will need a dues increase in the future.) Moreover, certain recommendations of the APA Task Force on Strategic Planning would, if implemented, shift costs to our state organization. Your NYSPA leadership has a proven record of responding to members' concerns regarding escalating dues and will remain vigilant to see that our moneys are used in a cost-efficient manner. New York State has also taken a leadership role in the Assembly by sponsoring an Action Paper recommending a moratorium on a national dues increases.

While the APA has been pursuing its own efforts at strategic planning, NYSPA has not been idle. At our last NYSPA meeting at the Spring APA Assembly Meetings, the NYSPA Council approved creation of a NYSPA Task Force on Strategic Planning and charged the NYSPA Executive Committee with responsibility for appointing the members of the Task Force and its Steering Committee. I am pleased to report that Ann Sullivan, M.D., was appointed as Chair of the Task Force and Barry Perlman, M.D., Deborah Cross, M.D., Seymour Gers, M.D., Seeth Vivek, M.D., Marc Tarle, M.D., and Marvin Koss, M.D., were appointed to the Steering Committee. The Steering Committee is charged with developing a proposal for a strategic planning effort.

In light of the recommendations from the APA Task Force on Strategic Planning, and their potential impact on NYSPA and NYS district branch functioning, relationship and finances, I am directing the NYSPA Task Force to focus its initial efforts and activities on coordinating and preparing a NYSPA response to the APA Task Force recommendations. The APA Task Force recommendations will be a

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Marketing Psychiatry

by Maurice Rappaport, M.D., Ph.D.

Dr. Rappaport is APA Trustee for Area VI (California) and past president of the California Psychiatric Association. He is in private psychiatric practice in San Jose, California. Dr. Rappaport has been very active in opposing psychologist prescribing bills in California by utilizing both his MD degree, and his PhD degree in psychology, to provide perspectives of why prescribing by psychologists would not be in the best interests of good patient care. -Ed.

M. Rappaport, M.D., Ph.D.

Socio-economic forces are nibbling at the edges of medical practices, particularly those of psychiatric physicians. We must become more aggressive in marketing psychiatry.

The idea of marketing does not have a good ring to it. It smacks of the rough and tumble and sometimes undignified competition of the market place. Nevertheless, this is the scene in which we are now embroiled. To help not only psychiatric physicians but people who need our services we must engage the enemy — that is, the lack of information about what a psychiatric physician is and what he/she does that really cannot be done adequately by anyone else, particularly the many useful but limited non-physician mental health workers.

Unless we repeatedly place such messages before the public, two adverse developments are likely: a decrease in quality mental health care and unnecessary increases in cost. To prevent erosion of cost-effective care, psychiatric physicians, and organized psychiatry must remain the primary advocates for good care. This means we must constantly develop strategies to help potential patients learn where to obtain the best care.

A continuous stream of brief public information messages must be launched that present over twenty reasons why psychiatric physicians provide the best care. Hopefully, with the help of the American Psychiatric Association this can be a nationwide effort supported locally by all District Branches as well as by family based and other organizations interested in promoting the best care for the

[See **Marketing Psychiatry** on page 5]

New Law Will Guarantee Independent Medical Review for Patients and Physicians

By Seth P. Stein, Esq.

When the Health Care Consumer Bill of Rights was enacted into law in New York in 1996, one issue not addressed in the bill was the right of patients and physicians to obtain an independent review of utilization review denials of care. While the 1996 legislation mandated that utilization review agents provide an internal review mechanism, there was no provision of an independent medical review. During this past legislative session, both houses passed new legislation introduced at the request of Governor Pataki to establish independent medical review for all NYS HMOs and health insurance programs. We anticipate that the Governor will sign this bill in the fall. (Of course, ERISA exempt plans, e.g. self-insured corporate and union health plans, are not subject to these new requirements. It will take federal legislation to achieve independent medical review for all health plans).

The new law will assure patients, their designees, physicians and other health care providers the right to an independent medical review when care or treatment is denied on the grounds of medical necessity or because the treatment is deemed experimental or investigational. In a case of denials based on the claim that the treatment is experimental or investigational, a patient can obtain review if the patient has a life-threatening or disabling condition for which standard care has been ineffective or for which a better treatment is not covered under the plan and where there is an adequate clinical basis in the scientific literature in the form of clinical trials and studies to support the proposed treatment. Health care providers can independently appeal denials rendered on a retroactive basis.

Patients covered under Medicaid and Medicare managed care are also covered by this new law. Patients and providers must pay a fee of $50 to initiate an external appeal, but the fee may be waived when the patient is on Medicaid or the payment would impose a financial hardship on a patient. If the patient or provider is successful in the appeal, the fee will be refunded.

The new law establishes a new licensing procedure for an "external appeal agent" that will conduct these independent medical reviews. Most important, the independent review must be conducted by a physician in the same or similar specialty and practicing for at least five years in the area of specialty of the care or treatment under review. Reviews must be completed in a timely manner including a provision for expedited reviews in emergency and urgent situations. The new law also tightens up current law governing internal reviews by providing that the failure of a utilization review agent to meet the time requirements of an internal review shall be deemed to be a reversal of the challenged determination.

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Information for Contributors
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double–spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. The Bulletin is received by all 5,000 members of the American Psychiatric Association who belong to a district branch in New York State. The Bulletin is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. The Bulletin is published quarterly. Both classified advertisements and display advertisements are available. Please contact the managing editor for current rates and media requirements. NYSPA members receive a discount of 50% of f the basic classified ad rate.

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From the Editor…


Leslie Citrome, M.D., M.P.H.

With the fall issue comes *controversy*. Instead of letters to the editor, I've received open letters to APA President Rodrigo Munoz, MD. One of the letters is from a NYSPA DB President - Marc Tarle, MD of the West Hudson Psychiatric Society — and makes a case against the proposed reorganization of the NYSPA DBs. The President's message on the front page and the Area II Trustee report on page 3, outlines aspects of the reorganization plan. This is a matter of critical importance to each and every one of our members. Please read these articles and provide your feedback.

Once again we have invited an *advocacy* organization to write about what they do. You will recall our inaugural issue (Spring 1998, Volume 41, #1) included an article from the Alliance for the Mentally Ill of New York State. In this issue we are pleased to include an article from Treatment and Research Advancements Association for Personality Disorder (TARA APD). The Bulletin encourages other advocacy organizations to inform the NYSPA membership of their activities.

The remainder of the issue includes our regular columns about Psychiatry and the Law, the MIT corner, and New York State and the Public Sector. We hope you will enjoy the piece on Marketing Psychiatry by Maurice Rappaport, MD, PhD. Your comments are always welcome.

You are urged to be listed on the *NYSPA online database*. In the last issue of The Bulletin there was a cutout section that you could complete and mail back in. Mailings were also sent to each NYSPA member. On the last page of this issue Michael Blumenfield, M.D. describes in more detail the program so far and answers some commonly asked questions about the database. You can sign-up on-line at <http://www.ptofview.com/nyspa/form.html>. When you go on-line, don't forget that prior issues of The Bulletin are now available for downloading and printing. Check it out at <http://www.nyspsych.org/bulletin>.

