THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Winter 2001-2, Vol. 44,#4 • Bringing New York State Psychiatrists Together

President's Column: Managing APA Finances

by Jim Nininger, M.D.

Jim Nininger, M.D.

At the November 2001 Assembly meetings in Washington, D.C., psychiatrists from across the country received a sobering assessment of APA's finances from the Steven Mirin, M.D., the APA Medical Director. We learned that for many years the APA has been operating with a ongoing operating deficit funded by drawing from APA reserves. The APA currently spends approximately $50 million each year to support its wide-ranging activities. For the past several years, APA has been operating from year to year with a budgeted operating deficit of several million dollars that was balanced only by dipping into APA savings and investment portfolio. Because of this practice, APA reserves have dropped from $30 million to $15 million. Many years of strong growth in APA investments permitted this approach to continue without significant adverse results. However, with the decline in the stock market, increase in operating expenses and the continuing operating deficits, the APA was faced with the prospect of depleting all its current reserves within a few short years if aggressive action was not taken. For a more detailed analysis of the financial problems confronting the APA, please read the detailed report of Herbert Peyser, M.D., Area II Trustee on page 3.

Therefore, at its December 2001 meeting, the APA Board of Trustees approved a 2002 budget that calls for significant cuts in order to bring expenditures in line with anticipated revenues without drawing upon reserves. NYSPA supports strong efforts to bring the APA operating budget into balance and urges the Board of Trustees to insure that APA management is held accountable for

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"Spirituality Matters" on a Research Unit

By Nadine Revheim, Ph.D.

Life will bring you pain all by itself. Your responsibility is to create joy. --- Milton Erickson, MD

Nadine Revheim, Ph.D.

Dr. Revheim is a Research Psychologist in the Life Sciences Division, Program in Cognitive Neuroscience and Schizophrenia, at the Nathan S. Kline Institute in Orangeburg, New York. This is a revised version of an article that originally appeared in the Fall 2001 issue of Headlines, a monthly publication for staff, patients and friends of Rockland Psychiatric Center. –Ed.

Patients with chronic mental illness and pervasive cognitive deficits, such as those with schizophrenia and schizoaffective disorders, have poor role functioning. They are limited in social skills and have compromised daily functioning. As a consequence of their recurrent symptoms, ongoing impairment and longstanding disability, they become disenfranchised from society. Individuals with chronic mental illness are frequently stigmatized and labeled. As a result, their personal identity can become synonymous with their illness that is marred by negative stereotypes. This can lead to low self-esteem, poor self-image and demoralization.

These secondary effects of a chronic psychiatric diagnosis are probable contributors to defensive mechanisms that may lead to denial of one's illness, poor treatment compliance and resistance to psychoeducational models that focus on symptoms and problem-based models for follow-up psychiatric care. I believe a potential antidote for this trend towards demoralization is to use social support from the religious community, and to address spiritual concerns as a coping mechanism. In fact, recent

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MediComment: Coding Q &A

By Edward Gordon, M.D.

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Q. Does Medicare allow one to bill for a couples session either as a couple or as a family unit? Neither is an identified patient. It's really for both.

A. Medicare is a program of medical care. As such, it allows for medically necessary treatment of individuals with a diagnosable medical condition. The therapy as you describe is perhaps desirable or helpful, especially where there are relationship problems, or to save a failing marriage, etc. But it wouldn't be covered by Medicare.

In order to be covered by Medicare, there must be a covered diagnosis and an appropriate, medically necessary treatment. For family therapy, the Local Medicare Review Policy (LMRP) specifies the coverage situation:

"The Medicare Carriers Manual, Coverage Issues 35-14, states that family counseling services are covered only when the primary purpose of such counseling is the treatment of the patient's condition. Examples are as follows:

When there is a need to observe the patient's interaction with the family members or caregivers (90847). Where there is a need to assess the capabilities, conflicts or impediments within the family or caregivers and assist, through psychotherapy or other intervention, the family members or caregivers in the management of the patient (90846 or 90847). These codes may also apply when the patient is comatose or withdrawn and uncommunicative due to a mental disorder."

Accordingly, the prescribed therapy must follow a diagnostic evaluation.

Moreover, although it is possible to treat an individual under Medicare with family therapy, the treatment notes must clearly show that the treatment is directed for the benefit of the designated patient.

Code 90847 is used for family psychotherapy with the patient present;

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INSIDE THIS ISSUE:

Remembrances of Things Past

By Herb Pyser, M.D.

Herb Peyser, M.D.

I was so deeply appreciative of the Area Council having given me the Warren Williams Speaker's Award. I hadn't expected it, hadn't even thought of it. When Sy Gers, who chaired the Awards Committee, got up and announced it I was astonished, opened my mouth, couldn't say anything. Ed Gordon laughed and pointed to me and said, "He's speechless! For the first time!"

True. After all, do we not find ourselves, reaffirm our value, our significance, our meaning, maybe our very existence, in the eyes of the other?

So there really is something to say, and I want to pay the Council back for the award by explaining what it means to me, by telling the story of how I got into this work and why.

When I went to medical school I had wanted not only to be a doctor but also to do something specific, something special. I wanted to do immunochemistry, and I did some bench work on that under Michael Heidleberger at P & S for about a half-year. One of the reasons I left it was that it seemed terribly monkish, terribly monastic to me. You can't really have a dialogue with a chemical, no matter how interesting the chemical is.

I decided I would have to do medicine then and be a doc, but I looked about for something specific again, something, as I said, special to add to it. I went to intern in Michael Reese then in its halcyon days before managed care, when it was a fervent hotbed of biochemistry under Samuel Soskin and Rachmiel Levine.

But Chicago was more than that. It was a hotbed of psychiatry under Roy Grinker and psychoanalysis under French and Alexander, and I got infected. There was dialogue indeed, all over the place.

