

The Westchester Psychiatrist

A quarterly publication of the Psychiatric Society of Westchester County

Spring 2014

2013-2014 Executive Council

James P. Kelleher, MD
President

Carlo Bayrakdarian, MD
President-Elect

Barbara Goldblum, MD
Secretary

Richard McCarthy, MD
Treasurer

Fady Hajal, MD
*Past-President
(2012-2013)*

Anthony Stern, MD
Program Coordinator

Karl Kessler, MD
Program Coordinator-Elect

Susan Stabinsky, MD
Legislative Representative

Richard Altesman, MD
APA Representative

Edward Herman, MD
APA Representative

Karen G. Gennaro, MD
NYSPA Representative

Enrique Teuscher, MD
Councilor

Alex Lerman, MD
Councilor

Sally Ricketts, MD
Councilor

Jerry Liebowitz, MD
Newsletter/Website Editor

Megan Rogers
Executive Director

Message From Our President—Building A Cathedral

James P. Kelleher, M.D.



There is a story of three men working underground. When asked what they're doing, the first two say they're digging a hole. The third answers, "I'm building a cathedral." I think that metaphor represents the attitude of the Westchester District Branch during the last year and I hope it has shone through in our work. Professional challenges are less formidable and accomplishments more rewarding with our pride and enthusiasm. It's been an honor to serve as President.

Since the last newsletter, members of our group attended meetings of the New York State Psychiatric Association, the Westchester-Bronx combined District Branches, and the American Psychiatric Association. Each provided an opportunity to meet colleagues and to learn. At the first, we were introduced to the new NYS Commissioner of Mental Health, Dr. Ann Sullivan, and the incoming NYSPA President, Dr. Seeth Vivek. From this vantage point, it appears we are in good hands as we enter a new healthcare era.

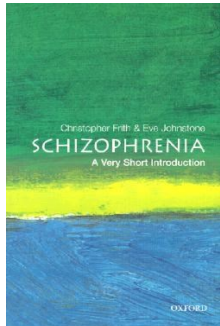
We are grateful to the Bronx DB for welcoming us this year and for providing a memorable evening. The speakers, Dr. Susan Whitley, Director of Chemical Dependency Services, Kings County Hospital Center, and Sandra Turner, Program Manager, Palliative Syringe Program, St. Ann's Corner of Harm Reduction, gave a very important presentation about saving lives through early intervention in heroin overdose. Some of their data indicated that by providing supplies of naloxone and training to community members, a life could be saved for about \$50. I admire their work.

The theme of this year's APA meeting, held in New York, was *Changing the Practice and Perception of Psychiatry*. I learned a great deal from the presentations of Drs. Matthew State (about developments in psychiatric genetics), Thomas Insel (about the BRAIN Initiative and the possibility of a new psychiatric diagnostic schema), and Nora Volkow (about the neurobiology of substance abuse). The conference, as always, represented the many ways our profession is developing.

Finally, I welcome Dr. Carlo Bayrakdarian, a respected colleague who has been of great service to our organization, as our new Westchester DB President. As we enter an exciting new year, we already have several different projects on the agenda. ■

Book Review— by Karl Kessler, M.D.

Schizophrenia: A Very Short Introduction by Christopher Frith and Eve Johnstone, Oxford University Press, 2003, 197 pages.



Oxford University Press has published a large number of texts in their “A Very Short Introduction” series. One of these books is A Very Short Introduction to Schizophrenia. The authors are British researchers and the book is written from a British/European perspective, which includes the Present State Examination, the CATEGO diagnostic program and the art of Richard Dadd. It is aimed at a non-medical audience, so the neuroscience aspects are very simply presented. Basic topics such as the experience of schizophrenia and possible causes of the illness are discussed at length. The authors also give space to their own research interests, such as the possible effects of institutionalization on the course of the illness and the effect of schizophrenia upon IQ. The discussion of epidemiology is weak. The book is altogether interesting, especially for its European perspective and its brevity makes it attractive to busy psychiatrists. ■

Genes

Eve Kellner, M.D., RFM Representative

Garnering recording historical mention as early as 1550 BC, psychiatry is a field of medicine that boasts a relatively long history, yet there remains an abundant need for the further study of many aspects of mental illness. The discoveries yet to come will undoubtedly be made with the assistance of an ever-expanding catalogue of developing diagnostic tools, including functional MRIs, transcranial magnetic brain stimulation, and gene detection assays. The brand of awe, respect, and wonderment being generated in the psychiatric community by these progressive feats of science and technology may not be unlike that produced by the introduction of the Wallace-Farmer Electric Dynamo at the first World's Fair in Pennsylvania in 1853. Whether the advancement is the aforementioned 19th century precursor to electric light or the more recent progress in psychiatric medicine, innovation captivates and motivates the human mind and spirit, consequently precipitating even further, even limitless, discovery.

Earlier this year, a psychiatrist introduced me to “Personalized Medicine” in the form of Gene Assay Reports during one of my didactic classes. He instructed us in its relative ease of use at no cost to the clinician and showed us a sample report. This was my first introduction to the practical use of enzyme testing by a psychiatrist, and I was instantly filled with childlike giddiness, vis-à-vis the first World's Fair.

There they were! The genes I studied for boards... Of course the famous CYP3A4... and let us not forget CYP2D6! These are the genes we study to make sure that we don't inhibit and don't induce when we don't want to... and what is this, a patient's own concentration of these genes! But wait, there's more! On the report, there is a literature review included alongside a list of relevant therapies that target these genes. This assay

can help guide treatment choices for psychiatric conditions such as depression, bipolar disorder, schizophrenia, anxiety disorders, OCD and ADHD. This is some next level technology!

Though there is no direct cost to clinicians who choose to use enzyme testing, the financial impact of medical interventions and treatments will always play a key role in everything we as physicians do; this is especially true in the light of the emergence of the newest health care policies. It is unfortunate that as of the time of this writing, the majority of these assays cannot be billed to government funded insurance plans, including Medicare, Medicaid, and Tricare.

What that means to me is that psychiatry also has the most exciting future of any field of medicine, which is one of the many reasons that I shoes to pursue Psychiatric Residency. The Wallace-Farmer Electric Dynamo was a only of a kind invention, a spectacle at a fair most onlookers appreciated but never believed would be practical in everyday use; but it wasn't long before there were lightbulbs in every home. Innovation has always taken time to evolve into common practice, but when it does, the possibilities for meaningful change are limitless. I believe this will prove to be the pattern of evolution with genetic enzyme testing as well.

The causes of the psychiatric disorders are vast and no one is immune. We are working to help human beings. We hope that one day we will find a cure for psychiatric conditions. I believe Gene Assays are a step in the right direction, shedding light on the complex physiology of the inner workings of the human mind, functioning as psychiatry's own Electric Dynamo. ■

INSURANCE COVERAGE **DESIGNED** FOR PSYCHIATRISTS

WHAT YOUR CURRENT POLICY MIGHT BE LACKING:

A STRONG DEFENSE

Of course we hope you'll never need our claims expertise, but if you ever report a claim we are with you every step of the way, whether it's simply an adverse event for which you need legal guidance or a lawsuit requiring a robust full-court defense.

Take comfort that you will have our full support working closely with you, your defense counsel, and experts to vigorously protect and defend you.