Let me close by a few remarks about the 1998 Annual Meeting held in Toronto May 30 to June 4. It was well attended, and the City of Toronto was a most gracious host. However, I couldn't help feeling somewhat guilty about enjoying some of the events sponsored by the pharmaceutical companies. These included trips to the Hockey Hall of Fame, the Symphony Hall, the CN Tower, and the circus. These were all attended by multitudes of psychiatrists and always included lavish buffets, open bars, and impressive entertainment. There was an event every night, some better advertised than others. These were above and beyond the private dinners for small groups of psychiatrists arranged by individual industry reps. On the one hand I am grateful for industry support for education, research, and of course, The Bulletin. Yet, on the other hand, a great deal of money was spent on purely social activities whose only purpose was to promote goodwill, without an educational component. Such funds could have been used differently, but the pharmaceutical industry sees an advantage to providing these social events. Should the industry be steered towards sponsoring more education, more research, and better access to treatment, rather than spending money entertaining psychiatrists? Let's also keep in mind how our profession is perceived by the public: how would your patients (and potential patients) feel if they knew you received more than just the occasional pen and pad of paper from an industry rep? Ultimately, the cost of these activities is passed on to patients (direct out-of-pocket costs), members of health plans (higher premiums), and the taxpayer (federal, state and local funding of health care paid out of taxes). Yes, I enjoyed those evenings at the Annual Meeting, but I also felt uneasy. Now, several weeks later, I remain ambivalent. Do you? ■

LETTERS TO THE EDITOR

Letters to the Editor are welcomed but are limited to 750 words. The full text of all letters will be available on The Bulletin web site at <http://www.nyspsych.org/bulletin>.

No letters to the editor have been received for this issue, however two NYSPA members have provided me with letters they had written to our APA President, Dr. Rodrigo Munoz. In order to disseminate these widely, they have asked that they be reproduced in The Bulletin.

The first is from Edward M. Stephens, MD, and outlines the lessons that we can learn from a class-action lawsuit that 40,000 retail pharmacists have initiated against pharmaceutical manufacturers regarding unfair pricing policies. At issue are discounts offered to huge organizations, to the disadvantage of the independent retail outlet. The newspaper article that Dr. Stephens references is from The New York Times of July 15, 1998 entitled "4 Drug Makers Move to Settle in Pricing Suit", and describes how four pharmaceutical companies have tentatively agreed to pay $345 million to settle the price–fixing lawsuit. Can these same anti-trust arguments be made against the managed care companies? Dr. Stephens thinks so, and is asking the APA membership to support this battle. You may remember Dr. Stephens front page article that appeared in the March/April 1997 issue of The Bulletin, where he outlined in detail his class-action antitrust suit filed October 15, 1996, on behalf of psychiatrists, psychologists and social workers, against psychiatric carve–out companies and managed care organizations.

Dr. Stephens is a member of the NYCoDB. He began confronting the illegal practices of HMOs in 1994 when he took PruCare to court. His contention was that legislation alone would not correct HMO practices that were already in violation of existing law and public policy.

Dear Dr. Munoz:

The enclosed article reports on the latest development in the brand name prescription drug case.

That case, a class action filed on behalf of the retail pharmacies against the major manufacturers of prescription drugs, alleges that the manufacturers conspired to fix the prices they offered retail pharmacies by refusing to offer them the same discounts they offered to others, including HMOs.

The complaint in the Mental Health Managed Care litigation is modeled on the complaint in that case and many of the lawyers representing the defendants in that case represent the defendants in this litigation.

The pharmacy case was filed in 1993. Based on evidence accumulated during discovery, some of the defendants agreed to settle in 1996 and several more have recently agreed to settle. So far, the settling defendants have agreed to pay the plaintiff pharmacists seven hundred million dollars and, in addition, to stop "no discount" policies.

Retail pharmacies across the country, large and small, actively supported that litigation. They cooperated in collecting evidence, contributed a great deal of money to lawyers working on that litigation, and generally let the defendants know that they were not giving up despite many set backs suffered along the way. That determination and their active involvement in the litigation undoubtedly had a significant impact on the defendants, who eventually recognized that they could not ignore the plaintiffs.

Learning from the lessons in the pharmacy case, we should work on the following: Keep our organization informed of the progress of our anti-trust action; continue to furnish support by way of information and evidence of the violations to our attorneys; continue to build bridges to the psychologists and social-workers and their organizations that are named plaintiffs along with our organization and contribute monies from our litigation fund on a regular and on going basis.

Right now, our case is in a better position than ever before. First we have an active appeal before the United States Court of Appeals in regard to Judge Kimba Wood's dismissal of Stephens vs. CMG. Next we have a case filed in the Federal District Court in Newark, New Jersey, alleging more detailed anti-trust complaints against the defendants. In effect, we have gained strength and momentum since the initial filing in October 1996.

I urge you to encourage all our members at all levels to continue their whole-hearted participation so that we will prevail in the same way the retail pharmacists are prevailing both in money judgments and most importantly, in regard to the agreement of the companies to cease the offending practices.

Edward M. Stephens, M.D.

The second open letter to Dr. Munoz is from Marc Tarle, MD, the president of the West Hudson Psychiatric Society. It has already appeared in that District Branch's newsletter, The Synapse, in July 1998, but the NYSPA membership as a whole will appreciate Dr. Tarle's candor, and his articulate defense of the current DB structure that has worked so well for his organization.

[See **Letter to Editor** on page 6]

AREA II TRUSTEE'S REPORT

The Reorganization of the APA

by Herb Peyser, M.D.

Herb Peyser, M.D.

The burning issue of the July Board meeting was the revealing of the long awaited *plan for reorganizing APA*. Only the broad outlines were sketched but the basic idea is clear: slimming down and tightening up APA structure at all levels: governance (officers, Board, Assembly, District Branches, Areas and state organizations), components (Councils, Commissions, Committees and Task Forces), central staff, and the dues (decreasing them significantly, with perhaps central integration of the dues). The details are not in final form yet but will follow in the next few months, the Board having approved this first, more general step. But everything is in the details.

First, the reorganization of the Assembly, DBs and state associations, which *affects our NYS Psychiatric Association* in a major way. It looks like there may be a significant cutting back on our Assembly Reps and our influence at the national level, and originally it appeared they intended also to convert NYSPA's DBs into Chapters under the state organization. Regarding the former, it is seen as *NYSPA being somewhat overrepresented in the Assembly*. Regarding the latter, I believe we have gotten them to bend.

To explain: The 40,000 or so APA members are gathered into 76 or so DBs, ranging in size from Wyoming (21) to NY County (over 2000). 46 of the DBs are state organizations (e.g., Connecticut.), some larger ones containing chapters under the state organization (e.g., Texas with 1530 members). The state DBs are gathered into five of the seven Areas (e.g., Area I, New England, including two Canadian provinces), but these Areas (I, III, IV, V, and VII) are merely APA organizational groupings with no external functions, no offices, no Execs, no dues.

