



# Synapse



THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

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## President's Inaugural Perspective

I begin my term as president of our Society with a rather unoriginal thought. For psychiatry, it is the best of times and it is the worst of times. We are all faced with the strange dichotomy of practicing an exciting, scientifically sound, and impressively effective profession in an atmosphere of merciless budgetary constraints and harassing oversight.

I can not imagine a more exciting time to be a psychiatrist. We are in the midst of not one but several revolutions in our understanding of human behavior and existence. When I began my residency over 30 years ago, only wild eyed visionaries would have imagined highly specific pharmacological interventions for obsessive compulsive disorders or social phobias. Treating patients with major Axis I disorders meant exposing them to potentially crippling neurologic or nephrologic damage. Our growing knowledge of neurochemistry, while still fragmentary, has allowed for an explosive growth in therapeutic options for our patients.

I believe that psychotherapy has also become much more effective. Controlled studies and head-to-head comparisons have allowed us to more knowledgeably tailor treatment to the individual patient. We now have the foundation for a differential therapeutics that is sophisticated, evidence based, and effective.

Dramatic advances in cognitive neuroscience, functional imaging, neuropsychological analysis, and animal modeling have provided us with amazing

insights into brain-behavior relationships, drastically altering our notions of "functional" psychiatric conditions. Molecular genetics and ever more precise population studies hold the promise of equally dramatic insights.

Our humanistic traditions have informed and kept pace with scientific advances. Just one example is the study of post traumatic stress disorder. Our ability to understand and treat this condition has expanded significantly over the past decades. Sadly, this expertise was put to the test after September 11. We can be proud of the contribution our profession made to aid the victims and survivors. Under the leadership of our past president, Dr. Lois Kroplick, our Society was in the forefront of this rehabilitation work.

It is painfully ironic that while publications from JAMA to the New York Times talk about how effective our interventions are, both the public and private sectors are cutting back on funds for psychiatric services. We are all painfully aware of the deleterious impact budget cuts and mismanaged care have had on our patients. They have taken a toll on our profession as well, as evidenced by stagnant incomes and growing shortages of child and adult psychiatrists.

I don't know of any way to respond to these unfortunate trends other than to work together in a committed professional organization. Despite shortcomings, the APA at the national level and NYSPA and the West Hudson Psychiatric Society locally are the only coherent and sophisticated

voices our profession has. Lobbying efforts are ongoing and often very successful, as with the New York State Assembly's recent passage of a bill providing for parity of psychiatric services.

Another critical function of our professional organizations is to provide a sense of solidarity and community. Our work is intensely demanding, isolating, and often frustrating. Demoralization and cynicism are real occupational hazards. We have to be proud of our professional accomplishments and supportive of our colleagues. Active involvement in our organization is I think the best way of affirming our professional identities and cementing important collegial relationships. I'll be talking more about this in future columns. ▲



*Andrew Hornstein, M.D.*

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## Professional Liability: Malpractice in Adolescent Psychiatry

Recently I had the privilege of presenting a paper to the American Society for Adolescent Psychiatry on current issues in professional liability and malpractice in the practice of adolescent psychiatry. What follows is a summary of that presentation:

The landscape of medical malpractice today has changed dramatically from 20-30 years ago. Physicians in many specialties have

modified the procedures they perform or have even become much more selective in the types of patients they treat as a result of the increasingly aggressive legal profession becoming much more creative in crafting causes of action in malpractice cases. Where they can't use traditional complaints they have literally created new ones and sadly juries, at times, have agreed. In part, this has been aided and abetted by psychiatrists ignoring legal constraints and requirements. In addition, as the late Dr. Seymour Polack stated in an article in the *Bulletin of the American Academy of Psychiatry and Law* some years ago, in no other branch of medicine do practitioners attempt so to deny authenticity to clinical procedures and judgments made by their colleagues. "In no medical field, other than psychiatry, do practitioners respond so individualistically and so idiosyncratically and in no other field of medicine is reliability so low. Reliability is reflected in credibility."

