

The Westchester Psychiatrist

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Message From Our Outgoing President—The Dream Team Carlo Bayrakdarian, M.D.



It's a cliché but I'll say it anyway: Time flies when you're having fun. And has time flown for the past year! Nothing —

neither sleet, nor snow, nor rain — could have held me back from delivering my duties as the 54th President of The Psychiatric Society of Westchester.

But being CEO was intimidating. The executive council members that I was lead were the most brilliant, the most capable, the most seasoned psychiatrists in their fields. Yet with the open-arm tradition most prominent under the leadership of the immediate past president, Dr. James Kelleher, they welcomed me — not only embracing my leadership, but treating me with a kindness and graciousness that was instrumental to making my presidency a success.

Of this past year, one of the accomplishments I am most proud of is the creating of our first ever social media Facebook page: PSWinc. I would like to take this opportunity to thank the executive council members, Dr. Richard Altesman and Dr. Karen Gennaro, for having the foresight to approve its creation, and Dr. Eve Kellner, our youngest member, for creating it.

Education is the foundation of The Psychiatric Society of Westchester. Our goal is to educate our peers of all disciplines and specialties by inviting top notch academics to present cutting edge innovations and technologies. We strive to educate our legislators by informing them of the realities

of our successes and difficulties; we aim to educate our communities, our patients and their families, by organizing health fairs and creating opportunities for better access to our services. And we fulfilled these obligations with flying colors because of the efforts and the connections of Dr. Kessler and Dr. Stern, an impressive feat that would not have been possible without them, nor without the shrewd guidance of executive council member Dr. Richard McCarthy, who helped us accomplish all this within budget, nor without executive managers, Ms. Megan Rogers and Ms. Donna Gajda, whose organizational skills made sure everything ran smoothly.

I would also like to remind and assure our members at large that every successful organization has mechanisms set up for it to have checks and balances. Our Society has this capability through the vast knowledge and experience of Dr. Deborah Cross and executive council members Dr. Barbara Goldblum, Dr. Edward Herman, and Dr. Richard Altesman. Without their “breaking” powers, the PSW would be a runaway organization.

So to our most capable incoming President, Dr. Barbara Goldblum, I say this: How lucky you are to have the most prolific group of physicians to lead. I am fully confident our Society will thrive and reach new heights under your leadership.

And finally, to my dream team: Job well done — let's do this again. ■

Message From Our Incoming President—Psychiatry: Where we have been, but where are we going?

By: Barbara Goldblum, MD



Walking through the 1,800-year-old entrance hall of the Roman ruins of Galen's medical center, the Asclepium in Pergamum (now western Turkey,) several years ago, the guide explained that this was probably the first psychiatric facility ever built. Galen, the famous Greek physician who

was born and grew up in Pergamum, created a then state of the art medical facility. He was a physician, an anatomist, a scientist and a philosopher, and he believed the body and soul were integrated.

Following the path the patients walked, I noticed the walls were studded with holes. Trained healers had been stationed behind the walls to whisper reassuring words through these openings to the arriving patients and immediately introduced calm. Rest, dream interpretation, and an individual therapist, without emotional reactivity (though an older, wise man,) were part of the treatments. Talk therapy was prescribed to reveal deep passions and secrets that would lead to psychological relief. The clientele was upscale to be sure, but the idea that an ill psyche, with unusual behaviors, needed some remedy was clear. Our guide could not tell us if any clinical records survived, or if they were even kept. History notes Galen cured a dignitary's wife of melancholia. All this coexisted with slavery and the gladiators' circus.

Madness has been recognized and dealt with throughout history in both kinder and more barbaric ways. What has remained a constant is that any population, as a whole, recognizes behavior that is out of its bounds, abnormal to the consensus, and distinct from what we could say would be moral issues. But here is the tricky part: when some of these

behaviors which are not illnesses but social reactions and moral dilemmas are reassigned as mental illnesses. They are confused for lack of understanding or for politics or for expediency: the Salem witch trials, the Russian forcing of anti-psychotics on political prisoners, housing the mentally ill in our jails. And the "treatments" included being burned at the stake, pharmaceutical torture, and incarceration.

At our level of psychological awareness, we could explain such fierce punitive behaviors as reactions to feeling threatened. The restoration of that society's mental security was achieved at any cost: burn them alive, teach the others a lesson, shut them away, even if illness and social actions were merged and confused. Look how long it took to un-diagnose sexual preference as a disease or as a perversion.

