The Westchester Psychiatrist
A quarterly publication of the Psychiatric Society of Westchester County

The term “Goldwater Rule” refers to the ethical guideline for APA members in regard to making clinical judgments about public figures. The Rule is Part 3 of Section 7 of the APA Principals of Medical Ethics.

Section 7.3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.

This guideline was enacted in 1973, in response to an event that had occurred much earlier. In 1964, just prior to the presidential election between Lyndon Johnson and Barry Goldwater, FACT magazine published an article entitled “What Psychiatrists Say About Goldwater.” FACT sent a questionnaire to over 12,000 US psychiatrists asking, “Do you think Barry Goldwater is psychologically fit to serve as president of the United States?” 2417 psychiatrists responded: 1189 stated that he was not fit and 657 stated he was fit and 571 stated that they did not know enough about Goldwater to answer the question. The article in FACT consists of the responses of selected psychiatrists. Most of the comments are signed, but some are anonymous. Many attack his character and declare him mentally ill or psychiatrically unfit, using terms such as “excessive aggressiveness” or “infantilism” or “unconscious sadism.” Others use more psychological terms such as “delusional, paranoid” or “thought disorder.” A few use diagnoses, such as “paranoid schizophrenic” or “I believe Goldwater to be suffering from a chronic psychosis.” Some responses give political reasons why Goldwater should not be president and ignore the mental health issues. Some of the terms used have a psychoanalytic tinge (“deep feelings of inadequacy”), consistent with the era. Many refer to two “nervous breakdowns” that Goldwater had purportedly suffered many years before.

Some psychiatrists object to asking the question and stating that it is not possible to make a psychiatric diagnosis without an examination. One response attacks a society that would elect Goldwater: “Senator Goldwater’s election would be sorry evidence of the psychopathology of American society and a sad reflection of the insanity of our times.”

My favorite response states, “If you will send me written authorization from Senator Goldwater and arrange for an appointment, I shall be happy to send you a report concerning his mental status. The same goes for you.”

The certainty with which some psychiatrists felt able to attest to Goldwater’s psychopathology in 1964 is disconcerting. The APA objected to the FACT article and stated that a thorough clinical evaluation was needed before any legitimate mental health assessment could be done. In 1969, the publisher of FACT, Ralph Ginzburg, lost a libel lawsuit initiated by Goldwater because of the article. Goldwater was subsequently elected to the Senate three more times, retiring in 1987. I am not aware that he demonstrated any signs of mental illness during this part of his career. Why the APA guideline was not enacted until 1973 is a mystery to me. The Rule was re-affirmed by the APA in March 2017, in light of the attacks by mental health professions, including psychiatrists, on President Trump.

Psychiatrists often have a difficult time diagnosing the patients that we actually examine. There is a dearth of laboratory or other objective testing to

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President’s Column By: Karl Kessler, M.D.

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confirm or rule out diagnoses. This weakness in our ability to make diagnoses belies the claim that we can do so on public figures we have not examined. Such diagnosing also demeans psychiatric professionalism and can lead the public to question the ability of psychiatrists to make sound judgments.

How then can a psychiatrist express a political opinion? The expression of a political opinion is allowed to every psychiatrist, as it is to any other person in the US. But such an opinion should not be made in the context of the profession of psychiatry, but rather as a personal view. The possibilities of political expression by psychiatrists are many. Psychiatrists can work for a political candidate or a political party. They can run for office themselves. A psychiatrist can serve in office at every level, from a town selectman to President of the United States. But they should not express their political opinions in medical terms.

Our Best Wishes

The Psychiatric Society of Westchester County gives its profoundest best wishes to our esteemed colleague and friend, Dr. Richard Altesman. Dr. Altesman recently moved from New York to California, ending a decades-long association with the Psychiatric Society. He is a Past President of the Society (1994-1995) and was for many years the Area II Representative to the Assembly of the American Psychiatric Association. His devoted hard work for the APA and the New York State Psychiatric Association and the Psychiatric Society of Westchester are deeply appreciated. We wish Richard the best in the pleasant climate of Southern California.

Karl Kessler, President, on behalf of the Executive Council

Psychiatric Society of Westchester’s 31st Annual Legislative Brunch

Reported By: Jerry Liebowitz, M.D.

Our 31st Annual Legislative Brunch was held at the Crown Plaza Hotel in White Plains on January 21, 2018. Ed Herman, MD, our Legislative Representative, opened the morning introducing the officers of our Executive Council and the NY State Psychiatric Association (NYSPA) and the legislative representatives present.

