

# *The Westchester Psychiatrist*

*A quarterly publication of the Psychiatric Society of Westchester County*

2019, Issue 1

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## Message from our President - Alexander Lerman, M.D. On Apathy, Agency, and Joining the APA



When I was a medical student, I joined the American psychiatric Association. I'm not sure why I did this, and the only consequence, aside from the occasional bill that I frequently failed to pay on time, was that I received a every month, which I duly placed on a shelf in my dorm room, and eventually threw away. Like many other habits acquired in early life, this practice of occasionally paying bills, and collecting and eventually throwing away ever-larger stacks of professional journals, persisted through most of my career up to this point – until about I got more engaged and something began to change.

I'll get back to what changed in a second, but first let's just consider the question: why join the American psychiatric Association? Wouldn't it make more sense to avoid paying a bill for a service you never use, and spare our national forests and landfills that mountain of journals one never reads? It's hard to argue the other side of this issue, as long as you stipulate that the Journal is unread, and one's involvement in the organization is as apathetic as mine was.

And there is the issue: apathy. "Apathy" generally arises out of a state characterized by some blend of ignorance, confusion, and helplessness. Gee, that doesn't sound good. What we do about that? What you fight apathy with? Well... What's the opposite of "apathy"? I'm sure there are a lot of different ways to define it, but for me the word that pops up as the opposite of "apathy" is "agency".

If an apathetic state of mind is governed ignorance, the first step towards agency involves trying to tune into what's going on around you. The next step towards agency are getting oriented, connecting with other people, figuring out what's good and not so good in your present situation,

and putting together some kind of plan – preferably one you don't have to try to put into effect alone. That's the short version of a map from apathy to agency.

In my opinion, that's a path we all need to be on. The issues at stake for patients, for the public, and our profession are just to work to ignore, or leave to somebody else. What issues might those be?

- The American Psychiatric Association is fighting onerous "maintenance of certification" requirements which almost all of us believe have little to do with actually monitoring clinical competence.
- The APA continues to work to inform legislators about the dangers of allowing unqualified practitioners to prescribed psychotropic medication
- The APA fights for mental health parity in insurance reimbursement, to make sure that patients can afford basic mental health care (you'd think that would be obvious, would you? It isn't)
- We urgently need more clinicians to sign on to efforts to defend the patient-doctor relationship, to maintain professional standards that ensure that we have an adequate to talk to our patients
- We have increasing scientific evidence on the impact of trauma and environmental factors on the mental health children and the adults those children become – and we need to speak up to preserve and protect the mental health of our children

There are innumerable other reasons to get involved with the APA, but I'll just give you one more: it's good to know other psychiatrists. Most of us are really busy, and perhaps some of you (like

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## President's Column By Alexander Lerman, M.D.

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me) are shy in large social gatherings, but you will never regret building relationships, friendships, and social and professional networks with your peers. Trust me – it's worth the time.

While you're at it, would it kill you to flip open the green Journal and read a couple of the editorials? When I started doing that, I was shocked (duh) to discover how informative and well-written they were. Does that mean I still skip the weird technical molecular biology stuff? Usually. But are there editorials in the Green Journal that are actually more interesting than the latest issue of Guns and Ammo (not really) or any of the weird blogs I go to on the Internet (why do I actually waste my time reading stuff)?

You'd be surprised.

So how do you get involved? The first thing is to fill out the paperwork

and join the organization. The second step is to start taking a look inside the green Journal and think about going to professional meetings. There are plenty of ways to get involved – like signing up for a class, present a poster, joining many of our already-existing efforts at the BHC. Then there's our local division branch, the psychiatric Society of Westchester (full disclosure I'm currently the president), which holds meetings every month, and special event several times a year.

So, have I convinced you?

Whatever you do, do everything you can do to overcome that old monster apathy. Whatever you do, your chances of doing it successfully skyrocket when you start linking up with other people and try it together. Our profession has its problems, but this is also a fantastic time to be a psychiatrist. I hope you come to see, as I have, that membership in the APA is a terrific way to make the promise of our profession a reality. ■

## Report From The APA Assembly November 2018 Meeting

By: C. Deborah Cross, M.D.

