Synapse

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Psychiatry in the News Again: Parity and Prescribing

This year marked a landmark event when President Bush endorsed mental health parity and vowed to work with Congress to get legislation enacted this year.

He announced creation of the New Freedom Commission on Mental Health, where members will advise him on improvements to the mental health system in the United States.

APA President Richard Harding, M.D. praised President Bush for his commitment to end discrimination against patients seeking treatment for mental illness by supporting parity.

President Bush announced his support of the parity in the state of New Mexico, which is the home state of Senator Pete Domenici, who is a leading sponsor of the parity legislation and whose son suffers from schizophrenia. As governor of Texas in 1997, Bush had signed parity coverage for people with serious mental illness. The details of the parity coverage that the Bush Administration would endorse were not explained.

The New Freedom Commission will have one year to recommend improvements to the public mental health system. Michael Hogan will head the commission, Director of the Ohio Department of Mental Health and the other members will be appointed to this commission.

In his speech to the public, Bush stated, "Stigma leads to isolation and discourages people from seeking treatment they need." All Americans must understand that mental disability is an illness and like other physical illnesses, it is treatable.

New Mexico was also the same state that Governor Guy Johnson on March 5, 2002 signed the nation's only Psychologist Prescribing Law. In other words, New Mexico became the first state in the nation where psychologists will be legally eligible to prescribe psychotropic medications to patients with mental illness (starting July 1, 2002). There are 31 psychological associations in the United States who have task forces lobbying their state legislatures for prescribing privileges.

APA President Harding issued a statement deploring this decision of the New Mexico Legislature and the Governor-stating it is bad medicine. The psychologists in New Mexico must meet the following criteria in order to prescribe:

1) Pass a national certification exam
2) Successfully complete pharmacological training by two boards (450 classroom hours)
3) Successfully complete an 80-hour practicum under physician supervision.
4) Complete 400 hours treating at least 100 patients under physician supervision.
5) Obtain malpractice insurance.

After completing the above requirements, the psychologist may prescribe for two years under the supervision of an MD, and after that time they can apply for an independent prescribing certificate.

President Harding issued e-mail to all APA members "Major lessons learned from this battle." One of these lessons is to be proactive "whatever it takes to get in and have personal meetings with your legislators."

As far as WHPS, we too have taken action in response to this battle. Dr. Tarle has arranged a meeting on September 12, 2002 with State Senator Thomas Morahan. Five members of the Executive Council will attend this meeting. Parity and psychologist prescribing will be important issues at this meeting.

In addition, we are trying to establish a closer relationship with our local medical society. At the spring dinner, Medical Society members were invited. Dr. Stuart Rasch, President-elect of the Medical Society of Rockland was one of our guests at our

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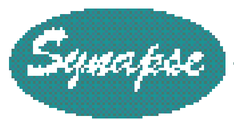
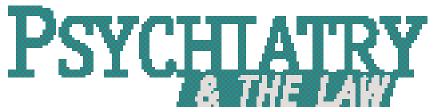



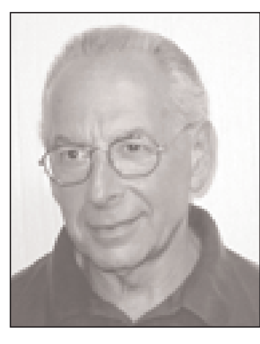
Distinguishing Between True and False Allegations of Child Sexual Abuse

It would seem that evaluating children who have allegedly been sexually abused, either for therapy or as part of a forensic assessment, in a child custody or visitation case, would be complicated enough without having to also concern oneself with whether the child's allegations are actually valid. Yet, we have discovered over these many years, that many allegations, either brought forward by the child to a therapist, a caseworker or teacher, or brought forward by a parent acting "in the child's best interest," are frequently found to be false upon further investigation. It has been believed for many years, based upon some small research, that child sexual abuse allegations brought during a custody or visitation action, or other matrimonial action, are frequently found to be false. Yet, more recent research has stated that while child sexual abuse allegations are frequently found to be false in about 50% of cases, this is also the approximate finding in cases where no matrimonial action exists.

Thus, it is critically important for the psychiatrist evaluating a child in a forensic setting or treating a child whose parents are concurrently or subsequently engaged in a custody or visitation action, to be especially knowledgeable about the distinguishing features between true and false allegations. It has been found that the following are typically found in children who have subsequently been proven to have been sexually abused and, not in children who have falsely accused someone of abusing them:

1.The details about the abuse are explicit, have depth and unique or distinguishing characteristics about the abuse or the environment in which the abuse allegedly occurred, including tastes, smells and other sensations.