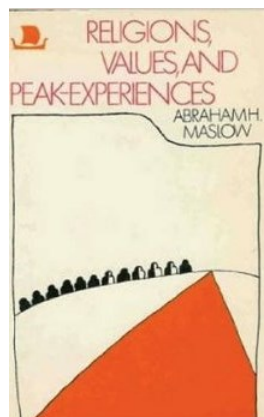
The illnesses that existed 2,000 years ago still exist. Perhaps smallpox has been eradicated but not much else; they keep reappearing. Our psychiatric attempts to make people better, to relieve a diseased state, to ease mental pain, continue with somatic treatments, medications, voices reaching us in various therapies, and now genetic approaches. These have brought so many suffering people to remission, or certainly to improvement. But there is still illness and it keeps coming. It disrupts individuals' lives, families' lives and societal life. Madmen can harm people and non-madmen certainly harm people. Our laws provide different penalties for these groups, but the cost to society is still great as we all too well know from so many news headlines.

Psychiatrists discriminate, that is we diagnose, we separate illnesses with their behaviors from human behaviors that each society defines as regular for its population, and then we treat the disease. Psychiatrists treat the mentally ill with objectivity, decency and all the moral fiber that the Hippocratic Oath commands of us. We do not participate in torture. We do not participate in carrying out death sentence decrees. We legislate for laws that demand treatments for all in our care.

Book Review: Religions, Values, and Peak-Experiences

Maslow, A.H. (1964) - Columbus, Ohio: Ohio University Press.

By: Tony Stern, M.D.



The Harry Potter novels dramatize a crucial conflict between wizards, those with a leaning towards magic, and muggles, those who are so concrete that they lack any taste for magic and harbor only fear and contempt for it. Decades before the era of Potter, in 1964, the American psychologist Abraham Maslow described a similar divide: between “peakers,” those prone to a sense of the transcendent, and “non-peakers,” those who are defended against the world of religious or mythical experience.

Maslow coined the term “peak experience” to refer to key moments of the sublime in a person’s life, and in the short collection, Religions, Values and Peak-Experiences, he provides the conclusions from his systematic studies of these

experiences. He presents a view of humanistic psychology as an alternative to the pathologizing focus of the Freudian school of behaviorism. It is also a third alternative beyond both traditional religion and narrowly “objective” science. In the process, he lays essential groundwork for an integration of spirituality and modern psychology.

The book begins with brief essays that all critique our dichotomizing tendency (the first 58 pages) and ends with several appendices that are highly useful summaries (the last 58 pages). Appendix A details the characteristics of peak experiences. Today it might be tempting to dismiss these features as evidence of manic or hypomanic symptomology. Despite the undeniable overlap between religious experience and psychosis, such pathologizing would be a serious mistake. Maslow’s pioneering work serves as a persuasive warning against just this sort of reductionism. ■

Teaching Day Review: Maintenance of Certification, Electronic Prescribing and Private Practice

By: Karl Kessler, MD—Program Coordinator

The Psychiatric Society sponsored a very interesting Teaching Day at the Staff Annex II at New York Presbyterian Hospital in White Plains on April 18th. The day began with an enlightening presentation on the **Maintenance of Certification (MOC)** given by Dr. Steve Epstein, representing the American Board of Psychiatry and Neurology (ABPN). Dr. Epstein reported that there has been pressure on organized medicine to: 1) reduce medical errors and increase patient safety, 2) provide more information to patients regarding physicians competency and as a means to assure patients that physicians are up-to-date in their clinical skills, and 3) reduce healthcare costs by improving medical care. The different medical specialties have responded to these concerns by establishing the MOC requirement.

A recertification process for Board Certification in psychiatry was begun in 1994. This evolved in MOC. In 2014, the process was again changed, to Continuous Maintenance of Certification (C-MOC). Completion of the requirements and passing the MOC and C-MOC examination allows Specialty Board Certification for a 10-year period.

The components of MOC are:

- 1) Professional Standing: That the physician has an unrestricted state medical license
- 2) CME and Self-Assessments (SA): the completion of a certain number of CMEs and SAs. A certain number of CME credits may be obtained through means such as peer supervision or publishing papers
- 3) The completion of an improvement in medical practice unit (called Performance in Practice or PIP).
- 4) Cognitive Expertise: Taking an MOC examination every 10 years: All of the CME and SA and PIP requirements must be completed before taking the examination.