Also, managed care companies, leading the way by cutting physicians' reimbursements, stimulated many physicians to engage in practices which increased their risk of malpractice. One of the more common situations today is the psychiatrist who sees patients for medication only, increasing his or her risk of being sued significantly, and if the psychiatrist sees more than 25 patients per day, the risk increases disproportionately. Lawyers have also not helped by advising psychiatrists that if a bad outcome occurs with a patient, the psychiatrist should not have further contact with the patient, especially if the patient has voiced any thought of suing the psychiatrist or has already initiated a malpractice action. In reality, malpractice claims primarily occur because of two related factors: (a) a bad outcome, but not necessarily bad practice, and (b) more importantly, bad feelings. Psychiatrists who are not accessible, who do not reach out to patients, who are arrogant or seemingly disinterested, run a much greater risk for a malpractice action after a "bad outcome." Avoiding malpractice actions always entails maintaining good practice but even more importantly,

maintaining a human, consistent, available attitude toward patients and family members at all times.

In addition, uncertainty is a common accompaniment in the treatment of many psychiatric disorders and in their outcome. It is extremely important to, when appropriate, share uncertainty about the treatment of a patient with the patient and family members. Thus, a chronically depressed and suicidal patient, having made several prior suicide attempts and having been hospitalized several times, poses an extremely high risk for a future suicide. This uncertainty must be shared with family members in order to avoid the possibility for litigation should a successful suicide occur in the future.

Moving on to more specific issues with adolescent patients, we well know that parents of our adolescent patients generally fall into two categories: those who are feeling frustrated and helpless and welcome any help with their problem teenager, and those who know their child needs help but are very threatened that you will be able to do something that they couldn't do. The latter group may attempt in various ways to undermine the therapy or to find fault with you in your work with their child as a means of proving to themselves that even you could not help. Therefore, the treatment of adolescents should always include regular contact with parents as well as being available for calls from parents. In the past, a frequent practice was to advise the parents of adolescents that nothing from the therapy would be shared with the parents. I believe this is blatantly wrong and may very well cause the parents to feel cut off and alienated from the therapy and their child. While the reality is that the person who is personally and legally responsible for the child is the parent and for therapeutic, as well as legal purposes, they must be part of the therapeutic



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## Kroplick Wins Bruno Lima Award: Nominating Letter

Ms. Linda Roll

February 26, 2002

American Psychiatric Association, 1400 K Street, NW, Washington, D.C. 20005

Dear Ms. Roll,

As president-elect of the West Hudson Psychiatric Society, I would like to nominate our current president, Dr. Lois Kroplick, for the Bruno Lima Award. As a founding member of the Rockland County Mental Health Coalition, Dr. Kroplick has won national recognition for organizing and leading interdisciplinary community action initiatives. This experience was skillfully utilized to aid the survivors and families affected by the September 11 terrorist attack.

Dr. Kroplick called an emergency meeting of the local district branch on 9/11, and arranged for the provision of gratis psychiatric care to those affected by the tragedy. Though she did not have a private practice, she took out malpractice insurance and took on five patients herself. She set up communications with local and New York City police and fire departments to let them know of the availability of free sessions. She spent several 12 hour shifts per week from mid-September to the end of November on Pier 94 providing emergency evaluations to dozens of grieving family members, relief workers, and those displaced by the attack. As an active member of our local Mental Health Core Group, Dr. Kroplick helped set up the Family Assistance Center where information and support were made available to affected families and debriefing provided to professionals working with trauma victims. She organized a group of local mental health professionals to go to Columbia University for training as part of the corps that is debriefing New York City police.

She took over the duties of colleagues who were away treating victims. She lectured and wrote extensively during this period to psychiatrists, family physicians, clergymen, kindergarten through college students, and the public about the needs of the survivors and the syndromes professionals might encounter. As part of this educational effort, she organized the semiannual meeting of the district branch as an interdisciplinary lecture on psychiatric aspects of public disasters, presented by Dr. Michael Blumenfeld. She wrote articles for the local newspaper and for Psychiatric News on PTSD and on where victims of 9/11 can get help. She is in the process of organizing a major conference for next fall on the effects of 9/11.