This is my first report to our District Branch as your APA Assembly Representative. Dr. Ed Herman, who had been our Rep, along with Dr. Rich Altesman, have both "moved on". Dr. Altesman has retired and moved to the West Coast and Dr. Herman was elected last spring to be the Vice President of NYSPA (New York State Psychiatric Association) and the Deputy Rep from Area 2 (NYS) to the APA Assembly. I am not new to the Assembly but it is a great pleasure to be your representative and to be following 2 very distinguished members of our DB.

Some of you may already know quite a bit about the Assembly, but others may not so I'd like to take a little time to share with you some of what the Assembly does and is. The Assembly meets 2 times a year (in November) and in May (at the Annual Meeting). We meet from Friday at noon until Sunday at noon and then there are also Assembly Committee meetings held early in the morning and late in the evenings and often phone conference meetings in between the 2 scheduled meetings. The Assembly is similar to the Senate and the House of Representatives of the US rolled into one big group. Every DB (of which there are over 200) has at least 1 Representative. There is at least 1 DB in every State (NY has 13) and Canada has several. In addition, there are some other "groups" which are represented in the Assembly; for example, Residents; Early Career Psychiatrists; Minority and Underrepresented Groups; and Allied Organizations, such as ACAP (Child Psychiatry); AAPL (forensic psychiatry), etc. The attendance at Assembly meetings is usually around 300 people.

The Assembly is the VOICE of the APA Member psychiatrist. We are YOUR representatives to the Board of Trustees (BOT) of the APA. Our "work product" is done through Action Papers which are presented to

the Assembly by any Representative, debated on the floor of the Assembly and, if passed, often are referred to APA Councils on specific topics and then if action is needed at the Governance level, goes to the Board of Trustees to be voted on and put into practice. The APA for example has a number of Policy Statements, which often have originated in the Assembly and which have become the accepted Policy of the APA. All of this may sound fairly vague and esoteric; however, the nuts and bolts of it are what I will go into now as I share with you some of the work we did in November in Washington.

One of the early papers we discussed and voted on was a proposed Position Statement titled "Separation of Immigrant Children and Families". This was approved and sent to the Board of Trustees, specifically for use in meeting with legislators and in talking with the press. (For those interested, you can find more information on this on the APA web site—or contact me.) An Action Paper that was brought by some of our RFMs (Resident and Fellow Members) had to do with developing a toolkit addressing racial discrimination against psychiatry trainees and practicing psychiatrists. Another Action Paper recommended convening a joint BOT and Assembly Work Group to draft a Position Statement "regarding the need for psychiatrists' input into the process of psychiatric facility design, construction and renovation." There were approximately 20 Action Papers discussed, along with numerous new Position Statements (and reviews of existing ones).

In addition, there were reports/updates from the CEO of the APA, Saul Levin; the President of the APA, Altha Stewart; the Treasurer of the

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## Messages from Pablo Sanchez-Barranco, MD in Afghanistan

Below are two messages and photos from our Program Coordinator, Lt. Colonel Sanchez-Barranco, who took a leave of absence this fall to return to active duty. He is part of a medical unit of the Iowa Army National Guard. He was called to 400 days of active duty and is being deployed with his unit to OPERATION ENDURING FREEDOM (SPARTAN SHIELD). This is an operation in the Middle East.

On December 1, 2018 he sent this first email and photo in reply to an email from PSW's Past-President, Dr. Karl Kessler.



Karl,

Glad hearing from you! Yes, I am Overseas. Not in one single location, not able to disclose specifics, as our area of operation comprise anywhere from Sinai to Afghanistan. Unfortunately, I am sure you all follow the news, many of these unforgiving places are not the most tranquil part of the World these days.

Demanding as the job may be, I cannot think of a greater group of people to be surrounded with, though. It is the beauty of the Armed Forces.

Send my regards to the team.

Best,  
Pablo

And on January 9, 2019, Pablo again replied to an email from Karl:



Happy Near Year from Bagram, Afghanistan!