The specific content needed for MOC depends on the year of the original MOC certification or recertification. Physicians certified 2005 or earlier are subject to slightly different requirements (270 CME credits over 10 years) than physicians

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Teaching Day Review: Maintenance of Certification, Electronic Prescribing and Private Practice

By: Karl Kessler, MD—Program Coordinator (continued from pg. 3)

certified or recertified 2006-2011 (300 CME credits over 10 years, but 150 credits must be obtained in the 5 years before taking the examination). Those physicians certified or recertified in 2012 or later are subject to yet a different program, called Continuous Maintenance of Certification (C-MOC). For C-MOC, specific MOC activities must be completed within every three-year period, apparently so that clinical skills are kept up to date and medical education is not postponed until the end of the 10 year certification period.

Each state has its own requirements for maintaining a medical license, but in most, if not all, cases, meeting the ABPN MOC program will fulfill the requirements for state maintenance of licensure.

The pass rate for those taking the exam the first time is approximately 70%. The pass rate for any subsequent examinations is greater than 90%. Beginning in 2016, a Patient Safety Course requirement will be added to the MOC.

At first glance, the MOC process is complicated and demanding. Complaints from physicians have resulted in some changes that attempt to simplify and rationalize the process. For example, the Feedback Module component of the PIP will become optional beginning in 2016.

Personal record keeping can be done through the ABPN "Folio Program," which requires an annual fee and can be found on the ABPN web site. This program keeps a record of your educational activities. If you remain enrolled in the Folio Program, there is no fee to take the exam every 10 years.

The ABPN website (www.abpn.com) includes information about the whole process of MOC and recertification and is the place to start when learning about the MOC requirements. The website also lists proprietary courses that can be used to fulfill the MOC education requirements.

Electronic Prescribing and Patient Disclosure

For the second presentation, attorney Rachel Fernbach, Deputy Director and Assistant General Counsel of New York State Psychiatric Association, talked about Mandatory Electronic Prescribing (e-prescribing) and some new physician disclosure requirements. Mandatory e-prescribing is part of the NY State Internet System for Tracking Over-Prescribing (I-STOP) law, which

was intended to reduce the abuse of controlled substances, especially opiates.

Passage of I-STOP was given impetus by the robbery of Haven Drugs in Medford, New York in June 2011, which was a particularly gruesome example of the many robberies of pharmacies by prescription drug addicts. It was carried out by a couple who were looking to steal opiates to satisfy their addiction. The robbery resulted in the murder of four people and the theft of 11,000 tablets of hydrocodone. Electronic prescribing is intended to reduce the abuse of prescription medications by preventing the alteration, forgery, or theft of paper prescriptions, as well as allowing better monitoring of the prescribing of controlled substances.

All electronic medical records systems already allow for e-prescribing of non-controlled substances and many now allow e-prescribing of controlled substances. In New York, The Bureau of Narcotic Enforcement of the Department of Health regulates controlled substance prescriptions and the Office of Professions of the Department of Education regulates prescriptions of non-controlled substances. For prescribing controlled substances, a prescriber must use prescribing software that satisfies the security requirements mandated by the Federal DEA and then register it with the NY Department of Health through the Registration for Official Prescriptions and E-Prescribing Systems (ROPES) application to be found on their website. The ROBES application can be found on the Health Commerce System website (part of the Dept. of Health). The date for mandatory electronic prescribing in New York was moved from March 2015 to March 27, 2016, because too many prescribers were unprepared for electronic prescribing.

Registration for e-prescribing includes identity verification ("identity proofing") of each prescriber through name, address, date of birth, Social Security number, active credit card number and their drivers license number.

Once an account has been established, each e-prescription must be created using a "2-factor authentication." For the prescriber, this includes a password to enter the prescribing site and a numeric code or biometric identity identifier. Biometric identifiers, such as a fingerprint, are rarely used at this point. The numeric code can be received over the internet using an application ("software token") on a computer or smart phone, or it can be

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Mental Health in Family Medicine—A Commentary By: Tony Stern, M.D.

A BRIDGE BETWEEN WORLDS

A COLLABORATIVE CARE PHILOSOPHY:

CONNECTIONS BETWEEN MENTAL HEALTH CARE AND PRIMARY CARE

What is the relation between the worlds of psychiatry and general medicine? The former stresses the less concrete reality of the mind, and family medicine has a greater focus on the more concrete facts of the body.

