The Westchester Psychiatrist

A quarterly publication of the Psychiatric Society of Westchester County

Winter 2015

Message From Our President—Diagnosis: S-PTSD

Carlo Bayrakdarian, M.D.

This new term stands for "Silent - Post Traumatic Stress Disorder." Silent, because the voice of the traumatized is muffled, and the cry of their pain falling upon deaf ears.

The symptoms of S-PTSD are elicited by replaying the devastating events repeatedly and over a prolonged period of time; the main symptoms being shame and fear, followed by despair and disdain:

Shame for being ridiculed, for not being able to defend oneself against the aggressor; shame for having trusted the aggressor, who had initially presented himself as a protector; and shame for not being able to provide and protect for one's family and property respectively.

But it is the fear that is the most debilitating symptom - fear of retribution from the new protector, fear of retribution from the descendants of the aggressor, and fear of the chronic fear itself, crippling the already suffering victim.

This term was coined recently, in commemoration of one hundred years of silence: the silence of a population badly scarred by the catastrophic events of the 1915 Armenian massacres. Twenty five years later, when his advisers told him that the German people will suffer in the future for what he is doing in the present to the Jews and other undesirable minorities, Hitler's response was, "Nonsense, who remembers the Aremenians today?"

Following the event, this very systematic extermination of over on and half million Armenians by the Ottoman Turks under the guise of WWI, Raphael Lemkin (the Polish-Jewish jurist) coined the term "Genocide" - impunity thereof paving the way to the Jewish Holocaust and the rest of the twenty-first century Genocides in Cambodia, Rwanda, Yugoslavia, and Darfur.

When explaining the causes and symptoms of S-PTSD, my great grandfather, Anania, comes to mind. He was famously known as "Sepastatsi Keri," or the "uncle from Sepastia." Although I never met him, I have seen his pictures in our family albums. I have listened to his story - a story that my mother, his granddaughter, made sure I remembered and passed on to my children, so that they in turn could tell their children and grandchildren.

Anania was born and raised in Sepastia, Armenian Cilicia (currently Siva, Turkey), and was throughout his life a devoted nationalist who staunchly protected the interests of his Armenian heritage - a passion that he instilled in his four children, too, my grandfather being one of them. While living in Sepastia, he owned a coffee shop where Armenian intellectuals routinely gathered. He also organized and spearheaded the athletic club for the local Armenian youth.

During the Armenian Genocide, Amania joined the ranks of the underground resitance to fight against its perpetrators. There were reports in circulation that spoke of Turks paying off their soldiers, along with rebel Kurds, with orders to kidnap young girls from neighboring Armenian towns and villages and cherry pick the beautiful ones. These terrified and traumatized children

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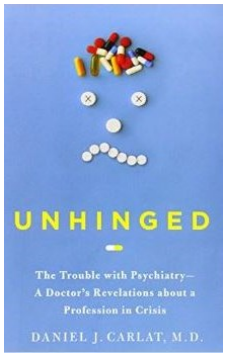
A Critical Review of Contemporary Psychiatry: A Review of Unhinged by Daniel Carlat

[The Free Press (2010), 256 Pages

By: Karl Kessler, M.D.



"Unhinged" is psychiatrist Daniel Carlat's very personal and very critical review of contemporary psychiatry. It is subtitled "The Trouble with Psychiatry: A Doctor's Revelations about a Profession in Crisis." The book begins with Carlat's history of his own training in Psychiatry, which exposed him to the claims and shortcomings of mental health treatment. He feels that much of his medical school education was unnecessary for the practice of psychiatry, which his psychiatry residency gave him inadequate training in psychology and psychotherapy. About his residency training in the 1990s and his experience as a teacher in the subsequent decase, he states, "… the main thing that you learn in psychiatric residency, then or now, is how to write prescriptions." Although he believes in the potential benefits of psychopharmacology, he is critical of the exaggerated claims often made for its efficacy. He laments the fact that psychiatry claims to know more than it really does. It psychiatry were more honest, it would admit that the reasons efficiency of most psychiatric medications are not known. Another example he gives is the commonly held concept that mental illnesses are caused by "a chemical inbalance," but unfortunately this chemical imbalance has not yet been discovered.

Carlat moves on to analyze several other areas in psychiatry to demonstrate the crisis in the profession. These include the DSM-5, the supremacy of medications over therapy and how money from the pharmaceutical industry has corrupted the profession. He has strong opinions, such as "… psychiatry has become a proving ground for outrageous manipulation of science in the service of profit." He names the names of those that he feels have subverted the profession, such is Dr. Joseph Biederman of Massachusetts General Hospital. His supporting evidence does not contain revelations, but rather marshals public information to make a cogent and well-written argument. He laments the fact that psychiatrists are losing the ability to practice psychotherapy, which he calls "The Missing Skill."