P

## Dealing with “Disservice” Animals

Ann McNary, JD — Senior Risk Manager, PRMS

I don't know about you but I've been seeing a lot more dogs lately in places I wouldn't have expected to see them. As a dog person it often brings a smile to my face to see a well-behaved dog accompanying its owner to the hardware store, or bookstore, or laying quietly beneath a table at an outdoor café. Many merchants are now welcoming dogs into their stores and I think that's a nice thing - if that's their choice. But what if they don't have a choice? What if a person throws an orange service dog vest on an unruly, mangy mutt and the merchant is required to allow the animal in? What if this happens in your medical practice?

Under the ADA, State and local governments, businesses, and nonprofit organizations that serve the public – including physician offices – generally must allow service dogs to accompany people with disabilities in all areas where the public is normally allowed to go. True service dogs can be a godsend to people with disabilities, allowing them greater independence, mobility, and security than they may otherwise have and laws have been written broadly to allow individuals to utilize service animals without enduring additional burdens. Unfortunately, these broadly written laws also make it easier for unscrupulous people to claim that their dogs are service dogs thus allowing them to bring the animal to places it would not normally be allowed to go.

A true service dog is a highly trained, well-behaved animal that quietly goes about its job and does not interfere with the businesses or people it encounters. However, there is no requirement for certification of service dogs nor is there any requirement that they undergo any type of formal training. Though many do, there is no requirement that service animals wear any special gear or identifiers such as vests or tags.

So how do you know whether the dog your patient brings into your office is truly a service dog? The ADA permits you to ask just two questions:

1) Is the animal a service animal required for a disability?

2) What work or task related to the individual's disability has the animal been trained to perform?

If the handler can answer these two questions, you must give them the benefit of the doubt and allow the dog into the office. Fortunately, this does not mean you are required to let out of control animals wreak havoc in your waiting area. Service dogs must be harnessed, leashed, or tethered, unless these devices interfere with the dog's work or the handler's disability prevents this, in which case the handler must maintain control of the animal through voice, signal, or other controls. If the handler is unable to control the dog or if the dog is not housebroken, you may ask that the dog be removed. Bear in mind, however, that you must still offer services to the handler without the dog present if he or she chooses to receive them.

For additional information about animals in your medical practice, check out my article [“Vetting” Service Dogs and Emotional Support Animals](#). For additional information on service animals, please visit: [Frequently Asked Questions About Service Animals and the ADA](#).



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## Report From The APA Assembly November 2018 Meeting

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APA, Gregory Dalack, and other Executives and officers. Committees and Work Groups of the Assembly also gave reports and often had proposed Actions which needed to be discussed and voted on. Some of these Committees and Work Groups include Procedures, Rules, Public & Community Psychiatry, Psychiatric Diagnosis & the DSM, Access to Care, Practice Guidelines, and Maintenance of Certification. Also, each DB belongs to one of 7 Area Councils across the US and Canada (NYS is Area II, Area I is Eastern Canada and New England, etc.) and each of the 7 Councils meet separately 3 times during the weekend to discuss Area business and review the Assembly business as it relates to our Areas.

The Assembly maintains its own List Serve so all Assembly members get information year round as to what is happening with the APA so I thought I would update you on some of the information passed along to the Assembly by Dr. Levin (CEO of the APA ). Dr. Levin updated us on the APA's response to CMS's release of their "final rule" for the 2019 Medicare Fee Schedule which actually incorporated several recommendations from the APA, specifically to delay the implementation of the proposed changes to the outpatient E&M fee schedule which

would have been very bad for psychiatry. He also told us that the APA had opposed the proposed changes on the "Apprehension of Immigrant Children" in which the government proposed changing the 20-day detention limit and other requirements which are in place to protect children. The APA also submitted comments regarding the Administration's proposed regulation that would change long-standing rules governing how and whether immigrants can be determined to be a "public charge", which would make it much more likely that lawfully present immigrants could be denied green cards or U.S. visas or even be deported.

