The Westchester Psychiatrist

A quarterly publication of the Psychiatric Society of Westchester County

Summer 2016

Message From Our President - C. Deborah Cross, M.D.

What The Westchester DB Means to You and to Our Field of Psychiatry

Being President of an APA District Branch is an honor and an obligation. As the incoming president of the Westchester DB for this next year, I have been reflecting on how much the district branches are the heart and soul of the American Psychiatric Association. The Psychiatric Society of Westchester County (PSWC) is one of many district branches, in New York State and across the US. I wonder how many of you reading this think about what your membership in the Westchester DB means both to you and to our field of psychiatry. This time of year, as we receive our dues statement from the national APA organization, is an excellent time to reflect on what our APA does for each of us. In my dues statement this week I received a letter outlining some of the areas that the national APA has been working on over the last year. I want to reiterate a few of the critical issues facing us. In the past year the APA has continued to promote the passage of legislation to not only protect and enforce the gains we have already accomplished in mental health parity, but to expand the scope. Additionally, the APA has worked diligently with CMS to ensure that psychiatrists who are working in the collaborative care model can actually bill for and receive payment for their work. The APA also provides a central place for continuing education and learning and offers a multitude of educational programs; many free to members. The APA is also committed to helping members meet MOC requirements and has worked behind the scenes to help modify some of the more onerous requirements.

But to many of our members, the national APA is an entity that is "far away" and "not relevant." There are two other parts of the APA, however, that are much closer to home and extremely relevant in your day to day practice – the New York State Psychiatric Association (NYSPA) and the Psychiatric Society of Westchester County! I find as I talk to many of our DB members that the work our DB and NYSPA do throughout the year on behalf of our members is a mystery, and yet it impacts our professional activities on a daily basis, from helping to ensure that insurance companies reimburse us fairly and equitably to testifying before the NYS Legislature on bills that directly affect our profession and our patients. I urge each of you to check out the NYS Web page (nyspsych.org) for some of the details regarding lawsuits against insurance companies which NYSPA has brought on behalf of all of us in recent years. Contact them at 516-542-0077, or at centraloffice@nyspsych.org if you need member sign on information.

Our own DB and your Executive Council are very active, both at the State level and in the national APA, and frequently join other APA members to meet with both State legislators and with Congressional representatives, in Washington, Albany and in their home districts to educate and urge lawmakers to adopt

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positions and legislation to support our profession and our patients. In December our DB hosts a local Legislative Brunch (this year it will be on December 4, please join us!) in White Plains where our members have an opportunity to meet and talk with our own local, State and Federal representatives regarding our issues.

Our DB hosts a number of educational events throughout the year (look for upcoming announcements and in this newsletter). I strongly urge each of you to commit yourself to attending these interesting presentations and engage in networking with your colleagues. Our DB is our professional home and being able to meet, and talk with other psychiatrists is a wonderful way to keep up to date on all the exciting activities which the DB, NYSPA and the national APA are working on. I look forward to seeing you and working with all of you this upcoming year and don't hesitate to contact me at any time with thoughts, questions or just to exchange ideas about our wonderful organization. . ■

A Psychiatric Interview Training Exercise: The Non-Disclosing Patient

By: Alexander Lerman, M.D.

Our psychiatry residents are trained to elicit and record a medical history: what symptoms are present, at what duration and severity, and so forth. But what happens when patients fail to disclose their complete history (and how often does any patient disclose a complete history)? This question leads to a non-traditional simulated patient exercise in which, unbeknownst to the interviewer, the actor playing the role of the patient was directed to minimize symptoms and misdirect, driven by a sense of shame and fear of involuntary hospitalization. The rest of the interview unfolded according to the degree to which the interviewer was able to be sympathetic to, as well as aware of, the patient's obfuscation – to follow non-verbal cues, to offer support and direct the patient towards a deeper therapeutic alliance.

The exercise was very popular with the residents, as well as the actors. Even less-successful attempts appeared to offer educational value.

"I totally blew it," one senior resident reported. "I was so focused on getting a complete history in the limited amount of time available that I forgot about the big picture. I learned a lot."

You can see segments of two of the interviews at these links:
https://dl.dropboxusercontent.com/u/71327784/Jazz3.mp4

https://dl.dropboxusercontent.com/u/71327784/Biggie%20Ife%20Oct%2016.mp4

Funding for simulated patient interviews is just one aspect of the reinvigorated atmosphere in the Psychiatry / Behavioral Science Department. We offer a dynamic series of Grand Rounds speakers, open to the professional public. ■

GRAND ROUNDS SCHEDULE - WMC/BEHAVIORAL HEALTH CENTER

11/1/16	William Carpenter, MD - "Thinking about Schizophrenia"
11/15/16	"Disorder of the Quarter"
11/22/16	Case Conference
11/29/16	Stephan Carlson, MD
12/6/16	Alexander Lerman, MD - "Guilt, Glory & Cocaine: Freud's Botanial Monograph Dream"
12/13/16	Jules Ranz, MD - Community Psychiatry
1/10/17	Lawerence Kegeles, MD
1/17/17	Elizabet Rosenthal, MD - "From the Affordable Health Care Act to Universal Health Care in the US"

Please feel free to join us. Call Patty Williamson at (914) 493-1939 for directions.

THE NARROW RIDGE: Insights from Zen, Judaism, and Psychoanalysis

By: Tony Stern, M.D.

The Paradox of Action

"How shall I effectively heal or be healed?" All of us, clinicians, patients, spiritual seekers, and clinicians as patients or seekers, find ourselves asking this "How." It takes a thousand different forms, most of them subliminal, implicit, and inarticulate. "How can I introduce a healing factor into this situation? How can I unearth it? How do I open to what's in front of me or within me right here and now? What's the best move *from* here? How do I begin or to renew my inner journey? How do I assist another to begin, or to find renewal?"