The Jewish philosopher Martin Buber writes, *“Our faith has our humanity as its foundation and our humanity has our faith as its foundation.”* What an evocative reminder. For those of us inclined toward faith, Buber nudges us to ponder how fully our humanity plays a role in it, and for those of us identified strongly with our humanity, he invites us to consider faith as more meaningful than we might have realized. Paradox is alive in Buber’s brief words, as it often is when we stand at the threshold of wisdom. An aphorism like this one deserves the same kind of reading and re-reading as a good poem. When we honor it with our soulful attention, we can play with its reverberations and mull over its multiple potential meanings and implications. I have made a beginning to that happy task, and what follows are reflections that are the outcome.

Trees draw their life from both sunlight and the soil; symbolically speaking, human beings are no different. As doctors we draw from the “light” of faith, whatever the specific beliefs we hold. For example, when we keep hope alive for our patients at their most dire moments, we lean on a kind of faith in the unknown, in things unseen. But this hope, this faith, also draws from our humanity in action, our kindness and patience and ongoing work with the known world in countless situations, past and present. The “soil” of nitty-gritty clinical experience gives us reason to hope—we have all been surprised at times by an unexpected healing or an unanticipated step toward acceptance and peace. Our simple humanness also gives us the very power to be present in a hopeful stance. The ability to present, as well as our perspective on these down-to-earth situations, draws in turn from our ever-renewed sense of meaning and higher purpose.

In other words, the stance of strength that we provide for our patients has an intangible, immeasurable, unworldly aspect that is faith, or a quality closely allied to faith. It also has a more tangible and worldly aspect to it, which is our humanity, or a quality intimately connected to our humanity. In this light, Buber’s

words can be read to imply that our sense of meaning relies on our concrete life, and our concrete life depends upon our sense of meaning. For some doctors and patients, this also suggests that the worlds of religion and medical science balance and bolster each other in complementary ways. For others, it would be more accurate to speak of the underlying connection between the spiritual and secular domains. In any case, the uncanny mutuality described by Buber points to a reality of two salutary tendencies mutually embedded in each other, or even as the Mobius strip that seems like it has two sides, but has only one side in reality.

Buber’s most famous insight is the distinction between “I-Thou” and “I-It,” and his aphorism about faith and humanity can be seen in these terms. When we bring our hearts in unreserved sincerity to the world, we are relating in an “I-Thou” way, and the world tends to reveal itself in kind, approaching in profound depths of contact and connection. When we bring our rational and reticent minds to the world, we have set up an “I-It” relation, which keeps our relationship to it well-boundaried, fully on the surface of using means to achieve particular ends. Our faith and our humanity can both contribute in their own ways to the sincerity of the heart and thus to “I-Thou.” We all need a balance between “I-Thou” and “I-It” modes of being, between relation and wholehearted engagement vs. distance and analytical detachment. But our culture today often limits the “I-Thou” connection mode too severely, keeping us in our minds and on the surface of the world.

This brings us full circle. “I-Thou” is the place of true relationship; it is also the single shared strength of mental health disciplines and primary care as compared with other medical specialties. The power of relationship has always existed as the bridge between different worlds as well as an essential, often neglected element in healing and comforting our patients.

As countless primary care doctors emphasize, “It’s about the relationship.” The work of family doctors and mental health providers alike has the relationship with the patient at its center. Whenever this relationship plays a role in healing, the heart is close at hand, and thus the wellspring of “I-Thou” is present too.

Teaching Day Review: Maintenance of Certification, Electronic Prescribing and Private Practice

By: Karl Kessler, MD—Program Coordinator (continued from pg. 4)

received over a special receiver (“hardware token”) supplied by the e-prescription software vendor, which is used solely for that purpose. The numeric code is then entered into the controlled substance prescription.

Written prescriptions will still be honored if there is a temporary technical or electronic failure or if e-prescribing will cause “an adverse impact on a patient’s condition.” Written prescriptions can also be used if the dispensing pharmacy is outside of New York State. This includes out-of-state mail-order pharmacies.

A physician can obtain a waiver from the e-prescribing program because of economic hardship or technological limitations or “other exceptional circumstances.” All waivers are for one year, after which a prescriber must apply for a renewal.

There is concern over the possible problems of electronic connections between prescribers and pharmacies. A pharmacy must be individually paired with each electronic prescription. If there is a problem with the patient obtaining the prescription sent to one pharmacy, the prescription must be cancelled and a new prescription will be sent to a different pharmacy. All of such time consuming steps could be avoided if a central electronic storage site were established where prescriptions can be sent and which can then be logged on to from the pharmacy to “drawdown” the prescriptions. Such a site has been proposed by NY legislators.