Dr. Kroplick has in the face of tragedy exemplified the best of our profession.

Yours truly, *Andrew Hornstein, M.D.*

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## Silas Weir Mitchell, MD. and The Yellow Wallpaper

The year 1884 marked the 50th anniversary of the formation of the American Medico-Psychological Association. The program committee of the Association searched for a prominent figure as a guest speaker at its golden jubilee celebration. Silas Weir Mitchell, M.D. was the most renowned neurologist, known for his treatment of peripheral nerve injuries during the civil war. He had an international reputation not only for his medical expertise, but also for the novels and poems he wrote. Although known for his critical views of psychiatry, the program committee in a bold gesture of collegiality, invited him as an honored speaker on this historic occasion. To the surprise of all, this proved to be a chastening experience for the organization, which was to be later called the American Psychiatric Association.

This was a time when the neurologists were already making incursions in the field of mental disorders. The psychiatrists had become confined and sequestered in the Asylums and had come to be known as alienists by their medical colleagues and the general public. The membership to their Association consisted solely of the superintendents of the asylums. There was

no treatment known for the illnesses that the alienists specialized in. There was no research or teaching activities going on in the asylums. The superintendents of these institutions acted as custodians and administrative heads. Inside the walled centers of their domain they wielded nearly absolute power for as long as they held their politically assigned position, which was mostly until the end of their lives.

In his speech, Mitchell was merciless in pointing to the drawbacks and shortcomings that existed in the workings of the asylums. He, at this time, was flush with his own eminence as a neurologist and a best-selling author, had started treating the non-psychotic psychiatric patients, who were mostly middle and upper class women of the affluent Philadelphian society. Most of his patients were diagnosed as hysterical, neurasthenic and depressed. His treatment method soon came to be known as Mitchell's 'Rest-Cure.' These expensive treatments were carried out at home or in well appointed resorts and 'rest homes' with a generous provision of nurses, masseurs and attendants. It was indeed a status symbol to have a female relative under the care of Dr. Mitchell. Many other neurologists, prominent among whom were William Hammond and George M. Beard, emulating

Mitchell had become famous in the medical profession in New York City and elsewhere. Dr. Hammond even went so far as to propose a resolution to exclude asylum superintendents from membership in the newly formed American Neurological Association.



When Mitchell stood up to speak at the fateful golden jubilee meeting he eschewed the conventional pleasantries and went on hitting below the belts of the gathered hosts. He criticized the lack of progress in the speciality, the isolation of psychiatry from the rest of the medical profession, the absence of resident physicians, labs, and nurse training facilities in the asylums. He lashed out at the customs, bureaucracy and politics that hampered progress. He said it was wrong to attempt both medical care and business management of the asylum. "Insist you are physicians and no more" he said, "the cloistered life you lead give rise, we think, to certain mental peculiarities ...asylum life is deadly to the insane..it should be the last resort not first." The initial reaction to his diatribes was a defensive embarrassment which later gave way to self searching and widespread reforms and improvements which continue to this day. Many years later, when Clifford Beers, a former asylum patient, launched his mental hygiene movement, Mitchell gave his enthusiastic blessings and support to his efforts (see Synapse May-June 2003).

To understand Doctor Mitchell let us take a look at his 'rest cure' treatment in his own words: "In carrying out my general plan of treatment it is my habit to ask the patient to remain in bed from six weeks to two months. At first, and in some cases for four or five weeks, I do not permit the patient to sit up or to sew or write or read. The only action allowed is that needed to clean the teeth. In some instances I have not permitted the patient to turn over without aid, and this I have done because sometimes I think no motion desirable, and because sometimes the moral influence of

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absolute repose is of use. In such cases I arrange to have the bowels and water passed while lying down, and the patient is lifted on to a lounge at bedtime and sponged, and then lifted back again into the newly-made bed. In all cases of weakness, treated by rest, I insist on the patient being fed by the nurse, and, when well enough to sit up in bed, I insist that the meats be cut up, so as to make it easier for the patient to feed herself.