This "How" is inevitable. It is also misled, because it is already a step away from the present, the only place where all aliveness, all renewal, all healing can be found. Strictly speaking, then, to ask "How" is already a hiding place of the mind from the immediacy of "what is." The great Indian philosopher and ex-messiah Krishnamurti was particularly clear on this point. More recently, Eckhart Tolle, in The Power of Now, has hammered home the essentials of Krishnamurti's teaching.

Krishnamurti explored the misstep implied in this question "How" with countless individuals, clusters of visitors, and large audiences, nudging all of them back to "what is" and to the movement of resisting "what is." Stay with "what is" and see your resistance to it, Krishnamurti kept reminding all of us. Resisting "what is," our own pride or pettiness, for instance, we fabricate a future for "what should be" or "what could be." Through moment-by-moment attention to the mind's wish to create "somewhere else" or "sometime else", we let go of psychological time and we discover the uncanny life of the actual here and now. In other words, being aware cannot be directly willed. Our moments of awareness occur when we are aware that we are not aware.

From the age of fourteen, I was a keen student of Krishnamurti's writings, and in 1972, at age seventeen, I heard him speak at Carnegie Hall. In 1984, during my fourth year in medical school, a friend of mine introduced me to this lovely sage at much closer quarters. The friend was the psychoanalyst David Shainberg, who was an active member of the Academy and died at too young an age in the early 90's. Meanwhile, in 1983, another friend contributed a wonderful essay to the seminal collection Awakening the Heart: East/West Approaches to Psychotherapy and the Healing Relationship, edited by John Welwood. This was Diane Shainberg, David's ex-wife. She translated her own contact with Krishnamurti and Zen into a piece that astutely and delicately showed that this "How," this search for concrete answers, can get us bogged down in the clinical setting.

Diane suggested that "What should I do next?" – the central worry on the minds of young psychotherapists – is a hiding place, an evasion of the uncertainty inherent in the here and now. We sometimes answer it much too quickly, just as these trainees are grasping for the "right" answer much too immediately. She proposed that we help our supervisees to sit with the question and to be with the question, and thereby to be in the anxiety-provoking but very real life of the present with their patients. We all know that when we provide a ready response to a supervisee, a patient, or anyone else looking for advice, this may be a premature move impelled by our own anxiety and our own over-determined need to be helpful. How well can our junior colleagues sit with the discomfort of "not knowing"? How well can we? This moment of uncertainty, this moment of truly recognizing and accepting "I don't know," is revered in both Krishnamurti's teaching and Zen, and Diane brought its value forward for the mental health field.

Hiding Places

The over-all goal we have for our patients is to help them lead fuller lives. What does this mean, "to live fully"? I'd like to suggest that above all it means to be in touch with the simple beauty of life and to be up to the demands of life. This is in turn depends on freedom *of* the mind and freedom *from* the mind. Our patients and all of us as well often relinquish our freedom and thereby lose touch with the simple beauty of existence and the work in front of us.

Why do we give up our freedom? From ancient times, all of the spiritual, psychotherapeutic, and psychiatric literature of the world has tried to provide answers to this question. What's implied by what Diane, Krishnamurti, and Zen are saying is that one important factor lies in the fact that we are afraid of the unknown, or our own "not knowing," and therefore we hide in the known. Unwittingly, we often choose either a more rational and scientific or a more heart-centered and spiritual point of view. Neither one alone does justice to the simple beauty and demand of our lives. Separated from the other, both positions by themselves usually reflect and reinforce the mind's effort to gain control over the unknown. Moment to moment, the beauty and requirement of life, the simplicity of the here and now, is a meeting point between the unknown and the known.

In other words, we hide in the known because we want to be in control. Thus we lose our freedom because we as human beings are prone to hide. In Western mythos, the first act of the first mortal Adam was to hide. We are hiding creatures, prone to make one of two mistakes. The first mistake is to hide *in* the world. The second mistake is to hide *from* the world. We often err through some combination of the two. When we have hit a crisis or impasse in our lives, these mistakes are at play, whatever the details of our predicament.

In other words, we can hide from life by being lost in our life situation, or we can hide by partly rejecting our life situation. When we hide *in* the world, spiritual practice becomes helpful and at times essential, to extract us from an entanglement with our life situation and open us to

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THE NARROW RIDGE: Insights from Zen, Judaism, and Psychoanalysis

By: Tony Stern, M.D. (continued from previous page)

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life as a whole. When we hide *from* the world, for explicitly spiritual purposes or otherwise, psychotherapy becomes helpful and sometimes crucial, to re-engage us with our life situation. This interesting dialectic of hiding in the world and from the world is why both spiritual practice and psychotherapy, or at least the energies and ideas animating each of these paths, are such important avenues of healing. Together, these two paths form a relatively complete inner path. Apart, they are less likely to provide an adequate view of our own errors.

One Reality, One World, One Moment

If we move from a consideration of human frailty to a view of reality, we find a complementary paradox. "The two worlds," that of the spirit and that of this material life, are in fact one world. We have separated them through our own habits of hiding, our own patterns of avoidance. Moment to moment, we continue to separate them – subtly, unwittingly, knowing not what we do.

The 20th century Jewish religious thinker Martin Buber spoke of "a narrow ridge" – that to walk the true way means to walk a narrow ridge between abysses. (The 19th century Hasidic rabbi Nahman of Bratzlav described the need in this life to walk fearlessly along a narrow bridge; Buber updated this image for our times.) This walk involves stepping and stepping again on the ground of reality, where the two worlds meet and are one. This narrow ridge is a place of paradox, a place where opposites are often both true. And this ground of reality is the present moment, the meeting point between the unknown and the known, the intangible and the tangible, the immeasurable and the measurable, the sacred and the mundane.