NYSPA with 13 DBs and 4800 members is itself an Area (II), and California, with 5 DBs and 3255 members, is another (VI). Both are state organizations with significant offices, Execs, legislative advocates, etc.

Every DB, state association or not, has one Assembly Rep for each 400 members, and if only one Rep then it also has a non voting Dep Rep. Consequently NYSPA (13 DBs) has 19 DB Reps and 10 DB Dep Reps (plus one Member-in-Training Rep and a Dep Rep, an Early Career Psychiatrist Rep and a Dep Rep, and two Minority/Under Represented Reps and two Dep Reps). The planners want NYSPA to get down to 12 or so DB Reps (although they have also thought of moving to a 1:600 ratio). Plans for the Dep Reps are not clear but there has been talk about continuing them but asking non-state association DBs to pay for their own Dep Reps.

There are some indications that NYSPA could ask some of the *smaller DBs to share a Rep and Dep Rep* with another DB but *without coalescing* their DBs (unlike Nassau and Suffolk that had voluntarily coalesced). The process could proceed as NYSPA and its DBs worked out the statewide Strategic Plan.

However, the original way the APA planners wanted to accomplish this was *to make Areas II and VI into state DBs, and their DBs into Chapters under the state DBs*. This produced *intense opposition* in NYSPA's DB Councils with resolutions and DB Presidents' letters to President Rod Munoz and others strongly opposing it. California was equally opposed (and Missouri too, not an Area but with three DBs).

We carried these messages to the DB/State Organization Committee, to Rod, and to the Board and the Task Force, and they responded. They appear to be willing, as we suggested, to *separate those aspects of state organization functioning which are central (Reps, Assembly, etc.) from those which are internal*, which they will leave to us. Other than sharing Reps, our DBs will, it seems, remain DBs and keep their membership and ethics functions and their independence in these and other matters. They will not have to report any more than they do now to the state but may have to report to APA through a state coordinator (perhaps one of the NYSPA officers). Dues, however, may possibly be integrated in some way, with central control, so that the total package can be significantly decreased (central APA has non-dues income in addition to dues income; that will help).

However, decreasing NYSPA's DB Reps and Dep Reps further *decreases DB and member input and participation in NYSPA governance and state business*. The Area II (NYSPA) Council, consisting of the DB, MIT, ECP and M/UR Reps and Dep Reps, has only two full meetings a year to do state business, the other two meetings being in conjunction with the Assembly and greatly preoccupied with Assembly business. That means that the NYSPA Executive Committee (President, Vice President, Secretary, Treasurer, Immediate Past President and Area Trustee), meeting monthly with conference calls in between, meeting with the Commissioner of Mental Health, the Medical Society, MCOs, the Attorney General's Office, etc., conducts the state business, and the Council may not get involved until later.

Furthermore, only one of the officers (the Trustee) is elected by the statewide membership, the others being elected by a majority of the 25 or so votes in the Council. It tends to look somewhat hermetic, with not too much member and DB participation, and it may become even more so if the DB Reps/Dep Reps decrease.

NYSPA's own Strategic Plan will address these issues, responding to the central APA's Strategic Plan's requirements and opening up the system in NYSPA. (California, Area VI, has its five DB Presidents on its Area Council and Executive Committee and elects its state officers state-wide, for one example.) And NYSPA will review its governance structure, dues and expenditures on all levels, DB and state, just as central APA is doing.

The APA Plan also has provisions for slimming down the Board, the Components, and the central office, but the savings will have to be balanced against the costs of important projects and the decreasing of membership participation in governance and policy making just at the time we want members to participate more.

Other Board matters: APA will have a toll-free number (1-888-35-PSYCH) and an interactive voice response system by the fall. The moratorium on the 1999 national dues was approved. Medical Director Steve Mirin is restructuring the staff's contracts, putting them on a businesslike basis with defined goals, and bonuses and raises dependent upon meeting those goals. APA is setting up *a Research and Education Institute* with funding from NIMH and elsewhere, to develop research, support fellows in training, work with consortia, etc. APPI and other APA publications do well and move toward more electronic textbook publishing and electronic editions of the journals.

The *Toronto Annual Meeting* was extremely well attended, 17,700, of which only 6500 were members (a continuing proportional decline) and 8300 non-members, and 6200 international attendees (a continuing increase). The NIDA Track was successful, and there will be a NIMH Track the next time. Industrial symposia were monitored, several were noted to have excessive degrees of bias, and APA is working to correct and prevent that. APA will be developing electronic access to the Annual meeting.

At the urging of our group of Trustees the APA developed *a midcourse review of its expensive but essential electronic communications project* by a nationally known firm, Booz-Allen & Hamilton. Their presentation at the Budget Committee was excellent, putting further movement on project technology on hold for the time being (except for what was ongoing, what was contractually obligated for, and urgent matters such as existing systems in trouble and the year 2000 problem). APA must now further develop and streamline its business procedures with a well-coordinated information systems process, and then integrate the technology as the servant of an information system, not a substitute for it. A Chief Information Officer will oversee this and other information systems.

I believe we are getting the APA on a businesslike, cost-efficient basis. APA's and NYSPA's Strategic Plans will contribute greatly to the process. ■

NNN NYSPA NEWS

New Law Will Guarantee Independent Medical Review for Patients and Physicians

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Finally, the new law includes provisions mandating that HMOs and health plans subject to NYS Insurance Department jurisdiction must include full disclosure in contracts with providers of all terms and conditions pertaining to reimbursement, including the calculation of "withholds." Physicians have long complained that plans failed to provide an accounting of the status of fee withholds. Now, all plans will be required to provide detailed information regarding the calculation of payment adjustments with a description of a dispute resolution process.

This law will go into effect on July 1, 1999, and represents a significant step forward in redressing the imbalance in power between managed care companies and patients and providers. When a psychiatrist is faced with a reviewer asking the psychiatrist to agree to cut the monthly visits in half, the psychiatrist will be able next year to advise the patient that an independent medical review by a psychiatrist is available to challenge this reduction in care. Of course, the new law will only prove effective if patients and their physicians avail themselves of the procedure to challenge denials and reductions in care. NYSPA will provide more detailed instructions for challenging denials once regulations are promulgated by the NYS Department of Health and Insurance Department.

More than a Decade of Technology Transfer

by John M. Oldman, M.D.

Dr. Oldham is the Chief Medical Officer for the New York State Office of Mental Health (OMH), providing leadership and oversight for the largest state hospital system in the United States. Dr. Oldham is also the Director of the New York State Psychiatric Institute, the main locus of activity for Columbia University's Department of Psychiatry. In this article Dr. Oldham writes about the Research Conference that OMH holds every year in December. NYSPA members are encouraged to attend. —Ed.


John M. Oldham, M.D.