In many cases I allow the patient to sit up in order to obey the calls of nature, but I am always careful to have the bowels kept reasonably free from costiveness, knowing well how such a state and the effort it gives rise to enfeeble a sick person.

Usually, after a fortnight I permit the patient to be read to, one to three hours a day, but I am daily amazed to see how kindly nervous and anaemic women take to this absolute rest, and how little they complain of its monotony. In fact, the use of massage and the battery, with the frequent comings of the nurse with food and the doctor's visits, seem so to fill up the day as to make the treatment less tiresome than might be supposed. And, besides this, the sense of comfort which is apt to come about the fifth or sixth day, - the feeling of ease, and the ready capacity to digest food, and the growing hope of final cure, fed as it is by present relief, all conspire to make most patients contented and tractable.

The moral uses of enforced rest are readily estimated. From a restless life of irregular hours, and probably endless drugging, from hurtful sympathy and over-zealous care, the patient passes to the atmosphere of quiet, to order and control, to the system of care of a thorough nurse, to an absence of drugs, and to simple diet. The result is always at first, whatever it may be afterwards, a sense of relief, and a remarkable and often a quite abrupt disappearance of many of the nervous symptoms with which we are all of us only too sadly familiar.

All the moral uses of rest and isolation and change of habits are not obtained by merely insisting on the physical conditions needed to effect these ends. If the physician has the force of character required to secure the confidence and respect of his patients he has also much more in his power, and

should have the tact to seize the proper occasions to direct the thoughts of his patients to the lapse from duties to others, and to the selfishness which a life of invalidism is apt to bring about. Such moral medication belongs to the higher sphere of the doctor's duties, and if he means to cure his patient permanently he cannot afford to neglect them. Above all, let him be careful that the masseuse and the nurse do not talk of the patients' ills, and let him by degrees teach the sick person how very essential it is to speak of her aches and pains to no one but himself."

In summary, the treatment had the following characteristics: seclusion and rest; massage; electric stimulation and a high calorie, high fat, diet. His patients were not allowed to see relatives, read, write or otherwise strain themselves. The average therapy lasted six weeks. In the case series he described, there was only one male patient, who perhaps suffered from tuberculosis. This rest cure became the rage for upper class women who did not seem to be thriving in the last quarter of the nineteenth century. Apparently it was also adopted in England, and in a limited way by Freud. Fame came to Mitchell as a result of his work as a contract surgeon to the army during the Civil War. His writings on nerve injuries became classics as did his description of causalgia with William Keen and G.R. Moorehouse. They also wrote about 'reflex paralysis', post paralytic chorea, erythromelalgia (Weir Mitchell's disease) and cerebellar function.

The state psychiatric hospitals, and most of the proprietary ones, tried to emulate some of Mitchell's rest cure methods. But with their limited resources and burgeoning patient population the closest they came to do that, was to restrict the reading of books, curtail letter writing and control the use of telephones. In some cases visitors were disallowed for fear of agitating the patient. In extreme instances padded cells and physical restraints were used to 'calm' an agitated patient. In most cases the rest of the features of Dr. Mitchell's practices, involving one on one staffing, were beyond the scope of the crowded psychiatric facilities. These are well illustrated in the book *A Mind That Found Itself* by Clifford Beers.

One of Dr. Mitchell's patients was a talented

and intellectually gifted woman, Charlotte Perkins Gilman who went into depression following the birth of her baby. At the termination of her treatment with Dr. Mitchell she wrote a short story titled *The Yellow Wallpaper*. During the treatment she was separated from her baby girl and confined to a room with no provision of paper or pen in order to prevent any 'mental exertion' or emotional strain. Later she wrote the mental agony grew so unbearable that "I would sit blankly moving my head from side to side to get out from under the pain. Not physical pain, not the least 'headache' even, just mental torment, so heavy in its nightmare gloom that it seemed real enough to dodge... I would crawl into remote closets and under beds - to hide from the grinding pressures of that distress." Charlotte Gilman later explained "The real purpose of the story was to reach Dr. S. Weir Mitchell, and convince him of the error of his ways. I sent him a copy as soon as it came out, but got no response. However many years later, I met someone who knew close friends of Dr. Mitchell's who said he told them that he had changed his treatment of nervous prostration since reading *The Yellow Wallpaper*.