2.The words that the child uses in describing the abuse are consistent with the child's developmental age. In similar fashion, sentence formation and quality of the description are also age appropriate.



3. In addition, the description of the abuse appears to reflect a child's perspective, as a child might perceive it, rather than from an adult's perspective.

4. The child's affect during the interview, when describing the abuse, should be consistent with the description and the child's situation. Children describing abuse are generally reticent, sad or depressed, withdrawn and hesitant in their descriptions. A sexually abused child describing the abuse also exhibits a sense of guilt and shame, as well as fear, rather than overt or blatant anger.

5. There is a characteristic pattern to the progression of the abuse as described by the child, with increasing severity or complexity over time, beginning with an "induction phase" of increasing familiarity progressing thru "semi-innocent" touching to greater and greater sexual activity. In addition, the child frequently describes having been threatened, coerced and told to maintain the secrecy of the activity.

6. There may be suggestions of pornographic involvement, including the use of audio and videotapes. Ritualism and satanism is rare.

7. The child's story, over time, while not necessarily having to remain exactly the same, does maintain a level of consistency.

8. While not always present, there is frequently a family history of

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SYNAPSE designed by Lydia Dmitrieff

substance abuse, prior abuse or neglect of the child or of other children in the family. Marital conflict or conflict between the mother and a paramour is frequent. In addition, other children in the household may be able to provide bits of information alluding to knowledge about the abuse.

9. Sexually abused children frequently show some symptoms of PTSD, although certainly not the full-blown picture, and often engage in traumatic play. When the abuser is removed from the household or the environment, the child's behavior frequently improves dramatically.

10. Sexually abused children frequently disclose the abuse to non-family members with whom they feel safe, such as schoolteachers, guidance counselors and psychotherapists. It is much less common for children to disclose to their mothers or other relatives, frequently because they feel that they would not be believed or that their mothers in some way, would advise them that the information the child would like to disclose is unacceptable.

11. Unfortunately, physical evidence of sexual abuse, including genital trauma, sexually transmitted disease or semen, is not commonly found.

Therapists must be extremely diligent in dealing with children who allege that they have been sexually abused and cannot routinely support those allegations as if they were true, especially since it has been found, as stated above, that fully half are found not to be valid. The therapist's posture should be that of helping the child deal with these issues, rather than attempting to support the allegations or validate them, despite wanting to do this with one's patient. All too frequently, overzealous therapists reinforce a child's misguided claims, lending emphasis to the child's thoughts and potentially reinforcing them to a point where the child, previously unsure, becomes much more committed to his or her position, and thus complicating the investigatory process by police and Child Protective Services. This is obviously an extremely difficult task for therapists who want to believe their patients, and seek to support their patient's contentions. Therapists must never take the position with the authorities in which the therapist acts as "validator" of the child's allegations. ▲

Alan J. Tuckman, M.D.

Diagnostic Guidelines And Clinical Realities

Diseases are not made to fit diagnostic guidelines. Guidelines are only good as long as they do not restrict the clinicians to rigid conformity. This is well illustrated in the case of a syndrome like Neuroleptic Malignant Syndrome (NMS), a spectrum disorder which is likely to be missed if the clinician is in total conformity with the DSM-IV guidelines. The prompt diagnosis and institution of appropriate treatment of this disorder can be life saving. According to the DSM guidelines the presence of severe muscle rigidity and elevated temperature, in patients on a neuroleptic, is required for the consideration of NMS. In recent case reports it has been claimed that in those on atypical neuroleptics, presence of severe rigidity may not be imperative. In a highly illustrative case review Reeves and Torres, et. al., have discussed this diagnostic dilemma.

Since the publication of our article on Neuroleptic Malignant Syndrome in the May-June issue of the Synapse there have been some interesting developments on the subject that are worthy of our readers, attention. The article by Roy Reeves, DO, PhD; Raphael Torres, M.D., et. al., (Pharmacotherapy 22 (5): 641-644, 2002) has questioned the restriction of the diagnosis to the rigid guide lines in the DSM IV. Doing so would lead to the under-diagnosis of this condition thereby missing or delaying the timely intervention which is so vital in saving the lives of those afflicted with this rare but potentially fatal condition.

In DSM IV NMS has been discussed in some detail and guidelines for the diagnosis have been spelled out as follows: the diagnosis of NMS should be assigned only to patients who develop severe muscle rigidity and elevated temperature while receiving a neuroleptic drug and who display two or more of the following signs and symptoms: diaphoresis, dysphagia, tremor, incontinence, changes in level of consciousness, mutism, tachycardia, elevated or labile blood pressure, leukocytosis, and laboratory evidence of muscle injury.