The British poet William Blake put it this way. He said that there is a moment in each day that Satan cannot find. Our own rational minds cannot find it, either. We can only open to it with our hearts and feel into it with our souls. That moment is now. Blake said that it is neither in nor out of time. More recently, another British poet, T.S. Eliot, described the here and now as "the still point of the turning world." Like Blake, he recognized this center as the place of intersection between the timeless and our time-bound existence.

The great 18th century Zen teacher Hakuin was aiming at the same territory as Buber's narrow ridge when he asked the question, "What is the sound of one hand clapping?" We think there are two hands making a sound. But what if there is only one hand? We imagine there are two worlds. But what if there is only one world, at once ordinary and holy, neither in nor out of time?

Being in touch with this subtle truth involves walking on a narrow ridge. It involves a profound engagement that is also a letting go of hiding – of hiding in the world and hiding from the world.

The Realist and the Seeker

I'd like to tell you now about two former patients of mine. Sally is a fifty-five-year-old attorney who is very well-boundaried and has a strong observing ego. When I first saw her, a friend had introduced her to Krishnamurti's teachings a year earlier. But she did not and could not "get" Krishnamurti. She is a hard-nosed realist, and "How" just means "How" to her. And this "How" was indeed meaningful to her when I saw her, because she was depressed, anxious and lonely, beginning to seek deeper answers. Peter is a twenty-six-year-old high school teacher who by nature is much more of a spiritual seeker and more of an artist and a dreamer than Sally. He's been reading Tolle, and he's been loving him. He does "get" the problem with "How." From a strict DSM standpoint, he's a bit bipolar, with schizotypal tendencies. He has fairly loose boundaries. He is not a marijuana abuser, but he almost might as well be, because he acts a little like he is.

In other words, Sally is reasonably neurotic, and Peter is slightly psychotic – or slightly inclined in this direction. She can instinctively relate well to the concrete side of the present moment, but grows anxious with any taste of the limitless sky. She can connect to the present as the only place to act, but she becomes confused when the notion of non-action is introduced. Peter is naturally disposed to "hanging out" in the timeless, but his anxiety rises when faced with time-bound limits. Non-action comes quite easily to him; he finds any serious demand for action somewhat of a strain.

Let us repeat now that to be human is to hide. We all hide from the depth and intensity of the here and now. I said before that the entirety of spiritual and psychotherapeutic literature can be viewed as an effort to understand why we relinquish our freedom. In other words, it is a collection of insights and descriptions of where and how we hide. Let us repeat also that we have two basic hiding places: we hide *in* the world, and we hide *from* the world. In other words, we hide within the details of our life situation, or specific love and work, or we hide within the inner journey itself, looking for the life beyond this life. The Sally in us more easily errs by *hiding in the world*, the Peter in us errs by *hiding from the world*.

These two former patients represent quite well, in the flesh, the two basic tendencies that live in all of us. Sally finds comfort in goal-directed focus, but does not truly know how to relax. Peter can relax, but has trouble with goal-directed focus. The wholeness of the here and now is therefore somewhat lost on both of them. Most of us have similar struggles in one direction or the other. Much of the time, we look upon the wonder of the present in one of two ways: like Sally, as something simple and ordinary, circumscribed as a series of time-bound tasks; or

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Ongoing Challenges in Parity Implementation

By: Jerry Liebowitz, M.D.

Rachel Fernbach, Esq., Deputy Director and Assistant General Counsel New York State Psychiatric Association, discussed "Ongoing Challenges in Parity Implementation" at the Psychiatric Society of Westchester's CME Dinner Meeting on July 13, 2016 at Tre Angelina in White Plains. Her talk helped those attending: to understand federal and state parity laws and how they interact; to recognize ongoing issues in parity implementation, including medical necessity reviews, reimbursement, and network adequacy/access to care; and to be aware of NYSPA's efforts regarding full enforcement and implementation of parity laws.

Overview of Parity Laws

Ms. Fernbach explained the three laws affecting parity in New York State: Timothy's Law, New York Insurance Law, and the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Timothy's Law, New York State's Mental Health Mandate, which went into effect in 2007, applies only to **group (not individual) health plans.** It states that **all employers must provide coverage for 30 in-patient and 20 out-patient days for essentially all mental health diagnoses.** In addition, **large employers only** (50+ employees) **must also provide FULL coverage for biologically based illnesses** – i.e., schizophrenia, psychotic disorders, major depression, bipolar disorders, delusional disorder, panic disorder, OCD, and bulimia/anorexia.

New York Insurance Law [§4303(k) and (l)], which is the mandate regarding **coverage of substance use disorder benefits**, states that group (not individual) health plans must provide a **minimum of 60 days of outpatient visits** for chemical abuse and chemical dependence. There is **no inpatient mandate.**

The **Federal MHPAEA**, which applies to all new plans on or after July 1, 2010, mandates that **financial requirements and treatment limitations imposed on mental health and substance use disorder** (MH/SUD) **benefits must be no more restrictive than financial requirements** (copayments, co-insurance, deductibles, out-of-pocket expenses) **and treatment limitations imposed on medical and surgical benefits** (med/surg). Separate deductibles for MH/SUD benefits are prohibited, even if the amount of the deductible is the same. Any quantitative treatment limitations (QTLs) for MH/SUD – i.e., limits on the number of inpatient days or outpatient visits, as well as any non-quantitative treatment limitations (NQTLs) for MH/SUD – i.e., all other types of limits on the scope or duration of treatment (e.g., medical necessity criteria, preauthorization requirements, standards for provider admission to participate in network, provider reimbursement rates, determination of usual and customary rates, and network adequacy), **must be comparable to and applied no more stringently than those imposed upon all other benefits.** There is one exception, Fernbach noted: plans may apply NQTLs for MH/SUD differently if recognized clinically appropriate standards of care permit a difference in coverage.