Barry Perlman, MD, presented NYSPA’s legislative priorities and initiatives, including Mental Health and Substance Abuse Parity Enforcement and Compliance, legislation impacting the mental health of youth and adolescence (prohibition of “conversion therapy” and implementation of NY’s raise the age law), support of “prescriber prevails,” and opposition to efforts to expand the scopes of practice of other licensed professionals into areas reserved to the practice of medicine (e.g., psychologists prescribing, NPs admitting to inpatient mental health units, non-MD MH practitioners diagnosing mental illness).

Noting that this was the 29th Legislative Brunch that he has attended and the end of Martin Luther King week, he gave a brief history over the last twenty years of human rights and civil rights legislation, especially as it affected mental health. Timothy’s Law (establishing mental health parity for insurance plans) was passed in NY in 2006 with bipartisan support under Governor Pataki. In 2009, after both houses voted to make it permanent, Governor Patterson signed it into law. In 2008, President Bush signed the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) into Federal Law. Perlman noted, however, that parity does not apply if one is not insured. In 2010, the Affordable Care Act, under President Obama, provided increased patient protection, complementing the MHPAEA by increasing the number of insured and including mental health and substance use disorders. And in 2016, the 21st Century Cures Act, championed by Paul Ryan as a way to speed up drug development, also includes provisions improving mental health care for millions of Americans and fighting the opioid epidemic. It also created a new position, Assistant Secretary of Mental Health and Substance Use.

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Mr. Latimer that Westchester County’s health insurance for its employees, in fact, eliminates parity through an exception under federal law. The County Executive was surprised to hear that and asked to be educated more about it. Several members of the audience agreed to do so.

Shelley Mayer, State Assemblywoman of the 90th A.D. (Yonkers) and a candidate for Latimer’s senate seat, thanked Dr. Perlman “for putting things in context.” She, also, is fighting proposals to reduce coverage. “Denial of coverage continues to be a substantial problem,” she noted. She added that she also strongly supports our stand on prohibiting “conversion therapy” and wants to continue to restore money to the budget for mental health services.

Benjamin Boykin, representing Westchester’s 5th Legislative District (Scarsdale, Harrison, and most of White Plains) and newly elected Chairman of the County Board of Legislators, explained what happens at the Board and that four new committees were appointed for budget and appropriations, legislation, appointments, and environmental health and energy. He sees his job and that of the Legislature as one “to protect the health, safety, and wellness of our residents.”

Sandy Galef, State Assemblywoman representing the 95th State A.D. (northwestern Westchester and Putnam counties), agreed that “the Federal Government makes a difference in our lives”—especially with its cuts in health care and education. She told of being at Venice Beach, California, over Christmas and seeing “so many homeless!” They were in front of service areas, not high-rent condos. This emphasized for her how much we need affordable housing for people with greater needs. She then asked the psychiatrists present why, with such a need for greater access, we oppose the scope of practice issues that would allow non-medical practitioners to prescribe and treat. She truly wanted to be better informed, she said, and several in the audience did respond, including Barry Perlman, who explained NYSPA’s stand about diagnosing, prescribing, and involuntary admission.

Lyndon Williams, representing Westchester’s 13th Legislative District (Mount Vernon), compared mental health issues on the news to those “in our own neighborhoods.” He noted that more than half the population with mental health issues are not treated. The ACA helped, he said, but is now being rolled back and the Federal administration is “oblivious” to the mental health crisis. He bemoaned the loss of county mental health clinics, which were taken out of commission and shut down at the beginning of the Astorino administration. And the resulting lack was not taken up by not-for-profits, as some had predicted. “The can was kicked down the road,” he noted. “Do more with less!” He promised that he would continue to advocate and encourage grass root efforts. He urged us to let our patients know that they must vote and write letters.

Nancy Barr, the new County Legislator from District 6 (Porchester, Rye Brook, and most of Harrison) and Chair of the Environment, Health, and Energy Committee, said that she was new to the job and “came here to
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learn.” She “cares a lot” about mental health issues, she explained, both because of growing up with family members with mental illness and because of her experience on the Blind Brook School Board and seeing firsthand how the stress students experience leads to self-medicating with drugs and alcohol. “They need more professional attention” (mental health), she observed, and encouraged all to advocate for the insurance and education that are needed. Grass roots action is what’s needed, she explained, adding that money is the key issue – “money spent on mental health is money saved on other services.”