He summarizes that "The essential problem with psychiatry is that it is hyper focused on psychopharmacology at the expense of other effective techniques. Any solution must lead to mental health practitioners who can expertly decide what the best treatment is for a particular patient and then implemented that treatment." After looking at several alternatives for training psychiatrists, he concludes that perhaps "two years of combined medical and psychological courses, followed by three years of psychiatric residency" would be better than the training we have today. It is questionable whether moving psychiatry farther away from the field of medicine would be beneficial for our field or for our patients. But every psychiatrist would do well to read this well-written book and ponder the problems that are facing our profession. ■

Editor's Column: EPCS - Not So Controversial

By: Jerry Liebowitz, M.D.

The procrastinators were lucky this time! As we were going to press, Governor Cuomo signed legislation to postpone mandatory e-prescribing (which was supposed to go into effect this March 27th) until next year. Many physicians in large medical groups or on large hospital staffs, supported by the APA and the AMA, had requested the delay in implementation to give them more time to get ready.

Nevertheless, many psychiatrists, especially those of us in solo practices, went ahead and signed up for e-prescribing, including EPCS (electronic prescribing of controlled substances).

I had already started with an electronic health records (EHR) program last summer, one that included electronic prescribing of non-controlled substances. I found that part especially helpful, reducing long "hold" times listening to the same music (CVS) or repeated messages. So, once I found out that many local pharmacies were ready to accept EPCS, I decided to sign up. The process was a relatively easy one, and I was ready to go, special token and all, two days before Thanksgiving, which my wife and I were spending in LA and Jacob's Tree National Park

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were snatched away from their families, packed together, and treated like cattle for purposes of slavery. While the massacres were in full swing, Anania was entrusted with the mission of freeing these young girls.

The news of the liberation of hundreds of kidnapped girls by my great grandfather travelled fast to the far reaches of Cilicia and beyond. Anania became a hero figure overnight and thus nicknamed "Sepastatsi Keri".

This infuriated the Ottoman authorities, who ordered his capturing… sadly succeeding in their villainous quest. He was tortured and left for dead in a mass grave with other innocent civilians. With only divine intervention he would escape a certain death and miraculously survive to tell his ordeal. When he came to his senses and realized his whereabouts, he crawled out of the pit during the night and escaped his captors by hanging on to the axle of a horse drawn wagon. He reached safety by traveling on foot during the night while hiding during the day. For the rest of his life he bore the marks of his torturers: horseshoe shape scars all over his back, the result of sizzled red hot iron imprints.

This trauma did not just permanently scar Anania physically, but mentally and emotionally. For the rest of his life, the mere mention of the word "Tadjik," synonum for Turk, would trigger vivid memories and visions of the brutal savagery he and his people endured, as well as feelings of overwhelming despair and disdain.

Today, I still think about the girls rescued by my great grandfather. I do not know how many survived, nor whether they are still alive, but I wonder how they, and the thousands of survivors of the Armenian Genocide lived after the massacres were over. What physical and mental scars did they try and conceal? I cannot even begin to imagine, but if you read this story and you know of anyone that fits the profile, make sure you think about the diagnosis of S-PTSD, remember all the Genocides of the twenty-first century, the case of my Sepastatsi Keri, and the beautiful girls. Never Again. ■

Editor's Column: EPCS - Not So Controversial (continued from page 2)

with our daughter and son-in-law - and for which I was unable to arrange any coverage. So, with trepidation and cellphone and iPad intact, I was off!

When they announced that JetBlue offered free Wi-Fi onboard, I decided to check my email. A patient, who did not know that I would be out of town, needed a refill prescription for a controlled substance and requested that I leave it on my office door for her to pick up later that afternoon (a common practice for patients I did not yet need to see again). I wrote back that I was on my way to California and would try prescribing electronically after I landed. (Although I could always call in a five-day supply, she was going away for a week.) Then I thought, "Wait a minute. I have free Wi-Fi and my EPCS token is in my carryon bag." I wrote to her to let me know which large chain pharmacy was near here, since I knew that the small pharmacy she usually used was not yet ready for EPCS. She wrote back within minutes - and minutes later, there I was prescribing a controlled medication from 24,000 feet up! And she actually was able to pick up the meds before I landed.

Sine then I have heard from others about the convenience of prescribing electronically. Except for the occasional glitch that requires a return phone call to a pharmacy, it saves considerable time, both for the patients and me - an unintended benefit to what was meant to be a part of the I-Stop program. Covering other doctors when they are away may pose a logistical problem: we will have to enter their patients into our database to prescribe for them. But, in the long run, I expect it to be not as controversial as it originally seemed.