In terms of who must comply with MHPAEA, Fernbach pointed out that six large groups must comply: 1) **insurance offered in connection with large group plans** (50+ employees), e.g., an employer hires a carrier to administer its employee health benefit plan and make benefit determinations and the carrier makes the benefit payment; 2) **self-insured large employee plans**, e.g., IBM hires a carrier to administer its employee health plan and make benefit determinations, but IBM makes the benefit payments itself; 3) **Affordable Care Act exchange plans; 4) individual plans; and 5)** Medicaid managed care plans; and 6) **Children's Health Insurance Program (CHIP)**. The last two were effective aa of May 29, 2016.

Ms. Fernbach noted the significance of the interaction of Federal Law and NY State Law: when the Federal MHPAEA law is combined with New York's Timothy's Law and Insurance Law [§4303(k) and (l)], the **Federal law creates full parity for New York State**. The 30/20 minimum of Timothy's Law, which applies to virtually all mental health diagnoses, is expanded into **full coverage commensurate with med/surg coverage**. And New York's 60-day outpatient benefit is expanded into a full outpatient and inpatient benefit with **no visit or day limits**. If a plan offers inpatient benefits on the med/surg side, it must also provide inpatient benefits on the MH/SUD side.

What does all of this mean practically? At first it means that any plan that covers unlimited visits to a primary care provider must cover unlimited visits to a mental health practitioner. Likewise, if a plan covers a certain number of inpatient days for med/surg, it must offer the same number of covered inpatient days for MH/SUD. Disparate copays or coinsurance amounts for MH/SUD will

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Ongoing Challenges in Parity Implementation

By: Jerry Liebowitz, M.D. (continued from previous page)

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be eliminated. And there will be no separate deductibles for MH/SUD, even if deductibles are of equal amounts.

Ongoing Challenges

After summarizing the implications and interactions of the parity laws and how they interact in New York, Ms. Fernbach enumerated three main areas of ongoing challenges that we face in parity implementation: parity in utilization review, parity in reimbursement, and parity in network adequacy.

According to Fernbach, a "hot button issue" at the center of parity in utilization review is **medical necessity** – that is, how medical necessity is determined for MH/SUD disorders. The standard for medical necessity, she pointed out, is Medicare's guidelines for Local Coverage Determination (LCD) for psychiatry and psychology services. According to CMS, local coverage determinations are defined by the Social Security Act, which states: "For purposes of this section, the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis." For psychiatry, this standard states, "the treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning." It goes on to say: "For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration of hospitalization is an acceptable expectation of improvement. 'Improvement' in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met."

Parity, or disparity, in **reimbursement for mental health** is another major issue. Using the Medicare RVU method of calculating reimbursement levels, she noted, for example, that the old 90807 (medical psychotherapy) had an RVU of 2.9. If an insurance company reimbursed that at $100, then it should follow that 99213+90836 (with a combined RVU of 4.37) should be reimbursed at $150. However, one carve-out doing business here in New York, she explained, has completely ignored the RVU framework. "They simply started with the 90807 fee and then subtracted their very low E/M fee and whatever was leftover simply 'became' the fee for the psychotherapy add-on code." Such an artificial way of setting fees that completely disregards the underlying work values assigned to each code, she argued, is an example of disparity. She went on to give a "real world" example of another form of **discrimination against mental health**: paying less for 99213 or 99214 for in-network psychiatric care than for any non-psychiatric condition under the same plan – $41 for 99213 and $47 for 99214 by a psychiatrist compared to $66.92 and $99.43, respectively, for a non-psychiatric condition.

This disparity, she explains, affects **meaningful access to care**. "Ongoing payment discrimination is a key factor in access to psychiatric care and treatment." Because low in-network behavioral health fees that do not represent reasonable compensation for the time spent or expertise and services provided discourage provider's from accepting the plan's fee schedule as payment in full, providers refuse to join or drop out of networks. And if patients cannot afford treatment without reimbursement, "**adequate and non-discriminatory OON reimbursement is essential**."

Parity in network adequacy is necessary if patients with MH/SUD are not to be discriminated against. Fernbach illustrated this point with a study, by the Mental Health Association of Maryland, of access to psychiatrists during the period June - November 2014. Only 43% of psychiatrists could be reached, and 19% of those listed as psychiatrists were not actually psychiatrists! In addition, less than 40% accepted the insurance they were listed as accepting, and less than 18% were listed as accepting new patients. Only1 out of 7 accepted new patients and could provide treatment in less than 45 days.

How NYSPA and the APA are helping

Fernbach listed three specific ways that NYSPA and the APA are helping us and our patients:

1) NYSPA et al vs. United Healthcare (UHC): A few years ago, Fernbach explained, NYSPA joined a class action suit to raise

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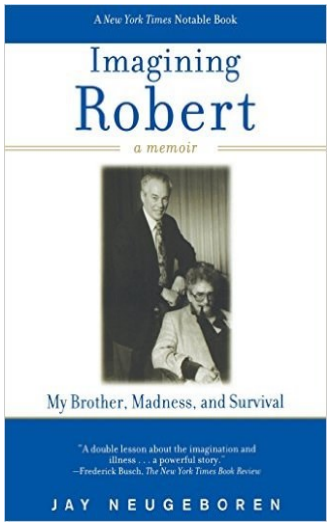
Book Review:

Imagining Robert. My Brother, Madness, and Survival: A Memoir written by Jay Neugeboren (1997)

Reviewed by: Karl Kessler, M.D.