The second part of Ms. Fernbach’s presentation concerned the **patient disclosure requirements** that are part of the NY Public Health Law Section 24, the “Surprise Medical Bill Law,” which became effective March 31, 2015. This law is an effort to stop the occurrence of “surprise medical bills,” where the patient is not

aware that care was received from out-of-network providers. These bills are often for substantial amounts of money, which the patient did not know would not be covered by their insurance, hence the “surprise.” These provisions especially apply to hospitals and outpatient treatment centers, but certain provisions also apply to individual physicians.

A physician or other health care professional is required to disclose to patients or prospective patients the following information:

- 1) The health plans in which the health care professional is a participating provider.
- 2) The hospitals with which the health care professional is affiliated.
- 3) That the amount or estimated amount that the health care professional will bill the patient for health care services is available upon request if the health care professional does not participate with a patient’s or prospective patient’s health plan.

Private Practice

The third presentation on Teaching Day was about “**Starting and Maintaining a Private Practice**,” by Dr. Jose Vito, President of the New York County Psychiatric Society. Dr. Vito gave a good deal of practical advice on the subject. Of particular interest was his advice regarding the formation of an LLC (Limited Liability Corporation) or a PLLC (Professional Limited Liability Corporation). As an indication about the business and legal complexities of private practice, he also recommended getting a tax advisor and a legal advisor. ■

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Mental Health in Family Medicine—A Commentary By: Tony Stern, M.D.

A BRIDGE BETWEEN WORLDS

A COLLABORATIVE CARE PHILOSOPHY:

CONNECTIONS BETWEEN MENTAL HEALTH CARE AND PRIMARY CARE

(continued from page 7)

I would be remiss if I failed to mention one other word that is quite central to this discussion. When we speak of “relationship” or we invoke associated phrases like “rapport-building” or “the therapeutic alliance,” we are ultimately, in our own way, referring to that four letter word “love.” We doctors, like all soldiers on the front lines, can be quite uncomfortable with such tender language. Thus we describe the benefits and other dimensions of love using more clinical terms, which may well be fitting for our role. But whatever we call it, psychotherapy research has revealed again and again the power of relationships as the major impetus for healing across various practitioners and spanning many schools of therapy; a fuller view of this power not only tracks the scientific literature about it, but also keeps the teachings about love in the great religions and philosophies of the world in mind. Clinical medicine has always stood at the crossroads between the sciences and culture as a whole, and we should not be ashamed of this fact.

With love in the picture, we can read the Buber saying in another way, seeing in it an implied glimmer of truth about this remarkable fact of human existence: “Our unworldly love relies on our worldly love, and out worldly love on our unworldly love.” Our faith has ties to a spark or hope or reality that lives beyond the world as we routinely know it; one might even say that faith is that spark. Our humanity is grounded in the world and the individuals and pursuits of this world that we know and love well.

To love a possibility beyond the things we see and to love the world we do see: these two loves depend on each other. They intertwine with each other and resonate with all we have mentioned above. The dynamic between them is two worlds working well together, helping in the healing endeavor and enriching our lives as providers of care, as receivers of this care, and in a multitude of ways that affect our life in the medical field and beyond it. ■

Treating Students Away at College - Could You? Should You?

By: Professional Risk Management Services, Inc. (PRMS)

Summer is rapidly coming to an end and many of you have patients who will be heading off to college for the first time. What should you do about the patient who is leaving the area and asks that you continue treating her while she is away at school? On the one hand, it may seem like a very logical thing to do. You know this patient and she trusts you. You have been making excellent progress since you began treating her so why would you want to end the treatment relationship now? Because 1) it may not be legal to continue to treat, and 2) it may not really be in your patient's best interest.

Begin by talking to your patient (and if appropriate, your patient's family) about her needs and expectations for ongoing care. Will the patient be just a short distance away and able to come back for regular appointments or will she be in another state and unable to be seen in your office except during school holidays? Are you doing medication management only or are you also providing therapy to a patient? If the latter, how does

the patient perceive this will be conducted?

Licensure and Other Legal Issues

If your patient is going to be attending school in another state, you will need to consider the issue of licensure. Remember, treatment is deemed to occur where the patient is physically located at the time of treatment. Once you have a clear idea of how you intend to manage your patient remotely, contact the licensing board in the state where your patient will be attending school and ask about the need for additional licensure. Each state varies a bit on this issue so whether you are required to have a local license may depend on expected frequency and the nature of your contact with the patient. Be as precise about your intended treatment as you can so that the individual you communicate with at the licensing board has a clear understanding of what you are planning to do. It's preferable that you communicate via email so that your proposed treatment

Treating Students Away at College - Could You? Should You?