As I wrote in our last newsletter, we want to focus on one (or more) of the controversial issues in psychiatry in each issue. In this current issue, we have a book review from Karl Kessler that focuses on Daniel Carlat's criticism of contemporary psychiatry and we have another thought-provoking opinion piece by Tony Stern, in which he reflects on Jung's concept of "synchronicity" and its implications for modern psychiatry—magical thinking vs. rigid realism.

Please send us your thoughts and experiences. ■

Notes on the Mystery of Life and Magical Thinking: Does the Rational Mind Have the Final Say? - By Tony Stern, M.D.

Trained as we are in medical science, what do we make of Jung's idea of synchronicity? Many of our patients, even the healthier ones, believe in it. Do we? If so, how? Or do we utterly reject this notion as magical thinking? Anyone can become locked in a rigid realism and see all mental phenomena merely as matter, merely as mundane. On the other hand, anyone can become stuck in magical thinking. I hope to shed a bit of light on this topic.

In Zen it is often said that we need to go beyond the distinction between "sacred" and "mundane." In an old Buddhist sutra much beloved in Zen, it is said, "Things are not as they appear, nor are they otherwise." If we remain with the first half, "Things are not as they appear," then we begin to posit two worlds against each other: the world of mundane appearances vs. the world of a deeper reality, and this can be a set-up for getting caught in magical thinking. The fuller statement brings us immediately back to the single world, the present moment, the meeting point between appearance and reality.

The 18th century Zen master Hakuin asked, "What's the sound of one hand clapping?" This points to the reality of a single world, not two worlds, just as there seem to be two hands, but actually… the sound of one hand clapping is the thrust back into the present, the place where the unknown meets the known. "Things are not as they appear" implies that all is sacred, all is mystery. Yes. They *are* not as they appear, yet at the same time "nor are they otherwise": all is as plain as day, too. All is also mundane and explainable.

It's a paradox. Can we learn to hold the tension of these apparently conflicting positions?

Perhaps this is one of the possible meanings of Jesus's saying, "Be ye as wise as serpents and as innocent as doves." To open to the holiness of everyday life, to "Things are not as they appear," relies on a dove-like innocence. To keep the vision of the ordinary, the clarity of "Nor are they otherwise," depends on a serpent-like wisdom.

But the crumpled grocery bag in the corner, as one of countless examples in everyday life: isn't that just a plain old thing, and nothing else? Isn't it one of many, many things that are just ordinary through and through? Or is it, too, inseparable from a more mysterious reality? If we exclude this one thing, or certain things, if we imagine them to be *nothing special*, then *we are equally caught in one half of the paradox* - in this case, not in "Things are not as they appear," but in "nor are they otherwise." We have been unduly swayed by the rational mind's view that all is mundane, all is nothing but matter.

Buber called this "the I-It relationship" in contrast to "the I-Thou" relationship, and he proclaimed that "signs" are happening to us all the time, but that we shut them away from us out of fear of being overwhelmed. It might be said that these signs, the magical moments in our life that Jung called "synchronicity" and M. Scott Peck called "serendipity," are times when the two worlds meet. But it is a bit more accurate to say that they are moments when *the two sides of the world reveal themselves to us as one world*. One world, all-embracing, both holy and ordinary. It is not even too accurate to speak of "two sides," because these two aspects of sacred and mundane essentially interpenetrate each other.

These hints of our single uncanny world, embraced in a spiritual orientation as "signs," "synchronicity" and "serendipity," are pathologized in modern psychiatry by the phrases "delusions of reference" and "ideas of reference." In my own life, I have tried to make sense of such hints or signs since the age of seventeen. At an ashram in Northern India at age eighteen, in 1972, I recall an elderly Dutch man referring to this magical dimension of life by declaring that everything that happens to us contains cosmic significance. Budding young pre-pre-med psychiatrist that I was, not yet even in college, I felt duty-bound to bring some reason to the scene, as he had attached a small crowd who seemed to me like so many naïve children this pied piper was luring to the edge of a cliff, with the yawning abyss of psychosis below. So I stepped up and told him that I knew what he was saying, but that it's a mistake to think that *every* moment is so fraught with meaning.