On October 25, 2015, the New York Times printed the obituary *"Robert Neugeboren, Survivor of Psychiatric Abuses, Dies at 72."*

The obituary cites a documentary film about him from 2002, *"… which was shown on public television — along with the 1997 book by Mr. Neugeboren's brother, Jay, from which it was adapted — made Mr. Neugeboren a celebrity of sorts in the world of the mentally ill: a survivor of the horrors of mistreatment, a case history for those who point to the positive effects of kindness and talk therapy, and, perhaps most of all, the embodiment of the bottomless mystery of the human mind.*

Eighteen years earlier, in 1997, Jay Neugeboren published his memoir about his brother Robert, Imagining Robert. Robert was born in 1943 and his illness began at age 19. The book is both a description of Robert's mental illness and Jay's experience of having a mentally ill brother. The narrative is somewhat disjointed and stylistically not what is expected from a professional writer such as Jay. It begins with a long exposition about Roberts's mental health state as it was in the 1990s and then turns to a more chronological description of the Neugeboren family: the two brothers, both very intelligent and with great promise, and their unhappily married parents. The very interesting description of a Brooklyn childhood in the 1940s and 1950s is followed by the onset of Roberts's schizophrenia in 1962. His mother is described as an extremely critical and negative person. The portrait of their father is incomplete, with the emphasis on what a failure he was as a businessman and provider for his family.

The effects of Robert's illness on his parents and especially the effects of their critical mother on both the sons are depicted. A good deal of the book is about Jay's efforts to help his brother or at least maintain contact with him. The author repeatedly ponders the cause of his brother's illness and sometimes blames himself or his parents and at other times blames his brother's treatments for exacerbating, if not causing, his illness. The memoir is focused on the family relationships and there is little about Robert's relationships, whatever they were, with his friends and roommates and lovers.

Most interesting to psychiatrists are the descriptions of Robert's mental health treatments. There are descriptions of Robert's very lengthy hospitalizations in the 1960s and 1970s, when he was put into restraints and spent lengthy periods (weeks) in isolation or was even allegedly beaten by the staff. There are many, mostly unflattering, depictions of Robert's various psychiatrists and therapists. Besides various psychotherapies, treatment consisted of medications and such techniques as insulin coma therapy and megavitamin treatment. There is even a description about carbon dioxide inhalation treatment, of which I was previously unaware. Jay complains, rightly so, that there is a lack of continuity of care for his brother: that there are not one or two psychiatrists or therapists who know him and treat him over the decades. The lesson for the psychiatrist is that care could be much more humane, that psychiatrists should be humble when treating schizophrenia and that when treatments don't work, most anything will be tried. The lesson for the author is that the promises and expectations that treatment will cure his brother or at least make him function better lead to repeated disappointments and frustration.

After strenuous and exhausting efforts on behalf of his brother in the 1960s and 1970s, Jay loses contact with his brother in the 1980s. At that time, the hospitalizations became briefer and eventually gave way to the revolving door hospitalizations in the 1980s. From what little information is given, Robert must have had a horrendous experience of homelessness and multiple arrests and incarcerations during this period. When contact is resumed in the 1990s, Robert is in his 50s and calmer than he was previously.

Although the book is sometimes interesting, it is often repetitive and Jay's reactions to Robert's illness make up too much of the story. What happened in the 1980s, when arrests and incarcerations and multiple brief hospitalizations became the norm, is left out of the book. The question of how much was Robert helped or harmed by his treatments remains unanswered. It is a sad story of a promising life lost to mental illness. ■

Freud in America - 1909 and 1967
Thoughts and Observations by Richard Silverman, M.D.

Freud's Visit to Clark University (1909)

G. Stanley Hall was the first person in America awarded a Doctorate in Psychology, after completing studies with William James. He became the first president of Clark University at its founding in 1889. He began the second department of Psychology in America, after the first at Harvard. Since his area of publications was Developmental Psychology, he popularized the concept of adolescence as a transitional period between childhood and adulthood. To celebrate the 20th anniversary of the founding of Clark University, Hall organized a conference on Psychology, Pedagogy and School Hygiene in 1909. Having corresponded with Sigmund Freud, Hall was aware of Freud's radical new ideas about the role of instinctual impulses being critical in development, from childhood through adult life. He invited Freud to speak.

Freud accepted the invitation after haggling over the honorarium (bargained up to $750, equal to between $18,000 - $30,000 today), rescheduling the date of the conference until September (so Freud would not have to cancel remunerative appointments), and being offered an honorary degree.

Freud struggled with limited acceptance in the academic institutions in Europe due to the controversy over his equating childhood instinctual impulses with adult sexuality and his belief that adult neurosis was due to repression of impulse. Freud sought acceptance by intellectuals and institutions of academia that he had been denied in Europe. He wrote to Jung, prior to leaving, "Once the Americans discover the sexual core of our psychological theories they will drop us." Freud stayed mostly in New York during his only visit to America, except when he traveled to Worcester, MA, as a guest of Dr. Hall, and delivered "Five Lectures on Psychoanalysis."

I lived in the house where Freud slept (1967)

I arrived at Clark in the fall of 1967. I was confounded by the redundant name of Hall Hall dormitory. I had no inkling I would live in the house where Freud slept. I did notice a small bronze statue of Freud that was kept on an open bookshelf on the third floor of the Psychology building. It was small, but striking. Freud is seated in his consulting chair, leaning comfortably back with his legs extended, crossed at the ankles, but with an expression of intense concentration. The statue was rumored to be valuable, Freud having sat for it in his lifetime.

In the spring of freshman year, I heard the rumor of the secret society known as "Phoenix." Its members had only three functions: 1) Steal the small statue of Freud, 2) Book a band, and 3) Declare "Spree Day." In May the statue was stolen. Detectives interviewed students on campus, but the identity of Phoenix members was never uncovered. A week later, on the first beautiful warm day, I arrived for my 8:00 am class only to find it cancelled. The day was lazy, students lying on the grass in the Quadrangle, experimenting with various mind altering substances in varying doses. At the concert that day, the Grateful Dead played Dark Star for an hour for the first set. The Freud statue appeared stage center after the curtains opened for the second set. The statue was returned to the Psychology building.