By: Professional Risk Management Services, Inc. (PRMS)

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is permissible without an additional license, make a note of the person with whom you spoke, the date, the time, and content of the conversation in case it's needed at a later date. Consider also contacting your own state board to verify you are not violating any of its rules.

In addition to ensuring that you are appropriately licensed, you will make need to make certain that you are complying with the relevant laws and regulations of each state. There may be specific requirements related to remote treatment such as the need for an in-person exam before prescribing, type of equipment used, necessary additional documentation, etc. Before undertaking remote treatment, familiarize yourself with each state's requirements and determine whether you will be able to meet them.

Standard of Care

Assuming that Licensure is not an issue — either because your patient is in-state or an additional license is not required, consider whether you will be able to meet the standard of care remotely. The standard of care for treating a patient at a distance is exactly the same as it would be were you seeing the patient in your office. Depending upon your mode of communication, there are lost abilities that must be considered. For example, if you are communicating via telephone, you lose the abilities of sight and smell. Video-conferencing to some extent restores your ability to see the patient but you may miss

things such as the development of a tremor or weight-loss. In all remote treatment, you will likely lose your "sixth sense" - the ability you've developed through the use of all your senses to just know something is wrong when you see a patient.

There are also practical issues to consider. For example, how would you assist the patient in a crisis? Do you know what emergency services are available at your patient's location and how to contact them? What would you do if your patient had a reaction to a medication you prescribed? Would time differences make it difficult to communicate on a regular basis? Will your patient be able to find a private location to have a meaningful exchange?

College is an exciting time but it can also be stressful. Being away from home for the first time with the stresses of trying to fit in socially and the pressure to succeed academically can trigger new mental health issues and intensify existing ones. Depending upon the nature of your patient's illness and her level of stability, you may determine that what is truly in her best interest is to be connected to a local psychiatrist who can more immediately respond to her needs. ■

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Message From Our Incoming President—Psychiatry: Where we have been, but where are we going? (continued from pg. 2)

By: Barbara Goldblum, MD

At a time when so much of the practice of true, fundamentally humanistic and interpersonal medicine is being eroded by managed care, insurance nibbling at every service code, machine take-over of the doctor-patient relationship with the electronic requirements, business institutionalization and take-over of the medical model, what is not different is that we take care of patients who have illnesses of the psyche with symptoms and behaviors that are viewed by society as abnormal. These un-medical insertions into our practices are just jagged points on

a time line that I hope will be dislodged, replaced with points that allow for increased separation from social issues and increased mental health access for all.

Thinking about walking through those ancient ruins that provided hope and healing 1,800 years ago, I hope we continue in the direction of Galen's humanistic mode, with added mental health care access for all in need, with separation from the business model of medicine, and removal of social and political intrusions. ■

Ann Hassell Appelbaum, M.D.

A Motherly Doctor and a Doctorly Mother

psychiatrist, psychoanalyst, mother, wife

b 1924 - d 2015

By: Karen G. Gennaro, M.D.

I heard that at one time 30% of all US psychiatrists had been trained at New York Hospital Cornell Medical Center, affectionately known as Bloomingdale's. And many psychiatrists were trained by Ann Appelbaum, who at one time concurrently ran two inpatient units, unheard of in that generation, under the medical director Dick Munich.

I'm writing this column today for myself and others who would like to remember Ann Appelbaum who was aptly described by her son at her memorial service as 'A Motherly Doctor and a Doctorly Mother'. I was her advisee, analyst and admirer.

My intent is to share the flavor of her memorial service with you. It took place on June 23, 2015 at the Columbia University Medical Center Faculty Club. Perhaps you knew Ann, were trained by her, read her articles and books or heard her lecture. But if you didn't know her, I urge you to read on and allow yourself to be inspired by the life of this remarkable woman.

Ann Appelbaum completed her residency in adult and child psychiatry at the Menninger Clinic. She then completed both adult and child psychoanalytic training at the Topeka Institute of Psychoanalysis. Her interest was in treating psychotic and borderline patients and linking pathology to developmental issues. Her writing included papers addressing basic concerns like motivation, the concept of change, bonding, the nature of psychotherapy, going beyond words and a courageous disclosure about a reaction to her own pregnancy. She believed firmly that patients needed, above all, to feel comfortable and at ease in their therapy. She found the tiniest positive traits to illuminate in these very impaired patients. She worked at the Menninger clinic for 25 years, lived in Kansas City with her first husband Steve Appelbaum until that marriage ended, worked at NYH Cornell Medical Center in White Plains from 1980-1995 and then worked in private practice and focused on psychotherapy research and writing.