View our 2013 claims results at
www.PsychProgram.com/Claims
and see for yourself how our strong
defense can work for you.

Dave Torrans, II
Senior Litigation Specialist, PRMS

Call us (800) 245-3333
TheProgram@prms.com
[in LinkedIn.com/company/PRMSprograms](https://www.linkedin.com/company/PRMSprograms)



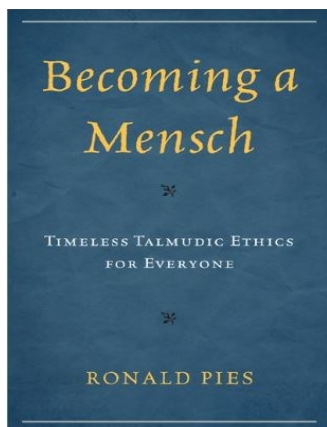
More than just medical
professional liability insurance.



Fair American Insurance and Reinsurance Company - New York, NY

Book Review—By Anthony Stern, M.D.

Becoming a Mensch: Timeless Talmudic Ethics for Everyone by Ronald Pies, M.D., Hamilton Books, 2011, 146 pages



Once upon a time, at the beginning of the twentieth century, the medical science of psychoanalysis was the new cure for all mental difficulties. Once upon another time, in the later years of the century, the medical science of psychopharmacology was the new key that would open the door to untold vistas of psychological healing. In both cases, psychiatrists and many others have believed that the expanding power of rationality would set us free from the emotional ills that beset our species. In this way, the optimism of the Enlightenment has had two resurgences in the same modern century and in the same medical subspecialty (1).

These days we live in humbler times. Just a few decades after our field turned from psychoanalysis to neurobiology as our main model of comprehension, most men-

tal health professionals hold out more modest hopes for the treatments we provide. We know that both medication and psychotherapy are solutions, but we also know that they are only partial solutions for the many if not most of the problems presented by our patients. We are less inclined to feel we have all the answers and more likely to perceive ourselves as new kids on an old block. We have come to appreciate more fully that "the old block" has its own time-tested set of sacred traditions whose understanding of inner truth and healing are worthy of consideration and inclusion.

In other words, we tend to recognize with more maturity and sobriety that we are as much students as teachers on a collective spiritual journey that has profound roots in the past and no end in sight, and that anything we can learn from tried and true sources is worth exploring and perhaps honoring, too.

In this light, it is a most welcome occasion whenever one of the pre-eminent leaders in our discipline steps forward with an endeavor to learn from ancient wisdom, and to suggest how it can be applied to our everyday life and times. This is precisely

what Dr. Ronald Pies has done in his book, *Becoming a Mensch: Timeless Talmudic Ethics for Everyone*; and he has done it exceedingly well. At the start, he invites us "to join the community of ethicists, rabbis and scholars" throughout Jewish history, and his sincere admiration for these insightful forerunners continues to shine through all of his writing to the end. His central aim is to describe and inspire us about the cluster of virtues embodied in a "mensch" — notably compassion, kindness, generosity, charity, self-mastery, self-discipline, humility, and flexibility. In the process of delineating the subtle ins and outs of "menschdom," each page of the book embodies and transmits the author's love of wisdom (in Greek, "philosophy"). This is meshed beautifully with his equal if not greater passion for "tikkun olam" (the Hebrew phrase for "repair of the world").

As readers of the *Psychiatric Times* already know, Dr. Pies is a first-rate guide to inner terrain, blending a raconteur's knack for the telling vignette with a therapist's intuition for the teachable moment. In *Becoming a Mensch*, he intersperses the

tales and brief sermons of the Talmudic rabbis with illustrative stories of current interpersonal challenges we all encounter. Thus the book emerges as a skillful interweaving of three elements: an introduction to the Jewish tradition, a set of down-to-earth case examples in practical ethics, and a fine running commentary about Jewish lore and how we can all reflect on it and be enriched by it. The tone of the writing is mainly gentle exhortation leavened by bursts of descriptive vitality. This combination serves the topic wonderfully. (I would have liked an occasional foray into gentle invocation as well, but we'll get to that.)

The book is a superbly easy read. It is not only highly accessible in style but also quite slender for all the territory it covers, weighing in at a total of 146 pages, including a useful time line, glossary and references. Some scholars might quibble with the author's reliance mostly on secondary and tertiary sources, but these references are generally more helpful than the primary sources for would-be mensches wishing to learn more about the history and lore of Judaism, especially as its time-worn rubber meets our modern

Newly Elected Officers

We are pleased to announce the newly elected officers for the coming year. They are:

Barbara Goldblum, MD	President-Elect
Anthony Stern, MD	Secretary
Richard McCarthy, MD	Re-elected to another term as Treasurer
Alex Lerman, MD	Program Coordinator-Elect
Edward Herman, MD	Re-elected to another 2 year term as APA Representative
Enrique Teuscher, MD	Re-elected to another 2 year term as Councilor
Eve Kellner, DO	RFM Representative

We thank our outgoing officers for a much appreciated job well done, and welcome them to their new positions. They are: **Barbara Goldblum, MD, Secretary**, and **Anthony Stern, MD, Program Coordinator**. **Karl Kessler, MD** will be stepping up as our new **Program Coordinator**.

Carlo Bayrakdarian, MD, will be taking over as **President**, and we look forward to an exciting year under his leadership and guidance. **James Kelleher, MD**, our current president, will be our newest **Past-President** and very active and appreciated member of our Executive Council. The rest of our Executive Council will be continuing in their current positions. You can see their names on our Newsletter masthead (left column).

Book Review (continued from previous page)

roads and post-modern rough patches.

Dr. Pies provides an accurate reflection of mainstream Jewish thinking, and one of the central strengths of this tradition is its powerful rationality. This is also a potential weakness if it is not balanced quite profoundly with a non-verbal, empathic inclination. My questions as I read boiled down to the

query, "Are our heads enough, even when they describe the key contributions of our hearts?" Martin Buber spoke of this concern in 1934 when he compared "Socratic man" to "Mosaic man," suggesting that the former believes that cognition is sufficient for virtue ("all that is needed to do what is right is to know what is right"), whereas the latter knows that his or her "elemental

totality" needs to be seized by the teachings (2). It is indeed possible that many Jewish teachers in the established tradition are more the heirs of Socrates than Moses. It is also entirely possible that this has been somewhat of a problem for Jews as well as the rest of humanity.

To put the point differently, do we need to discover at least a bit of the mystic with-

in our own souls to be more truly successful in our quest to become mensches? Would it help to tap into some strain of prayerful invocation as we respond to the set of exhortations that comprise this book? Might most of us require spiritual practices like prayer and mindfulness to balance and deepen our intellectual questioning as well as our best efforts at good deeds?

It's Time to Make the Right Choice!

Life is full of many choices, but making the right one is easier than you think. You need the level of expertise that can be measured by 40 years of experience writing Psychiatric Medical Liability Insurance Policies and providing Risk Management strategies. Why not take advantage of the program offered to you by the most prominent associations, the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, who have chosen to be represented by the American Professional Agency, Inc.



AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY
WWW.AACAP.ORG

- ☒ Superior protection provided by Allied World Assurance Company rated "A" (Excellent) by A.M. Best Company
- ☒ Access to a Risk Management Attorney 24 hours daily
- ☒ Individual Customer Service provided by our team of underwriters
- ☒ Telepsychiatry, ECT coverage and Forensic Psychiatric Services are included
- ☒ Interest-Free Quarterly Payments / Credit Cards accepted
- ☒ Many Discounts including Claims-Free, New Business and No Surcharge for claims *
- ☒ Great Low Rates
- ☒ Years in the previous APA-endorsed Psychiatry program count towards tail coverage on our policy
- ☒ Fire Damage Legal Liability and Medical Payment coverage included



American Professional Agency, Inc.
www.APAmalpractice.com
(877) 740-1777

* Subject to State Approval

Book Review (continued from pg. 5)

Here there is a connection between the worlds of therapy and ethics. The Dr. Pies we know and love as a teacher of psychotherapy has championed the work of Albert Ellis and has had his major focus on secondary process. He has turned less attention to matters of primary process than psychoanalysts often feel is needed. Similarly, as he guides us into the spiritual teachings of the rabbis, where are the gifts in the murkier, more disorienting depths? Do these more elusive hints and glimmers get somewhat short shrift, and if so, how much does that matter?

Whatever the wiser or wisest answers to these questions, they do not take away at all from the splendid work our colleague has done as he has mined priceless treasures of Jewish lore and brought them forward for our consideration. Some significant pay dirt may be found where morality meets mysticism, but Dr. Pies has indeed pointed at times in this direction. In the meantime, he has also revealed for us a large garden's worth of fertile soil poised on its own to nourish our inner lives, our interpersonal connections, and our wider community.

(1) Coupe L, Myth. London: Routledge, 2009; 119.

(2) (2) Buber M, Israel and the World. New York: Schocken, 1948; 141. See also Buber M, The Way of Response. Glatzer N (ed.). New York: Schocken, 1966; 95.

Dr. Pies's response:

I would like to thank my friend Tony Stern for his kind review of my book. Dr. Stern raises an important issue – one that has resonances in both rabbinical Judaism and in our work with patients: how much do we emphasize the "rational" and cognitive aspects of personal growth and change; and how much do we address more emotive and "primary process" elements? Or, as Dr. Stern puts it, "...do we need to discover at least a bit of the mystic within our own souls to be more truly successful in our quest to become mensches?"

I would reply on two levels. First, in the rabbinic tradition, rational and mystical elements are surprisingly compatible, and even complementary. For example, Rabbi Nahman of Bratslav (1772-1810) is generally regarded as "anti-rational" or mystical in his approach, emphasizing simple faith over logic or reason. And yet, Rabbi Nahman himself tells us that, "...the primary essence of man is his comprehension, and wherever one's reason is focused, there one has his being... whatever deficiencies a person suffers... they all stem from a lack of knowledge...." [Liqqutei Moharan 21; italics added]

Indeed, as Rabbi Lawrence Kushner has facetiously put it, "If anything, Jewish mystics are tediously rational."⁽¹⁾ I discuss these issues in detail in a paper published in Hakirah.⁽²⁾

Similarly, practitioners of Rational Emotive Behavioral Therapy, like the late Dr. Albert Ellis, knew that change occurred in psychotherapy only when "heart and head" were both involved. Therapy sessions with Ellis were often quite heated, as he argued passionately with his skeptical patients. Ellis was also capable of considerable warmth and empathy, as are all successful therapists. Or, as Frieda Fromm-Reichmann famously put it, "The patient needs an experience, not an explanation."

In terms of my book, I would say that to become a mensch, "heart and head" are both required. Indeed, I often quote Rabbi Abraham Joshua Heschel when I think about this balance. Heschel wrote, "When I was young, I admired clever people. Now that I am old, I admire kind people." Now there was a mensch!

(1) Kushner, Lawrence. The Way into Jewish Mystical Tradition. Jewish Lights, Woodstock: 2001.

(2) Pies R: Integrating the Rational and the Mystical: The Insights and Methods of Three Hassidic Rebbeim. Hakirah, vol. 6, 2008 [<http://www.hakirah.org/Vol%206%20Pies.pdf>]

Motivational Interviewing Changed my Life

Sally Ricketts, M.D.

When I completed my psychiatric residency at Payne Whitney Clinic in 1997, I was a convert to the power of therapy as an integral part of treatment for people with mental illness. I had been well schooled in psychodynamic long-term therapy, and after 2 years of biting my tongue as directed by my supervisors and saying very little to my patients, I became an avid student of CBT, Interpersonal Psychotherapy, and psychodynamic brief therapy. I actually go to have a collaborative conversation with my patients, actively providing information, and advice. I became intrigued by the experience of the time limit catalyzing change, and the change occurring rapidly. I participated in 2 clinical trials—one for IPT and one for supportive therapy—and enjoyed the challenge of adhering to strict guidelines of what I could and couldn't say.

10 years passed and I was acutely aware that there was something missing both professionally and personally in my conversations with others. Despite how persuasive, empathic, and insightful I was—in long-term therapy with people with borderline personality disorder, in my psychopharmacology practice, doing consults on medical services, people who just didn't do what I recommended, even though agreeing in the moment. My colleagues would chalk it up to "the patient is in denial," "the patient is exhibiting resistance," or "the patient isn't ready."

During those 10 years I became acquainted with DBT and the "rules" for the therapist. Fireworks went off in my head when I read, "Patients cannot fail. Therapists can fail." And "patients are doing the best they can, but they need to do better." Of course! So I was primed to embrace Motivational Interviewing. In 2009, I began working at a state hospital which had embraced the goal of training unit staff—the mental health workers, nurses, MDs, recreation therapists, social workers, even the cleaning staff—in Motivational Interviewing. We started training classes and 1:1 coaching on a unit for men with psychotic disorders who had been in the hospital for 10 years or more—the infamous back ward. The rates of assaults to both patients and staff were high and medication adherence low.

The training did not go well initially. First barrier: it was mandatory, and people resented it. Some of the staff actively resisted engaging during the sessions. Second, we had to cover three shifts. Third, and most important, the staff—many of whom had worked with these patients for 10 or 20 years—was unwilling to consider an alternative way of working with patients. We modi-

fied our game and focused on a few situations. Some of the staff started to respond to medication refusal with the reflection, "You must have a good reason for refusing your medication today." And then, as MI devotees say, the fight went out of the fish. Rates of violence fell and medication adherence increased. (There is a small paper published in *Psychiatric Services* about this intervention; Matthew Levy is first author) I decided to go to Albuquerque to attend a two-day training done by Bill Miller, Steve Rollnick, and Terri Moyers. I came back dancing to a different tune. What follows is my description of what makes MI so powerful not only in patient care but in all communications.

Motivational Interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change, in an atmosphere of acceptance and compassion. There are 3 main components that are explicitly different than the health care provider's usual mindset:

1. There is collaboration between two **equal** experts. The health care provider is the expert in her area—diabetes, weight loss, health promotion, treatment of illness, and the client is the expert in himself.
2. The conversation is based on evocation of the client's goals, interests, and life values. The client decides what and how to change. The health care provider lets go of any agenda for change she may have. The word "should" is explicitly excluded from the health care provider's vocabulary.
3. The health care provider's task, once the client is engaged and has chosen something he is interested in changing, is to uncover ambivalence and selectively focus on and evoke change talk.

