# The Westchester Psychiatrist

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

**Fall 2016**



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

## May We Live In Interesting Times

I'm sure many of you have thought of this Chinese saying often in the last several months, since we certainly are living in very interesting – and perhaps somewhat uncomfortable – times. I, like most of you I imagine, have found myself wondering what sort of changes lie ahead for us, our profession and our patients. And yet, I also feel very grounded in our profession, since our mandate is and always has been to stand for our patients. Our patients will continue to look to us for guidance and care in the days, months and years ahead, as they always have done.

December 4th was the 30th annual Westchester District Branch Legislative Brunch. For 30 years, the members of this DB have met with the legislators of this County, our State and our Nation to share with them the role that they and we play in the lives of our patients -– and what we feel is vital to the well-being of our patients and their families. The meeting this time was more important than ever in this uncharted future for health care. We (and our patients) are very fortunate to live in New York State. Consistently we have heard from our legislators that they also feel a commitment to make sure that people with mental health issues are "at the table" when issues vital to their well-being are at stake.

It is our professional obligation in the coming months to make sure that we are alert to changes in health care coverage and especially issues with insurance coverage parity for our patients. We have fought for many years to ensure that people in NYS can access mental health services. I know some of you are saying that it ISN'T ENOUGH, and I realize that we still have a long way to go. However, NYS is light years ahead of many of the other areas of the United States and though I also get frustrated about having to get "prior authorization" for this medication or that coverage – the reality is that NYS STILL has better mental health access and coverage that virtually anywhere else in the US. The coverage that we all pay for through taxes for Medicaid and the uninsured (and underinsured) to be able to obtain care means that NY is one of the few states where almost everyone can get the basic mental health treatment they need.

It is quite possible that in the months ahead we in New York will be pushed to stand our ground on these issues – that our patients deserve and MUST HAVE the care that they need! At this very moment there is in the US Congress an omnibus bill focusing on a multitude of issues having to do with mental health. This bill ("21st Century Cures") was passed by the House and goes to the Senate this month. I'll quote Saul Levin, the CEO of the APA, who says the following about the bill: "Included in the package were several landmark provisions from The Helping Families in Mental Health Crisis Act, the Mental Health Reform Act of 2016, key provisions from the Mental Health and Safe Communities Act and the Comprehensive Justice and Mental Health Act." Our APA has been a strong supporter of this bipartisan bill and there is much hope that

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the Senate will also pass it (by the time you read this, we will know what has happened). In any event, the bill itself helps clarify many loopholes in prior mental health laws. The bottom line, however, is that we, as the community of Westchester psychiatrists, MUST be ever watchful and fight for our patients, so that they and their families are able to obtain the treatment that they need and that we can provide them.

If, in fact, Medicaid as we know it is changed (in funding, scope, and practice), our patients will still need AND MUST HAVE ACCESS TO mental health care. It is up to us to be the standard bearers for our patients and to continuously put these issues in front of legislators, the public and government. This is what our profession means to me and to us – that our patients and their needs must come first and we must honor that commitment by continuing to ensure that they are able to access the mental health care they need and deserve. ■

## WMC Grand Rounds Review - Treatment of Opioid Disorder

### Presented by: Stephen Ferrando, MD

Reported by: Sahil Munjal, MD, Chief Resident, WMC Dept. of Psychiatry & Behavioral Health

Dr. Stephen Ferrando, chairman of the Department of Psychiatry at Westchester Medical Center, presented at Grand Rounds regarding the treatment of opioid use disorder. This is in response to the escalating opioid crisis in the country including the lower Hudson Valley as well. The statistics paint a picture themselves with more than 200 people dead in the Lower Hudson Valley from pain-pill abuse since 2010 and deaths in Westchester have more than doubled from 21 to 47 per year. A recent letter by the surgeon general has emphasized the need for screening our patients for opioid use disorder and to provide or connect them with evidence-based treatment services.

Dr. Ferrando talked about the various evidence-based medication-assisted treatment options available to treat opioid use disorder, which includes methadone, buprenorphine and naltrexone. Methadone and buprenorphine fall into the category of agonist treatments, being full agonist and partial agonist, respectively. Naltrexone is a full antagonist.