I returned to New York where I had committed myself to a fellowship in pathology before I would move on, but at once began to look about for a residency in psychiatry. My chief there, Dr. Paul Klemperer, was one of the most wonderful mentors I ever had. Maybe the best, despite all the fine teachers, supervisors, psychoanalysts, whatever, that I have known. I believe, the wisest in many ways, a man rich in spirit and knowledge and understanding and wisdom, and with the highest integrity.

As you can see I was a bit in awe of him, still am, I guess. And I was nervous as I went in to see, him. I thought how difficult it would be. A pathologist takes a liver up in his hands, looks at it, cuts it, he looks at that, he takes little pieces of it out and fixes them and stains them and then looks very closely at them. And psychiatry? Words. Evanescent, ephemeral.

And it wasn't made any easier by the pictures of those German pathologists on the walls of his office. I can see

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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 editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

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From the Editor's Desk...

As We Enter 2002

by Leslie Citrome, M.D.

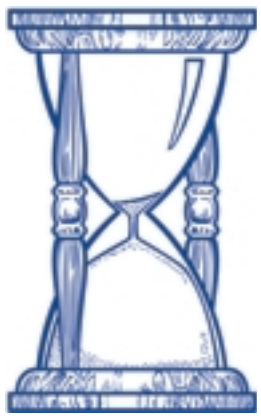
As we usher in the 2001-2002 holiday season and New Year, we are faced with new realities and changes to our everyday routine. In our professional lives, many NYSPA members have generously donated their time and services to those affected by the events of 9-11 – a story reprinted from Psychiatric News can be found on page 4. The events also impacted on those whom we were already treating, whether in the office or in the hospital. This will surely be reported on in the near future and will be a subject in our upcoming professional meetings. *The Bulletin* can also serve as a sounding board – I encourage NYSPA members to e-mail their stories to me at <citrome@nki.rfmh.org>.


Leslie Citrome, M.D.

The Trustee report on page 3 summarizes the current issues regarding the APA budget and different ideas on how to reduce a projected deficit. The next issue of *The Bulletin* will continue to report on these late-breaking developments, including the controversy surrounding the contract and salary of the Medical Director. The NYSPA Executive Committee is hard at work to protect our interests and to maintain or increase the impact we have on APA governance.

In the next issue of *The Bulletin* we will hear about the new plans for our website, <www.nyspsych.org>. This revamping explains the "This site is under construction. Please check back soon." message. In addition, although *The Bulletin* looks the same, we have switched to a different vendor for our layout, printing, and mailing. This should result in timelier publication at a reduced cost. I thank all of you who have taken the time to write, call, or e-mail to keep the printed Bulletin alive.

In closing, we are still searching for my successor as Editor-in-Chief. Annum 2002 will mark my fifth and last year in this function. If you interested in applying, I would be happy to personally discuss with you what the job entails. Monetary remuneration is of course zero, but the job provides an inside look at the APA, NYSPA, and the NYS mental health agenda. I have had the pleasure of meeting many interesting and thoughtful people who have made substantial contributions to this newsletter. As a courtesy, editors receive subscriptions to all of the other DB newsletters, and I have had the opportunity to network with other newsletter editors from across the country. Prospective candidates should send a cover letter with CV to: Bulletin Search Committee c/o Donna Gajda, NYSPA, 100 Quentin Roosevelt Blvd, Garden City, NY 11530 before February 1, 2002. The successful applicant will be appointed Associate Editor for the remainder of 2002, and then take the help on



Triplicate Forms No Longer Valid After 12/31/01

Existing triplicate prescription forms will not be honored after Dec 31, 2001. Beginning Jan 1, 2002 the physician prescribing Sched 2 and some Sched 3 and 4 drugs (e g, benzodiazepines) that required the triplicate will now require instead a new single-part form. One will not have to keep copies of the new form (as was required with the triplicate form), but of course must make a note on the record of the prescription. The patient will take the single-part form to the pharmacist who will transmit it electronically to the Dept of Health's Bureau of Controlled Substances in Albany. We have been informed by the Dept. of Health that the information is encrypted and secure at the various nodal points in the transmission and at the point of storage.

To obtain these new forms one must write or contact in another way the:

Dept of Health
Bur of Controlled Substances
433 River St, 5th Floor,
Troy, NY 12180-2299

Fee is $12.50 for a book of 25 forms.

The New PSA Health Plan Complaint Form is Now Live!

In the summer of 2001, the House of Delegates directed the AMA to establish an electronic information clearinghouse so physicians could report information about administrative disputes that they encounter with third party payers. Consistent with this resolution, Private Sector Advocacy (PSA) developed the "Health Plan Complaint Form" (HPCF). This form serves as a tool for the collection of information related to the administration of health plans by health insurers and third party payers. It gathers very sophisticated data on the types and the severity of the administrative "hassles" that physicians experience on a day to day basis in the managed care environment. Using these data, PSA will provide updates and present findings associated with the information collected through the Health Plan Complaint Form. This information will be used to identify trends, and to facilitate discussions with national health insurers to resolve the administrative hassles and complaints that physicians are encountering with health insurers or third party payers on a regular basis. In addition, this information will be used to promote legislative and regulatory changes to benefit patients and physicians. No physician names are used, gathered, or retained as part of this data collection.

The official HPCF can be seen at the Private Sector Advocacy Web site at: www.ama-assn.org/go/psa . This form is intended to be completed by physicians or physician staff only. Therefore, physicians using the form will be required to register and use an AMA Internet ID. The AMA Internet ID ensures that the information submitted is coming from a physician located in the AMA database. However, once the physician is verified, there is no way to track who submits the form. The survey itself is completely anonymous and confidential.

*NOTE: The AMA Internet ID is different than an AMA members only username and password. All physicians, whether they are an AMA member or not, are eligible to register for an AMA Internet ID and to fill out the Health Plan Complaint Form.