David Buchwald, State Assemblyman representing the 93rd A.D. (covering White Plains to North Salem), noted that this was his 6th year at our Brunch. As he explained previously, much of his knowledge of mental health comes from his sister, a psychologist – “and she doesn’t believe in psychologists prescribing.” Also, as a tax lawyer before becoming a state legislator, he learned how federal tax law creates many mental health issues, because of decreased funding. He supports raising the age of criminal responsibility and parity for mental health and substance abuse. Regarding scope of practice bills that are introduced “year after year,” he exhorted, “Don’t let your guard down!”

Steve Otis, State Assemblyman from the 91st A.D. (New Rochelle, Larchmont, Mamaroneck, Portchester, Rye, and Rye Brook), commented that it was an insult that there are real problems with health care and people are hurting, yet there are others in government who ignore these issues and “are concerned more about finances and funding.” “Our job is to ensure access,” he emphasized. “It is a life and death matter for so many of us,” he noted, citing statistics on suicide and addiction as examples. Regarding our concerns about scope of practice, he said that he sides with medical training. He concluded by thanking PSW and the psychiatrists present “for what you do.”

Thomas Abinanti, State Assemblyman from the 92nd A.D. (Greenburgh and central Westchester), who apologized for coming late, explaining that he had to be with his son with special needs (autism), said that he was “living some of what you talk about.” He confessed that he and many other legislators often suffer from a lack of understanding and rely on us for guidance. “We are not doing what we should be doing,” he said, and noted that he often calls on Richard Gallo for information. “We need to hear from you,” he urged, because he and others do not always know what is happening. For example, he said, the government wants to increase the budget for autism. But the proposal is not even enough for direct care. “There is a $50 million shortfall,” he explained. He joined us in our concerns for parity but noted that there is a big problem with insurance. There are not a lot of mental health services in many plans, and many psychiatrists do not accept Medicaid.

Amy Paulin, State Assemblywoman from the 88th A.D. (Scarsdale, parts of White Plains, New Rochelle, Eastchester, Tuckahoe, Bronxville, and Pelham), who noted that she is now on the Appropriations Committee (no longer Education), touched on other issues, including the budget and how we are facing a tremendous state deficit. The governor’s 2% spending cap is only partially the source of the struggle, she explained. “This year is unique,” she emphasized, with the new Federal tax plan. The State needs to find new revenue sources and taxes. In that light, many of our proposals are timely and very important – citing as one example, the opioid crisis. Regarding one of our other legislative issues – the scope of practice, she said that she is often on the other side, but psychiatry is a “unique medical specialty.”

State Senator Terrence Murphy of the 40th Senate District (northern Westchester and parts of Putnam and Dutchess counties), sent a representative, who noted that the pendulum swings both ways. But, he said, “your organization will be here for years.” He said that the senator generally believes in what we stand for.

Robert Laitman, MD, representing NAMI, said that he believes that “grassroots” efforts are the way to proceed to get results. “We need to work together,” he urged – not just psychiatrists, but also legislators. He told how he broke a cardinal rule of medicine (to not treat your own) years ago when he treated his son, who suffered from schizophrenia, with medication that helped when others failed. And now he has over 100 patients with severe, persistent mental illness. We should all be abhorred by the homeless population, citing Miami, where 85% have persistent mental illness. They need treatment as well as housing. And the opioid crisis is now the number one killer (64,000) of those under fifty years old. He had one “little disagreement” with our legislative priorities – he believes that we need to expand the scope of nurse practitioners.

The talks were followed by a lively and informative Q&A period, which included discussions of Project Teach, the OMH, homeless veterans, the single-payer healthcare system, and prior authorizations. Several psychiatrists informed the legislators of the issues clinicians experience with insurers, managed care, and other matters that many of the legislators did not understand or were not aware of.

At the end of the Brunch, State Assemblywoman Sandy Galef, speaking for herself and the other legislators, expressed her thanks to our group for an informative, intellectual discussion. It was good to hear from us directly, she said – rather than just from other legislators.