The case of NMS described by Reeves and Torres did not meet all the criteria of DSM IV but was otherwise typical of the syndrome. For the sake of clarification I am giving an abridged write up of the very instructive case report by the authors:

A 53-year-old African-American man with a long history of paranoid schizophrenia had been in stable condition for approximately 3 years while taking olanzapine 10 mg/day. His medical history was unremarkable

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Anna Munster, M.D.: A Story Of Survival, Growth and Service

On May 3rd 2002, West Hudson Psychiatric Society, at its Spring Dinner meeting, honored Anna Munster, M..D. a longstanding member of our district branch. It was a well attended gathering at the Dellwood club where our District branch presented her a plaque in recognition of her dedication to the profession and service to senior citizens. She also received a certificate of commendation from the county executive Mr. C. Scott Vanderhoef and another one from the Governor's Office of Aging. It was a festive occasion made complete by the presence of many of her friends, students and well-wishers.

She was born in 1913 in Buscovina, an Eastern European Region which was part of the Austro-Hungarian Empire. Later it became part of Romania, then was occupied by Germany followed by occupation by Russia. Presently, it is in Romania. Anna's schooling was in a French elementary school. She had her Baccalaureate at 17 and went to the Medical School in Strasbourg, France. graduating from the faculty of Medicine in 1937, she was trained as a chest specialist and in tuberculosis. It was a time when war clouds were gathering over Europe. In 1940, as the German armies marched into France, she fled south with only a suitcase in hand. She survived on the run by working in vineyards and gardens and occasionally as a lab technician. She stayed in the middle regions of France until the Germans came threateningly close.

With the help of an Austrian priest she found safety in a series of French camps for the refugees established by the Vichy government. Here she was safe but restless. Finally she reached the Swiss border and in 1941 crossed the border to start a life hopping from camp to camp as a refugee. She worked as a pediatrician and general practitioner in six different camps in Switzerland. In 1944-45 she won a scholarship for an intensive course in social work which comprised child psychology, social psychiatry and prevention of mental illness. She stayed in Switzerland from 1941 to 1946, during this time she availed of every opportunity to do whatever postgraduate courses she could find.

In 1944 she married a Frenchman in Switzerland who had climbed the 600 foot mountainous border with her. Her daughter, Angela, was born in 1945. Today Angela, who has a PhD in philosophy, teaches at the University of N. Carolina in Asheville. In 1946 the family returned to France where she took further courses in pneumonology in Paris. In 1949 she came to the USA for the first time, accompanied by her husband who, having worked as an interpreter during the Nuremberg trials, had a permanent job as an interpreter with the United Nations. Their son, Marc, was born in 1949 in the USA. He holds a PhD in communications. From 1951 to 1953 she was a chief resident in the pulmonary division of Montefiore hospital, Bedford Hills NY. In 1954 she went to Israel, where she worked for two years in a number of camps as a pediatrician and general physician.

In 1956 she immigrated to USA. She obtained a Maryland license in 1957, a NY license in 1958, a NJ license in

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1970, and a N. Carolina license in 1983. She completed her psychiatric training and took the General Boards in 1961 and Child psychiatry boards in 1965. She was in charge of a 175 bed unit for children and adolescents at Rockland Psychiatric Center, where she did some pharmacological studies. She also used physical exercises based on Eastern Yoga routines with asthmatic children. Later she moved on to a teaching position in Child Psychiatry at Cornell and Mt. Sinai Medical Schools. She was there until she turned 70 and retired.

In her 'thank you' address, on May 3rd, she included the following remarks: "Since my medical school days my interest was in prevention. Thus foreseeinng my old age and the possibility we all dread, namely loss of independence through bodily impairment and acuity of mind, I started to practice Yoga, pursuing it to this day. It helps to deal with common stresses of living and helps body and mind functioning.

Professionally, an unexpected side-effect of this knowledge was the successful application of breathing, posturing and relaxation techniques, during psychotherapeutic sessions with asthmatic, disturbed and hyperactive children. Most notable with adults was the change of direction in the stream of thought, when breathing and posture were attended to. In conclusion, I gained personally and professionally from the practice of Yoga."