Non-physicians do not have access to the form via the PSA Web site. Therefore, if you are not a physician and wish to view the HPCF, go to:

https://ssl3.amaassn.org/physinfo/survey/forms/public/hpcf.htm.

This version is not password protected, and the "submit" button at the bottom of the official form has been removed. Therefore, non-physicians will not be able to submit any data while testing the form.

The AMA press release is attached, as well as a one-page announcement about the form that is going to the AMA's House of Delegates at the AMA's Interim Meeting. If you have any questions, contact Marcy Basrawala at 312. 464.4285 or email: <marcy_basrawala@ama-assn.org>. ■

Area II Trustee's Report

Budget, Medical Director's Contract & Central APA Move

by Herb Peyser, M.D.


Herb Peyser, M.D.

The December Board meeting was in great part occupied with APA's difficult financial situation. In November the Medical Director had presented the Assembly with APA's unbalanced budget and the erosion of its reserves. The Assembly, deeply concerned, strongly and critically questioned top management and top governance as to how it happened and what would be done.

Crisis requires leadership, which means no excuses, admitting one's responsibility, confronting one's role in the matter, and laying out a program to turn it around. Here is the Board's response. Top management is to do similarly.

APA has in effect been running a structural deficit despite the appearance of balanced budgets. The Assembly, Board, and management, each, had been developing multiple programs, for the most part well intentioned and valuable, but revenues were not keeping up with those newly added expenses.

Budgets had not shown this clearly because, under the auditing system inherited from the past and continuing four years into the present, they appeared balanced as presented to the Finance/Budget Committee and the Board. However on the expense side there had actually occurred significant cost overruns, particularly where the IS (Information System) was concerned, but elsewhere as well. On the revenue side the estimates of publishing and Annual Meeting revenue, etc. often did not live up to expectations, nor did dues income as membership slowly decreased in APA (as in other professional organizations, the medical societies, etc.). Dependence on pharmaceutical advertising was of increasing concern.

To fund programs APA borrowed from its reserves (less expensive than borrowing from banks), planning on replenishing them when revenues came in. Unfortunately it had not been clear that revenues were not adequate for that, replenishing was falling short of expectations, and reserves were being eroded. Investment in costly activities (e.g.,Medem, the IS, legal expenses) additionally decreased reserves and therefore investment income. Furthermore, returns from investments in the financial markets were decreased due to the national economic climate.

New auditors were brought in as a new CFO and finance team came in over the past couple of years. By last fall the situation and the direction to be taken was clear. The Board developed a planning committee under President-Elect Paul Appelbaum to recommend draconian cutting of programs and activities. The APA cannot do everything and must concentrate on core advocacy, the member-given priority.

APA is a membership organization. Its Board, with the fiduciary responsibility, consists of members elected by members, unlike other non-profits where board members are business and financial people. The Board lacks that expertise, meets four times yearly, the Finance/Budget Committee less, and neither can be intimately involved with APA's day-to-day business. Many financial matters are rather arcane, and the Board and the Committee rely on management for explanation and interpretation. Some structural reorganization here may be in order, and legal/administrative consultant help will be sought. In addition and to help governance I developed and chair a Workgroup to set up a Business/Financial Expert Advisory Panel.

The Board voted to renew the Medical Director's contract but with changes that will be published in this Bulletin as soon as he signs it (as he most probably will). I cannot go into details until then but can assure the members that they will see that there has been movement to address many of their concerns. The key APA officers have taken cuts in honoraria and travel expense reimbursement. The Board and the Assembly have taken further cuts. The components (councils, committees, task forces, etc.) will be seriously reorganized, cut and made much smaller, with conference calls replacing most face-to-face meetings.

Decreasing member participation, although not desirable, may be necessary. Management, with staff overhead (space,salaries, benefits, etc.), must do its part too, reducing infrastructure and activities not contributing toward covering overhead. Programs must reflect sustainable revenue. Other organizations must be surveyed re relationship of staff to revenue, number of members, size of governance, and the budget. Programs must be narrowed to core activities. A business process review is taking place prior to the March meeting to aid this and set the stage for further development of the IS.

Plans are being laid to rebuild the reserves, but two major expenses have not yet been figured in the budget. One is office space. Moving across the river to a new building in Rosslyn, Va., was put off. The long-term inexpensive lease (about half the space) will be continued, and one smaller, expensive short-term lease due this year will not be renewed. The staff will move into the remaining space that will have to be reconfigured, causing some expense. The other smaller, expensive short-term lease comes due the following year and we shall determine what to do at that time. Move some staff into another, less expensive building elsewhere? Reducing staff as programs are slashed? There are, nevertheless, significant office space expenses down the road.

Similarly there are IS expenses. In March the Board will be presented with the possible purchase of an off-the-shelf software association management system to replace the present expensive inadequate system and save money in the long run, but there would be considerable up-front capital costs. The IS Workgroup I developed has helped greatly in improving the management of the IS, cutting its ongoing operating costs and turning its performance around, as one will find if one speaks with the DB Execs. They get their checks and adequate reports, but full credibility and trust has yet to return after the less than satisfactory experience with the IS over the past few years.

A sort of comptroller function is being developed. A financial management group (President, Medical Director, Finance/Budget Committee Chair, probably President-Elect, Treasurer and Assembly representative) will confer monthly, reviewing current finances, making adjustments, and reporting to the Board Executive Committee that confers twice monthly. Minutes of those sessions are distributed to the Board.

Several of us on the Board had been arguing for legal and administrative consultant advice to help with the APA reorganization process, and I expect that this, as noted, will occur. I anticipate that the Business/Financial Expert Advisory Panel Workgroup may be of help here.

APA net non-dues revenue sharing is now decreased to $5K per state. The Spurlock Office has been put off. The question of increased dues was raised but not acted upon. All these matters will be closely reviewed before the next Board meeting.