Last December, we celebrated the tenth year of the New York State Office of Mental Health Research Conference, an event held each year in Albany during the first week of December. It seems hard to believe that it has been over a decade since I suggested to the Commissioner of Mental Health at the time, Richard Surles, that the Office of Mental Health (OMH) should have a research conference. "We should hold it in Albany, the headquarters of the agency," I added, "so that in addition to the clinicians, others can come such as legislators, budget types, and administrators. But our target audience should be the rank and file psychiatrists working throughout the state at the state hospitals; we should let them count it as work time, and pay their way." "Let's do it!" Richard said, "and let's make it an annual event."

"Great!" I said. ("Fat chance," I thought to myself.)

Research Conference Delivers

Well, indeed it *has* been an annual three–day event, with the goal of bringing the latest clinically–relevant research findings to clinicians working in the state and local public sector, plus a growing audience of consumers, families, advocates, and other interested parties. I remember the first conference vividly: we had about 600 registrants, and the clinicians and researchers sort of nervously eyed each other, not sure they could comfortably talk to each other. To a number of people's surprise, however, the conference was a big success. The second conference had a larger audience, and by the third year, the clinicians "owned" the conference; since then it has become non-negotiable, as a "must" event. By now, we have over 1,000 registrants, and it is by far the largest conference held by OMH.

Ten years ago, OMH had a fairly generous conference budget, and the research conference was funded by the agency. Several years thereafter, when the state budget was becoming very tight, it was only with the good fortune of obtaining a grant from the van Ameringen Foundation that we were able to sustain the conference, and ever since the conference has been entirely non–state funded. New York State, I guess I should say "if I do say so myself," should be proud of what has become a nationally–recognized conference — truly seen as a one–of–a–kind conference in the public sector.

Breadth and Depth in NYS Offerings

New York State supports some of the most important psychiatric research, throughout its system and at its two dedicated research institutes —the Nathan Kline Institute for Psychiatric Research, and the New York State Psychiatric Institute, both of which have just moved into magnificent new facilities. Researchers at both institutes have generously and regularly presented their work at the research conference. But a glance at the programs over the years quickly shows the breadth and growing stature of the event. Presenters over the years have included some of the most prominent psychiatrists and mental health advocates from the United States and beyond. We have been privileged to hear from Nancy Andreason, Charles Bowden, Biff Bunney, Laurie Flynn, Fred Goodwin, Eric Kandel, John Kane, Heinz Lehmann, Jeff Lieberman, Bob Liberman, Herb Meltzer, Steve Mirin, George Vaillant, and many others. *[The list was too extensive to reproduce in its entirety; I apologize in advance for any and all omissions. —Ed.]*

As you can see, with speakers like these the audience has many opportunities to stay truly at the frontier of new findings. In addition, we have programmed workshops, courses, updates, and other special events to round out the program each year. For those of us who have worked hard each year to put the program together (and there have been many!), it has been a most gratifying experience.

Upcoming Offerings – Save these Dates

This coming December 1, 2, and 3 we will launch a second decade of technology transfer, with this year's conference, the program of which is already looking terrific. Anyone interested in attending can obtain registration information by contacting me or my office (telephone 212-543-5300; fax 212-543-5200; e-mail jmo2@columbia.edu). I hope to see you there! ■

The Psychopathic Personality

by James Hicks, M.D.

Dr. Hicks is a Fellow in the Program in Psychiatry and Law, Department of Psychiatry, New York University Medical Center, New York, NY. In this article he describes the concept of psychopathy and Dr. Hare's Psychopathy Checklist, which has been getting increased attention within the New York State Office of Mental Health. This scale has the potential to be useful for forensic psychiatrists doing patient assessments, and in clinical research focusing on violence and schizophrenia. —Ed.

The concept of "psychopathy" is rich with history and practical application, but you will not find it listed in DSM-IV. The concept shares some features with Antisocial Personality Disorder, but with crucial differences that affect validity and usefulness. Though the term "psychopathy" has been used more broadly over the century, the concept of "the psychopath" has been understood by mental health practitioners, correctional workers and legislators to refer to a recognizable personality type prone to criminal behavior and exploitative social interactions.

The term "psychopath" was popularized by Cleckley in "The Mask of Sanity," first published in 1941. He argued that there exist, apart from those suffering from neurotic and major mental illnesses, "a large body of people who are incapable of leading normal lives and whose behavior causes great distress in every community" (p.7). He theorized that psychopaths suffered from a deficit in emotional and social capacity, "a persistent lack of ability to become aware of what the most important experiences of life mean to others" (p.229), and that their superficial social skills were a "mask" that concealed a profound disturbance in human relatedness. He presented numerous illustrative cases, and outlined sixteen clinical features that characterized the psychopath.

After working as a psychologist in a Canadian prison, Dr. Robert Hare became interested in the Cleckley psychopath. For the past thirty years, he and his colleagues have been refining and applying the concept through clinical research. He describes psychopaths as "intraspecies predators who use charm, manipulation, intimidation, and violence to control others and to satisfy their own selfish needs" (Hare et al). They have developed and validated a rating scale, the Psychopathy Checklist, which has been used to identify psychopaths and to predict dangerousness.

Clinical Features of Psychopathy

Psychopathy is a personality disorder in which emotions, behavior and interpersonal relationships are disturbed. The psychopath is self-centered and shows no empathy for others. His relationships are brief and exploitative, though he may be superficially charming. He engages in reckless, impulsive and frequently criminal behavior. He feels no remorse for his victims or regret for his actions. The clinical features that characterize the psychopathic personality are delineated in the twenty items of Hare's Revised Psychopathy Checklist (Hare et al):

1. Glibness/superficial charm
2. Grandiose sense of self-worth
3. Need for stimulation
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse or guilt
7. Shallow affect
8. Callous/lack of empathy
9. Parasitic lifestyle
10. Poor behavioral controls
11. Promiscuous sexual behavior
12. Early behavior problems
13. Lack of realistic goals
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility
17. Many short-term relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility

Validity and Factor Structure

Hare's Psychopathy Checklist was initially tested for reliability and validity in male prison populations in Canada, but the scale has been validated in forensic psychiatric populations, and in other groups. Each item of the scale is scored from 0 to 2, with total scores (on the revised scale) ranging from 0 to 40. Psychopathy is indicated by a score of 30 or higher. It is unclear whether psychopaths represent a distinct population, or if psychopathy can be present in various degrees.

Factor analysis of the items in the Psychopathy Checklist suggests that psychopathy is built on two factors (Hare et al). Factor 1 consists of selfish and callous traits that are generally inferred from clinical interviews. Several of these items are described in the "Associated Features" for the DSM-IV diagnosis of Antisocial Personality Disorder, but are not represented in the diagnostic criteria. This factor shares some features with narcissistic and histrionic personalities. Factor 2 consists of a "chronically unstable and antisocial lifestyle" and correlates with a diagnosis of Antisocial Personality Disorder.