Her memorial service included speakers who were her supervisees, students, friends and family. These included Eric Marcus, Irv Rosen, Diana Diamond, Frank Yeomans, Martin Leichtman, Glen Gabbard, Karen Chase, Nathan Szajnberg,

Otto Kernberg and Eric Nicholas. I'll weave their comments alongside mine, knowing her as an advisee and analyst. Hopefully you'll see a glimpse of her life unfold throughout this article and know why she was so admired and cherished by everyone whose life she touched.

Eric Marcus described Ann's commitment to treating the seriously mentally ill and her special way of connecting with psychotic patients which created the vital framework within which therapeutic work could happen. Eric was one of Ann's students, and he credits her with instilling in him this nonverbal ability that she had deep within her soul to respect and connect with very ill patients, a sensibility he now tries to pass on to the current generation of residents. He said, "she was indomitable!" Eric then read out loud her surviving husband Herb Schlesinger's dedication to her in his last book: *"To my Ann Hassell Appelbaum, whose sweetness and patience are exceeded only by her good judgment."*

One of Ann's dear friends, **Irv Rosen**, was a contemporary of hers studying at the Menninger clinic over 50 years ago. His memorial was read by Ann's daughter, Brooks. Irv described Ann's insatiable search for knowledge, her ability to see the world through a psychological prism, her willingness to challenge 'pompous and highly placed icons,' her mastery of the simple declarative sentence, her lucid straight forward writing, her crisp speech and her ability to command the best of herself and everyone around her. Irv described her scorn of mediocracy and at the same time her streak of playful hilarity. Irv remembered the Menninger tradition of an annual production of the *Freudian Follies* and the year Ann sang a scathing tune about Masters and Johnson's mathematical approach to human sexuality, 'There's No Love in this Unlovely Book!', to the tune of Rodgers and Hammerstein's song from *South Pacific* 'I'm in Love with a Wonderful Guy.' Irv stated that Ann married two bright psychologists, Steve Appelbaum and Herb Schlesinger, and that "those two wonderful guys were, in their sequence, in love with a wonderful girl".

Diana Diamond spoke of how Ann fostered her own development as a writer and a scholar. She said that Ann would

Ann Hassell Appelbaum, M.D. (continued from previous pg.)

have surely resisted this memorial service because she was so modest, all her life focusing instead on the achievements and development of others. Diana described Ann's exuberance, creativity and courage at each stage of her life, and told the story of Ann riding her bicycle from Los Angeles to San Francisco when she was accepted to medical school, both feats being very unusual for a woman at that time. Diana went on to describe Ann as the only woman she knew who consulted with Wilhelm Reich and had the experience of being in an Orgone box. Dianan then noted that Ann bore twins in her late 30's and continued a vigorous career in psychoanalytic research, decades before that concept had become friendly. Diana described how Ann drew inspiration for her work from multiple sources including philosophers, musicians, writers and family members.

She was spontaneous in her joy of life. **Frank Yeomans**, her assistant unit chief at the time, shared a story about her belief in 'moral treatment', shared humanity, comradery and respect for others and how she practiced what she believed. Frank described the yearly outings Ann organized for the inpatients from the hospital (renting two large yellow buses, one driven by herself and the other by her assistant unit chief) for a day of fun and frolic at Jones Beach when staff and patients swam together. Frank stated Ann was never a friend of the complacent.

She prided herself in teaching and mentoring. **Glen Gabbard** described how Ann encouraged him to make his first presentation (on stage fright) and then insisting that he write it up, encouraging him all along the way. Glen had never fancied himself a writer and he said he had no intention of ever becoming an academic or a writer, however Ann truly believed in him and she was relentless. Ann insisted that he submit the paper to the International Journal of Psychoanalysis. When Glen questioned that anyone would have an interest in what he had to say, she said "of course they will, and your ideas will make the IJP a better journal!" Glen said he was flabbergasted when the paper was accepted. Glen credits Ann with instilling in him a confidence in his writing that he had always lacked. Glen then went on to write 350 peer reviewed articles as well as author or edit 37 books. And when he became the first non-British editor of that same journal which gave him his start as a published author, Glen said he called Ann to thank her for believing in him and encouraging him. He said Ann had a knack for seeing potential in her students and supervisees that they themselves could not see and he will be forever grateful for her believing that he had what it takes to make meaningful contributions to the literature.