The important facts to remember regarding methadone include: half-life of 24-36 hours (withdrawals from methadone might not be present for 2-3 days); metabolized by liver enzyme system CYP450 2D6; doses of 20-40 mg per day sufficiently block withdrawal symptoms but are not sufficient for maintenance purposes; and maintenance dose is usually 80 -200 mg per day. As originally proposed, methadone stimulates opioid receptors and "normalizes" functioning of the system. It is not a heroin substitute, prevents withdrawal symptoms, relieves drug cravings, stabilizes affect without producing euphoria or impairment in functioning, minimizes pathological brain response to stress and drug cravings, and blocks effects of other opioids (tolerance blockade). By reducing drug-seeking, methadone provides an opportunity for patients to begin changing their behavior and address other problems. Treatment with methadone is a "corrective, not curative" intervention, and therefore may need to be used long-term or even indefinitely.

Buprenorphine, on the other hand, is the first and currently the only opioid available to U.S. physicians for prescription in office-based opioid treatment (OBOT), first approved in the U.S. in 2002. The pharmacological pearls to be kept in mind include: high affinity to mu receptors and displaces full agonists from the occupied sites, which may lead to precipitated withdrawals; poor bioavailability when swallowed but fair bioavailability when taken sublingually; highly lipid soluble, it crosses the BBB and circulates within blood, highly plasma protein bound (96%); undergoes metabolism via CYP450 3A4 enzyme system; half-life is 37 hours, allowing a daily dosing; and, it can be detected in drug testing (urine or oral) but needs to be ordered separately. When combined with naloxone (4:1 ratio), buprenorphine is marketed as "Suboxone." Naloxone is added to decrease diversion and, as it has poor bioavailability when taken sublingually, it has no effect in added doses. It can lead to precipitated withdrawals if tablet is crushed and used IV. Physician qualifications are required: valid state medical license, DEA certificate, ability to refer patients for counseling, and/or completing an 8-hour training course or equivalent board certification in addiction medicine/psychiatry. The original "prescriber limit" was for 30 patients, then it was raised to 100 patients, and then up to 275 patients per physician in 2016. An implantable preparation was just approved recently as well which can last up to 6 months.

Buprenorphine has certain advantages over methadone, including ceiling on some effects (no possibility of overdose), lower risk of tolerance, less withdrawal on discontinuation, low abuse potential, less monitoring required, less stigma, and participation in the program not being mandatory. However, retention in treatment is superior in methadone maintenance (MMT) vs buprenorphine maintenance (BMT). Overall, greater benefits of MMT may be balanced by better safety of BMT and preference of the patients.

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## WMC Grand Rounds Review - Treatment of Opioid Disorder

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Naltrexone has high receptor affinity and blocks virtually all the effects of usual doses of opioids. In the presence of naltrexone, opioid agonist administration (heroin, morphine, methadone) is no longer rewarding. It can be given as infrequently as 2-3x a week if compliance is an issue. Tolerance to the antagonism of opioid effects does NOT appear to develop, even after more than one year of regular naltrexone ingestion. Extended-release preparations (Injectable) of naltrexone are more effective than the oral preparations. There are no studies to suggest which patients will have a better response to naltrexone XR vs buprenorphine, and patient's preference and clinical indications should determine the choice of medications.

In conclusion, there are three evidence-based pharmacotherapies for opioid addiction. Dr. Ferrando recommended to choose one based on the patient safety profile and preference. ■

## Fall 2016 APA Assembly Meeting

### Reported by: Richard Altesman, MD, Our DB Assembly Representative

The following is a brief unofficial summary of the Fall 2016 APA Assembly Meeting. Actions passed by the Assembly still require approval of the APA Board of Trustees before being considered final APA policy. There is much that transpired during the course of the meeting, which lasted from November 4th through November 6th in Washington, D.C. This, therefore, does not cover the full depth and breadth of the meeting. I want to acknowledge and thank Adam Nelson, MD, an Assembly Rep from California who was kind enough to compose the original draft of this summary.