So what if the client chooses to focus on something that has nothing to do with "the real problem" as we see it? The alcoholic with recent hospitalization for DTs who says, "My problem isn't my drinking, it's my wife!" or the diabetic, morbidly obese, medication nonadherent person who decides, "I'd like to work on getting my kids to obey me." Or the 16 year old with an intellectual development disorder, psychosis, and an IQ of 60 who says, "I want to have a baby." How can we possibly work with someone on something so counterproductive when we feel that the house is on fire?

Let's consider the last example. Many of us would cringe at the

thought of working with a person, who will never be able to take care of herself, toward becoming pregnant. We would want to give advice that getting pregnant was a bad idea, that it is hard to take care of ourselves and a baby too, that our client would not be able to go out with her friends in her group home anymore because she'd have to take care of the baby, she might even have to move, and she'd have to spend all of her SSI check on food and baby things. And these thoughts are completely legitimate. Stop for a minute and think of the psychology of trying to redirect this lovely young woman. Here she is, aware of the joy a baby would bring into her life, and we block the path, make her feel bad about herself and feel she is inadequate to the task of loving and nurturing. She responds—verbally if we're lucky, or in her thoughts an actions if we're not, with all her reasons for wanting to get pregnant. We have just engaged in the **righting reflex**—our well-meaning desire to fix what seems wrong, and set people on the right course. And instead of doing so, we have provoked our client to talk and think even more about getting pregnant. And we know that the more a person talks and thinks about doing something the more likely he is to act.

Here's what transpired with the use of MI.

Tina: I've decided that I want to have a baby.

Me: You've been thinking about your future and deciding what would make you happy in the long run. (*Reflection: shows her that you understand where she's coming from, and honors her autonomy in shaping her life.*)

Tina: I'm not a baby anymore

Me: You're pretty close to being a grown woman! (*Reflection: builds empathy by agreeing with what is true, and validates Tina's view of herself*) I'd love to hear what your thoughts are about adding a baby to your life. (*Evoking—I really want to know in detail what goals and values are driving her choice*)

Tina: Well, I see people my age on the street with baby carriages which are really cute, and snuggling with the baby. And babies are soooo cute. One of the girls at my residence had a baby and let me hold it! At first I was afraid I would drop it, but once I got over that, it felt soooo good. The baby smiled at me!

Me: You've discovered the magic of babies! Who doesn't love a baby! (*Validation*)

What do you know about getting a baby? (*Evocation*)

Through a series of evocative questions over 10 minutes, I find out about the client's goals, her knowledge about pregnancy and parenting, and her values for what makes a good parent.

Me: We've talked about a lot of things—getting pregnant, how your life will change after you have a baby, and your values for being the kind of parent you want to be. (*Summary*) What are your thoughts? (*Open-ended question/evocation*)

Tina: I didn't know it was so complicated. I guess there are a lot of things to get ready if I want to be a good mom.

In Tina's case using MI strategies developed her ambivalence—being able to recognize both side of a choice, and, as a consequence, change her plan.

Motivational interviewing is based on four core techniques, illustrative above.

1. **Open-ended questions** require the client to answer in more than a word or two, and can open the door into a topic that you and the client can look at together.

2. **Affirmations** are genuine statements of support for the client's efforts, experiences, and strengths.

3. **Reflections** are unique to MI (though resemble clarifications as proposed by Grace Bibring long ago in the psychoanalytic literature). A reflection is a statement—a guess—about what the client means by what they have just said. Reflections can be simple, complex, or reflect nonverbal content.

Consider these reflections to someone who says, "I don't want to stop smoking."

Simple Reflection: "Stopping smoking doesn't work for you right now."

Complex Reflection: "You're willing to accept the health consequences of smoking at this time."

Reflection of feeling: "It makes you angry when other people bring up your smoking."

4. **Summaries:** A summary gathers together all the ideas expressed by the client in a conversation like bouquet of flowers you then give back—keep the flowers (change talk) and throw out the weeds.

What about giving advice? The health care provider is the expert in his area of health and wellness, and our client may benefit from knowing more about something. The paradigm used in MI is **Ask-Provide-Ask**. First, ask the client's permission to provide your expertise. "I have some thoughts that might interest you." "Are you interested in hearing some of the solutions other people have found who grappled with this problem?" If the client agrees (and I've never had someone say no), proceed with offering your ideas. Finally, ask the client what she thinks about

Motivational Interviewing Changed my Life (cont'd from previous page)

Sally Ricketts, M.D.

this information and whether it may be useful. Ask what the client is going to do now.

The final principle in Motivational Interviewing is building both the client's belief in the **importance of change** and the **confidence to change**. If either is low, change is unlikely to occur. Using a ruler from 1-10 for the client to rate importance and confidence is helpful in developing both.

Motivation Interviewing has been studied in multiple health care setting. Originally developed for use in substance use disorders treatment, early research demonstrated that a single session of MI before discharge from an inpatient rehabilitation unit increased sobriety and reduced drinks per day consumption for up to one year afterward. Recent randomized studies in periodontal practice has demonstrated similar benefits of one MI session related to mouth care and decline in periodontal disease one year later.

For me there are no more patients from hell. If I start to feel like I'm wrestling with someone, that's my cue to figure out how I need to change my approach. The client is doing just fine. ■

An Introduction to BA (Behavioral Activation): "The Other AA"

Anthony Stern, M.D.

Winston Churchill's well-known saying could be said to be one of the mottos of BA: "If you're going through hell, keep going." In other words, movement is linked with life and growth. BA is a short-term psychotherapy for depression and anxiety that has become an increasingly popular evidence-based modality. It is a form of Problem-Solving Therapy, it is now the preferred psychosocial treatment in collaborative care efforts nationally and internationally.

"Collaborative care" in this context means the provision of mental health care in a primary care outpatient setting. The Impact Program at the University of Washington's AIMS Center (this can be googled and downloaded free; its chief psychiatrist is Jurgen Unutzer) has been a leading pioneer in this arena for nearly two decades; the team there has championed BA as a central element in their treatment of depressive disorders. Local leaders in the tri-state area include Henry Chung and our own Sally Ricketts, both at Montefiore Medical Center.

BA boils down to "AA" and the stepwise teaching of AA to patients. AA here means "Avoiding Avoidance." Research, as well as clinical experience, reveals that depression and anxiety lead to avoidance (withdrawal from life), and this in turn leads to further depression and anxiety. Thus a vicious circle is established that all too often becomes a swamp of lethargy and inactivity. Patients retreat from activities and relationships due partly to decreased energy and motivation as well as shame and self-blame. This deepens the swamp of low self-esteem, hopelessness, and self-

hatred, which then promotes further withdrawal from people and activities. A compelling downward cycle and unhealthy homeostasis ensues.

Christopher Martell, together with colleagues, has created BA to break this kind of vicious cycle and replace it with a vitality-giving cycle of greater and greater engagement with life. The 20th century philosopher Martin Buber summarized the core of his own thinking by stating, "All real living is meeting." This could be considered a second motto of BA, along with Churchill's words above. Buber also stressed the key significance of choice and decision-making in any human being's journey. Facing choices is implicit in BA, which relies heavily on MI (Motivational Interviewing; see article on page 8, by Sally Ricketts, MD.) A dialogue about baby steps that the patient himself/herself opts to take is the lynchpin of this highly effective method.