Distinguished from Antisocial Personality Disorder

In the official psychiatric nomenclature, Psychopathic Personality has been replaced by Antisocial Personality Disorder, which attempts to eliminate the inferential aspects of diagnosis and concentrate on objectively observable behavior. Hare and his colleagues have argued that, "the criteria for [Antisocial Personality Disorder in DSM-III-R] appear to define a diagnostic category that is at once too broad, encompassing criminals and antisocial persons who are psychologically heterogeneous, and too narrow, excluding those who have the personality structure of the psychopath but who have not exhibited some of the specific antisocial behaviors listed" (Hare et al). In forensic or correctional settings, psychopaths form a subset of those who meet criteria for a diagnosis of Antisocial Personality Disorder. The base rate for psychopathy in prison is 15% to 25% while the rate for Antisocial Personality Disorder is 50% to 75% (Hare et al). Psychopathy is a more refined concept, which more specifically identifies a category of especially dangerous offenders.

[See **Psychopathic Personality** on page 8]

Treatment Works

MENTAL ILLNESS AWARENESS WEEK

October 4-10, 1998

Outreach Helps

And Materials Bring the Message Home

All new "Let's Talk Faces About" pamphlets and a catalog of other awareness–raising resources for Mental Illness Awareness Week are available! Call toll–free (888) 35-PSYCH to request your materials today!

Marketing Psychiatry

Contined from page 1

mentally ill.

What is done best by psychiatric physicians that cannot be done by non-physician mental health workers? Here is a partial list:

1. Obtain and understand medical histories.
2. Review body systems for important physical complaints about which psychiatrists, as physicians, can make helpful recommendations.
3. Analyze, incorporate and integrate information from medical records into medically based psychiatric evaluations.
4. Establish primary and secondary medical diagnoses integrating physical and mental conditions.
5. Decide when it is necessary and appropriate to refer to other medical specialists.
6. Conduct medical inspections identifying important physical signs.
7. Conduct medical–psychiatric examinations identifying important symptoms.
8. Conduct initial neurological examinations.
9. Develop combined medical–psychiatric and psychosocial treatment plans.
10. Provide on–going medical support and reassurance to: patients, family, significant others.
11. Provide medication and timely medication adjustments.
12. Provide information on medication side effects.
13. Deal directly with adverse medication effects and emergency developments such as: Hypertension, hypotension, impact on thyroid, renal, liver and other systems affecting body functioning, neuroleptic malignant syndrome, cardiac arrythmias, paralytic ileus, allergic reactions, anaphylactic reactions, extrapyramidal symptoms, convulsions, coma, imminent death, etc.
14. Provide information on interaction effects with non–psychiatric medications.
15. Provide on-going medical follow-up.
16. Order appropriate laboratory tests initially and periodically to monitor patient condition and minimize development of adverse effects of treatment.
17. Arrange somatic therapies when needed, including but not limited to electroconvulsive therapy.
18. Arrange medically supervised hospitalization with an attending psychiatric physician.
19. Consult with/about family on related medical/psychological matters.
20. Consult with primary care and physician specialists on a physician–to–physician basis.
21. Consult with human services workers on medical-psychosocial matters.
22. Complete necessary medical forms.
23. Prepare integrated medical/psychological summaries efficiently, timely and cost–effectively.
24. Provide close biopsychosocial follow-up care to detect and treat inevitable biopsychosocial changes that occur during the course of life.

This list, undoubtedly, can be amplified.

Perhaps a psychiatric promotional campaign might include a rhyme such as:

When Upset, Troubled and Down
Don't Be A Dummy or A Clown
Get Help from the Best in Town

Of course such a tongue–in–cheek rhyme may not represent an acceptable strategy and undoubtedly other approaches can be developed by those in the business of selling good ideas to the public.

We may have to find compromises between notions of absolute dignity and effective whimsy.

The goal is to place upper most in the mind of the public, particularly those who can benefit from psychiatric help, where to turn first to get the best care.

The approach must be sufficiently vigorous and prolonged to override ill–advised managed care and other health coverage restrictions. Those in need of good psychiatric care must be educated to demand such care. Marketing psychiatry will not be easy or inexpensive. But let us at least emphasize the quality of care difference between services that can be provided by psychiatry compared to other useful but non–psychiatric mental health services. ■

MIT CORNER

School's Outreach: The Challenges are Exceeded only by the Rewards

by Craig Katz, M.D.

Dr. Katz is one of two MIT members of the Editorial Board of The Bulletin. MITs are urged to contact either Dr. Katz or Dr. Harwitz for input into future columns of the MIT Corner. All correspondence should be sent care of the editorial offices of The Bulletin as noted on our masthead on the left side of page 2.

The Bulletin would also be pleased to publish other accounts of outreach projects by NYSPA members. The West Hudson District Branch participates in school programs as part of the Rockland County Mental Health Coalition. Do other district branches in New York State do this type of work? From talking to those who have participated in programs such as these, it can be a fascinating experience. -Ed.

Craig Katz, M.D.

The New York County District Branch's Resident's Committee has, since 1994, organized a "School's Project" designed to conduct psychiatric outreach to public school children in Manhattan. Initially born of the Resident's Committee's desire to play a role in the newly developed National Mental Health Awareness Month, this project provides us with a valuable example of the rewards and challenges that psychiatric residents, if not all psychiatrists, are likely to experience in bringing their psychiatric expertise into local communities.

Dr. Elizabeth Haase, while a psychiatric resident on the NYCoDB Resident's Committee, was the School's Project's creator. Her initial aims were to use art to help explore and educate public school children's knowledge of, and attitudes towards, mental illness. Dr. Haase was able to work with fourth graders in Manhattan's P.S. 173 over a three–year period during which they addressed their conceptions of mental illness, the brain, and popular attitudes towards mental illness via painting and drawing. The project produced murals that were presented at the "Picnic for Parity" and a pilot study that formally presented the children's thoughts on these issues. But, it was clearly the intangible benefits of the program, which meant the most to Dr. Haase. Now an attending psychiatrist on a private inpatient unit, she reflects back on the School's Project as an overwhelmingly positive experience, noting especially the joys of working closely with kids and hearing their often poignant and honest views of people. Related to this was the unique chance to leave the "ivory tower" of the academic medical center in order to shape children's nascent notions of the human experience while becoming a positive role model for them in the guise of a psychiatrist.

Dr. Mark Wilson took over the mantle of the School's Project for the Resident's Committee in 1997, and, with the help of co-organizer Dr. Mara Goldstein, has steered it in a new but related direction. Beginning with the current 1998-99 school year, they will be coordinating focus groups at an intermediate school that will provide psychoeducation to targeted groups of kids with known psychiatric illnesses. The year's time that it has taken them to organize this phase of the project bespeaks the enormous challenges that such community work presents. These challenges, echoed by Dr. Haase, include finding other residents who have the time and interest to participate, and working within a complicated system of overlapping authorities, among which are school administration, school clinic workers, teachers, and parents.