These are only a few of the things that the APA and your Assembly have been involved in since November! I look forward to keeping you updated on the work of your Assembly and also urge you to contact me at any time with questions or ideas of what you feel the APA might be able to do to help you and your patients. ■

C. Deborah Cross, MD

APA Assembly Rep, Psychiatric Society of Westchester

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January 2019

## 2018 Teaching Day: Child Abuse & Mental Health

By: Jerry Liebowitz, MD

On Saturday, October 13, The Psychiatric Society of Westchester presented its Fall Teaching Day at the Phelps Hospital Auditorium with three CME presentations.

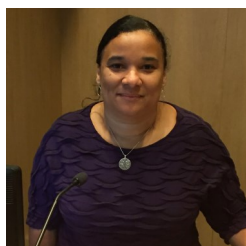
After a refreshing breakfast buffet, our President Alex Lerman welcomed everyone, noting the importance of the topic to all psychiatrists, since many adult disorders start in childhood.

We had great presentations from Billye Jones, LCSW, who spoke on child trauma and the ACES study; Jeanette Sawyer Cohen, who discussed attachment theory and attachment trauma; and Richard Gallagher, who discussed the complex history of psychiatric concepts of trauma. Kevin McGuire, the Westchester County Commissioner for Social Services, discussed various programs and efforts to support at-risk children in Westchester County.

considerations in identifying and treating early trauma, which includes the impact of trauma on the brain and the limbic system, the meaning of the trauma, and aspects of the self and others. She noted that children have difficulty communicating about their traumas (which are often pre-verbal), which leads to difficulties as adults, who also are unable to verbalize what they feel and have experienced and are unable to link their adult distress with early trauma.

In working with adults like this, she emphasized the importance of "changing the conversation" – from problems and symptoms (pathology) to "What has happened to you?" For example, not to feel blamed for dissociation that at one time was adaptive.

She urged adopting a public health view of ACEs (e.g., smoking and drug abuse) and described the **CDC-Kaiser Permanente ACE Study (ACES)**, one of the largest investigations of childhood abuse and neglect and later-life health and well-being, that resulted from Dr. Vincent Felitti's study of the dropouts at his obesity clinic. Most of them had been sexually abused as children and, for them, eating was a solution to a problem. Their weight was not experienced as a problem; not eating led to increased anxiety and depression. Other consequences of high ACEs include: impaired relationships; increased likelihood of



The first speaker, **Billye Jones, LCSW**, spoke on the **Long-Term Impact of Adverse Childhood Experiences (ACE)** and the importance of trauma-informed practices. She pointed out that there are so many experiences a child can have that are traumatic and that many of these experiences have a life-long impact. She discussed special

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## 2018 Teaching Day: Child Abuse & Mental Health

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being in a violent relationship; impaired parenting skills; more likely to become homeless or have less educational/employment attainment; more likely to report sexual problems; substance abuse; and addictions.

She then discussed in depth the findings and conclusions of the **ACE Study**, which included a questionnaire asking ten questions ascertaining a history of abuse, neglect, and household dysfunction to over 17,000 Kaiser HMO members from Southern California undergoing physical exams. She noted that the study, which was conducted from 1995-1997, did not address discrimination or bullying. (See [www.cdc.gov/ace/index.htm](http://www.cdc.gov/ace/index.htm) for details.) The study resulted in a **lifespan perspective**, visualized as a pyramid with adverse childhood experiences at the base progressing through levels of disrupted neurodevelopment, social, emotional, and cognitive impairment, and the adoption of health-risk behaviors, to disease, disability, and social problems and, finally, early death.

Of the 17,000+ respondents, two-thirds had at least one ACE. More than 25% grew up in a household with an alcoholic or drug user; 25% had been beaten as children; and 1 in 6 people had four or more ACEs. The consequences of high ACEs, as noted above, included many medical and public health issues. Individuals with high ACEs, for example, were twice as likely to smoke; seven times as likely to be alcoholics; six times as likely to have had sex before age 15; twice as likely to have cancer or heart disease; twelve times more likely to have attempted suicide; and men with six or more ACEs were 46 times more likely to have injected drugs than men with no history of adverse childhood experiences.