The impact of Freud's lecture in America – in 1909 and 1967/68

In 1909, Freud joked that the reason he was coming to America was to see the American porcupine. He was pleased to be accepted to speak at a prestigious conference with 50 listed participants, including Franz Boas, Adolf Meyer, A.A. Brill, Ernest Jones, William James, and others I fail to recognize. When their ship entered New York, Jung and Ferenczi discuss bringing enlightenment to America. Freud replied, "They don't realize we are bringing them the plague." Freud began his lectures with: "But first one word. I have noticed, with considerable satisfaction, that the majority of my hearers do not belong to the medical profession. Now do not fear a medical education is necessary to follow what I have to say." The lectures (available on Google) followed the sequential development of his theory. They chronologically covered his work with Breuer, Janet, Charcot, Jung and included, in the fourth lecture, his own theory of infantile sexuality. "Freud's lectures were well attended and occasioned no objections as he had suffered in Europe." [Alan Lawson, Freud in America, Boston College 2004] Freud ended the letters with a long parable from German literature to illustrated his central thesis that repression of libidinal impulse was the cause of neurosis: "Little ought we to strive to separate the sexual impulse in its whole extent of energy from its peculiar goal. This cannot succeed; if narrowing of sexuality is pushed too far it will have the evil effects of robbery."

William James wrote after that Freud "made on me personally the impression of a man obsessed with fixed ideas…his dream theories and obvious 'symbolism' is most dangerous method."

Freud in America - 1909 and 1967
Thoughts and Observations by Richard Silverman, M.D.

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Ernest Jones wrote, "I strongly suspect Freud, with his dream theory, of being a regular hallucine." The local Worcester paper did not comment on Freud specifically, in an article titled "Conference Brings Savants together: Long-haired Type Hard to Discover." The N.Y. Times' only reference to Freud and Ferenczi was in the manifesto of the boat that took them back to Europe. Emma Goldman, anarchist and original radical feminist, wrote that, she "was deeply impressed by Freud's lucidity and simplicity of his delivery." Watching the ceremony where Freud received an honorary degree, she remarked he was "unassuming in his ordinary attire but a "giant among pygmies."

In 1968, I rented the ground floor of the President's house, with two other psychology majors and a fine arts major. That year I found the only secluded comfortable, quite spot in the library. In the stacks, on the 4th landing there was an old stuffed chair next to the shelves with all of Freud's books. I spent hours in that chair, not needing to get up to find a new book. The only course offered related to psychoanalytic theory was one senior seminar taught by a clinical analyst, trained at New York Psychoanalytic Institute, who spoke with a heavy eastern European accent. The course was "Myth, Dreams and Symbol," that the mental processes in all were identical. I got my only C in 4 years.

Of the President's House, I believe G. Stanley Hall's grandniece lived on the top floor. The gracious Victorian home was on Kilby Street, a block from the campus. The street had become a one block Puerto Rican ghetto, with the migration of young families from the only remaining American colony. The old Victorian homes were crowded by New England triple deckers, rental homes for factory workers, 3 apartments with outside wooden stairs connecting the floors. It was the only street in Worcester that had craps games on Friday night, cock fights on Saturday, and heroin dealt on the street every night. The house had been renovated around WWII, but we found the original fixtures in the open, dirt floored basement. We brought the original toilet up to our living room and the fine arts major made an elaborate Shrine to Freud.

In summary: Freud understood the universal human impulse to create Shrines. Freud's visit to America was a success, bringing him to a wider audience. His understanding of the mind has entered popular culture, although his theory of the mind is judged unscientific because it is not provable by blind, controlled scientific method. Despite the fact that functional neuroimaging has greatly expanded our understanding of brain function, the human mind remains an abstraction. ■

Back row (L to R): A.A. Brill, Ernest Jones, S. Ferenczi
Front row (L to R): S. Freud, G. Stanley Hall, C.J. Jung

THE NARROW RIDGE: Insights from Zen, Judaism, and Psychoanalysis

By: Tony Stern, M.D.

(Continued from page 5)

like Peter, as something deep and extraordinary, unconstrained by time altogether. In other words, as we noted already above, we often get lost in either a rational perspective or a mystical perspective.

These days, even spiritual teachers tend to talk about "being in the present" with an emphasis on how such a practice is relatively practical, accessible, and straightforward, and on how such an experience is relatively mundane. In other words, they talk about it as though it is easily talked about. Alternatively, some teachers, like Krishnamurti and Tolle, lay stress on the boundless essence of the present, its limitless freedom. But this, too, though harder to express, is often still talking about it as though it can be grasped with relative ease. Our minds come to rest on either side of the equation; in the middle, between the two sides, gleams the actual razor's edge, the actual narrow ridge of the present.

It is well and good, in fact, to be reminded of either side of the story – either the practical simplicity or the fathomless depth. But let's tread very carefully here, for we can be seriously misled by the preferential leanings of our own minds. Can we notice these preferences? Our realist/seeker tendencies beguile us into appreciating one side, while all but bypassing the other side.

The wonder of the present cuts through all our categories, all our ways of speaking about it. It includes anything you can say about it, and it also leaves those words in a swirl of dust. We can lose touch with the here and now if we are convinced that it is an everyday thing that we can understand with little or no trouble. We can also lose touch with it if we have concluded that it is a "way-out" thing that we cannot comprehend at all, and that it can only be "allowed." Whenever the logical mind tries to grasp life as a whole, it leads us astray. Yet giving up the grasping is often a pseudo-surrender, not the real thing – another trick of the mind, jockeying to be the master, that leads nowhere.