I am deeply grateful to the Assembly and the Assembly Executive Committee for their strong questioning of top management and governance. It has contributed greatly to the above corrective actions. The Assembly must continue to increase its participation in the governance process as a kind of checks and balances with the Board.

Inside-the-beltway is not outside-the-beltway. Outside is vastly larger. The Bronx DB President-Elect asked that dues be decreased, said APA was not paying enough attention to the serious problems of members in community hospitals, should cut its infrastructure, and, along with the Indiana DB President-Elect, reported on low general membership interest in APA. This problem too must be addressed.

So much for the most difficult Board meeting, in terms of the seriousness of the problems confronting APA, that I have encountered in the five and a half years I have been on the Board. ■

Throughout New York Area, Psychiatrists Respond

Reprinted from Psychiatric News October 19, 2001 Volume 36 Number 20

Members of district branches in and around New York respond to the World Trade Center attacks by generously volunteering their time and services.

Rosalie Landy, executive director of APA's New York County District Branch in Manhattan, started getting calls from psychiatrists offering to help within 24 hours of the World Trade Center attacks last month.

"The number of calls has been overwhelming. Psychiatrists in New York, New Jersey, Connecticut, Massachusetts, Florida, Colorado, and even Argentina have offered to come here to assist us," Landy told Psychiatric News.

She is not turning anyone away because the need for psychiatrists is expected to increase in the coming weeks and even months. Untold millions witnessed the terrorist attacks in person or on television and were directly or indirectly affected by the deaths of approximately 5,400 people at the World Trade Center. In addition, many more people are experiencing a range of symptoms—from anxiety to insomnia—because of these tragic events and fear that more attacks could occur at any time.

Although psychiatrists are still needed to go to family-assistance and crisis-counseling centers in Manhattan, Landy said she is starting to get calls from people seeking individual counseling by psychiatrists.

She is keeping a list of New York County DB members who have offered to provide free initial counseling sessions and can refer people commuting to Manhattan from Connecticut and New Jersey to district branches in their home area.

Landy said that APA's Erich Lindemann disaster support grant her DB received last month will be used to educate state and federal legislators about the psychological trauma resulting from the attacks, update the DB's disaster Web page, conduct workshops to educate members about treating disaster victims, and cover related administrative costs.

The Web page, under the heading "Disaster Outreach," features a bulletin board, which includes a peer-support group. Messages cover a gamut of topics from requests for volunteers to information on mental health services for victims and their families and rescue workers. There are also links to trauma-related Web sites and downloadable documents that include information for clinicians and patients.

The workshops will be organized by the cochairs of the DB's disaster committee, Craig Katz, M.D., and Francine Cournos, M.D. Cournos directs the Mental Health Training Project at Columbia University, which presented a free mental health disaster training session last month with the Center for Trauma Studies at Columbia.

Katz is president of Disaster Psychiatry Outreach (DPO), which has been recruiting, training, and sending psychiatrists to sites run by the Salvation Army and American Red Cross.

Lois Kroplick, D.O., president of the West Hudson Psychiatric Society (WHPS), took the DPO training before she volunteered at the Pier 94 Family Assistance Center, which was set up to help the families of the victims of the World Trade Center attacks. Kroplick lives in Rockland County, about a 40-minute drive north of Manhattan.

Kroplick said she learned about the disorders that victims are likely to develop, medications appropriate to dispense on site, and crisis interventions.

"Katz emphasized that our purpose was to meet people's basic needs while helping them regain some equilibrium," Kroplick told Psychiatric News.

She described the Pier 94 Family Assistance Center as consisting of miles of booths with representatives from numerous organizations, including the New York State Office of Mental Health, American Red Cross, Salvation Army, police and firefighter unions, and companies with missing employees. There were also insurance company representatives on hand to help people file for benefits, said Kroplick.

During the third week of September, when she worked her first shift, Kroplick talked to tour guides employed by the World Trade Center who just missed the plane crash and lost colleagues. "They were jobless and having trouble eating and sleeping. I encouraged them to maintain as much of a normal routine as possible and showed them where to apply for financial help," said Kroplick.

Frank Dowling, M.D.,secretary/treasurer of the Greater Long Island Psychiatric Society (front row, far right), is pictured with police officers and clinicians trained in crisis intervention at the Stress Management Center in Manhattan.

She also helped families of security guards who perished at the World Trade Center obtain free counseling near their homes and apply for financial aid.

Kroplick helped a woman who was unable to live in her building because of its proximity to the World Trade Center. "She had symptoms of acute stress disorder from watching the planes crash into the building, people jumping to their death, and the buildings collapse. Because she said she hadn't slept in days, I gave her some sleeping pills. The Red Cross gave her unlimited funds to live in a hotel until she can move back," said Kroplick.

She observed that the mood of family members had changed when she returned for her second shift at the Pier 94 center at the end of September. "Last week they still hoped their relatives might still be alive; this week the reality set in, and there were anger and depression."

She continued, "I was able to help a family obtain funds for a memorial service for their uncle. That was a success story."

She and another WHPS member, Bharati Palkhiwala, M.D., also presented a training session for psychiatrists in their area about disaster psychiatry and were recruiting more volunteers to work with DPO and at the Pier 94 center, said Kroplick.

Other WPHS members, including Palkhiwala, volunteered to go to Manhattan and help people affected by the attacks. She went to the New York University Law School near the World Trade Center, where students had witnessed the unfolding tragedy and were concerned about their safety.

In addition, several members of the WHPS and the Psychiatric Society of Westchester County offered to provide three or four free counseling sessions to people affected by the disaster.

Other New York DBs Respond

The following are among the actions taken by other New York district branches in the wake of the terrorist attacks:

■ The New York State Psychiatric Association signed up more than 100 volunteers at the request of the state Office of Mental Health to assist victims and family members across the metropolitan area and state.