These statistics are quite sobering and should alert us to the **high incidence of early childhood trauma** in many of our medical, as well as psychiatric, patients, Ms. Jones observed. These early experiences trigger a fight or flight response physiologically, which, she explained, affects frontal lobe development. Because of this, she emphasized, it is critical it is to use the harm-reduction model when dealing with substance abuse. She urged us to continue to work with these patients, even while they are abusing.

Addressing trauma can be extremely helpful with medical patients, she noted, giving an example of a young adult with high blood pressure whose blood pressure responded to psychotherapy dealing with his earlier traumas. Because of this, it is very important to identify ACEs early. Not doing so has been shown to reduce one's lifespan by 20 years. A corollary is to treat children early. Completely removing them from the source of trauma may not be enough.

Because of the wide array of medical conditions that are associated with early trauma (at least 15 were listed on her slides), she noted how important it is to have **more trauma-informed physicians**, she noted. Just seeing a doctor (e.g., OB/GYN or dentist) itself may be a trigger for early trauma to cause distress. Many patients avoid going to a

doctor, and this needs to be a treatment goal of therapy, she explained.

She concluded by pointing out that early trauma survivors, who usually take a long time to engage in therapy, need long-term treatment and consistency, especially if there is a borderline presentation.

Her talk was followed by a lively Q&A, which included questions and observations about the role of resilience adverse childhood experiences.

Before the second CME presentation, **Kevin McGuire, Commissioner for Social Services of Westchester County**, addressed the group and



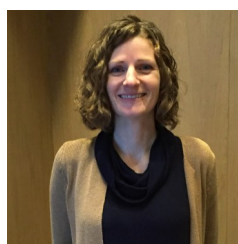
spoke about the various programs and efforts of the county to support at-risk children. He observed that his agency was the largest in the county, with the most employees and the largest budget (over \$600 million), as well as “the most problems.” He emphasized the importance of changing the question from “What’s the matter with you?” to “What happened to you?” This has helped focus attention on the **traumatic issues of poverty**. “Trauma impacts everything we do,” he noted, “from prenatal care to burial assistance.”

He stated his belief that “children should be raised in home-like settings, preferably their own.” “Removal,” he stressed, “even if necessary, is traumatic” and should be of short duration. Utilizing this concept of a **home-based environment** has reduced the need for residential treatment from over 200 to only 48 last year.

Concerning the **early death of a child**, he noted that, even though some are not due to abuse or neglect, most involve some **ACE risk factors**, including family violence, sexual traffic (runaways), and gender and sexual identity issues.

He personally reviews every case of **termination of parental rights** to ensure that such action is absolutely necessary, considering how serious and traumatic such an action is.

Saying he was “honored to be here,” he reached out to the participants for help and ideas, asking for proposals “to move the conversation forward.” He spoke of his own personal experience in overcoming adversity, noting that many children he grew up with in the Bronx “were dead or in prison by age thirty!” He was fortunate to have adults take interest in him and provide mentoring. “The people you help,” he told the audience, “affect you and your families in ways you often don’t know.” “Don’t give in to cynicism,” he urged.



The next presentation was by **Jeanette Sawyer Cohen, PhD**, whose talk was titled, “**Trauma in Young Children: A Relational Lens**.” She explored how nurturing relationships provide children with a sense of safety and confidence

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## 2018 Teaching Day: Child Abuse & Mental Health

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and offer a buffer against stress, focusing on understanding **potential protective factors within caregiving relationships in early childhood**.

She stressed the importance of “**creating a safe space**” – for us, too. Emphasizing our need for self-care, she urged each of us, “treat yourself kindly.” For example, she explained, we regularly deal with difficult material – in our own practice and in the news.

Following up on our earlier discussion of resilience, Dr. Sawyer Cohen spoke about protective factors and our need to understand **attachment** and the importance of social “**serve-and-return interactions**.” These include “good enough” parenting with satisfying interactions: “she gets me” vs feeling misunderstood (caregiver sensitivity); joint attention (shared); predictability (no unsettling surprises); and reciprocity, the flow of turn-taking. Children’s expectations should be “I am safe,” “I am capable,” “I am lovable,” and “life makes sense.” Babies develop in relationships and, within relationships, children come to understand the world and their place in it. It is through close, nurturing relationships, she explained, that babies and young children learn what people expect of them and what they can expect of others. Nurturing relationships provide children with a sense of safety and confidence and offer a buffer against stress.