**Speaker's Welcome and Report - Dan Anzia, MD:**

Speaker of the APA Assembly, Dan Anzia welcomed everyone to the fall 2016 meeting of the APA Assembly. Dr. Anzia and the executive leadership personally greeted several new members to the Assembly. As an inspiration, Dr. Anzia recited a poem by Robert Frost to the members and guests present before the work of the Assembly would begin.

***There Are Roughly Zones***

*We sit indoors and talk of the cold outside.*
*And every gust that gathers strength and heaves*
*Is a threat to the house. But the house has long been tried.*
*We think of the tree. If it never again has leaves,*
*We'll know, we say, that this was the night it died.*
*It is very far north, we admit, to have brought the peach.*
*What comes over a man, is it soul or mind*
*That to no limits and bounds he can stay confined?*
*You would say his ambition was to extend the reach*
*Clear to the Arctic of every living kind.*
*Why is his nature forever so hard to teach*
*That though there is no fixed line between wrong and right,*
*There are roughly zones whose laws must be obeyed.*
*There is nothing much we can do for the tree tonight.*
*But we can't help feeling more than a little betrayed*
*That the northwest wind should rise to such a height*
*Just when the cold went down so many below.*
*The tree has no leaves and may never have them again.*
*We must wait till some months hence in the spring to know.*
*But if it is destined never again to grow,*
*It can blame this limitless trait in the hearts of men.*

**Rules Committee - Glenn Martin, MD:**

Dr. Martin presented the Consent Calendar for consideration by the Assembly. Once again, the Rules Committee reviewed close to 40 Action Papers and Position Statements referred from the JRC and placed 15 on the Consent Calendar, which, after voted on by the Assembly, left 21 items for deliberation by the Assembly, along with one item of new business.

**Report from the APA President - Maria Oquendo, MD:**

Dr. Oquendo described the recent and upcoming efforts by the APA to streamline the development and updating of Treatment Guidelines, to make them more user friendly to clinicians. Also, the DSM is evolving into a "living document" which will be updated in a more easily and timely manner. Her recent attendance at a "listening session" with the FDA revealed that they are not interested in enforcing medication use exclusively for FDA indicated disorders. Rather, the FDA is relying on professional groups, like the APA, to develop guidelines for off-label use of medications already approved by the FDA. She also spoke of developing a "tree" algorithm to promote the multi-

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## How Do You Train a Psychiatrist?

By: Alexander Lerman, MD
Director of Residency Training, WCMC and Secretary, Psychiatric Society of Westchester

As we work to reinvigorate the Westchester Medical Center/New York Medical College Psychiatry Residency Training Program in Valhalla, we confront the question of what our mission is. Sure - we want to train excellent young psychiatrists. But what is the end product supposed to look like?

Should a residency program be focused on producing can-do clinicians, whose training and experience prepares them to work with unpredictable patients and ever-changing diagnostic assessments? Or does the ideal residency produce young scientists, who contribute to the academic community through meeting attendance and literature and incorporate current scientific research into daily practice?

If we place clinical practice as our paramount goal, then do we mean psychopharmacology, cognitive behavior therapy, family therapy, group psychotherapy - or any of the hundred permutations of these techniques? If, on the other hand, we place science first, then what kind of science: genomics, biomolecular neuroscience, fMRI imaging of neural networks, bundled and un-bundled comparisons of DBT against alternative manualized psychotherapies, or longitudinal studies of defense mechanisms.

Yet - perhaps there's something beyond science and clinical practice that is the defining factor in the training of a psychiatrist: a tradition of disciplined humanistic thought and practice that begins with Charcot and extends through the greats of the 19th and early 20th centuries - Freud, Kreapelin, Bleuler, Jaspers, to name a few - giants of independent thought who defined the problems we still engage today. Surely any training program is incomplete that does not have its graduates place themselves in this procession.

And yet - isn't there something more to the making of a psychiatrist than clinical, scientific and intellectual development? Isn't it the case that psychiatrists - uniquely among physicians - face a special challenge to both understand mental illness, to establish intimate relationships with their patients, and to simultaneously maintain a professional and intellectual position of independence from them? Isn't it the case that almost every psychiatrist must - to one extent or another - inevitably confront themselves, and develop personally and morally, if they are to find their way in what some have called "the impossible profession"?