Any seasoned clinician could test the BA waters by a simple three session intervention (or "TSI") in this mode. The first session involves a little psycho-education, where the psychiatrist/therapist meets with the patient and describes the self-reinforcing swamp-like cycle of trap briefly mentioned above, and then discusses the possibility of moving to break the pattern with the patient. A picture of the two cycles can be drawn and given to the patient, and s/he is invited to pose questions and to commit to beginning a set of efforts toward greater health. It is critical here that a "no" is a real alternative for the patient to take. This first meeting introduces a conversation between doctor and the patient and empowers

Continued on next page

the patient with the seeds of a sense of agency, even if as an agent s/he decides on “no, not now”. (Buber might well add that the conversation itself has a healing function, and observations on the power of therapeutic rapport over the decades in addition to more formal research findings would concur.)

If the patient chooses to commit to a new course, the clinician can then end the first session by outlining three areas to which the patient might apply himself/herself: physical activities (specifically, exercise), pleasurable activities, and relationships (connections with others). The patient is then asked to choose one of these arenas for the first foray “out of the swamp of inertia and indecision” (or other words to indicate the difficulty of the current situation) and to begin to think about a single small step to be weighed and eventually tried.

The second session embarks more fully into an open ended discussion, beginning with a list of three to ten possible actions the patient might take between this time and the next session to become more engaged. This list follows directly from the two person thinking process begun in session one, but it is entirely “the patient’s ballgame,” with the clinician serving as a coach and a cheerleader who recognizes the patient as the only one truly “in the driver’s seat.” The patient then selects a single step

from the list to be attempted in the week or two (or even a month) till the next and last meeting.

The third session is then a non-judgmental review of how the plan went or did not go. If the patient did not follow through, the focus is placed on possible obstacles in the way. This session, like the previous two, is conducted in the spirit of “live and learn”; even an apparent failure is something from which to learn and grow, when approached even-handedly. This last TSI time ends with a discussion of possible future directions and concrete steps, including the option of another three sessions to continue the process.

The above “TSI” is my own idiosyncratic set of suggestions based on BA principles. It assumes that the clinician who applies them is already well-trained and relatively skilled. For the interested reader/therapist, I would strongly recommend a far more complete discussion of BA. Two of the better sources are Overcoming Depression One Step at a Time: The New Behavioral Activation Approach to Getting Your Life by Christopher Martell and Michael Addis (a workbook for patients) and Behavioral Activation for Depression: A Clinician’s Guide by Christopher Martell, Sona Dimidjian, and Ruth Herman-Dunn. ■

Changing The Practice And Perception Of Psychiatry: A Distinctive Challenge

James P. Kelleher, M.D.

The theme of this year’s American Psychiatric Association meeting was timely. Our specialty can expect extraordinary changes of the next decade. The introduction of genetic screening for drug metabolism is here, numerous device-based treatments, such as magnetic seizure therapy, are in advanced testing, and a wealth of new targets are being explored for drug development. Over time, brain research will yield a new diagnostic system. Even models of care are changing, e.g., the Delivery System Reform Incentive Payment (DSRIP) program of NY State is fostering regional collaboration in care provision. The parity law should increase access to care. Behavioral health is likely to be a key service line of accountable care organizations.

What of psychiatry’s perception? The legitimacy of our work rests on its scientific foundation and sophisticated treatment. Service provision is, at the same time, best facilitated by a humble approach. During the next few years, increased use of objective measures, including biomarkers and rating scales, and more transparent medical records should facilitate a more positive image in all of these dimensions. These advances should also be helpful in distinguishing psychiatry in the scope of practice challenges to come. My hope is for a future of improved treatment, more utilization of appropriate services, and highly functioning caregiving teams. ■

**INTERESTED IN WRITING AN ARTICLE?
HAVE A CLASSIFIED YOU WOULD LIKE TO INCLUDE?**

Contact Megan Rogers to have your article/classified featured in our next newsletter!!

centraloffice@wpsych.org or (914) 967-6285

Captain of the Ship

Carlo Bayrakdarian, M.D., President-Elect

While in training, I had multiple opportunities to be in court on behalf of my patients. Not infrequently, the judge would say: "Doctor, you are the captain of the ship, what is your opinion?"

In a court of law we are still considered the ultimate authority in within our specialties. However, in a hospital, thirteen years of graduate medical education barely grants the privilege to be called "doctor". Four years of college, four years of medical school, four years of residency, and one year of fellowship, and physicians are still considered rookies. This is understandable, as we deal with the most precious commodity: human life.

How do we reconcile this with the fact that several ancillary health care providers want to prescribe medication after attending a few biology courses? How much medical information and knowledge is needed to make a reasoned medical decision? Maybe "Dr. Google" would be enough in some situations, or the pharmacist at the drug store can be trusted with this task. What puts us in the unique position that we are so privileged to occupy?

Today in NY State, a pharmacy is no longer able to fill a prescription for a Medicaid patient unless it's written by a Medicaid "fee for service" Physician. Today in NY State, even for Medicaid "fee for service" Providers, the reimbursement rate is way below the Medicare rate. Today in NY State, when a physician is treating a dually eligible patient (Medicare and Medicaid), the Medicaid portion is reduced to 20%, and if those patients have home health care then they are automatically enrolled in Medicaid Choice/HMO and the copayment stops. As this continues, it creates a precedent for other insurance companies to follow suit.

I find our profession is perilously close to a slippery slope. If we sit idle, the ship will no longer have a captain. Does it need a captain or can it be remotely controlled by a committee of bureaucrats? It seems that already the decision making is shifting gradually to ancillary healthcare providers in the name of economics, accessibility and control.

What do you think we should do? Please email or send us your comments and opinions. ■

Report from the APA Ethics Committee

Mark Russakoff, M.D.

The good news from the APA Annual Convention is that there has been a distinct drop in ethics complaints against psychiatrists in recent years. This is true for the Westchester District Branch, too. There had been a period in which many ethics complaints surfaced, often regarding events from many years ago. This "backlog" of allegations has now subsided. There has been a change to the Principles which has put a statute of limitations on allegations.

But with the changes in times, come new hazards for ethics violations. The most prominent new areas are in: HIPAA violations; telepsychiatry; Internet activities. There have also been refinements in the process of conducting an ethics investigation.

Allegations of **violations of privacy** are not new. The HIPAA law clarifies when privacy rights may be violated, that is the limitations on patient rights. It behooves all psychiatrists to fully understand the law. It is especially important to understand the "minimum necessary" principle when information is to be released.

Telemedicine and telepsychiatry are in their infancy. There are legal, fiscal as well as ethical issues that emerge. These issues

have not been fully resolved but, nevertheless, telepsychiatry services are expanding especially in rural areas. Before one embarks on a telepsychiatry endeavor, one should consult with a lawyer knowledgeable regarding the issues as well as be certain that the technology one is using ensures confidentiality. Telepsychiatry raises issues regarding licensure as well as reimbursement.