**Trauma** results when this sense of safety and confidence is disrupted. But “ruptures always occur,” she noted. “It’s the repair that counts.” Potentially traumatic events include witnessing violence (domestic and other), natural disaster, terrorism, accidents, abuse, neglect, and loss of the caregiver. Trauma can be caused by factors other than being a victim of a traumatic event. It can be caused by being a witness to an event, by being related to a victim, and even by listening to the details of an event. She cited Judith Herman’s description that “traumatic events **overwhelm** the ordinary systems of care that give people a sense of control, connection, and meaning.” She quoted Robert D. Macy, who explained trauma as occurring when there are “**overwhelming demands** placed upon the **physiological** system that result in a profound felt sense of **vulnerability** and/or **loss of control**.” She enumerated and described in some detail the various types of trauma: **acute trauma** (a single traumatic event limited in time) which causes a variety of feelings, thoughts, and physical reactions that are frightening and contribute to a sense of being overwhelmed; **chronic or complex trauma** (either multiple and varied events or longstanding trauma such as physical abuse, neglect, or war), the effects of which are cumulative, as each event serves to remind the child of prior trauma and reinforces its negative impact; and **systemic trauma** (such as racism or any discrimination), which can be multi-generational and historical resulting in feeling “less than>”

She then discussed our body’s **physiological response to trauma** – the fear, startle, fight or flight response that can be positive or at least tolerable and then such pathological conditions as **toxic stress** (strong

and prolonged activation of stress response systems in the absence of protective relationships) and PTSD. She explained how toxic stress changes brain architecture in the prefrontal cortex and the hippocampus.

Various “red flags” in children, signs of trauma, include lack of responsivity, withdrawal, dysregulation, failure to thrive, clinging to caregivers, refusal to go to school or other settings, sleep disturbances, difficulty concentrating, unexplained medical problems, behavior problems, and others. “Trauma can even look like ADHD,” she observed.

Dr. Sawyer Cohen’s presentation concluded with a focus on how to help children of trauma by understanding mitigating factors. She emphasized how important it is to **Invite and contain**, quoting Fred Rogers, who noted, “People have said, ‘Don’t cry’ to other people for years and years, and all it has ever meant is, ‘I’m too uncomfortable when you show your feelings. Don’t cry.’ I’d rather have them say, ‘Go ahead and cry. I’m here to be with you.’” This is the first step in creating a **coherent narrative** (life makes sense). Ways of containing feelings include such things as consistent routines and rituals. She also emphasized the importance of **empowering through play**, turning passive into active, not to feel helpless.



After a break for lunch, the next presenter was **Richard Gallagher, MD**, Professor at NYMC, Faculty at Columbia University Psychoanalytic Center, Director of Psychological Services at SJS, and formerly on the faculty at Weill Cornell-Westchester Division, where he directed the Borderline Unit. Dr. Gallagher spoke on **The Abused and Traumatized Patient: An Update on**

**Understanding and Treatment and Recent Controversies**, focusing on understanding the history of treating abused individuals from Freud to the modern conception of Post-Traumatic Stress Disorder.

He started with a review of definitions, trends, and prevalence studies and put the concept of the traumatized patient into social and cultural contexts. He then went on to explicate the richer and broader theory that has been developed in recent years, focusing on the biological underpinnings, attachment theory, and its broader application to our theories of psychotherapy in general.

Dr. Gallagher reviewed the findings of the Yale VA Experience with exposure therapy and other treatments, noting their limitations – that many at the VA were not doing well. “The wisdom of experienced therapists” is important, he noted. Non-trauma focused therapies (like exposure, EMDR, and cognitive processing) and even interpersonal psychotherapy and mindfulness-based therapies were not enough. The **abuse and traumas in their past** had to be addressed. Referring to John Allen’s recent book, *Plain Old Therapy*, he emphasized the “need for a longer-occurring secure attachment relationship” that is “focused on

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## 2018 Teaching Day: Child Abuse & Mental Health

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the whole person” rather than distinct disorders. He also noted that Judy Herman, in her work on **Complex Stress Disorder**, stressed that such treatment takes time. He quoted Philip M. Bromberg that, to “cure them of what they will still do to themselves or others,” requires establishing a safe and secure relationship to help them cope with what was done to them in the past. There is always **a need to individualize treatment**, he observed.