If that is a fact, I have not lived in vain."

*The Yellow Wallpaper* was written in 1890 and eventually published in 1892 in the *New England Magazine*. The story is written in the form of a loosely connected journal. It follows the narrator's private thoughts which become increasingly confusing. One can follow the author becoming more and more disjointed, as she gradually descends into madness as her only escape from an oppressive husband and an authoritarian physician. Her protests and remonstrations are dismissed as a mere prattle of an unreasoning female who does not know what is good for her. She was confined to a room as part of treatment for the nervous breakdown. Isolated and forbidden to express herself creatively, she becomes obsessed with the garish yellow wallpaper. She starts imagining that there are women trapped behind the hideous patterns in the paper. Eventually she becomes delusional in her efforts to free the unfortunate women thus trapped. By frantically tearing up the wallpaper, she symbolically frees herself from the bondage of her circumstances.

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## News From Capitol Hill (from APA Advocacy Newsletter)

### States Get Boost in Medicaid Funds

Congress provided states with a short-term boost of \$10 billion in Medicaid funds as part of the recent tax bill signed into law by President Bush on May 28. APA strongly supported this bipartisan effort to assist states in meeting their obligations to Medicaid enrollees. Prospects for long-term Medicaid restructuring remain unclear. Recently, the bipartisan National Governors Association Medicaid Reform Task Force failed to reach consensus on overhauling the Medicaid program. Although the Democrats and Republicans on the Task Force agreed on broad general principles, they could not reach agreement on key issues such as proposals to block grant those portions of the Medicaid program that provided optional services to non-mandatory populations.

### U.S. House Bans Mandatory Psychiatric Medication in Schools

The House approved a bill (the Child Medication Safety Act H.R. 1170) in May that would prohibit schools from requiring parents to place their

children on psychotropic medication to attend school. At press time, the Senate had not yet reviewed the measure. A strong coalition of groups, including the APA, American Academy of Child and Adolescent Psychiatrists, American Academy of Pediatrics, Children and Adults with Attention-Deficit/Hyperactivity Disorder and National Alliance of the Mentally Ill, voiced their opposition H.R. 1170, noting that current law does not permit schools to require medication as a condition of attendance, that the bill is unnecessary, and would stigmatize mental and emotional disorders.

### Mental Health Parity Pushes Forward

The APA has secured 63 Senate and 240 House cosponsors of the *Senator Paul Wellstone Mental Health Equitable Treatment Act* (S. 486 & H.R. 953). APA, along with the Mental Health Liaison Group, sent a letter to President Bush urging him to reiterate his support for the passage of mental health parity and to increase his outreach to key members of Congress.

In a related development, Sen. Norm Coleman (R-MN) and Rep. Jim Ramstad (R-MN) introduced the *Help Expand Access to Recovery and Treatment (HEART) Act of 2003* on May 22. The legislation (S. 1138, H.R. 2256) would prohibit health plans from imposing limitations or financial requirements on substance abuse coverage that differ from other health services. Sen. Coleman and Rep. Ramstad introduced the legislation in Minnesota and were supported by the Minnesota Psychiatric Society.