Internet activities, as well as other digital media, present challenges. The first obvious issue is confidentiality. An interacting issue is that of records. Emails and text messages can be found on servers. Edward Snowden has educated us about how private electronic media are. But the biggest concern has been that of social media such as Facebook and the challenges that social media can make both to issues of confidentiality as well as maintenance of professional boundaries. As postings replace phone calls, inadvertent violations of privacy may occur as one recounts one's day. Statements that are inappropriate in any media—for example, talking on the phone about a difficult patient and revealing information that might make the patient identifiable—are memorialized in social media postings.

Social media are wonderful at breaking down communication

Report from the APA Ethics Committee (continued)

Mark Russakoff, M.D.

barriers but in the process, may smash professional boundaries. There are no formulas for dealing with challenges—it's a work in progress, but it is easy to see how trouble may emerge. Psychiatrists need to be mindful of what they post, whom they friend, and who their friends 'friend.' The "six degrees of separation" principle applies.

There are no new rules to easily guide one through these challenges. Consultation with one's colleagues, members of the Ethics Committee and lawyers may be helpful. ■

Editor's Column: The APA Meetings—a Smorgasbord to enjoy

Jerome Liebowitz, M.D.

In addition to attending the opening ceremony and hearing Nobel prize-winning psychiatrist, Eric Kandel, and actor and science communicator, Alan Alda, speak to each other about the science of psychiatry and the impact of the media on psychiatry and the future of mental health care, prompted at times with questions from the outgoing APA President, Jeffrey Lieberman, and, the following day, hearing former Congressman Patrick Kennedy speak to the group and then introduce Vice President Joe Biden, who spoke on the importance of psychiatry—understanding the brain and the treatment of mental illness—and access to mental health services in America, I decided to taste a few select samples from the large buffet offered. I specifically avoided topics I was well-versed on, especially those on child & adolescent psychiatry or ADHD. By the end, I believe I had a good sense of the breadth (and in some cases, depth) offered — from DSM-5 and neurobiology to horror films and shamanism. I also enjoyed spending time chatting with colleagues and former residents and fellows, as well as discussing practical and theoretical issues with several of the vendors. Here is a summary of some of the more interesting and informative sessions I attended.

I really enjoyed the clinically-oriented session on **DSM-5: Cases that Clarify the New Nomenclature**, chaired by **John Barnhill, MD**, with clinical presentations illuminating some of the new diagnostic categories and the "paradigm shift" that was the goal of DSM-5—to be more "etiological," using scientific validations, and "dimensional" rather than just categorical, to facilitate research and improve patient care. As Barnhill pointed out, psychiatric diagnoses are not perfect—e.g., descriptions don't explain, treatments are not disorder-specific, efforts at diagnostic "purity" lead to an increased rate of NOS, and there are high rates of comorbidity. Concerning recent criticisms of DSM-5, Barnhill emphasized, "DSM-5 doesn't over-diagnose... people do!" After a brief overview of DSM-5 and an explication of

why Barnhill considers it "an especially well-vetted textbook of psychiatry," three clinical researchers focused on their areas of expertise to "flesh out" some of the new diagnostic areas.

Janna Gordon-Elliott, MD (NY Presbyterian Hospital), spoke on "**ARFID and the Changes in the DSM-5 Eating Disorders**" and reviewed the current evidence base for these changes and the new disorder, Avoidant-Restrictive Food Intake Disorder (ARFID). She conceptualized the various types of Eating Disorders on a continuum—e.g., from healthy weight to preoccupation with weight or shape to fasting to anorexia; or from healthy eating/exercise to compulsive overeating or excessive exercise to calorie counting to bulimia. Real clinical cases were presented to illustrate the differential diagnoses of Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, ARFID, and Other Specified Feeding or Eating Disorders (that replaces the old NOS diagnosis), such as Atypical AN, BN or BED of low frequency and/or limited duration, purging disorder, and night eating syndrome.

Anna Dickerman, MD (Fellow in Psychosomatic Medicine, NY-PH/Columbia UMC) spoke on "**Changes in the Disorders Marked by Somatic Symptoms**" and reviewed the significant changes to what used to be called Somatoform Disorder—changes in nomenclature, criteria, and suggested clinical approaches. Three clinical cases were presented to explicate and clarify the new diagnoses of physical symptoms marked by abnormal or maladaptive thoughts, feelings, and/or behaviors and to point out what was wrong with Somatoform Disorder in DSM-IV—how there was too much overlap and lack of clarity about diagnostic boundaries, an over-emphasis on the lack of medical explanation that reinforced a mind-body dualism, the arbitrarily high symptom count requirements, and pejorative terminology (e.g., Hypochondriasis, now replaced by Somatic Symptom Disorder or Illness Anxiety Disorder, depending on whether or not there are significant somatic symptoms in the presence of signifi-

Editor's Column: The APA Meetings—a Smorgasbord to enjoy (continued)

Jerome Liebowitz, M.D.

cant health anxiety.) In DSM-5, she pointed out, there are three main improvements in the section on Somatic Symptom Disorders: It reduces the number of disorders and sub-categories to avoid problematic overlap and diagnostic confusion; it defines disorders on the basis of positive psychiatric symptoms rather than on the absence of medical explanation for symptoms (except for Pseudocyesis and Conversion Disorder); and its streamlined and simplified diagnostic boundaries are more useful in non-psychiatric settings. She concluded with a discussion of some remaining diagnostic ambiguities and other problematic or controversial issues: The inherent arbitrariness of what constitutes “excessive” or “disproportionate” concern; the possibility that these broadened criteria may lead to an increased rate of missed medical diagnoses; and the degree to which cultural factors may influence the expression of medical symptoms.

Katherine A. Phillips, MD (Rhode Island Hospital/Alpert Medical School of Brown University), who chaired the DSM-5 Work Group, spoke on **“Body Dysmorphic Disorder and the DSM-5 Reorganization of Disorders of Anxiety.”** She joked how she and her group “wrote the Bible; the rest are Talmudic scholars!” And, she added, “There’s a lot to like in DSM-5.” She gave an overview of the organization of DSM-5 and the clinical and scientific evidence for grouping the various disorders together in separate chapters for the Anxiety Disorders, the Obsessive-Compulsive and Related Disorders (OCD), and the Trauma and Stressor-Related Disorders. Highlighting the changes for Anxiety Disorder and Selective Mutism to Anxiety Disorders and simplifying the criteria for phobias and panic disorder. She described two new disorders, Hoarding Disorder and Excoriation (skin-picking) Disorder, that are included in OCD. She also noted that an insight dimension was added to OCD, Body Dysmorphic Disorder (BDD), and Hoarding Disorder. With this, delusional beliefs no longer exclude the diagnosis. And, of course, these kinds of delusions often improve with SSRIs. Using two clinical cases, she focused on the new diagnostic criteria Body Dysmorphic Disorder and its inclusion in the chapter on OCD (instead of Somatizing Disorders, where it used to be). Although often missed because of secretiveness, BDD is important to recognize. It is a common disorder that is very distressing; functioning and quality of life are markedly poor; suicide attempts are common; and the rate of completed suicide appears markedly elevated. Dr. Phillips concluded by pointing out that the goal of all the changes in DSM-5 is to improve patient care.

Wanting to learn more about evaluating and treating sleep problems, especially since insomnia is a prevalent issue among my patients, young and old, I decided to attend the symposium, **To Sleep or Not to Sleep: “Psychotropics and Sleep Architecture”** and felt richly rewarded by the combination of the neurobiology of sleep and practical clinical considerations about sleep disruption in a variety of psychiatric disorders, not only the primary sleep disorders.