■ The Queens District Branch secured half-hour public television slots for panel discussions consisting of trauma experts.

■ The Greater Long Island Psychiatric Society sponsored a talk at a community day care center on depression, posttraumatic stress disorder, and grief. The DB also worked with the American Red Cross to provide counseling to the families of airline victims and a local agency to provide counseling services to widows and children of deceased firefighters.

DB Secretary/Treasurer Frank Dowling, M.D., has been counseling police officers and emergency workers at a stress-management center near the World Trade Center.

Dowling, who is a medical advisor to the Police Organization Providing Peer Assistance (POPPA), estimated that 1,500 to 2,000 police officers rushed to the scene to assist or rescue people after the planes crashed into the north and south towers and were inside or near the buildings when they collapsed. A number of them are now presumed dead, Dowling told Psychiatric News.

The vast majority of the 40,000 officers in the New York Police Department (NYPD) have been working at ground zero since the attacks. They have been securing the area, digging for survivors, searching for remains, and working at the morgue and the landfill where removed material is sent, said Dowling.

"While we are especially concerned about the initial responders, we are aware that nearly all of the NYPD has been exposed to the trauma in real, vivid, graphic, and painful ways and can benefit from assistance coping with the effects," said Dowling.

Many police officers have come to group debriefings led by peer-support officers trained in crisis intervention, with clinicians present in case police officers develop serious emotional problems, said Dowling.

"Our goal is to help them cope with the common stress symptoms that result from such exposure and prevent PTSD, depression, alcohol abuse, relationship and marital problems, and, of course, suicide," said Dowling. ■

"Spirituality Matters" on a Research Unit

continued from page 1

studies have focused on healing aspects of spirituality and its integration into standard therapeutic practices for recovery, especially with the chronically mentally ill. Results of one such study (Tepper L et al: The prevalence of religious coping among persons with persistent mental illness. Psychiatric Services, 52:5, 660-665, 2001) suggest that involvement with religious activity may be associated with a reduction in symptoms when religious beliefs and activities, such as prayer or reading spiritual materials, are used by individuals to cope with daily difficulties and frustrations.

In light of these issues, a group that focuses on spiritual themes has been offered to patients on the Clinical Research Evaluation Facility (CREF) at the Nathan Kline Institute since February 2001. I initiated this group at NKI as an outgrowth of my previous involvement with such a group at the Second Chance program at New York Presbyterian Hospital during 1999-2000, co-led with Chaplain Amy Manierre. We learned that despite stereotypes, individuals who chose to attend the group did not profess religious delusions, but rather, focused on the source of strength and emotional stamina that religious affiliation related to diverse backgrounds and ongoing use of spiritual values afforded them. The group protocol was presented at CREF and the program initiative quickly gained support from the director and unit chiefs at CREF, Leslie Citrome, MD, MPH and Henry Epstein, MSW. The CREF Spirituality Matters group began with co-leaders Chaplain Ariel Verdesi of Rockland Psychiatric Center, Vera Hill, COTA, and various unit staff, including students and volunteers that are interested in group process training.

The "Spirituality Matters Group" meets weekly and is comprised of individuals who are self-referred. This allows inpatients to experience personal causation and the opportunity for making choices. It also establishes a point of identification with peers that goes beyond diagnostic categories by fostering a commonality that is grounded in a sense of self that has positive valence and meaning apart from one's hospitalized status.

In addition, many patients on CREF exhibit difficulty with impulse control and aggressivity. This group attempts to facilitate the prerequisite mechanisms that inspire self-control, instill comfort and hope and provide resources for positive esteem vis-à-vis the affirmation of a 'higher self' and 'higher power' and by using an emotion-focused coping style. Individuals are coached to envision ways to gain control by changing the meaning of a situation that may in fact be beyond personal control. Cognitive reappraisal and reinforcement of positive emotions heighten awareness that even in situations that appear to be hopeless, a sense of faith can help an individual to prevail when used in the context of social support and open communication about life's difficulties. This validates the reality of coping with chronic mental illness without negating the frustration of one's daily realities of taking medication one doesn't want to admit needing, dealing with family abandonment and limited personal resources, or living on the edges and boundaries of society due to stigma.

The group offers highly structured exercises that are designed to facilitate verbal expression and appropriate social interaction while focusing on the use of spiritual beliefs for coping. Use of easels and handouts with large print are used to compensate for prevalent cognitive and auditory processing deficits. During the course of a group session, individuals receive support and encouragement that may restore self-worth and repair self-identity so that they move beyond the devalued self attributed to persistent mental illness. A typical group begins with an affirmation called a 'covenant' that delineates the group climate of respect for others; reading from the Psalms, using a story or prayer that evokes spiritual discussion; reviewing themes, such as gratitude, forgiveness, mourning, and anger that are explicitly described in the shared materials; personalizing how these issues are affecting individuals in the group in the here and now; describing plans of action and contemplation that facilitate empowered ways of coping using spiritual resources; and for closure, the group ends with a reading of a prayer written by group members ("My CREF Prayer for Peace…Give me light and insight so that I may trust…Let me learn the way of peace so that I may grow…Your power changes hearts… May those who find themselves off track, be guided…May those who are afraid, find comfort…and may we all find patience on our path…. Strengthen us to give witness to these truths by the way we live.")

To date, there is an average weekly attendance of 8-10 individuals (35% of patients on the unit), from Judeo-Christian and Muslim backgrounds, who demonstrate appreciation and commitment to the group. Eighty percent of those who initially join the group continue their participation while enrolled in various research protocols on the unit.