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Photos from the 31st Annual Legislative Brunch

Edward Herman, M.D.  
PSW Assembly Representative

Barry Perlman, M.D.  
NYSPA Legislative Representative

Westchester County Executive  
George Latimer

Assemblywoman  
Shelley Mayer

Legislator  
Benjamin Boykin

Assemblywoman  
Sandy Galef

Legislator  
Lyndon Williams

Legislator  
Nancy Barr

Assemblyman  
David Buchwald
Photos from the 31st Annual Legislative Brunch

Assemblyman
Steven Otis

Assemblyman
Thomas Abinanti

Assemblywoman
Amy Paulin

Joseph Angiletta
Staff to Senator Terrence Murphy

Robert Laitman, M.D.
Head of Advocacy, NAMI Westchester

Richard Gallo
NYSPA Government Relations Advocate

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Book Review By Karl Kessler, M.D.

Mad In America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill by Robert Whitaker (Perseus Books, 2002)

This deeply flawed book is an indictment of American psychiatry. Following a brief introduction regarding the development of modern attitudes to the mentally ill in the 18th century and the development of “moral treatment” by Quakers in the 19th Century, the book moves to an extended review of somatic treatments in psychiatry. Somatic treatments are those that have been the purview of physicians, and this book focuses on mental health treatments given by psychiatrists. These include insulin-induced comas and metrazol-induced seizures and electroconvulsive therapy and lobotomy. The author often uses hyperbole and several times states that the primary goal of a treatment was to make money for the physicians. Much of this material is better reviewed elsewhere and in a more unbiased manner, such as in Elliott Valenstein’s “Great and Desperate Cures”.

The book merits attention in its discussion of medication as treatment for psychiatric illness. The author focuses on the use of anti-psychotic medication in the treatment of schizophrenia. “The record of care provided to the severe mentally ill in America from the early 1950s to the early 1990s, the period when the standard [“typical”] neuroleptics were the drugs of choice, is … a disturbing one.” He gives a good deal of information regarding the deleterious side effects of these medications but very little information about their positive effects. He then states that these medications worsen schizophrenia. There is some interesting information indicating that, for some patients, their schizophrenia symptoms became worse because of their exposure to neuroleptics and that they would have been better off if they had never taken them. He describes aberrant behavior caused by neuroleptics (“behavioral toxicity”) and side effects such as akathisia and violent behavior caused by withdrawal from neuroleptics. The author hurts his case by making comments such as “… by the mid–1980s, a fairly clear profile of the long-term course of ‘medicated schizophrenia’ had emerged in the medical literature. The drugs made people chronically ill, more prone to violence and criminal behavior, and more socially withdrawn. Permanent brain damage and early death were two other consequences of neurologic use.”

The author goes on to condemn the newer (“atypical”) anti-psychotics that came into use in the 1990s. His indictments regarding exaggerated efficacy claims and research bias and the deleterious influence of pharmaceutical corporations on research have been borne out by other authors. He describes the rise of the for-profit business of clinical research (for-profit clinical trials). He describes the way pharmaceutical studies are constructed to make them likely to give favorable results (“bias by design”). That both the efficacy and a better side-effect profile of the atypical versus the typical anti-psychotics were exaggerated was indicated by the CATIE trial, which was published after (2005-2006) Whittaker’s book came into print. At times, the author appears to question the very existence of schizophrenia or to posit it as an illness with a natural history that is short-term, but which is exacerbated and made long-term by treatment with anti-psychotics. Stating that medication treatment can have deleterious side effects or that medication treatment is ineffective is very different from saying that medication treatment is a cause of an illness.

Nonetheless, the author presents some interesting information about the lack of efficacy of medication treatment of schizophrenia, which would have benefited from a more balanced discussion. For example, he presents the results of studies comparing “stay-well rates” for patients treated with antipsychotic medication with those not treated with medication. Closer examination of some of these studies reveals the complicated nature of the outcomes presented, which the author does discuss. The author also claims that the better outcomes for schizophrenia in developing countries versus those in (wealthier) developed countries is due to the more common use of neuroleptics in developed countries.

The author states, “This Book began with a straightforward goal, and that was to explore why schizophrenia outcomes are so poor in the United States today.” Unfortunately, the author does not achieve this goal. In looking through book reviews of “Mad in America,” I did not find that his critiques were adequately addressed. Although the book is dated, he raises some interesting questions about medication efficacy that merit further consideration and review.
“DOC, I'M HEARING VOICES” - THE CHALLENGE OF DETECTING AND ENGAGING MALINGERING AND FACTITIOUS ILLNESS ON THE INPATIENT UNIT
WCMC Grand Rounds 2/27/18
Presenters: Alaa Alnajjar, MD, Argyro Athanasiadi, MD, Huifen Feng, MD, Ife Osewa, MD, Vishnupriya Samarendra, MD, Alexander Lerman, MD
Reported by: Vishnupriya Samarendra, MD & Aryro Athanasiadi, MD

The practice of medicine is predicated on the appeal of a patient to a physician: “help me.” And how does a physician help? He/she begins by taking a history and conducting an examination; then reflects on what he/she has learned, making use of professional knowledge and experience; and finally educates the patient and lays out a plan of treatment that reflects best medical practice. While all of this is being done, there’s a further condition: the patient is “under the care” of the doctor. This means that the patient is the object of the physician’s compassion and concern and implies that the patient and physician are united in a kind of partnership.