He suggested we put it to a test. Okay, I was game. I pointed to an old brown grocery bag at the corner of his tent. "That bag. I doubt," I said confidently, "that it has any message of cosmic import anywhere on it." As I walked over to it, I began to grow concerned that it might read, "Grand Union." Who would have won our little contest in this case? But when I turned it around, it read neither "Grand Union" nor "A&P" nor anything else that

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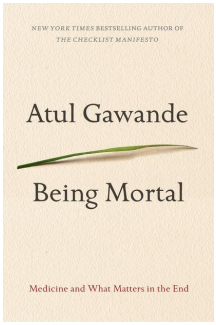
What *Really* Matters in Life: A Review of Being Mortal by Atul Gawande, MD

[Henry Holt and Co., Metropolitan Books (2014), 304 pages]

By: Jennifer Colby, LMSW



In his new book, Being Mortal, Dr. Atul Gawande discusses end of life issues that physicians must address on an increasingly frequent basis. Through anecdotal tales, Gawande explains how in his opinion, the medical profession is losing sight of how people experience the end of life. He believes while advancements in medicine may increase the length of life, physicians ignore what quality that life may have. Therefore Gawande's call to action is for the medical profession to reevaluate how to approach health care. He urges physicians to pause and treat the whole person, not just the chief complaint, even if that hastens the end of life.

The first half of the book explores the way people in industrialized countries currently age. One hundred years ago, concepts like nursing homes or assisted-living did not exist. Those who reached the ripe age of 70 stayed in their family homes, cared for by their 50 year old children. Today, however, parents living into their 80s and 90s are often in need of extensive medical care beyond what can be given at home. Hence the nursing home (and later assisted living) was born. Gawande describes the evolution both facilities, from their altruistic conception to their somewhat regimented existence that is commonplace today. While critical of the regulations both skilled nursing facilities and assisted livings impose on their residents, Gawande admits that there are no easy answers for balancing health related safety concerns and residents' rights to personal freedom of choice.

The second half of the book is a discussion on aggressive treatment as opposed to quality of life. Many times, Gawande believes that end of life conversations between doctors, patients, and families occur too late, or not at all. He urges doctors to explore what matters most in life to their patients before they face a terminal situation and then guide them through treatment should the worst occur. Gawande criticizes what he calls "medical lottery tickets," or aggressive, intrusive, and often painful treatments that may or may not extend life by a few months. By contrast, Gawande is a strong supporter of services like hospice, which will not affirmatively attempt to extend life but may give the patient a better experience during their last days.

"People live longer and better than at any time in history," Gawande writes. "But scientific advances have turned the processes of aging and dying into medical experiences, matters to be managed by health care professionals. And we in the medical world have proved alarmingly unprepared for it." While Gawande offers no concrete solutions to this issue, nor does he discuss the added complication of a dementia diagnosis, he urges physicians to return to their roots of caring for the patient as a whole. His book is a useful tool for those working with people in a state of decline. Although more global in nature, Gawande's professional and personal experiences cause the reader to stop and think about how to best help those struggling with "being mortal" write an empowered ending to their story. ■

[This book review, by Jennifer Colby, LMSW, Social Worker for the Assisted Living Community at Five Star Premier Residences of Yonkers, was submitted for our edification by our President, Carlo Bayrakdarian, MD.]

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Notes on the Mystery of Life and Magical Thinking: Does the Rational Mind Have the Final Say? (continued from page 6)

any reasonable paper bag should have said. Instead were the rather shocking words, "Alpha & Omega." The beginning and the end, as Jesus himself in the Book of Revelation. I confess to a queasy moment of feeling just how weird a place India is and almost muttering to myself, "What kind of crazily weird grocery stores does this country have?" But ultimately it's not India's fault at all. As much as my rational mind resists it, the world itself is the real place that gets a bit weird at times. It is the meeting point between the unknown and the known; our rational faculty is unsettled by the former, and thinks it can conquer this vast territory. It is only reassured with the latter, when the unknown becomes known in its own I-It language.

I can reflect back on my little contest in India and, now that I have done pre-med, gone to medical school, trained in psychiatry, and worked for more than 25 years in the trenches, I now have the great wisdom to add to my original wish to mutter to myself about the outcome this single thought: the old man had a moment of psychotic insight on his side. On a more serious note, I have recently considered the words on the grocery bag, "Alpha and Omega," and felt that it is indeed true, signs seem to occue especially at the beginning and ending of things, at times of great transition.

One simple take-home question that is worthwhile inquiring of ourselves in the dead of night and discussing together in the light of day is contained in the title above: Does the rational mind have the last word on all of our experiences and those of our patients? ■

Psychiatric Ethics and Allegations of Unethical Conduct

By: Jerry Liebowitz, MD

The Psychiatric Society of Westchester and the Bronx District Branch held their annual joint dinner meeting March 11th at the Tre Angelina Restaurant in White Plains. The topic was **"Psychiatric Ethics: Allegations of Unethical Conduct and the APA Process for Makine a Determination of Unethical Behavior."** L. Mark Russakoff, M.D., Chair of the PSW Ethics Committee, and Robert Neal, M.D., Chair of the Bronx Ethics Committee, presented background information and outlined the steps required for handling complaints of unethical behavior against a District Branch member. A lively discussion with pointed questions and answers followed.