At age 50 she had started taking Yoga classes, and ended up inheriting her teacher's class and teaching it. She developed a system which enhances and maintains physiologic functions. She attended classes by other yoga teachers, in France and Switzerland, and incorporated their techniques into her own methods. She has made a video of a class in action and has donated it to the Pearl River Public Library where it is available for borrowing. For many years now she has been teaching, with her assistant Linda Morrisey, a free class at the library every Monday at 10 AM. You are welcome to join it or just come and witness the class in progress. I had personally gone to observe one such class and was instantly sold on it. Anna is 88 years old and will turn 89 this August, we wish her many more years of active community work that represents a bridge between our profession and the people we serve. ▲

Syed Abdullah, M.D.

Diagnostic Guidelines, cont'd.

except for heat stroke over a year earlier, during which he had a high fever and weakness after prolonged exertion in hot weather. The patient was taking olanzapine at the time; no other details are available. During those 3 years the patient had intermittent employment and did not require hospitalization. Then, after experiencing a number of stressors, he became progressively more paranoid and isolated. He lost his job. Under financial stress, he and his wife decided to move to Mississippi to live with the wife's relatives.

The 4-day drive from Tacoma, Washington, was stressful for the patient, and he became increasingly paranoid. He heard voices and other sounds underlying road noises and felt that other drivers were following him. He began taking extra olanzapine to control these symptoms. How much extra he took was unknown. After noting that he was coughing and had a fever, his wife took him to the emergency room, where his temperature was 102.9°F. He was diagnosed with sinusitis and treated with amoxicillin 250 mg 3 times/day. He complained that he was still hearing voices, and he was prescribed olanzapine 5 mg 3 times/day. Over the next 2 days his wife gave him the drugs as prescribed, but he became increasingly paranoid and confused. He returned to the hospital the following day but would not allow anyone to examine him because he was so paranoid. He was given olanzapine 10 mg and lorazepam 2 mg. Approximately 45 minutes later, physical examination found him to be lethargic and diaphoretic, with a temperature of 104°F, blood pressure 85 mm Hg, heart rate 80-115 beats/minute, and respiratory rate 20 breaths/minute. He was confused and oriented to person only, but with no other abnormalities and no source of infection. Neurologic examination revealed symmetric movement of all extremities and symmetric reflexes. Muscle tone was normal. Laboratory tests revealed white blood cell count $5.7 \times 10^3/mm^3$, hemoglobin 11.4 g/dl, hematocrit 33.9%, platelet count $105 \times 10^3/mm^3$, sodium 132 mEq/L, potassium 3.0 mEq/L, chloride 95 mEq/L, glucose 117 mg/dl, blood urea nitrogen 21 mg/dl, creatinine 1.5 mg/dl, creatine kinase 1388 IU/L, aspartate aminotransferase 56 IU/L, and lactate dehydrogenase 271 IU/L. Urinalysis, drug screen, and chest radiograph showed no abnormalities.

The patient was admitted to the intensive care unit (hospital day 1) and treated with intra-venous hydration. All antipsychotic drugs were withheld. Computer tomography of the head, lumbar puncture, thyroid function studies, rapid plasma reagin, human immunodeficiency virus testing, and electroencephalogram results were unremarkable. On day 2 the patient's blood pressure was stable at 105/62 mm Hg, and his temperature was 102°F. His mental status slightly improved, in that he was oriented to person and place, although still unable to perform cognitive tasks. His creatine kinase declined to 1203 IU/L, and his electrolytes became closer to normal. Intravenous fluids were continued, and on day 3 his electrolytes and renal and hepatic function tests were within normal limits. At that point, the patient's temperature was 100.9°F, blood pressure 135/85 mm Hg, and creatine kinase 551 IU/L. He was less confused and scored 17 of 30 possible points on the Mini-Mental State Examination. However, he continued to express paranoid ideations. On day 4 he was afebrile with normal cognitive functioning and his creatine kinase level was 211 IU/L. At no point did he have rigidity or increased muscle tone. He received no intramuscular injections. During his illness the patient's white blood count fell as low as $3.3 \times 10^3/mm^3$. His red blood cell count, hemoglobin, hematocrit, and platelet count were also slightly low. A complete evaluation for causes of pancytopenia found that the abnormalities were consistent with anemia of chronic

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Diagnostic Guidelines, cont'd.

disease, and no active treatment was recommended. This probably explains the failure of his white blood count to elevate, as often occurs with NMS.