This has been the case since ancient times. This is how most of us make sense of what we do with our professional lives, the principles which justify the sacrifices we make to become physicians and health practitioners. When people call for “equal access to health care” – this is what they are talking about.

But what happens when a patient lies? What happens when a patient’s “illness” reflects underlying psychopathology which leaves a patient, for one reason or another, invested in being ill? What happens when a patient gains knowledge of medical practices and procedures, and begins to manipulate them with criminal or malicious intent?

What happens then is that, whether physician or patient is aware of it, the process of treatment grinds to a halt. In its place arises a pseudo-treatment, i.e., a process that resembles the processes of diagnostic assessment discussed above, but where the assessment is false or distorted, and the “treatment” is nearly meaningless, because it is directed at a problem that the patient either does not have or is actively resisting relief from.

What happens then is, whether physician or patient is aware of it, the process of treatment grinds to a halt. In its place arises a pseudo-treatment, i.e., a process that resembles the processes of diagnostic assessment discussed above, but where the assessment is false or distorted, and the “treatment” is nearly meaningless, because it is directed at a problem that the patient either does not have or is actively resisting relief from.

We propose the following:

- The problem is far more widespread than is commonly recognized.
- Because we don’t recognize it, we do a terrible job of engaging it.
- The consequences of this program for our mental health care system are serious.
- There are serious problems in our models of mental illness.
- Improving our model and engaging and detecting this psychopathology can lead us to better solutions.

Factitious Illnesses and Malingering

All patients withhold and distort information to some degree, due to multiple underlying factors such as feelings of shame, anxiety, mistrust; pragmatism, as a way to equalize the power gradient; a response to clinician failures in empathy and engagement; or as an end result of disorganized patient perception.

“Normal” withholding can be resolved through establishing communication and trust between patient and clinician. Many psychiatric inpatients display “benign” deceptive tendencies and find shelter and comfort in the hospital. They may, in fact, represent efforts by patients to seek voluntary hospitalization.

Unlike the above, the psychopathology we refer to is “malignant.” In our research, we focus on both Factitious Illnesses and Malingering. Malignant Factitious Illness and Malingering are characterized by the following: deceit/nondisclosure, disruptive behavior on the unit, power struggles with unit staff, treatment noncompliance, and disposition problems.

Factitious Illnesses (FI) are physical or psychological symptoms that are produced by the individual and are under voluntary control. However, these acts have a compulsive quality, in the sense that the individual is unable to refrain from a particular behavior, even if its dangers are known. Behavior under voluntary control is used to pursue goals that are involuntarily adopted (DSM-III, p. 285).

Malingering (M) refers to conscious and intentional production of symptoms for material gain.

FI/M pose a unique challenge to the process of conventional psychiatric assessment and treatment. Minor vulnerabilities and weaknesses in the treatment system are magnified. FI/M represents the impact of an underlying personality disorder – but presents with putative symptoms of a major neuropsychiatric disorder. We treat the wrong disease, and the results are predictably poor.

FI/M induces intense frustration and psychological withdrawal on the part of clinical staff, equivalent to “countertransference,” which then leads to clinician impairment in various forms and degree, such as: Clinician frustration, therapeutic nihilism, ethical challenges as clinicians struggle to document rationale for continued care, fragmentation of the treatment team, false allegations leading to adverse professional consequences, and enhanced risk of clinical error and system breakdown.

Clinicians must recognize an important caveat in this model – (Continued on next page)
“DOC, I’M HEARING VOICES” - THE CHALLENGE OF DETECTING AND ENGAGING MALINGERING AND FACTITIOUS ILLNESS ON THE INPATIENT UNIT (cont’d)

(Continued from page 10)

specifically, the effect of confounding factors, such as poverty, trauma, substance use, patient anger over institutional failures, and major mental illness. Patient behavior may be indistinguishable from malignant MFI; but given sufficient resources, an effective treatment can be established with remission of behavioral features.

