

acterized by abnormally rigidity and fastidiousness, has been grouped with cluster C.

In clinical practice, we often see patients with combined borderline and antisocial traits for whom *DSM-IV* and *ICD-10* do not provide clear-cut categories. The term "psychopath," even though it has clinical descriptive value, is not an easy term to explain to a patient and is a misleading description of the complex mixture of personality traits that are evident in this patient group. The term "cluster B personality disorder" is rather unwieldy, and our nonpsychiatrist colleagues may not know what the term means without having to look it up. We suggest the term "borderpath," a fusion of borderline and psychopath, which describes a clinical entity and is relatively self-descriptive.

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References

1. Sartorius N, Kaelber CT, Cooper JE, et al: Progress towards achieving a common language in psychiatry: results from the field trial of the clinical guidelines accompanying the WHO classification of mental and behavioral disorders in ICD-10. *Archives of General Psychiatry* 50:115-124, 1993
2. Tyrer P, Alexander J: Classification of personality disorder. *British Journal of Psychiatry* 135:163-167, 1979

Bridging Psychiatric Services Between Asia and America

To the Editor: In the October issue of *Psychiatric Services*, Dr. Chen and his colleagues described the Bridge Program in New York to improve access to psychiatric services among Asian consumers (1). The authors explained that a primary reason for developing the Bridge Program is the profound stigma associated with mental illness in Asian-American commu-

nities, which is a major cause for the low use of mental health facilities. I am in full agreement with Dr. Chen's team on this issue. A recent study in Hong Kong, in which 11 interviews were conducted with patients' relatives to explore the relationship between stigma, accessibility of mental health facilities, and family burden, yielded the same conclusion (2). Data analyses showed that much of the burden was related to stigma and to a lack of mental health and rehabilitation services. Consequences included the families' social isolation, patients' difficulties obtaining competitive employment, and financial difficulties for both patients and families.

One of the salient features of the Bridge Program is its goal of enhancing the skills of primary care providers to improve identification and treatment of mental disorders. I am delighted that the program is a success. I would like to propose another component for the Bridge Program, if the authors are interested. The program should encourage exchange of information about research and services between Asia and America. The importance of addressing cross-cultural differences in the development of instruments for psychiatric research has been widely recognized. I believe it is equally applicable in the development of treatment protocols. As a psychiatric researcher in Asia, I have found that advances in psychiatric rehabilitation in America have helped me to better direct my research efforts. By the same token, I believe that the outcomes of research conducted by my group and by other researchers in Asia will be of help to researchers and practitioners in America who work with the Asian population.

My primary concern is to ensure the effectiveness of the programs that my group has developed for use in the Asian context. However, I would be most delighted to learn that the culturally relevant assessment instruments and treatment programs we have developed in Asia can be successfully applied among Asian Americans. Assessments developed and validated in Hong Kong, such as the Workshop Behavior Checklist (3) and

the Vocational Social Skills Scale (4), may be useful with Chinese Americans. Similarly, the integrated supported employment program (5) and the Chinese version of the basic conversations skills module on which we are currently working might also be helpful to American practitioners who work with Chinese Americans.

In summary, facilitation of exchange of information about research and services will further enhance the Bridge Program.

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References

1. Chen H, Kramer EJ, Chen T: The Bridge Program: a model for reaching Asian Americans. *Psychiatric Services* 54:1411-1412, 2003
2. Tsang HWH, Tam, PKC, Chan F: Sources of family burden of individuals with mental illness. *International Journal of Rehabilitation Research* 26:123-130, 2003
3. Tsang HWH, Ip YC: Development and validation of the Workshop Behavior Checklist: a scale for assessing work performance of people with severe mental illness. *International Journal of Social Psychiatry* 46:110-121, 2000
4. Tsang HWH, Pearson V: Reliability and validity of a simple measure for assessing the social skills of people with schizophrenia necessary for seeking and securing a job. *Canadian Journal of Occupational Therapy* 67:250-259, 2000
5. Tsang HWH: Augmenting vocational outcomes of supported employment by social skills training. *Journal of Rehabilitation* 69:25-30, 2003

In Reply: We are pleased that our Frontline Report on the Bridge Program has been well received by colleagues in both America and Asia. The concept of "bridge," developed by Dr. Henry Chung, a New York psychiatrist and a researcher and community leader in minority health care delivery, was an attempt to improve the connection between community needs and psychiatric services and to effect better communication and referral patterns between primary care providers and mental health professionals. We welcome Dr. Tsang's proposal to extend the bridge concept toward building more productive con-

nections among similar or related service and research programs and across cultures.