He reviewed the relevant research related to **memories of abuse and trauma** and the prevalence of such experiences to psychopathology, noting the **extreme variability of the stress response to abuse** and the resultant fundamental controversies and debates over diagnoses and treatments. For example, there are many psychiatric comorbidities in PTSD. Different types of abuse and abuse-related traumas in childhood impact the adult’s response to trauma.

Although the **prevalence of abuse**, narrowly defined, is decreasing, Dr. Gallagher emphasized the importance for uncovering a history of abuse. He discussed **cultural differences**, citing rape and sexual abuse by relatives in India as examples. While noting the decrease in the approval of spanking in the U.S., he pointed out that child pornography was not illegal in many states in the 1980’s. Child kidnapping by strangers, fortunately, is a fear decreasing in incidence. In the Borderline

Unit study at NYP-Westchester Division, abuse was more common and more intense in borderlines. He also pointed out the stunning results of the ACE study discussed earlier in the day, especially some of the strong associations of abuse/trauma to many medical conditions. Are they causative, he wondered, or simply a correlation?

Abuse must be viewed in a social and cultural context, he urged, with a need for historical perspective. We need to look at families “most at risk,” different “grooming” behaviors, and institutional factors (citing the Catholic Church, schools, and Penn State as examples).

Dr. Gallagher also reviewed some of the most recent empirical studies of psychopharmacology with such cases. He pointed out that SSRIs enhance brain-derived neurotrophic factor (BDNF), which has been shown to be decreased by chronic stress. And some medications being studied are antagonists of corticotropin-releasing factor (CRF), which is activated by stress.

In summarizing the history of abuse and trauma, he observed that Freud caused a problem with his seduction hypothesis that de-emphasized abuse too much. “Abuse is a significant factor in many patients, although not all.”

He concluded with a discussion of a related topic that he has studied and practiced for some time – Satanism and Satanic Ritual Abuse (SRA) and its victims. ■

## Report from the Fall NYSPA Area II Council Meeting

By: Karl Kessler, MD, APA Representative

The New York State Psychiatric Association (NYSPA), Area II Council of the American Psychiatric Association, held its Fall meeting at the LaGuardia Marriott in East Elmhurst, New York on October 20, 2018. Some of the highlights of the meeting are given below.

### Officers of NYSPA

President	Jeffrey Bornstein, MD
Vice – President	Edward Herrmann, MD
Secretary	Felix Torres, M.D.
Treasurer	Marvin Koss, MD

### NYSPA BUDGET

NYSPA expects a 2019 deficit of approximately \$30,000 (with total expected dues of \$398,000) because of the impact of the Rule of 95. The Rule of 95 offers reduced dues to APA members whose age added to their years of membership equals 95 (for example, a member who is 64 and has been a member of the APA for 31 years has a rating of 95 and is entitled to reduced dues). The rule of 95 is impacting all the organizations of the

APA and will be changed because of this impact.

### NYSP-PAC

The contributions by NYSPA members to the NY State Psychiatric Political Action Committee (NYSP-PAC) have been increasing, which allows to PAC to have increased clout in achieving the legislative goals of NY psychiatrists.

### 2018 NY LEGISLATIVE SESSION

The 2018 NY Legislative Session was reviewed. NYSPA’s 2 main legislative priorities were:

1) Passage of legislation mandating data collection and reporting on parity of insurance payments for mental health and addiction services, with the goal assuring that insurance coverage parity is being carried out. This bill was passed by both the NY Assembly and the NY Senate in June 2018, but as of this time had not been sent to the Governor for signature and thereby it has not yet been enacted into law.