Ann was a poet and she had a poet in residence, **Karen Chase**, work with her patients on the inpatient unit at NY Hospital. Ann was exposed to poetry early as her mother recited poetry of the masters outloud throughout her childhood. Ann was very close to her mother across all her epochs, taking care of her mother as they lived together in the Gate House on the grounds of the hospital. Ann referenced her mother as one of her icons in the poem she wrote on the occasion of her own 70th birthday, placing her mother alongside Linus Pauling, Bertrand Russell, Pablo Casals, Andres Segovia and Karl Menninger. (This poem, entitled 'Septuagenerian Celebrant', which makes reference to her beloved surviving husband Herb Schlessinger with whom she shared a love of water, is also printed in this newsletter, on pg. 14.)

She had a love of nature and fought for justice. For years, NYH has considered ways to earn income from its 300 wooded acres of prime White Plains property, a treasured Frederick Law Olmstead landscape. **Otto Kremberg** remembered Ann being the first one to the microphone objecting to the perceived misuse of the land in one of the town hall meetings. Otto also recalled her discontent regarding many social ills and injustices and that she spoke her mind clearly and often. Otto referred to her as a brilliant intellectual, a sharp thinker and an excellent writer with a passion and intensity that was illuminating. Otto had asked her to edit his later papers and credits her with making his concepts clearer. Otto said Ann was an active participant and key member of the Personality Disorder Institute at NY Hospital Cornell Medical Center. She le the supportive arm of The Comparative Psychotherapy Research Project which randomized borderline personality disordered patients to supportive, DBT and transference focused psychotherapy. One of Ann's late life achievements included a book which manualized supportive psychotherapy.

Ann's son **Eric Nicholas** commented on the relative paucity of Ann's writing compared to her nurturing the writing careers of others, as well as editing Otto Kremberg's later papers. Eric said she was burdened by her son Kathryn Hepburn like beauty, professed scorn for mere physical appearance, but did love it in art. Her cultural heroes included Goethe, Bach, Joyce, Mozart, Yates, Erikson, Piaget, Karl Menninger, Oliver Sachs, Shakespeare and Freud. Eric said he and his sister Brooks were troubled that their mother's top heroes were all male, noting her preference for Bob Dylan and William Faulkner over Joannie Mitchell and Virginia Wolfe. Eric recalled her urging her own

children to help improve society and to help women not subordinate themselves to men, as she felt she had. Eric described likely contributors to his mother's sense of herself — an aloof mother, an alcoholic father and her little brother's death in childhood. Eric said that Ann kept a marvelous journal of her own children's early years which showed the analyst and the mother so entwined as to almost converge. He said that in her later years she wrote a book of letters to her young granddaughters' older selves because she knew she would not live long enough to see them mature. And he shared Ann's journal entry from 2008, 'Grandma's Lecture on Feminine Rage', written for her granddaughter on the occasion of her becoming angry at her tiny step brother:

"I hope, Penelope, that you will never lose the capacity to look

formidable and use the full power of your voice if necessary to see that you are always treated fairly. Don't let anyone question your right to rage when treated wrongly. In time you will learn to forgive people, to understand why they misbehave, to overlook unimportant transgressions, but you need to keep that core of white hot indignation for when it's needed!"

Ann suffered with Parkinson's disease but continued to write, teach and see patients even as the illness progressed. She sought to maximize her mental and physical capacities by engaging in cutting edge treatments including neuro feedback, breathing techniques, Feldenkrais method for physical endurance, herbal treatments and pharmacology. She squeezed every bit of potential from her 91 years of living and her family, colleagues, students and patients are all the better for it. ■

SEPTUAGENARIAN CELEBRANT

by Ann Hassell Appelbaum, M.D. (Rev) 10/18/94
b 1924 - d 2015

They've been out there beyond the breakwater for a long time —
Linus Pauling, Bertie Russell, Casals, Segovia —
Karl Menninger — my mother —

splashing about
shaking briny drops from their ears
waving skinny arms, shouting.

I've been glancing out toward the glitter of their spectacles
now and again for years

(as waves shoulder in from beyond where the old ones play,
waves hunching themselves, gathering themselves up
for the final lift

and break
with just enough randomness to inflict on the heart
the faintest dread:
What if the next wave doesn't come?)

But out there the old ones are insouciant
They infect us with their nonchalance
and why not? They keep hollering
It's good out here — the farther out the better!

And you, holding my hand over the stony shallows,
us steadying each other in the surf,
we're becoming ancient sirens ourselves
saucy, irreverent, naked
heading for the seas beyond the breakwater
hollering to the young ones to swim out.



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