Dr. Neal opened with an explanation of what "ethical behavior" means, focusing also on what it is not. Using Mae West's saucy remark - "Between two evils, I always pick the one I never tried before!" - he noted that unethical is not necessarily "bad" or "evil." And then, playing a recording of Richard Nixon's famous "I am not a crook" remark, he pointed out that just because something is legal does not mean it is ethical.

Psychiatrically ethical behavior is defined in the **Principles of Medical Ethics with Annotations for Psychiatry** (which can be downloaded from the APA website at www.psychiatry.org/practice/ethics). This was first published in 1973. The most recent version, updated in 2013, includes changes to the Principles approved by the AMA in 2001. As noted on the APA site: "… these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems."

Dr. Russakoff, using fictional case examples, walked us through the steps with a flowchart. The first step involves determining that the complaint is presented in writing by someone with personal knowledge of the complaint to the appropriate District Branch and that the DB has jurisdiction (that is, the complaint is against a member of the DB and the complaint is less than 10 years old). The next step is the preliminary determination that, if the allegations were true, the complaint would indeed allege a recognized ethics violation as set forth in the Principles. Dr. Russakoff pointed out that this is not a determination on the merits of the complaint. In addition, there must be a signed

Psychiatric Ethics and Allegations of Unethical Conduct (continued from previous page)

By: Jerry Liebowitz, MD

Confidentiality Agreement in which the Complainant agrees that all information and documents concerning the ethical procedures and all communications from the APA and DB, including their ethics committees and Hearing Panels, are confidential and shall be used solely in connection with the ethical proceedings and not for other purposes or legal proceedings, e.g. it cannot be used in a malpractice case.

If all this is in place, a review team is selected to obtain more information (from the complainant and possibly the accused DB member) and determine if, indeed, there seems to be a potential ethical violation. Following this notifications are sent to the APA secretary, the accused member, and the complainant for an exchange of information (concerning the evidence, the principles at issue, and due process rights) at the same time that a Hearing Panel is appointed.

After this, and at any time before a final determination of whether the accused member violated the ethical standards published by the Principles, an Educational Option may be employed to resolve the complaint. In deciding whether to use this approach, the DB's Ethics Committee shall consider such factors as the nature and seriousness of the alleged misconduct and any prior findings or allegations of unethical conduct.

Once a Hearing takes place and the panel determines that an ethical violation has occurred, it must submit its findings, recommendations, and reasoning in writing. (Of course, it is possible that, after all this, no violation is found and the process stops.) After review of the committee's findings by the DB Executive Council and the APA Ethics Committee, appropriate sanctions must be determined. This determination may include consideration of any mitigating or aggravating circumstances such as illness or prior findings of unethical conduct that are relevant to the current violation. The three sanctions, in increasing order of severity, are: reprimand, suspension, and expulsion. If the sanction is either reprimand or suspension, the DB notifies the member of the decision and his right to appeal and notifies the APA ethics office. The complainant is not notified until the appeal concludes or no appeal is filed. If the sanction is expulsion, the most severe outcome, the APA Board of Trustees must be notified and approve the decision. ■

2015-2016 BALLOT

Listed below are the names of the nominees for the 2015-16 year as proposed by the Nominating Committee and accepted by the Executive Council:

☐ Anthony Stern, M.D.	President-Elect
☐ Karl Kessler, M.D.	Secretary
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☐ Richard Altesman, M.D.	APA Representative (2yr term)
☐ Karen Gennaro, M.D.	NYSPA Representative (3yr term)
☐ Sally Ricketts, M.D.	Program Coordinator-Elect
☐ Susan Stabinsky, M.D.	Legislative Representative (3yr term)
☐ Mansukh Bhatty, M.D.	Councilor (2 yr term)

After voting above, please return your Ballot to the Society by fax at (516) 873-2010 or by mail to:
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Please note that Ballots must be received by April 30, 2015 in order to be valid

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New Rochelle: Attractive psychotherapy office available mid-town New Rochelle, F or P/T.
Contact: M. Hollar, MD (914) 576-7735

White Plains: Accessible, desirable spacious full time office in White Plains, right by North White Plains train station in a 3 office suite. Exit 6 off of 287, or Bronx River.
Contact: Joyce (914) 806-6877

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