### House, Senate Approve Medicare Prescription Drug Coverage

Following marathon mark-ups in two House and one Senate Committees, followed by equally lengthy floor debates, the House and Senate have approved sweeping legislation to establish, for the first time, a Medicare prescription drug benefit. The House bill would require seniors to pay an estimated monthly premium of \$35 for a benefit that would cover 80 percent of drug costs to \$2,000 (after a \$250 deductible), followed by a coverage lapse until a stop loss of \$3,500 in out of pocket drug expenses is reached, when catastrophic coverage kicks in. The Senate bill (S1) would require seniors to pay an estimated monthly premium of \$35 and an annual deductible of \$275, for a benefit that covered 50 percent of drug costs to \$4,500, followed by a coverage lapse to \$5,800, after which catastrophic coverage kicks in. Both bills provide for varying degrees of additional support for low-income seniors.

### APA Pushes End to Medicare 50% Coinsurance

Throughout the Medicare debate in the House and Senate, APA has actively promoted ending the 50% coinsurance required for outpatient psychotherapy services under



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Continued on back page 

**Malpractice cont'd.**

process. Therapists forget that their adolescent patient is still a child and that the parents control the child's destiny. Jurors have very strong feelings about parenting and rights of parents and they always utilize their own beliefs about parenting and the control and management of their children, as well as the decision-making afforded to them. As a matter of fact, adolescents, despite their dependence/independence struggles, understand that caregivers share information with their parents and they see this regularly in school with the child's pediatrician and others.

Another very important issue in the treatment of adolescents has to do with a duty by the therapist to warn parents if their child may be dangerous to themselves or others and this "dangerousness" may very well extend to their child's use of drugs or other illegal substances (an extension of the Tarasoff warnings). While we do usually tell the child and parents at the onset of therapy that everything is confidential "except if we believe there is a danger to the patient," we are more lax in our statements to the adolescent patient and parents with regard to more subtle dangers such as the use of drugs or "potential" violence against others.

Adolescents are still children with significantly limited judgment and, when a child is using drugs or suspected of using drugs or alcohol excessively, they should never be treated except with the understanding of their parents about the substance abuse and even more importantly, with regular blood/urine drug tests to monitor their non-use. Also, no psychiatrist should even treat a patient with a substance abuse problem without that patient also concurrently attending a Twelve Step or a substance abuse treatment program. It is naive to think that any psychiatrist can treat a patient, especially an adolescent patient, without these additional services.

Another issue, uncommon but potential, relates to erotomania, the intense and at times delusional belief in a love affair with a public figure. We are aware of this occurring with movie stars, politicians, judges, and other public figures. We well know that adolescents, as part of their

psychodynamic conflict resolution, utilizing removal and displacement, often become enamored with movie stars and other public figures. But they can just as easily develop an eroticized transference, not only feeling sexually attracted to the therapist but as with erotomania in adults, imagine that the therapist has similar eroticized feelings toward them. This must be identified and dealt with very early with the patient since, as I stated, the adolescent dynamic lends greater weight to this problem. If necessary, bringing in a "consultant psychiatrist" or discussing it with a supervisor or even the parents can help to insulate the psychiatrist against a future accusation of sexual misconduct.

Another extremely important issue with adolescents has to do with e-mail and communications. The Internet and e-mail have taken over our lives and most of us today regularly communicate with family members, friends and colleagues via e-mail. Adolescents used to spend significant amounts of time on the telephone and now, with the advent of the Internet and e-mail, spend as much time communicating with each other via that modality. Thus, it is not uncommon for adolescents to also use e-mail to communicate with their therapists. Therefore, every e-mail communication from and to every patient, especially every adolescent patient, should be printed and retained since legally they have the same importance as face-to-face therapeutic communications. As a matter of fact, the adolescent may retain copies of all of those e-mails and they may even be discovered by the child's parents. Since children may not have any realistic concept of the impact of their words and writing on others, and since they frequently say things in a dramatic and exaggerated manner, any unclear or inappropriate statements by adolescents in those e-mails must be discussed with the adolescent and that discussion should be entered into the patient's chart including the documenting of a face-to-face discussion about it, clarifying the actual meaning of the statements.