We hide in both the realist's logic and the seeker's surrender of logic, but along with these positions, we are hiding in fear or hope. When we are afraid and reaching for a greater sense of control, perhaps only on a subliminal level, we tend to see the present as plain and ordinary. We wouldn't want to get our hopes up. We wouldn't want to risk the disappointment of beginning to believe great things. When we are excited and hopeful, we see the present as extraordinary. In this state of mind, however slight or subtle it may be, we are no longer fully grounded. We start chasing rainbows; we become caught in believing great things. The errors of our logical mind are fed by the undercurrents of emotionally driven strivings. We hide from the wholeness and the intensity of the present in stances of logical thought, but the preferential logic is sustained by passionate wellsprings of fear and hope. These wellsprings are in turn fed by the reservoir of pain that we all carry. The dynamic of fear and hope becomes more problematic when such a reservoir has few if any outlets, including the outlet of acknowledging its presence and expressing its pain. Another view on this same dynamic involves the vocabulary of idealization, linked with hope, and devaluation, linked with fear.

When Sally began hearing about the timeless, the sacred dimension, her jaw would tighten. When Peter listened to such teachings, he would routinely break into a big grin. This is because Sally couldn't really tune into the miracle of grace; she only knew the world of effort.

In contrast, Peter couldn't really "get" the value of work, but he intuited the miracle of grace and what it might mean. As a result of their life experiences, their spiritual practices, and perhaps also their time in psychotherapy, after about ten years I am happy to report that Sally's immediate jaw tightening and Peter's instinctive grin are both greatly weakened as habitual reflexes. Sally now knows how to grin a little, and more often than not, Peter's grin has been wiped off his face.

Signs and Psychosis

How well can Sally and Peter help us understand more severely ill patients? This remains an open question. I *do* think they can help, but how far we take the insights they imply and how much we can apply them is always a question. Let us come back to non-duality – to the idea that the two worlds are "not two." To believe in both worlds, the sacred world and the mundane world, and to see that they are one is either the essence of psychosis or the essence of spiritual sanity. Every place and every hour is holy, but they are also ordinary. To see only the holiness spells at least temporary manic psychosis. To perceive both sides of the oneness spells spiritual sanity.

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 appearances vs. the world of reality, and we are caught in magical thinking. The fuller statement brings us immediately back to the single world, the one hand clapping, the one and only: the present moment, the meeting point between appearance and reality. The boundless blue sky of "Things are not as they appear" meets the solid ground of "Nor are they otherwise." Thwack! One hand clapping.

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 a sacred mystery. Yes. They *are* not as they appear, "nor are they otherwise": all is as plain as day, too. The sacred is seamlessly meshed with all that is ordinary and familiar; the mystery of oneness abides perfectly within multiplicity. The vast unknown lives in

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THE NARROW RIDGE: Insights from Zen, Judaism, and Psychoanalysis

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the form of every particular place on earth, no less in the form of every being.

Is this perhaps one of the meanings in Jesus's saying, "Be ye as innocent as doves and as wise as serpents"? 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: 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 the sacred magic of oneness? If we exclude this one thing, or certain things, if we imagine them to be *nothing special* – dat's all folks! – then *we are again 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, that all is nothing but matter. Buber called this "I-It relation" in contrast to "I-Thou" relation, and he proclaimed that "signs" are happening to us all the time, but that we shut them away from us out of the 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 particularly accurate to speak of "two sides," because these two aspects of sacred and mundane interpenetrate each other fully.

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 man from Holland holding court at a corner of the ashram grounds and referring to this magical dimension of life by declaring that everything that happens to us has cosmic significance. A small group of seekers had surrounded him. Some were intrigued with what he was spouting. Others, I suspect, were concerned.

As I approached and heard him talk of Moses and loosely connected matters in a rapid and pressured way, I quickly fell into the latter category. Here was someone, I felt, who was at the least "ungrounded," if not truly disturbed. He turned to someone and asked, as if someone's life depended upon it, "Don't you see? *Everything is significant*."

Budding young pre-pre-med psychiatrist that I was, not yet even in college, I stepped up and interjected with a little empathy-laden, condescension-based reality-testing: "I know what you're talking about. Sometimes, especially if we're open to it, the universe does seem to give us messages. But *everything* isn't cosmic; *everything* doesn't contain some special message." I was trying to convey that it's a mistake to think that every moment is so fraught with meaning, or that *every* moment is stamped with universal life.

My sadly misled prophet disagreed: "You're mistaken. Every moment is significant." I began getting irritated that he wasn't open to my sobering input. "Okay," I countered. "That grocery bag over there." I pointed to a common old brown A&P style bag sitting nearby, at the corner of his tent. "I'll bet we wouldn't find any cosmic meaning written anywhere on it," I stated confidently. "Go ahead. Take a look." I strode over and turned around "people's exhibit A." It didn't say "A&P." It didn't even say "Grand Union," which either side might have tried to claim as a victory. It didn't say anything that any reasonable paper bag should have said. Instead it read, where it should have said "Stop'n'Shop" or something else typically mundane, "Alpha and Omega." The beginning and the end, as Jesus called himself in the Book of Revelation. I confess to a queasy moment, feeling almost dizzy, and thinking just how weird a place India is. It was tempting to exclaim, to no one in particular, "What kind of crazy grocery stores does this insanely weird country have?" But it's not India's fault: the world itself is truly the place that is a little weird, because it is the meeting point between the unknown and the known, the boundless sky and the solid ground.

Publically, I had to concede to the Dutch gentleman. "Maybe you're right." Privately, it took no time to convince myself that he'd just been lucky. In a moment my sense of bewilderment and nausea passed, and the world regained its normality. Now, with the benefit of the wisdom accrued from years of work as a psychiatrist, I can look back and see more clearly. There is one notable result of this great clarity: I can mutter for good measure, "Maybe more than just lucky. Maybe he has some psychotic insight, too."