Reflecting upon our experience and Dr. Tsang's comments, we feel that there are five essential components for developing culturally competent psychiatric services in ethnic minority communities.

First, antistigma community education must always be part of the long-term plan of a service program. Given the profound misconception and emotional resistance in the community toward mental disorders and psychiatric services, persistent efforts to provide basic mental health education with effective consumer involvement are key to improving access to community-based mental health services.

Second, training service providers—especially equipping primary care physicians, nurses, case managers, and culturally competent mental health professionals with updated knowledge and skills for delivering mental health care—is a crucial strategic step toward eventually closing the gap between the enormous mental health needs and limited service capacity in these communities (1).

Third, development of culturally competent instrumentation, such as the efforts led by Dr. Teng and her colleagues (2) and Dr. Mui (3) in geriatric psychiatry and Dr. Tsang in rehabilitation psychiatry, provides crucial tools for detecting clinical cases and assessing treatment outcomes. Despite the research efforts of cross-cultural psychiatrists over the past half century, much important work remains to be done in this field.

Fourth, developing and testing the effectiveness of treatment protocols and care delivery models that are adapted or created for ethnic minority populations is an inevitable step in the development of evidence-based psychiatry for these populations. Research that can improve our understanding of culturally relevant expectations, explanations, and service barriers, as well as effective treatment protocols, typically requires long-term collaborative efforts and funding.

Fifth, even more interdisciplinary collaboration is required to build

much needed community-based systems of care (4) that ensure effective linkages among different care programs in order to systematically address the myriad health, economic, and educational needs typically found in ethnic minority populations. Until we can achieve the strategic goals of enhancing service integration, service linkage, and the continuum of care, equal access to appropriate care for all will remain an unfulfilled dream, and individuals suffering from mental illness, particularly immigrants and members of minority groups, will continue to be denied the opportunity to attain their full potential.

Achieving our goals requires interdisciplinary and international cooperation and collaboration, which combines the benefits of technology with the richness and wisdom of tradition, and a continued dedication to advocating for the mentally ill population and to ensuring adequate funding for this increasingly important work.

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References

1. Chung H: The challenges of providing behavioral treatment to Asian Americans. *Western Journal of Medicine* 176:222–223, 2002
2. Teng EL, Hasegawa K, Homma A, et al: The Cognitive Abilities Screening Instrument (CASI): a practical test for cross-cultural epidemiological studies of dementia. *International Psychogeriatrics* 6:45–58, 1994
3. Mui AC: Geriatric Depression Scale as a community screening instrument for elderly Chinese immigrants. *International Psychogeriatrics* 8:445–458, 1996
4. Kiser LJ, Lefkowitz PM, Kennedy LL (eds): *The Integrated Behavioral Health Continuum: Theory and Practice*. Washington, DC, American Psychiatric Publishing, 2001

Unethical to Speculate?

To The Editor: I thoroughly enjoyed the Personal Accounts column in the October issue (1). John Stuart Mill's description of the depths of his depression was most compelling and can be used to educate patients, families, and providers. The account also raises interesting points about spontaneous recovery from major depression and the psychodynamics

of father-son relationships.

However, I was baffled when I read column editor Jeffrey Geller's comment: "I shall refrain from analyzing this case—to do so would be to violate the American Psychiatric Association's code of ethics." Intuitively it didn't make sense that speculating about the psychodynamics of someone long deceased would be unethical. And why would such a prohibition be applicable only to posthumous psychodynamic appraisals while Dr. Geller was comfortable assigning a retrospective diagnosis of major depression?

The relevant subsection of the APA's code of ethics (2) states the following:

"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/her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he/she has conducted an examination and has been granted proper authorization for such a statement."

The code doesn't distinguish between patients who are alive or deceased. But I can't imagine that the intent is to preclude consideration of deceased historical figures. If so, then a vast body of literature about the psychopathology of long-deceased persons could be taken to be ethically deficient. Also, the requirement for direct examination and authorization would generally preclude future psychodynamic and other considerations of deceased persons.

The APA should consider revision of the ethics code if it continues to be interpreted in such a counterintuitive fashion.

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References

1. Mill JS: A crisis in my mental history. *Psychiatric Services* 54:1347–1349, 2003
2. *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. Washington, DC, American Psychiatric Association, 2001