Split therapy, in which the psychiatrist sees the patient for medication while a non-physician "therapist" sees the patient for therapy is a rampant practice today and many therapists believe that it is helpful,

especially with adolescents, in order to dilute or reduce the intensity of transference of feelings. I believe the practice generally is a terrible one, leading to many dangers, increasing legal liability for the psychiatrist for the mistakes of the non-medical therapist. The hazard lies in having to deal with a patient who is sharing very little with you in "short medication management sessions" while you ultimately know nothing about the sessions with the therapist and for which you may also ultimately become responsible. If something were to go wrong a jury might question whether a 15 or 20 minute "medication management session" could ever meet the standard of care of a "therapy session" in the minds of jurors. There are many other problems with split therapy, not the least of which is that this practice perpetuates the myth that the mind and body are separate and therefore must be treated separately.

Other problems commonly dealt with in therapy with adolescents and which may increase liability for the therapist include handling of repressed memories, boundary violations of a non-sexual nature, especially when practicing in a small community, and the prescribing of medication for adolescents without adequate discussion with the parents. ▲

*Alan J. Tuckman, M.D.*

**Wallpaper, cont'd.**

Charlotte Gilman eventually terminates her treatment, leaves her husband, moves away to California and plunges herself into writing and publishing. She joins the fledgling feminist movement speaking, and organizing the first wave of the suffrage campaign. The story, considered as a tale of horror initially, had fallen into oblivion until the resurgence of feminism in the sixties when it was established as an important piece of feminist literature. Some critics have used the story to highlight how women function in a patriarchal society as well as in a masculine psychological model.

*Syed Abdullah, M.D.*

## Capitol Hill cont'd.

Medicare Part B. Representative Ted Strickland (D-OH) offered an APA-proposed amendment in the House Energy and Commerce Committee to immediately reduce the coinsurance to the same 20% charged for other Part B services, but did not press for a rollcall vote because of the amendment's \$9 billion cost. Commerce Committee Chairman Billy Tauzin (R-LA) praised the amendment and pledged to work with Representative Strickland on the problem. Separately, House committee staffers approached APA DGR staff to reiterate their interest in addressing the issue. In the Senate, DGR staff worked around the clock with Senator John Kerry (R-MA) to secure passage of a 6-year phase-out of the 50% coinsurance; when that effort also fell victim to costs (\$6 billion), APA staff worked to secure passage of a "sense of the Senate" amendment that the discriminatory 50% coinsurance should be addressed. At press time, it was still unclear whether the amendment had been approved.

## Medicare Bill Includes Fix for Physician Payment Problem

HR 1 provides a temporary, two-year fix for underlying technical flaws in Medicare's physician payment formula. The bill sets a floor of at least a positive 1.5 percent update, as opposed to the expected negative update of roughly 4.2 percent that would otherwise occur next year. The bill also includes additional assistance for rural physicians, as well as relief from Medicare's regulatory burden. APA strongly supported these changes. S 1 addresses the payment update problem in different ways. These differences will have to be worked out in conference.

## House provides Increases Over President,s FY04 Recommendations for Center for Mental Health Services

The week of June 23rd set a frantic pace for FY04 appropriations. Republican leadership, in an attempt to action on contentious legislation early in the year, brought the FY04 Labor, HHS and Education Appropriations bill to mark-up at the sub-committee and full committee level in both the House and Senate.

As expected, The House provided increases over the President,s FY04 recommendations for the Center for Mental Health Services (CMHS), specifically for the PATH program addressing homelessness and the children's mental health demonstration grant program; adding and \$9 million and \$6.7 million dollars to respectively to current levels. The House Committee held to the President,s recommended NIH increase of 2.8%. The Senate was more generous with NIH adding approximately a 4% increase which would add an additional \$59 million to NIMH, \$36 million to NIDA and \$15 million to NIAAA.

Both the House and Senate bills reported out of committee must go to the chamber floors for approval but more than likely the week of July 14. The Senate would likely pick it up the week after and the bills would be conferenced during the August recess which is scheduled to begin Friday July 25. Historically, the House numbers for CMHS prevail as do the Senate figures for NIH and Community Health Centers. ▲

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