Durga Prasad Bestha, MBBS (Carolina Healthcare Systems), co-chair of the symposium, spoke on **“The Neurobiology of Sleep”** and gave a clear and succinct overview of sleep disturbances in psychiatry and the complicated way in which sleep is “intricately regulated by multiple pathways formed by nuclei predominantly located in a column running from the hypothalamus down to the medulla, with some of them having synergistic actions and others showing antagonistic actions.” I cannot summarize his presentation in any detail here (especially without his slides), but suffice it to say that his discussion of sleep neurobiology, including involvement of the various neurotransmitters, neuropeptides, and processes that regulate onset and duration of sleep, did not put me to sleep! It really did accomplish what it set out to do—to form the foundation to understand the sleep architecture, sleep disorders, and the effect of mental illness and psychotropics on sleep.”

Venkata Kolli, MBBS (Creighton-Nebraska Psychiatry Residency Program), spoke on **“Sleep Architecture and Psychiatry”** - the bridge between neurochemistry and psychiatric disorders and medications. Dr. Kolli reviewed normal sleep architecture (REM and NREM sleep and EEG changes across sleep and wakefulness) and how it changes across the lifespan, necessary for understanding the impact of psychiatric disorders on sleep. He then discussed the sleep architectural changes associated with mood disorders, anxiety disorders, PTSD, psychotic disorders, eating disorders, dementia, and substance intoxication and withdrawal. He then reviewed various treatments, including chronotherapy for MDD, clonidine and prazosin for PTSD, and the use (and misuse) of benzodiazepines and the “Z drugs,” melatonin and ramelteon, antidepressants, antipsychotics, and gabapentin. He then reviewed the use and effects of wake promoting drugs. He concluded by describing various non-pharmacologic interventions that have been shown to help with sleep regulating, including sleep hygiene, behavioral treatments, and CBT.

Vishal Madaan, MD (University of Virginia Health System), the other co-chair of the symposium, spoke on **“Inviting the Sleep Fairy’: Developmental Sleep Patterns and Challenges in Pediatric Sleep Disorders.”** After describing normal sleep differences in children, he went on to discuss the changes associated with childhood psychiatric disorders, chronic interrupted sleep of adolescence, some of the neurobiological advances in pediatric sleep disorders (including dyssomnias and parasomnias), the assessment of pediatric sleep disorders (both objective and subjective), and pharmacological and non-pharmacological interventions for sleep disorders in children and adolescents. He emphasized how important sleep is for normal neurocognitive, emotional, and psycho-social development—and how over 60% of adolescents do not get enough sleep.

Finally, **Alexandra Schuck, MD** (University of Virginia Health System) presented a comprehensive review of **“Psychotropics and Sleep”** and, specifically, those that are used in clinical practice for their effect on sleep. She reviewed each class of sleep-promoting medications and their effects on total sleep time, slow-wave sleep, sleep latency, frequency of awakenings, and REM sleep. She also discussed briefly, but in a practically useful way, the receptor-based mechanisms through which these actions are mediated. Finally, she described the adverse effect profiles of these psychotropics in relation to their sedative properties.

Continuing with my taste for the neurobiological, I went to hear **Eric Kandel, MD**, author of [Psychotherapy and the Single Synapse](#) and Nobel Prize-winning psychiatrist, speak on **“Memory and the Aging Brain”** in what amounted to an entertaining, informational and intriguing presentation that raised as many questions as it answered. The first part of his talk focused on how different memory systems were identified in the human brain and how they are involved in two major forms of neural memory storage: [simple memory](#) for perceptual and motor skills and [complex memory](#) for facts and events. He discussed the role of dopamine as a modulatory transmitter and the “functional” prion required for the maintenance of long term memory. He described experiments with mouse genetics that helped to understand the role of the hippocampus and how both explicit and implicit memory storage use modulatory transmitters and a CREB-mediated transcriptional switch for converting short to long-term memory and a functional prion (CPEB) for maintenance. He then went on to discuss how our insights into the molecular biology of memory storage are allowing us to understand age-related memory loss (benign senescent forgetfulness) and to distinguish it from early Alzheimer’s disease (mild cognitive impairment) and, of course, full AD. This involved exploring the

molecular underpinning of age-related memory loss in the dentate gyrus, a subregion of the hippocampus.

After reviewing some interesting experiments with mice, he asked three questions that must be left to be answered: 1) Does the aging body act on the aging brain? 2) Are there humoral or hormonal factors that contribute to the hippocampal dysfunction observed with cognitive aging? 3) Might exercise help overcome these blood borne insufficiencies? He concluded with descriptions of two factors that have emerged from exciting research in the last few months: 1) young blood and 2) young bones. In the former, it was shown that young blood reverses age-related impairment of cognition and synaptic plasticity in mice, raising the question: what are the blood-borne factors that mediate cognitive enhancement? In the latter, it was shown that bone is an endocrine organ, that osteocalcin is an osteoblast-secreted multi-functional hormone that influences brain function and, when injected into the dentate gyrus, enhances memory performance of novel object recognition in both young and aged mice. He hypothesized intriguingly that, because aging is associated with a decrease in bone mass and therefore osteocalcin release, this could contribute to age-related memory loss. Conversely, he noted, this might explain the beneficial effect on cognition in the aged of vigorous exercise, which builds bone mass. A sound body helps assure a sound mind!

I will skip over some other serious topics I dropped by to savor and tell you about two workshops that I found delightfully appealing, more as dessert than a main course.

The first was a workshop on **“American Horror Film and Psychiatry”** that focused on the way mental illnesses – and the mental health environment – have been represented throughout the genre and the history of American horror film. In a most entertaining manner, through the use of clips from many horror films, the presenters addressed several serious topics – how psychopathology is viewed, the stigmatization of psychiatry and psychiatric patients, and the commonalities and profiles of serial killers from a forensic perspective.

Fernando Espi Forcen, MD (University of Chicago) reviewed the phenomenology of psychiatric disorders in the history of horror films, indicating how movies, and horror movies in particular, influence the public’s (and our?) view of psychiatric patients. Dr. Forcen explained the popularity and psychological appeal of horror films – the “rush,” “rubbernecking” (morbid curiosity), and the desire to be scared (a safe way to experience strong emotions such as fear), and used clips from several films to illustrate how the lighting, music, point of view, etc., all contribute to a

Editor's Column: The APA Meetings—a Smorgasbord to enjoy (continued)

Jerome Liebowitz, M.D.

sense of fear. The danger of associating fear with psychiatry, he notes, is that it is stigmatizing – the “crazy” perpetrator is seen as a “maniac,” “psycho,” or “lunatic.” He also noted that some scholars have proposed that horror films can actually be used as a teaching tool – that some films beautifully and accurately depict psychotic episodes.

John Shand, MD explored the portrait of psychiatry in selected American horror films – from D.W. Griffith's portrayal of a manic cook (the earliest negative stereotype in films) to such films as “Don't Look in the Basement” (1973), “Halloween” (1978), “The Shining” (1980), and “Sanitarium” (2013), among others – to explicate how media is at the root of the stigmatization of psychiatric patients and, with its scary depiction of the mental health care environment (including restraints, seclusion, unhygienic, dirty settings, torture treatments, and boundary violations), the often negative view of psychiatric care.