The answer to each of these questions, as most of us will agree, is - "yes." Modern psychiatric training is deficient if it does not include awareness of all these domains of knowledge and, likely, many others I've failed to mention.

The problem of integrating diverse data and theoretical concepts represents one more aspect of the challenge psychiatrists face on a daily basis - and one of the reasons psychiatry remains the most fascinating branch of medicine.

The goal of our training program is to begin a process of lifelong learning. In addition to our four-year adult psychiatric residency training program, we also have fellowships in Child and Adolescent Psychiatry and Psychosomatic Medicine. Our yearlong OPD rotation includes training in a broad range of psychotherapies. Psychoanalytic courses taken by residents trained in either adult or child may be integrated into a separate advanced psychoanalytic training program or a selective during the PGY4 year. We are building our curriculum in biological psychiatry and psychopharmacology, and building a Department -wide commitment to education and research.

Under the leadership of Dr. Stephen Ferrando, our Chairman, we are committed to the mentorship of our residents as leaders, scholars and clinicians. We're receiving new levels of support from NYMC and are searching for additional funding to allow us to expand our Simulated Patient interview series, increase access to other training materials, and draw Grand Rounds speakers from all over the country. Our program has expanded to a total class of 40 residents in our new partnership with the Montrose VA Hospital.

After many years in full-time private practice, I joined the staff at WMC for the same reason I serve on the Westchester APA Division Branch's Executive Council - because I care about the future of psychiatry and I wanted to expand my ability to make a difference. If you feel the same calling, you may want to consider joining us to train what the Star Trek fans among us call the "Next Generation" psychiatrists. We'd love to have you and can tailor a voluntary position to your schedule and available time.

We also welcome all psychiatrists in the area to our Grand Rounds and complimentary CME. ■

## Neurobiology and Treatment of PTSD - Chadi Abdallah, MD
## WMC Psychiatry Department Grand Rounds - September 6, 2016
### Reported by Alexander Lerman, MD

Dr. Abdullah is a specialist in neuroimaging, translational neuroscience and psychopharmacology at Yale University. He has published extensively regarding the role of the glutamatergic system in schizophrenia and PTSD.

Dr. Abdullah addressed the neurobiology of chronic stress. Underlying his presentation is the question of whether a subpopulation of individuals suffering from depression, anxiety, and PTSD are afflicted by abnormalities in glutamatergic functioning, and whether an improved capacity to make this distinction may lead to better treatment outcomes, and identification of a select group who require different therapies (e.g., ketamine, see below).

Dr. Abdullah stated that acute stress is beneficial to the brain, vs. trauma (by definition a chronic stressor), which is detrimental to the brain. Take for example the level of depression in medical students and residents (a mild stressor compared to refugees) – up to 43% of this population experience depression. Among men in the general population, 4% suffer from PTSD. In combat veterans, the rate is 36%. In refugees, up to 86% (depending on circumstances). Chronic stress in children increases the rates of a variety of other psychopathologies.

Chronic stress results in dysregulation in glutamate release. Initially glutamatergic transmission is increased, but in chronic conditions it is then decreased. You have the abnormality of uptake of glutamate through glial cells, leading to spillover of glutamate outside the synapses. We know that the glutamate outside the synapses is toxic, and affects the brain negatively.

Imaging of neurons in rats after 21 days of mild stress shows diminished branching and arborizations. We see diminished spines where most glutamatergic synapses are found.

More than 90% of cortical synapses are glutamatergic. Glutamate is the "gas" of the brain. These are the excitatory synapses. The other common synapses are GABAergic, the "break" or inhibitors of neurotransmission.

When glutamate is released inside the synapses, we see brain growth, activating postsynaptic changes which promote neural plasticity, increased number of receptors, increased synaptic strength. These changes are most marked in the prefrontal cortex and hippocampus. (We see the opposite effect in the nucleus accumbens.)

Glutamate outside the synapse promotes reduced growth, reduced neural functioning, and in the whole organism, we see depression.

Ketamine is a NMDA antagonist which reverses glutamate-induced excitotoxicity.