Detection of Malingering

Detecting malingering represents a challenge for clinicians. Indications of malingering include:

- “Scripted”, often repetitive, complaints
- Resistance to questions that subjects are not prepared to answer
- Selective cooperation in providing information that advances the patient’s agenda
- Excessive friendliness or familiarity and/or overt or cover threatening behavior towards interviewer.

Helpful interviewing techniques include:

- Prior to the interview, review all available information. The interviewer should not reveal the extent of his or her knowledge to the interview subject, until or unless there is a reason for doing so.
- Watch for evidence of distortion or selective information
- Watch for absence of affect in relating scripted material, and breakthrough irritability when challenged

On the inpatient units, M/FI patients often display a range of aberrant behavior, including disruptive conduct, threats to the safety of others, sexualized acting-out, demands for controlled substances, false reports of maltreatment by staff, and failure to comply with aftercare.

Such behaviors provoke powerful negative and aversive emotional responses by staff. When shared and examined, such “countertransference” can serve as an indicator of undetected deception and manipulative behavior. Unexamined, such emotional responses can adversely affect the integrity and efficacy of the treatment team.

The Effect of Personality

Numerous different personality factors contribute to FI/M. A meta-analysis by Gregory Yates of 455 cases showed none of the study population presented with factitious psychiatric illness: 42% displayed comorbid depression; 17% "personality disorder"; 17% substance abuse; 16% anxiety symptoms; 14% suicidal ideation. 44% worked in healthcare. 66% were female. Authors suggest that factitious illness is linked to depression, though they acknowledge that shared risk factors (e.g. adverse childhood events) may account for this covariance.

Psychopathic tendencies require recognition by clinician. Antisocial Personality Disorder, as a DSM diagnosis, can be understood as two underlying impulses; the first of antagonism, which involves manipulation, callousness, deceitfulness and hostility; the second of disinhibition, involving risk taking, impulsivity, and irresponsibility.

Unlike in therapeutic alliances, this psychopathology worsens with therapeutic engagement, with worsening paranoia, sexual aggression, antisocial (often criminal intent) and malignant narcissism.

Malignant narcissism is identified as “a disturbing form of narcissistic personality where grandiosity is built around aggression and the destructive aspects of the self become idealized (Rosenfeld).” As per Kernberg, these people have antisocial tendencies, with ego-syntonic aggression, absence of conscience, and a need for power and self-importance.

Unengaged, these dynamics can disrupt or destroy any treatment intervention. Within the hospital, the behavior manifests as aggression in multiple ways: deceit and rejection of the treatment alliance; paranoid response to authority such as violation of psychiatric unit rules, sexual acting out; manipulation of peers and staff, including exploitation of vulnerable patients; violence and threats of violence (terrorizing behavior), which may be as understated as invasion of personal space or escalate to physical and sexual violence.

Treatment in which malignant narcissism is not the focus will always fail. Malignant dynamics have deep, disruptive effects on treatment systems. Improvements in diagnostic assessment, conceptualization of FI/M, and institutional procedures can lead to better allocation of resources and better care.

Our good friends at NAMI Westchester are having their 6th annual fundraising walk, NAMIWalks Westchester, on Saturday, May 19, 2018, at Rye Town Pak in Rye, NY. Check-in at 8:30AM and start time is 9:00AM.

There is no registration fee and no minimum donation to raise, so the 5K walk is for everyone. You can simply go. However, if you would like to register and donate to NAMI, go to www.namiwalks.org/westchester
Listed below are the names of the nominees for office for the 2018-2019 year as proposed by the Nominating Committee and accepted by the Executive Council:

_____ **President**: Alexander Lerman, M.D.

_____ **President-Elect**: Richard McCarthy, M.D.

_____ **Secretary**: Naveed Iqbal, M.D.

_____ **Treasurer**: Rehana Latif, M.D.

_____ **Program Coordinator Elect**: Gurjeet Dhallu, M.D.

_____ **Councilor**: Jerry Liebowitz, M.D.

_____ **ECP Representative**: Reena Baharani, M.D.

_____ **ECP Representative**: Liz Leung, M.D.

_____ **Assembly Representative**: C. Deborah Cross, M.D.

Write In: ________________________________________________

Please note that Ballots must be received by May 31, 2018 in order to be valid.

Thank you for your participation.

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