What stands out in the story of the School's Project is the remarkable amount of determined searching necessary to find lay (and sometimes medical) persons in the community who were receptive to the ideas of the School's Project. With this came the need for Drs. Haase, Wilson, and Goldstein to occasionally modify the program's structure in order to meet the needs and outlooks of the large number of constituents in the public sector while still remaining true to the School's Project's ideals. For example, Dr. Wilson encountered considerable resistance to his psychoeducation project from one school based clinic which felt that psychoeducating kids would open a "Pandora's Box" of emotional problems in their school's children without providing an adequate clinical infrastructure with which to respond and help them.

Dr. Wilson thereafter added an individual evaluation component to his program by linking up with an on-site clinic. Still, the school-based clinicians felt that more treatment options were needed, at which point Dr. Wilson recognized that his resources were not adequate to address their concerns. He thus made the pragmatic decision to re-locate the project to another school where it would better mesh with the on-site staff. This led the School's Project to I.S. 218, where the Project will resume this Fall.

All told, the School's Project various coordinators uniformly speak of the many virtues of community outreach work for psychiatrists-in-training, as it has provided a valuable contribution to their training. They have acquired a sophisticated sense of the role of psychoeducation in public psychiatry, the experience of professional work in a non-traditional setting, and an invaluable education in the politics of both psychiatry and their local communities. Their idealism, mixed with a healthy pragmatism, most assuredly serves as a model for public activism in all young psychiatrists.

Those interested in learning more about the School's Project may call Dr. Wilson at (212) 543-5551. ■

President's Message

Contined from page 1

top priority for review and discussion at the Fall NYSPA meeting on October 10-11, 1998. We are delighted that Rodrigo Munoz, M.D., APA President, and Steven Mirin, M.D., APA Medical Director, will both be attending the Fall NYSPA meeting to meet with members and to discuss APA reorganization and restructuring.

We cannot seriously undertake an examination of our own NYSPA structure and operations until the results of the APA efforts are resolved. I invite every district branch and every member to review carefully the Report and Recommendations of the APA Task Force and forward their comments to the APA Board of Trustees and to NYSPA Central Office. Additionally, as the restructuring of the APA emerges, I urge all district branches to conduct their own strategic review (a self–examination of structure, budget, priorities, etc.) to help inform this process.

Our NYSPA Executive Committee is actively engaged with the APA process. Herbert Peyser, M.D., and I are participating in several conference calls with the leadership of the other states with multiple district branches, and will attend the Institute of Psychiatric Services in Los Angeles in October to address how the proposed restructuring affects these states and to coordinate our response.

Waste, overlapping of committee and component functions, overly cumbersome avenues of communication must be trimmed on all levels. At the same time, we must assure that our numbers are fairly represented in any downsizing of the Assembly. Currently, representatives are apportioned to district branches (46 of which represent state organizations) based on multiples of 400 members. *However, 28 of the states have less than 400 members, but are nevertheless assigned a full voting representative.* Therefore, New York does not seem significantly over–represented. It could be argued that even the current ratio of one representative for each 400 members is not adequate for the nearly 5,000 members in our state.

Our members want an organization that addresses their economic and professional issues and they want an efficient and cost effective organization to address these issues, but they also want fair representation on the national level. We must be ready to meet the members' concerns and needs on all levels of our organization. ■

Letters to Editor

Contined from page 2

Dear Dr. Munoz:

I understand that there is an initiative to abolish local District Branches, such as the WHPS, and replace them with newly bloated statewide organizations to address the many needs of our membership. The old DBs would then be called Chapters (DCs?), and lose an as yet unspecified degree of its current autonomy to the State. The supposed benefits of this plan would be a modest financial saving from the consolidation of branches, better coordination of statewide lobbying efforts for legislative activities and a more equitable system of representation at the APA's General Assembly. We at the WHPS feel these benefits are chimeric and insubstantial when the liabilities are considered, and strongly oppose this initiative.

District Branches did not come into existence overnight. Many of them are old organizations, which have prospered over the years because they serve a tangible and vital function. They are a vehicle for the grassroots membership to devise programs and activities, which suits the specific needs of their locality. No state-run central office could ever have as good a sense of what a specific slice of geography needs for its members and community. What is good for the Queens DB may work in Brooklyn, but could be wrong for the WHPS. Any organizational change that adds an extra layer of bureaucracy would only hamper the efforts of the DB to run its programs effectively. I can only imagine the demoralizing effect on future DB members if they must consult a faceless central office on every budgetary issue. Even if the proposed changes in autonomy for the DBs are minimal, who can guarantee that future state organizations would not become despotic and take more control away from the local chapters? Or what if a particular chapter, say one of the more populous branches in New York City, becomes politically dominant, and sets the agenda for the state at the expense of the smaller branches? There are many possibilities for mischief once local autonomy is lost.

Obviously, not all district branches are equal in the scope of their activities or general effectiveness as an organization. For example, we at WHPS are very proud of our accomplishments. We have developed CME meetings, a nationally recognized depression screening program for the community, a multiple award winning bimonthly news-letter, a vibrant alliance with local community mental health groups and a network for legislative lobbying efforts. Our committee groups, such as Private Practice, Ethics, Public Affairs, etc., are highly effective and are run by extremely motivated individuals. We operate on a shoestring budget, (i.e., we do not employ a secretary and do the detail work on our own) and have the lowest DB dues in the country. In short, there is so much to be lost if this fine organization were reorganized to serve some elusive goal. If a particular DB is having organizational problems and cannot revitalize itself, then it should have the option of merging with another DB or even a statewide organization. But to impose this sort of change for every DB nationwide, regardless of its level of success, strikes me as drastic medicine.

Finally, this initiative could not have come at a worse time. Psychiatry is being ravaged by managed care and is trying to preserve its identity. At such a time, it seems imprudent for our own national organization to launch a wholesale revision of the DB system, which has served Psychiatry so well for so long. The APA should be working on the common goals of its membership, rather than on issues which cause disunity within the organization. Any financial gains that are realized by this reorganization may be lost by individual members who become frustrated with this process and resign from the APA in protest. (A number of members have told me they would do so, if this initiative goes through.) Issues such as statewide lobbying efforts and representation at the General Assembly can be creatively addressed in other ways, without resorting to these proposed changes.

We at the WHPS urge you, Dr. Munoz, to drop this plan before it becomes yet another divisive issue within the APA.

Marc Tarle, M.D. ■

Advocating for Borderline Personality Disorder, A SISYPHEAN TASK

By Valerie Porr, MA

How many of us are guilty of using "Borderline" in the pejorative? The term can be stigmatizing for those seeking treatment and is sometimes used as an excuse for therapeutic nihilism. In this issue of The Bulletin we are pleased to have an article about an advocacy organization for Personality Disorders. Ms. Porr is the President and Founder of the Treatment and Research Advancements Association for Personality Disorder. Their Board of Directors includes psychiatrists John Oldham, MD, and Larry Siever, MD. -Ed.