In addition to the clinical aspects of the group, I am now planning to collaborate with William Greenberg, MD, newly appointed Director of the Outpatient Research Facility at NKI, on a research project that looks at aspects of spirituality status, perceived social support, hopefulness, coping and impact on self-efficacy, quality of life and treatment outcome for members of the group compared to those who do not choose to attend. A poster presentation at the OMH Research Conference in December 2001 in Albany will be used to communicate findings of a qualitative content analysis of 8 months of group material regarding themes (e.g. coping with chronic illness, medication compliance, improved self-care) that emerge during the innovative structured group activities of a spiritual nature designed to optimize treatment responsiveness. Future exploration of this treatment group will attempt to use a model of psychological treatment that incorporate a new perspective called the 'broaden-and-build theory of positive emotions' that suggests personal resources are enhanced by experiences of joy, interest, contentment, pride and love (Fredrickson BL: The role of positive emotions in positive psychology: the broaden-and-build theory of positive emotions. American Psychologist, 56:3, 218-226, 2001). Should you desire further information regarding the group, you may reach me at <revheim@nki.rfmh.org>. ■

NEWS RELEASE: November 13, 2001

The Bernard L. Pacella, M.D., Parent Child Center of The New York Psychoanalytic Society

The Parent Child Center of the New York Psychoanalytic Society is pleased to announce that it has received a major donation from an anonymous donor as a tribute to Bernard L. Pacella, M.D. The Center will be renamed, The Bernard L. Pacella, M.D., Parent Child Center of The New York Psychoanalytic Society, honoring Dr. Pacella for his work with children dating back to co-editing a book with Nolan D. C. Lewis, M.D. in 1945, "Modern Trends in Child Psychiatry." Dr. Pacella, first certified in neurophysiology and neurology, trained in psychoanalysis with Ernst Kris, Edith Jacobson, and Otto Isakower and collaborated with Phyllis Greenacre and particularly with Margaret S. Mahler. He is a past President of the Margaret S. Mahler Psychiatric Research Foundation and a past President and Treasurer of The American Psychoanalytic Association.

The Parent Child Center, established in 1990, has developed a model program of parent child groups, with parents and children (birth through 3 years). Examples of its work can be seen at<www.theparentchildcenter.org>.

Over the last few years, the Center has begun to receive funding that has allowed it to begin the development of a research program and since 9.11, begun a Trauma/Support Center.

With the inauguration of the Pacella Parent Child Center, we will be able to expand our programs to include services for children up to adolescence, families and children from disadvantaged situations, and most importantly establish a solid research program.

The Center, The New York Psychoanalytic Society and Institute, and The New York Psychoanalytic Foundation are most grateful to the generous donor and to Arnold D. Richards, M.D., without whose energy and devotion to psychoanalysis and The New York Psychoanalytic Society, this gift would not have occurred.

For More Information, Contact:

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Remembrances of Things Past

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them now, Cohnheim and Ritter and Loehlein and Virchow, all staring down at me with their stern, anal facies, their pince nez on, their high, starched collars. "Doctor Klemperer," I began, as I said, a bit n ervously, "I have decided what I want to do. I would like to resign my fellowship and begin a residency in . . . uh . . . psychiatry." And looked up at him.

"Young man! Dot's a vonderful ting! Dot's vot I vould do iff I vas going into medicine now! Dot's vere da challench iss. You know, I verked in der Algemeine Krankenhaus ven Freud vas dere. But I vant to varn you. A surgeon can only kill vun person, but a psychiatrist can make a whole family miserable!"

He was a wonderful man. You can see how one could love such a man. And I have thought about it since, from time to time. For it means that we don't only deal with chemicals. Yes our patients are chemicals and so are we. But they, and we, are more than chemicals. They and we have an organ, the brain, but are more than that organ. They and we have organ systems, but are more than organ system. They and we are organisms too, entire organisms, but they and we are more than organisms. We exist in networks of organisms and find in those networks our being reaffirmed.

There are many networks for each of us. APA is not the only one and certainly may not be the most important network in our lives, but it has been an important one, a crucial one, nevertheless. It is our vehicle for collegiality, for education, and, most important, for combat for advocacy, for our commitments to our patients, our profession and each other. It is all we have for that combat. Without it we are alone, fragmented, weak. As the answer to that weakness it is a serious commitment to each other and our profession, which makes it therefore an important part of our personal identity.

Small wonder I am so appreciative of this award for it tells me that I am not alone, that we are not alone, or that, if we are alone, we are all alone together. ■

Below are the comments from Dr. Nininger...

This year's Area II Warren Williams Award is presented to Herb Peyser in recognition of his many years of service to psychiatry, his patients and his profession. Next May, Herb will complete his second term as Area II Trustee. Before serving as Area II Trustee, Herb represented the NY County District Branch as DB Representative. In addition, Herb has served as Chair of the Psychiatry Committee of the Medical Society of the State of New York, Chair of the Addition Psychiatry Committee of the NY County DB and the New York State Psychiatric Association.

One of Herb's finest efforts was his participation in the creation of the Committee for Physician Health under the auspices of the State Medical Society. The Committee for Physician Health is a diversion program for impaired physicians suffering from mental illness, substance abuse or other impairments. This program permits impaired physicians to defer formal state disciplinary proceedings if they participate in treatment and rehabilitation and do not represent an imminent danger to patients or the public.

Herb Peyser wins Area II Warren Williams Award

Herb's interest in impaired physicians springs from his long-time professional interest in the area of substance abuse and addiction treatment. Soon after completing his psychiatry residency and starting a private practice, Herb was a consultant at the Smithers Alcohol Center in New York City. Anyone who talks to Herb for any period of time about public policy knows his fierce and unyielding insistence that parity for mental illness must also include substance abuse. Every NYSPA position statement on parity includes at least in a footnote if not in the test a statement that mental illness includes substance abuse disorders.