The patient continued to hallucinate and was paranoid after his condition stabilized, so he was transferred to a psychiatric unit and started on risperidone 1 mg twice/day. His psychotic symptoms improved moderately, and 2 days later the dosage was increased to 3 mg at bedtime. He complained of headache with each dose, so risperidone was replaced with ziprasadone 20 mg twice/day. The dosage was increased to 40 mg twice/day, which fully alleviated the patient's hallucinations and improved his paranoia such that he was suitable for discharge. He has experienced no adverse effects with this drug. The authors contend that cases of this type may support a spectrum concept of NMS. Possibly, NMS is not a single entity with a uniform presentation, or it may represent the extreme end of neuroleptic-related toxic reactions. Incomplete or atypical presentations of the syndrome may represent early or impending NMS. This is an area with many unanswered questions requiring further research. It would appear that one should not always require the presence of strict DSM-IV or similar criteria to consider a diagnosis of NMS.

Any patient under treatment with an atypical antipsychotic who exhibits unexplained fever, alteration of cognition, rigidity, or autonomic instability should be evaluated for atypical NMS and receive appropriate treatment. Adherence to a rigid diagnostic paradigm for NMS may interfere with prompt diagnosis and treatment, especially because this condition may present in a variety of ways. Diagnostic requirements based on flexible major and minor criteria would be more sensitive than rigid paradigms in a clinical setting, and still retain diagnostic specificity.

The above statement is a rejoinder to clinicians to consider a diagnosis even if all the rigid criteria are not fulfilled in a given case. This stance is expected to avert diagnostic and treatment indecisions in many instances. ▲

Syed Abdullah, M.D.

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Psychiatric Records

Complimentary risk management tips from The Psychiatrists' Program

- Document fully the type of treatment and rationale, as well as alternatives to the treatment and why they may have been rejected.
- Document dates (and length) of services, pertinent history, prescription of medication, and consultations with other professionals. Document legibly.
- When dealing with a potentially suicidal or violent patient, document all actions taken (and why), and all actions considered but rejected (and why).
- Include written informed consents, lab reports, and correspondence in the record.
- Record retention is often governed by state law. Keep in mind that there is no "statute of limitations" for licensing board or ethics complaints.
- Instruct staff regarding handling of records, stressing confidentiality concerns.
- Do not alter records after an adverse event.

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Parity, cont'd.

meeting. We intend to invite members of the medical society to our fall meeting.

Finally, we are strengthening and increasing our membership. Dr. Madhu Ahluwalia is doing an excellent job in recruiting new members and setting up a mentoring system. If you know any psychiatrists in Rockland, Orange, Sullivan, or Delaware County who are not yet members of the WHPS, please encourage them to join!

With the upcoming depression screening coming up in October 2002, we need volunteers. Dr. Mona Begum, and Dr. Jane Kelman will chair the depression screening this year. I urge each of you to be proactive. Help us to show your community that psychiatrists are leaders in mental health. Help out with the October depression screenings, attend Mental Health Coalition Meetings (next meeting June 20, 2002), join the WHPS and the Medical Society.

Call me at (845-634-6306) to see how you can become an active member of WHPS and how you can make a difference in our community. ▲

Lois Kroplick, D.O.

News from Capitol Hill

APA Makes Strides in Capitol Hill Push for Parity

For the first time, a majority of the U.S. House now formally supports mental health parity. As of late last week, 223 Representatives (a majority of the house) are co-sponsors of HR 4066. Sponsored by Reps. Roukema and Kennedy, HR 4066 is the companion bill to S 543, the Domenici-Wellstone parity bill. Two-thirds of the Senate (66 Senators) support S 543.

On June 6, Sens. Domenici and Wellstone and Reps. Roukema and Kennedy joined nearly 2,000 parity supporters on Capitol Hill to urge Congress to pass mental health parity now. Continuing the push for parity, the APA spearheaded Coalition for Fairness in Mental Illness Coverage and placed full page ads for parity in Roll Call on June 6 and the CQ Daily Monitor on June 5 and 6.

Additionally, APA placed an ad in Roll Call on June 16, which highlighted "The Truth About the Impact of Mental Health Parity."

For copies of the ads, please contact advocacy@psych.org.

Read the latest DGR Update on parity at:

http://www.psych.org/pub_pol_adv/parity52802.cfm.

White House Meets with APA to Discuss Privacy Issues

APA President Paul Appelbaum, M.D., Immediate Past President Richard Harding, M.D., and DGR staff met with White House officials on the privacy rule changes on June 23. APA urged the White House to reinstate the requirement for providers to obtain patients' written consent before the use and disclosure of their medical records. APA also recommended that if written consent was impractical, then oral consent could be obtained and documented in the medical record. APA suggested limited exceptions to prior written consent for situations where it is impractical, or where it could have unintended consequences.

This might include when patient information is needed to fill a prescription, schedule a referral, or review previous treatment records to expedite treatment.

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