The Treatment and Research Advancements Association for Personality Disorder (TARA APD) has undertaken a sisyphean task as the only non–profit national organization dedicated to increasing awareness, fostering education and supporting research into the etiology and treatment of personality disorder, specifically but not exclusively Borderline Personality Disorder (BPD).

When we examine the plight of people suffering with BPD and those who treat them, two factors are immediately apparent. Appropriate treatment is not readily available and many clinicians refuse to treat these patients. BPD patients are currently the most stigmatized of all patients in the mental health systems, making a positive prognosis very difficult.

Latest research indicates that BPD is a biologically based disorder of the emotional regulation system that may be due to genetic and/or environmental factors. These biological "vulnerabilities" may place a person at increased risk for developing BPD, given certain developmental factors such as prenatal stresses, infections, nutritional deficits, stressful events in the early family environment or a family history of mental illness such as BPD, major depression, bipolar disorder, or addiction.

BPD is estimated to affect 2-3% of the general population, 11% of the patients seen in psychiatric outpatient clinics and as many as 20% of psychiatric inpatients. About 8-10% of people with this disorder die by suicide. Between 21-67% of people with BPD meet the criteria for substance abuse. Of the MICA population, 50-67% meet criteria for BPD. BPD worsens the outcome and complicates the treatment of any other co-occurring disorder such as Major Depression, Bipolar Disorder, Manic Depression, Eating Disorders and Substance Abuse. BPD, difficult to diagnose, is often misdiagnosed as schizotypal or schizoaffective disorder, depression, bipolar disorder or antisocial personality disorder.

BPD is a disorder in which a person is unable to regulate emotions or control impulses. These people frequently experience lack of validation or acknowledgment of their feelings or perceptions. Their behaviors can be interpreted as maladaptive methods of coping with constant emotional pain. Affective instability may make it difficult for them to maintain a stable sense of self and/or stable relationships. To view these patients as "manipulative" *subsumes that persons with BPD can change their behavior if they so chose*. It is tantamount to saying they are treatment resistant, reflecting a failure to understand the underlying etiology of BPD, and becomes a predictor of treatment failure. The patient, extremely vulnerable to emotional nuance, treated by a professional who dislikes people with BPD, will not develop the trust or therapeutic alliance needed to bring about positive results.

Treatment

TARA APD's first priority is to bring hope for a better quality of life to people with BPD by assuring that clinicians reframe their concept of BPD to reflect the latest research findings. Professionals must have the courage to revise treatment and adopt new methods. Although we have yet to develop a "one–size–fits–all" medication for BPD, optimum treatment now includes a combination of carefully managed psychopharmacology, cognitive behavioral therapy with skills training and individual psychotherapy. Traditional psychotherapy, a long–term process, may have uncertain results. Medications may reduce symptoms of depression, anxiety, irritability, and paranoid thoughts. Medicating a patient with BPD is not an easy task, given the constraints of managed care environments and that a single medication for BPD does not yet exist. To obtain symptom relief, medication must be closely monitored to find the point of efficacy for the particular patient and to deal with symptoms that may constantly change.

Recent research has demonstrated the effectiveness of individual cognitive behavioral therapy along with group psychoeducation and skills training that teach emotion regulation skills, distress tolerance, improvement of interpersonal relationship behaviors and awareness (mindfulness). This method, Dialectical Behavioral Therapy (DBT), developed by Dr. Marsha Linehan, PhD of the University of Washington in Seattle, has outcome studies demonstrating its effectiveness. DBT combined with careful medication management may allow the patient to experience significant progress. When taught skills to help them to regulate their emotions and to tolerate distress, people with BPD can do better.

Families must also be a part of this treatment. They need the same reframing of their understanding of BPD as do clinicians. Not infrequently patients return to their families who must then try to cope with this complicated disorder with very little information or support. Simply learning how to validate the experiences of someone with BPD and offering compassion without blame or judgment can cut down on stressful interactions.

Education

To change the grim prognosis generally facing people with BPD, TARA APD is actively engaged in professional education. Our Board of Directors and Scientific Advisory Board represent the leading researchers and clinicians in the US and Canada. Our Resource Center, located at our administrative office, distributes research articles and information to families, consumers, clinicians and mental health organizations nationwide, and refer callers to BPD specialists in their area. We sponsor a monthly professional lecture series that will soon offer CASAC accreditation, a monthly Ask the Doctor series and support groups for families and consumers. We are a resource for Grand Rounds speakers.

TARA APD has formed a Personality Disorder Committee in New York City comprised of the small group of 20-25 therapists who practice DBT. This committee aims to explore how interaction of the various DBT programs can provide patients with a greater continuum of care. The committee hopes to increase the utilization of DBT in clinical settings in NYC and to advocate for professional training programs.

TARA APD has produced a unique comprehensive informational brochure on BPD. Our Helpline receives requests for referrals from associations including NIMH, NMHA, APA and NAMI. We co-edited the BPD issue of the *Journal of the California Alliance of the Mentally Ill*, (Vol.8, 1997) which contains 33 articles on all aspects of BPD, including an overview of the latest research. *The TARA Times*, our newsletter, is distributed nationally. We have recently been featured in several newspaper articles on BPD.

Advocacy

Without advocacy, people with BPD will continue to be misdiagnosed, misunderstood, overlooked and inappropriately treated. A voice is needed to call attention to their suffering. TARA APD advocates with legislators at state and federal levels and with mental health policy makers for parity for BPD with other major mental disorders, for decrease in stigma, and for appropriate treatment, particularly for comorbid conditions such as substance abuse.

We are now a Partner with the DANA Alliance for Brain Disorders. As such, we participated in Brain Awareness Week with a lecture on the Neurobiology of Personality Disorder given by our esteemed Board member, Dr. Larry Siever, cosponsored with the NYC Dept. of MH, MR & AS and the DANA Alliance.

At the recent American Psychiatric Association Convention in Toronto, Jack Maser, PhD, from the Division of Extramural Activities at the NIMH, addressed the American Researchers in Personality Disorder Association, advising the group that advocacy for personality disorder was vitally needed. Consequently TARA APD visited the NIMH and introduced our work and the population we serve to appropriate departments heads at the NIMH. We provided the educational department with our BPD brochure and various research articles by Board members. Our visit allowed us to advocate for increased research funding for personality disorder and support for pending grants. Most importantly, we have become a squeaky wheel at the NIMH. While in Washington we also made our issues known to various members of the House and Senate including Senators Wellstone, Domenici, D'Amato and Moynihan.

Our non–stop advocacy efforts have been successful with NAMI. They have finally included BPD in their definition of serious mental illness, and will now include BPD in their Parity Campaign.