Herb applied the same focus and attention to his activities on behalf of the APA. As Area II Trustee, and even earlier as NY County DB representative, Herb led efforts to impose a national dues increase moratorium and provide revenue sharing for DBs and state associations. When he became Area II Trustee, Herb focused his attention on APA finances. Herb spearheaded efforts to insure fiscal accountability, reform budget process, hold down dues increases, improve APA central office communication with DB and State Associations, focused on APA information systems, led efforts to secure support for the establishment of a business advisory council for the APA, and finally insisted on full disclosure of the financial terms of the APA Medical Director's contract.

However, any of you who know Herb know that this list of achievements cannot begin to provide a full picture of Herb.

First, anyone who had the pleasure of dining with Herb might describe Herb as a raconteur, wine connoisseur and gourmet - perhaps even a bon vivant. Any dinner with Herb is guaranteed to be filled with good food, good wine, good talk. His stories, literary references and quotations, and his jokes and jokes and jokes never fail to amuse and amaze.

On the family side, Herb has three children and four grandchildren. One daughter is a pediatric cardiologist - a graduate of Columbia Physician and Surgeons, the same medical school attended by Herb and an uncle of Herb's. His son is a partner in an investment firm in Manhattan and his other daughter works in management for the NY Philharmonic.

When I as preparing my remarks and reviewing Herb's bio, I learned something I don't know about Herb. Before Herb entered his psychiatry residency, Herb was enrolled in a pathology fellowship. Think of it - Herb the pathologist - no doubt his dinner repartee would have been much less entertaining had he pursued a career in pathology.

Fortunately for psychiatrists in New York and throughout the country, Herb decided to abandon the world of biopsies, autopsies and tissue samples and pursue the far more lively world of psychiatry. His professional career is an outstanding example of commitment to patients, to the medical profession and to his chosen field of psychiatry.

For all these reasons, please join with me in congratulating Herb Peyser as we bestow upon him the 2001 Area II Warren Williams Award.

MediComment: Coding Q &A

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90846 for psychotherapy without the patient present.

To repeat: Family therapy is not a covered service for treatment of other members of the family, although there may be incidental benefit. Documentation must show how the treatment is directed at solving the designated patient's problems, as indicated by the diagnosis.

For example, a depressed man was despondent after a decision by his wife to end their long marriage. Family therapy was recommended after an evaluation of the man and an interview with his wife indicated that family therapy would be helpful. As a result of family psychotherapy, the marriage was saved, and his depression lifted.

However, there are situations in which a couple asks for treatment, and neither, although covered by Medicare, meets ICD9 criteria for mental disorder. They might need assistance in making decisions, etc. In this case, the only appropriate diagnosis might be a "V" code, such as "V61.1 Partner Relational Problem". The couple should be informed that family therapy would not be a Medicare covered service. The fee should be agreed upon, and a note placed in the record. The couple should sign the note, indicating they have been so informed. ■

Send questions regarding coding, Medicare, managed care practices and denials, documentation, other problems with managed care, or other practice problems that you have experienced, together with documentation to: MediComment c/o The Bulletin (address on page 2) or by email to NYSPA at <centraloffice@nyspsych.org>

A Reflection

A Patient's Destiny

Hagit Bat-Avi, M.D., PGY-IV, Beth Israel Medical Center

Many patients spend years of their lives cared for by psychiatrists working in hospitals outpatient clinics and on inpatient units. Some patients become well known to the staff and an integral part of the working team. Residents rotating through the different psychiatric services become familiar with these "conventional" patients. Residents happen to be so absorbed in the practice of psychiatry treating depression, schizophrenia, bipolar, and personality disorders we sometimes overlook the co-morbid medical illnesses that many patients have.

Such a common case was that of Mr. R. A 50 years old white male diagnosed with schizoaffective disorder in his early twenties. Mr. R. a tall gentleman was often treated in the inpatient psychiatric unit when his psychotic episodes would creep upon him making his sharp mind confused and in a total disarray.

Indeed he was very intelligent. I first met him during one of my inpatient rotations. He was sitting alone in the common area where a piano occupied the left side of the room, and bookshelves lined the other side along the wall. Mr. R. did not look up when I peaked through the open door. He was absorbed in reading a political review on the history of the USA government.

I was quite amazed at the sight knowing that only two hours earlier he was running in the corridor saliva drooling down his curled lips, and his speech made no sense. Now he was sitting quietly doing what he often liked to do: read.

I did not disturb him, but I was curious to know more about him. The nurses on the floor have known him for several years. He was hospitalized on the average of four to five times each year, and in the interim between hospitalizations was seen in the outpatient clinic. He lived alone, had no known relatives and was supported by public assistance.

His symptoms were treated for years with haldol but when he developed signs and symptoms of tardive dyskinesia he was switched to one of the atypical neuroleptics, and did well for longer periods of time without a need for hospitalization.

I also found out that he was quite an avid reader. He read philosophy, politics, history, and when the nurses found the daily newspaper, he read it from front to end. He was not my patient but I watched him while I was working on the floor. He mostly stayed by himself. He hardly talked to anyone. His sole communication was apparent when he was irritated, and threw a tantrum. It usually happened when he was asked to take a shower, to change his gown, or when he was expected to join the other patients for daily meals. Once or twice I saw a woman come to visit him. She said that she was his girlfriend, and together they sat in the common room conversing. She later on simply disappeared, and it was not clear from Mr. R. explanation why she stopped visiting him.

After that, I have not seen Mr. for almost a year, in fact I forgot about him. I was rotating in the outpatient clinic in my third year and one afternoon I saw him shuffling his feet slowly toward the registration desk. He carried a book under his arm and was very unsteady on his feet. He was receiving ECT treatment because he was depressed and catatonic, and the trial of ECT has helped him. He came to the outpatient clinic diligently to be seen both for individual sessions and for group.

As the year passed, I saw Mr. R. several times and he looked more confused, unsteady, and unsure of where he was headed to in the clinic. I could not help myself in making a mental note that he was deteriorating despite the fact that he always carried reading materials under his arm. It was the one item he never forgot to take along with him.