Susan Hatters-Friedman, MD (Case Western Reserve University) discussed the psychology and forensic aspects of horror movies. She showed how many could be viewed as morality tales (“bedtime stories for teens”) – a timid, vulnerable teenager saves the day – that help adolescents manage anxiety. She then entertainingly presented an Emotional Movie Database (EMDB) for consideration. She pointed out that there are three main types of movie psychiatrists – Dr. Dippy, Dr. Wonderful, and Dr. Evil, and used clips of films to show some of the forensic issues implied, e.g. the “shady” doctor who works as a “hired gun” for the defense, the Hannibal Lecters, the “activist” doctors with pseudoscience, the psychotic professor, and the positive “Jack of All Trades” (e.g., CSI, Criminal Minds, and Alex Cross). She also discussed the role of ECT in film (and not just horror films) and how it has been portrayed progressively more negative and cruel, used as punishment or even, in “The House on Haunted Hill” (1999) as a murder weapon. She then reviewed several “slasher” films (“Psycho,” “Halloween,” Friday the 13th,” an “Nightmare on Elm Street”), noting that the villain of each had “mother issues” and that the teenagers killed in each were all “morally lapsed.” She concluded with a description of “Cinematic Neurosis” – becoming highly anxious after viewing horror films such as “The Exorcist” and “Jaws.”

The second workshop was on “**Shamanism in Mental Health Care: Views from the Outside and the Inside**” that encouraged one to recognize “transpersonal” moments in ordinary healthcare

encounters and to consider possible responses to them, while presenting the state of the current evidence base for the therapeutic use of shamanic practices. I was especially interested in this, since one of my patients has been attending workshops to become a shaman and has found benefit from the introspection that comes with shamanic journeying. And, particularly since the inclusion in DSM-IV of “Religious or Spiritual Problem” (V62.89), psychiatry has striven to recognize the spiritual dimension of the lives of patients – a bio-psycho-social-spiritual model.

Janet Lewis, MD (University of Rochester), a psychiatrist with academic interest in psychodynamic psychotherapy and the “integral model” and co-chair, introduced the subject, noting that a growing popular interest in shamanism and “neo-shamanism” has spurred professional and academic interest in these subjects and what the relationship of psychiatry is or should be to this oldest of healing traditions. She noted that shamanism, wherein practitioners are encouraged to “journey” for encounters with spirits, may engender particular discomfort in many clinicians. She discussed six controversial issues related to shamans and shamanic practices: 1) Shamans are not more mentally ill than the general population, although some experienced brief psychotic episodes; 2) The professional integrity of shamans is often questioned, since some shamans engage in slight-of-hand and others may use deception as a placebo response or to create a symbol; 3) The existence of spirits is controversial and there is no known means for proving or disproving their existence; all we have is anecdotal evidence and case studies; 4) In several studies reported there were no negative effects or “bad trips” with shamanic journeying (although some positive altered state experiences), possibly because of the guidance and support of the shamans; however, Dr. Lewis expressed concerns regarding the mentally vulnerable; 5) The issue of the developmental maturity of the practice is a controversial one; the goal of shamanic practice is to develop a helping community, not to access a higher experience of unity; and 6) The appropriation of native practices by non-natives is also controversial. Dr. Lewis then reviewed reported mental health benefits, using case reports, in autism (e.g. “imaginary journeys” with high-functioning autism middle school students), chronic pain, conversion disorder, PTSD, substance abuse, and grief (through positive shamanic experiences with the deceased), including decreasing death anxiety and increased acceptance of death in seriously ill patients. She concluded by noting that there is some limited evidence that shamanic counseling or shamanic practice may also have general

mental health benefits in nonclinical populations for those who are open to it. However, she cautioned, “At this point, there is insufficient evidence to recommend shamanic counseling for psychiatric conditions.”

Cecile Carson, MD (Integrated Health Institute, Rochester, NY), an internist with a shamanic counselling practice and the other co-chair, spoke about “transpersonal” work and the internal subjective experience. She described three differing models of healthcare –the biomedical (that asks, what’s wrong?), the bi-opsychosocial (that asks, why now?), and transpersonal medicine (that asks, what’s trying to unfold here?). The latter includes the role of expanded states of consciousness in the healing process with a sense of “mystery vs. mastery,” of not knowing what is required for healing, with a focus on the patient’s meaning of illness and healing. Making a deep connection to the patient without expectations or judgment beyond roles, the “healer” witnesses the suffering, “being present to the patient’s wholeness as well as his/her brokenness, being present to what is unfolding.” She explained that healing is possible outside the usual 3-dimensional physiologic parameters – with miracles, spontaneous remission, and healing at a distance. According to this understanding, the purpose of shamanism is “to make contact with spirit healers in on-ordinary reality to bring back information/insight or healing to individuals or the community.” In shamanism, she explained, “the spirits are in charge and guide the process of treatment,” rather than the clinician or therapist. She emphasized that shamanic interventions heal the spiritual aspect of an illness, which this may or may not result in emotional or physical healing. Shamanism, in other words, can be used alongside western medical therapeutics. Shamanic interventions heal the

loss of spiritual power or protection (which can manifest as chronic types of problems, including URI’s, depression, anxiety, or chronic misfortune), soul loss (which can manifest as unresolved grief, complex medical disorders, addictions, PTSD, and dissociative disorders), and spiritual intrusion (which usually manifests as a localized problem, e.g., pain, ulcers, lesions, or localized cancer). She explained in some detail various aspects of shamanic practice and the shamanic journey, including the use of “sonic drivers” (mainly drums). Contrary to what many think, she noted, only about 10% of indigenous shamanic cultures use psychotropic plants. She concluded her presentation with some fascinating clinical examples from her practice and ways of adapting shamanism to western medical settings.

The workshop concluded with audience participation, including discussions of our own clinical or personal experiences with the spiritual or transpersonal. We also had to confront our own countertransference issues that interfere with our understanding and accepting shamanism and therefore hamper our understanding of its role within a patient’s life. Even if not fully embracing the use of shamanism in our own clinical practices, most of us felt enlightened to aspects of the approach and the power of spirituality and belief in healing.

To conclude my account of “dining” at the APA, I want to encourage all of you to try out “using” the meetings this way – to pick and choose from the unfamiliar in order to make it a worthwhile experience. Live presentations should also be enlightening as well as informative. One can always read reports of research in the journals. ■

CLASSIFIEDS

LARCHMONT

Sunny, well proportion office in four person suite available September 1st (may be available sooner). Lovely, spacious waiting room, small kitchen, walk-in storage. Town of Larchmont, walking distance (five minutes) from Metro North. Currently occupied by two Psychiatrists and a Psychologist. Contact Dr. Dora Atterman at (914) 522-4789 for further info.

WHITE PLAINS

Furnished, part-time or full-time office space in renovated suite shared with mental health professionals. Large waiting area, ample parking, centrally located. Contact Jonathan Sinowitz (914) 946-4466 ext. 1501.

We're On The Web!
www.wpsych.org

The Psychiatric Society of Westchester County
400 Garden City Plaza, Suite 202
Garden City, New York 11530
T: (914) 967-6285
F: (516) 873-2010
E: centraloffice@wpsych.org