Various members of the TARA APD Board discussed a name change for BPD at the APA meeting in Toronto. Emotional Intensity Disorder or Emotional Dysregulation Disorder were suggested as alternative names which might be beneficial in leading clinicians, consumers and families to a better understanding of the disorder and might invite less stigma. We are interested in knowing what you think about a change of name for BPD. Please write to us at TARA APD, 23 Greene St., NY 10013

American Public Health Association Invited Workshop

TARA APD has been invited to present a workshop entitled: "An Unrecognized, Refractory Illness—Public Health Policy Issue or Private Pain? Borderline Personality Disorder and Its Fiscal Impact in Community and Institutional settings: What You Don't Know May Cost You," at the forthcoming American Public Health Association Annual Meeting in November, 1998 in Washington, D.C. Each year millions of dollars are spent by Medicaid, Medicare and managed health care companies on emergency room visits, physicians' offices and hospitals stays treating individuals who present with multiple symptoms but whose underlying illness may be BPD. These treatment failures contribute to interactive, refractory conditions that are costing the nation millions of dollars.

Sisyphus pushed his rock up to the top of the mountain only to repeat his labors. Advocating for people with BPD is the same except our rock has become massive as we see how much needs to be done to improve life for those with BPD and those who love them. We must advocate for an increase in research funding, a change in curriculum for psychiatric residents, psychology interns, and social work interns, education of practicing professionals, and greater availability of clinical training in effective cognitive therapy for BPD. We must teach families how to cope, and offer support to them and to people with BPD. We need to help the substance abuse community to acknowledge and treat their clients who are comorbid with BPD and may make up more than 60% of this population. And, last but not least, we need to raise funds to continue our much-needed work. ■

Sign Up Now!

by Michael Blumenfield, M.D.
NYSPA Public Affairs Chair

Eight hundred New York State psychiatrists have already signed up to be part of the NYSPA Searchable Database. If you are not one of them, why not?

Here are some of the concerns you may have and the answers to them, which should encourage you to sign up as soon as possible.

Q. I don't want new patients, so why should I sign up?

A. You can indicate that you are not accepting new patients and that information will be clear to anyone who finds your name in the database. However, we expect that the database will be used for other reasons by physicians, mental health professionals, academic colleagues, media and others who may want to contact you.

Q. I don't want my office listing available to the general public, so why should I sign up?

A. You are already listed in the telephone book and the APA Directory, as well as other places. In addition you are most likely already listed online: your listing is already easily accessible on the Internet at the AMA site (even if you are not an AMA member) and through other organizations that you belong to or are certified by. In many cases the information is not accurate. Why not be listed as a member of NYSPA and you choose the information that is listed?

Q. Can I sign up and avoid being flooded with e-mail?

A. Yes, you can sign up and you don't have to list your e-mail address.

Q. If I don't have a computer and I am not on the Internet, what good does this do me?

A. It is not a requirement that you have a computer or be on the Internet in order for you to be part of the Searchable Database. By signing up, even by completing this form by mail, your professional information is available to people who may want your services and who will use a computer to search for the name of a psychiatrist. There is an increasing trend for people to search the Internet in order to find a professional. The person who uses a computer to find you can then call your office phone number.

Q. If I am listed in the Searchable Database, how will the public use it to reach me?

A. People who are searching will first indicate which locale (District Branch) that they wish to search. They will then get a screen which will show every town or city in that DB which has a psychiatrist. For Manhattan they will get a listing of zones. Other District Branches in NYC will not require zone listings. The searcher can check the entire DB or as many cities or zones that they wish to be included in the search. They will then get the opportunity to indicate special areas of interest which will be matched with the psychiatrist interests. There will then be an opportunity to indicate any particular insurance plan which is a requirement in choosing a psychiatrist. The public will be informed that such plans are always changing and it might be best to first check with the individual psychiatrist. The searcher will then get a listing of psychiatrists who meet either search criteria. Further information which the psychiatrist has provided can then be read on a special page for each doctor. This information includes office address, telephone number, e-mail, board certification, hospital and medical school affiliations. We also hope to be able to provide an up to date map showing the route to the psychiatrist's office from any location.

We need to have as complete a listing of our members as possible for the searchable database. The application form was mailed to every psychiatrist and was also in the last issue of the Bulletin. If you don't have it, you can call the NYSPA office and asked that it be sent to you. You can also sign up directly online at the following Internet address:

<http://www.ptofview.com/nyspa/form.html>

The public interface of the database is currently being designed and we expect to have it available within the next month or two. We anticipate that we will publicize the Internet address and will encourage the wide use of it.

If you have any questions, please call me at (914) 472-5035 or (914) 493-7618 or e-mail me at Ronellan@aol.com. ■

Psychopathic Personality

Contined from page 4

Psychopathy as a Predictor of Dangerousness

The presence of psychopathy in an offender is highly predictive of future dangerousness (Hare et al). In prison populations, a score indicative of psychopathy on the Psychopathy Checklist predicts recidivism, especially for violent crime. It is more predictive than history of criminal behavior, demographic variables, or any combination of these factors. Among forensic psychiatric patients, psychopathy also predicts recidivism and violence. In these studies, rates of recidivism among psychopaths are generally more than double the rates among non–psychopaths. Psychopaths are more likely to commit instrumental (purposeful, dispassionate) crimes, to use weapons, and to attack strangers.

It is no surprise that the items scored in the Psychopathy Checklist predict violence. In addition to possessing a history of delinquent or criminal behavior, the psychopath is impulsive, reckless and lacks empathy for potential victims. He may feel entitled to break rules, and may use his charm to avoid consequences. There are few internal checks on potential violent or criminal behavior, and external checks are often ignored. What is surprising is that treatment may actually make psychopaths worse. A Canadian program designed to treat offenders actually increased recidivism among psychopaths (Rice), perhaps by teaching psychopaths to feign empathy.

The Future

Research continues in the nature of psychopathy. Though initial studies concentrated on prison populations, researchers are currently studying psychopathy among the mentally ill. A shorter, revised version of the Psychopathy Checklist has been developed for use in the MacArthur Foundation project on the prediction of violence in mental illness. Future research may also clarify how psychopathy may co-exist with psychotic illnesses. Can psychosis conceal an underlying psychopathic personality? Conversely, can apparent psychopathic traits resolve when an underlying psychosis is treated?

Finally, Antisocial Personality Disorder has not generally been accepted as a serious mental illness when determining criminal responsibility. Will a fuller understanding of the nature of psychopathy affect legal conceptions not only of dangerousness, but also of insanity?

References

Cleckley H: *The Mask of Sanity*. New York, Plume, 1982.

Gacono C & Hutton H: Suggestions for the clinical and forensic use of the Hare Psychopathy Checklist-Revised (PCL-R). *International Journal of Law and Psychiatry 17*: 303-317, 1994.

Hare R, Hart S, & Harpur T: Psychopathy and the DSM-IV Criteria for Antisocial Personality Disorder. *Journal of Abnormal Psychology 100*: 391-398, 1991.

Rice M: Violent Offender Research and Implications for the Criminal Justice System. *American Psychologist 52*: 414-423, 1997.

■

NYSP-PAC

1998 Contributors to the New York State Psychiatric Political Action Committee, Inc. (after 5/4/98)

Contributors prior to May 4, 1998 were listed in the Summer issue of The Bulletin.

Sustaining Member ($150)

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