As many of us have witnessed, people in the throes of psychosis do show startling insights at times, and these have been dubbed "psychotic insight." 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 occur especially at the beginning and ending of things, at times of great transition.

Hiding as we do *in* the time-bound ordinariness of the world, we often hide from signs of anything uncanny. In this case, yielding to the Sally in us, we are prone to scientism and literalism in all of our views. We are prone to shutting off even the unpleasant *possibility* of such queasy moments as I've just described. No longer innocent but only clever, we

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Ongoing Challenges in Parity Implementation

By: Jerry Liebowitz, M.D.

(Continued from page 7)

parity law claims on behalf of our members and their patients. UHC filed a motion to dismiss, which was granted, even though the judge acknowledged that NYSPA had made a colorable parity law claim." NYSPA appealed to the Second Circuit Court of Appeals and won. The court ruled that NYSPA does have associational standing to bring claims on behalf of its members and patients and that UHC was the proper defendant in the case, because, as claims administrator, it exercises total discretion and control over claims for benefits. NYSPA is now looking to pursue additional claims against United and other carriers using the foundation laid by the Second Circuit Court's decision.

2) NYSPA is working with our lobbyist to establish a state Parity Cabinet, a part of the executive branch devoted solely to parity enforcement, and to institute a parity report card that would require health plans to report annually on their parity compliance.

3) The APA (and NYSPA in NY specifically) are supporting **enforcement of Attorneys General's parity settlements** in all states.

How we can continue to fight this

Fernbach also listed three ways we can all help to fight parity violations:

1) By writing to state and federal regulators advocating for parity; 2) by soliciting EOB's from providers and patients to help collate data that demonstrates the differential between what psychiatrists are being paid and what other physicians get; and 3) by impacting legislation. "The out-of-network reimbursement issues," she noted, "seem a more direct opportunity for victory." NYSPA is looking for members and/or their patients to join its lawsuits as named plaintiffs. In some cases, she explained, patients may need to designate their provider to sue on their behalf.

There is much that we can do as psychiatrists, Fernbach noted. She urged us to help in continuing the lawsuit against United HealthCare and their parity violations. If anyone has such evidence, or if you find some violation with another insurance company, please let NYSPA or your District Branch know about it. For example, you may send copies of your patient's EOB for psychiatric services that show different reimbursement rates (percentagewise) when compared to an EOB for medical services.

If you log into the NYSPA site at www.nyspsych.org/parity and click on "Read More," you can get helpful information about the Parity Enforcement Program and forms you can use to report violations.

As this newsletter's Editor's Column two issues ago (Fall/Winter 2015) noted, "the more we stay informed and share our concerns with both the public and our legislators, and the more we do to be pro-active by taking action rather than just being acted upon – the better we take care of ourselves, our profession, and our patients." ■

CLASSIFIEDS

ANDRUS is seeking a part-time Child Psychiatrist in Peekskill, NY and full-time Child Psychiatrist in Yonkers. ANDRUS nurtures social and emotional well-being in children and their families by delivering a broad range of vital services and by providing research, training and innovative program models that promote standards of excellence for professional performance in and beyond out service community. To find out more about these two openings, as well as our other available positions please visit our website at http://www.andrus1928.org or contacnt Holly Oths at andrusjobs@jdam.org

THE NARROW RIDGE: Insights from Zen, Judaism, and Psychoanalysis

By: Tony Stern, M.D.

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become locked in a rigid realism, lost in our life situation. Most scientifically-oriented therapists and healers are likely to be somewhat stuck here, robbed of the poetic spirit, and therefore of less complete value to those seeking their help.

Alternatively, like Peter, we can hide in signs – and thereby hide from the world. Then, to one degree or another, we may become lost in magical thinking and a rigid "hyper- religiosity," as we psychiatrists are in the habit of calling such states of mind. This often involves a manic flight from our life situation, or something akin to a manic flight. It is dove-like innocence with no worldly shrewdness at all. Many psychiatrists are hiding in the world themselves, and as a result they often see hiding from the world as a far graver error than it is. Nonetheless, the psychiatric perspective is partly right in seeing an escape from the world as mistaken.

Zen stories and Hasidic tales themselves spell out the pitfalls of magic. As one Hasidic teaching in particular points out, the purest magic is so seamlessly woven into our ordinary world that it is not even noticed as magic. When the ground of the heart is closed to the sacred, sparks "from above" bouncing off the hardness of this ground are often easier to notice and to identify as special. Yet when the ground of the heart is open, the magic of the spiritual is usually perfectly merged with the mundane. All then unfolds naturally, with no fireworks and no fanfare.

Is there a real option in between the realism embodied by many psychiatrists and therapists and the magical thinking embodied by some spiritual seekers and many of our psychiatric patients? Is there an alternative between Sally and Peter? Yes, there is. It is the narrow ridge; the one hand clapping; the actual reality of the present moment.

[To Be Continued In Our Next Issue….]

SAVE THE DATE!

November 9, 2016 - 7:00pm

Implementing Pharmacogenetic Testing in Psychiatry

Presented by: Daniel Dowd, PharmD

Medical Science Liasion

Genomind:East

Location: St. Vincent's Hospital, Harrison, NY

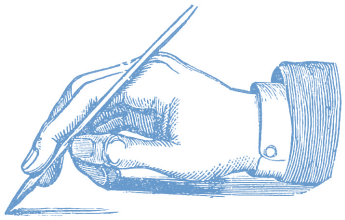
RSVP by November 4th at (914) 967-6285 or centraloffice@wpsych.org

December 4, 2016 - 11:00am

30th Annual Legislative Brunch

Location: Crowne Plaza Hotel, White Plains, NY

Formal invitation to follow



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Contact Megan Rogers to have your article, classified or opinion

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