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## Report from the Fall NYSPA Area II Council Meeting

(Continued from page 10)

### 2) Legislation to prohibit “conversion therapy” for minors.

#### AWARD

Barry Perlman, MD was given an award for his many years of service as Chair of the NYSPA Legislative Committee

#### PROPOSED CHANGES IN CPT CODING

Proposed changes in CPT coding from the Centers for Medicare and Medicaid Services (CMS) were presented in a detailed and thorough presentation given by NYSPA’s Executive Director, Seth Stein. CMS usually issues a proposal for changes for the following year during the summer, so that the interested parties can comment on the proposal. A final rule is issued in November, incorporating some of the suggested changes. This year CMS proposed rule changes that would have a major impact on both documentation and physician payment for Medicare Part B. These rules are of relevance to all physicians because the rules governing Medicare payment are generally adopted by other insurers, public and private.

The proposed changes are to the documentation guidelines and payment for outpatient evaluation and management services (E+M codes). The proposals allow physicians to select from one of the following three documentation options:

- 1) To continue using the current 1995 or 1997 CPT coding guidelines
- 2) To use face-to-face time with patients as the fundamental criteria for billing
- 3) To use only the level of medical decision making (medical complexity) as the fundamental rule for billing

All three options would simplify the documentation process,

because for all three options the physician would need to include only the documentation required for the current level 2 E+M Service for a Medicare audit.

In return for simplifying the documentation process, CMS proposed replacing the separate fees for each current level of E+M Service (levels 2,3,4,5) with a single fee. The new fee will be calculated using a weighted average of the current fees.

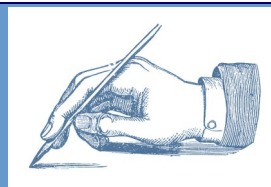
The goal of these changes appears to be to save money by restricting the number of E+M codes that psychiatrists can use. CMS is apparently worried about the amount of “upcoding” that has occurred with the use of E+M codes. In return, physicians would get reduced documentation requirements. Seth Stein extensively explained the differences among the three proposed CMS options. NYSPA is against the changes and believes that the current graduated levels of reimbursement and graduated levels of documentation (for levels 2,3,4,5) should be maintained.

[Note that on November 1, 2018, CMS issued the following guidelines:

*For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare.*

*Beginning in CY 2021, CMS will further reduce burden with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient visits will be simplified, and payment would vary primarily based on attributes that do not require separate, complex documentation.] ■*

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## 2019-2020 Election Ballot

Listed below are the names of the nominees for office for the 2019-2020 year as proposed by the Nominating Committee and accepted by the Executive Council:

**President-Elect:**

*Rehana Latif, M.D.*

**Treasurer:**

*Neil Zolkind, M.D.*

**Secretary:**

*Naveed Iqbal, M.D.*

**Program Coordinator-Elect:**

*Richard Gallagher, M.D.*

**APA Representative:**

*Karl Kessler, M.D.*

**Councilor:**

*Bradford Perry, M.D.*

**Write In:**

\_\_\_\_\_

**Please note that ballots must be received by May 31, 2019 in order to be valid.**

If you wish to vote by regular mail, please return this ballot to Megan Rogers at:  
Psychiatric Society of Westchester, 400 Garden City Plaza, Suite 202, Garden City, NY 11530.

If you wish to vote electronically, please check your e-mail for an electronic ballot being sent the week of March 25, 2019.

If you have any questions, please contact Megan Rogers at (914) 967-6285 or by e-mail  
centraloffice@wpsych.org



## Westchester Medical Center Grand Rounds 2019

**March 19, 2019**—GUN! Assessing Firearm Possession and Safety in Clinical Practice

**April 2, 2019**—Clinical Case Conference

**April 9, 2019**—David F. Tolin, Ph.D.—Hoarding

**April 16, 2019**—Kenneth Frank—Convergent Psychotherapy

**April 23, 2019**—Disorder of the Quarter

**April 30, 2019**—Case Conference

**May 7, 2019**—JoAnn L. Robinson, PhD—Child Mental Health Representations of Trauma & Attachment

**May 23, 2019**—Andrew Skodol, MD—Personality Assessment

**May 28, 2019**—Otto Kernberg, MD—Borderline Personality Organization

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