I saw Mr. R. again just several weeks ago. He had a long overgrown beard with many white strings woven into the once black color of his hairs. He looked emaciated, weak, and there were bruises on his face, he was falling a lot, he told me later on. He was sitting on a wheel chair unable to stand up by himself, and was staring straight at the wall in front of him mumbling something incomprehensible.

"Mr. R. " I could not help myself from asking, "how are you"?

He kept his blank look at the wall in front, " I want to get up," he answered, ignoring my question. "You have become very thin since I last saw you" I continued, surveying him with a thought that he may be quite sick.

" I have cancer, and I am dead" he said, still looking at the wall.

"You are not dead' I said, "You are here with all of us". One of the nurses came over to join the conversation; she has known him for a long time. Mr. R. threw one of his well-known tantrums, as he wanted to get out of the chair, he was persuaded to lie on a stretcher while he was singing the wedding hymn saying that it was his favorite song.

[See **Destiny** on page 8]

A Patient's Destiny

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I left Mr. R. while the nurses were battling to take him to his room, he was resisting in every possible way. He made up his mind to stay where he was despite the discomfort.

As the nurses were trying to convince him to lie still while they guided the stretcher to his room, I walked away free thinking that he indeed knew of his illness. He was completely aware of the fact that he lost half of his body weight. Even with mental confusion, frequent bouts of tantrum, and memory impairment, Mr. R. was aware of his medical condition and the outcome of the terminal diagnosis of cancer. Still, he was alone; no one seemed to bother with his present hospitalization. He, like many other patients was confronting both cancer and mental illness in the end of life, all alone. Like many of the severe mentally ill, Mr. R. lived alone all his life, and now alone he was vanishing slowly, and it made me feel sad and helpless. ■

President's Column continued...

managing APA resources in a prudent manner.

However, we do take issue with certain of the proposed cuts - a $90,000 cut in the Assembly budget. From this overall APA budget of $50 million, the Assembly operates on a budget of only $800,000 - less than 2% of APA total costs. Moreover, this year the Assembly took a substantial budget cut of $225,000 or a 20% reduction from the 2000 budget. The Assembly is the "backbone" of membership participation in the governance of the APA and the only direct link between APA central administration and its members. The Assembly includes representatives from every district branch and state in the country and includes representation from minorities and under-represented groups, residents and early career psychiatrists - it is only national forum where members drawn from the grassroots membership of the APA meet to discuss and debate issues. The Assembly budget funds the twice yearly meetings of the Assembly, the operations of the Assembly and the area council meetings - including the twice yearly NYSPA meetings.

Because of the importance of the Assembly to the APA and because the Assembly has already absorbed disproportionately larger cuts than other components of the APA, we were very disturbed to learn that the recently approved 2002 budget includes an additional $90,000 reduction in the Assembly. The NYSPA Executive Committee recommended that the Board re-focus its fiscal priorities on core advocacy activities such as legislation, managed care and membership activities essential to maintain our strength and effectiveness.

Finally, I wish to assure you that your NYSPA representatives will vigorously advocate that that APA finances be maintained on a secure and fiscally prudent basis and that cuts are not directed at those critical functions essential to our organization. ■

The New York Academy of Medicine and The Tri-State Chapter of The American Academy of Psychiatry and the Law
in cooperation with The Society for Adolescent Psychiatry and The Forensic Psychiatry Clinic for the Criminal and Supreme Courts of the State of New York (First Judicial Department), Presents Its 27th Annual Conference:

New Applications Of Forensic Psychiatry: The Workplace

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Medical Director, UnumProvident Company

Daniel L. Alterman, Esq. *The Legal Aspects of Workplace Harassment & Discrimination, What the Psychiatrist Needs to Know*
Partner, Alterman-Boop, P.C.

Stuart B. Kleinman, M.D., Seymour H. Block, D.O.,F.A.P.A., Barry Rosenfeld, Ph.D. *Lunch Time Panel Discussion on the Evaluation of Psychiatric Pain & Suffering*

Cheryl R. Saban, Esq. *Psychiatric Disabilities, Reasonable Accomodation, The Challenges of The ADA*
Partner, Paul Hastings Janofsky & Walker LLP, Employment Law Dept.

Kerry J. Sulkowicz, M.D.. *Psychiatric Consultations to The Workplace*
Clinical Associate Professor of Psychiatry, New York University School of Medicine; Founder and President, The Boswell Group, LLC

Saturday, January 26, 2002, 8:30 a.m. – 5:00 p.m.
New York Academy of Medicine: Fifth Avenue & 103 Street, Manhattan

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The New York Academy of Medicine relies upon invited faculty participants to provide educational information that is objective and as free from bias as possible. In this spirit, and in accordance with the guidelines of the session sponsor, faculty participants are required to indicate any commercial relationhip that might be perceived as a real or apparent conflinct of interest.

The educational objective of this program is for the attendee to understand the latest developments in selected areas of psychiatry where it interfaces with the law. Attendees should gain an understanding of current and emergent employment law issues relevant to forensic psychiatric practice.

The registration fee is $100 prior to December 15, 2001, and $120 thereafter. Residents and students with ID may register for $30 at any time. Registration includes the price of the luncheon. Make checks payable to "APPL Tri-State Chapter" and send to Eric Goldsmith, M.D., New York Forensic Psychiatric Associates LLP, 595 Madison Ave., #803, New York, NY 10022. For further information call (212) 486-2828.

___ **Yes,** Register me for the conference and luncheon. My check for $100 is enclosed (before 12/15).
___ **Yes,** Register me for the conference and luncheon. My check for $120 is enclosed (after 12/15).
___ **Yes,** Register me for the conference and luncheon. My check for $30 is enclosed (trainees).

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