In humans, cortical thickness can be taken as a measure of dendritic arborizations and other indications of neuronal health. Cortical thinning is normally seen in humans over age 30, but it occurs in much younger persons in a setting of PTSD. Cortical thinning tends to correlate with severity of PTSD symptoms. Combat exposure in the absence of PTSD is likewise associated with cortical thinning.

In a study of depressed patients, treatment resistant depression was associated with smaller hippocampal volume. Treatment with riluzole (a glutamatergic drug used in the treatment of ALS, which is believed to reduce the toxic spillover of glutamate outside the synapse) achieved positive results in subjects who had small hippocampal volume, suggesting that glutamatergic toxicity mediated diminished volume and resistance to other treatment.

This research holds out some hope of identifying a subpopulation among depressed subjects that may respond to glutamatergic drugs. Many results show a trend, not necessarily statistically significant.

Depressed subjects as a population tend to show less global glutamatergic activity in the brain, particularly in the prefrontal cortex and anterior cingulate cortex. Once again, measures of diminished glutamatergic activity correlate with treatment resistant depression and cortical thinning.

Measures of brain activity with carbon13 labeled glutamate + glucose show significant reduction in energy (glucose metabolism) but not in glutamate metabolism. This is a surprising finding because glutamate activity is generally tightly coupled with metabolic activity in the brain in studies of humans and other animals.

Subjects with childhood histories of trauma show higher levels of

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## Neurobiology and Treatment of PTSD - Chadi Abdallah, MD

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glutamatergic activity (particularly in the occipital cortex), even in adulthood. Emotional abuse is most correlated with elevated glutamatergic activity. Clinical improvement tended to correlate with reduction to baseline in this activity.

Ketamine has a powerful effect on synaptic strength and animals. Ketamine treatment can reverse trauma-induced synaptic shrinking within 24 hours. And this effect tends to last for 7 to 10 days in animals, slightly longer in humans. Ketamine appears to work on 2 pathways, including the inter-synaptic pathway (the "go" pathway), as well as blocking the extra synaptic NMDA receptor. This dual activity may be the means by which the unique antidepressant effect of ketamine is mediated.

FMRI studies of "global connectivity" (i.e., a cumulative measurement of the connectivity of each voxel with the rest of the brain) once again showed a reduction in prefrontal connectivity in many stress-related disorders, including depression. Connectivity in posterior cingulate and occipital cortex is increased.

Another measure of connectivity is "seed-based analysis." This method measures BOLD signal fluctuations over a period of time up to 5 minutes in duration both globally, and in relation to a single voxel "seed". Connectivity is then calculated based on the relation between these fluctuations. Greater levels of correlation suggest a higher degree of connectivity.

Seeds are selected in the "affective network" (i.e., the region beneath the genu of the cingulate gyrus), in the "cognitive control network" (anterior cingulate), and the default and mode network. In depressed subjects, connectivity within the prefrontal cortex locally is increased, but connection between the prefrontal cortex and the rest of the brain is diminished. Similar findings are present in the default mode network.

Ketamine tends to reduce prefrontal dysconnectivity. Dr. Abdullah emphasized that ketamine is an investigational drug only, and the scientific basis for its efficacy is limited. A major problem with ketamine is that if it is overused, and taken on a daily basis, it can replicate glutamatergic excitotoxicity, leading to cognitive and gray matter deficits. Ketamine should not be taken more than once or twice a week. Other problems with ketamine include abuse potential and rare side effects of perceptual disturbances verging into psychosis.

PTSD and hippocampus: Anterior hippocampus is connected to the amygdala + thalamus, prefrontal cortex. This is associated with emotions and fear, whereas the posterior hippocampus is more involved with navigation and emotional context. Interestingly PTSD may be associated with increased "context" error in the posterior hippocampus.

PTSD symptoms were divided between depressive equivalents such as numbing + avoidance versus "hyperarousal" symptoms such as flashbacks and nightmares. PTSD subjects suffering from hyperarousal tend to show increased hippocampal connectivity. PTSD tends to be associated with structural shrinkage in the anterior hippocampus.

Another investigative technique is diffusion tension imaging (DTI), which examines diffusion of water inside the brain. Using this technique, the same result: numbing tends to be associated with reduced connectivity; flashbacks and hyperarousal are associated with increased connectivity. ■

## Upcoming Grand Rounds at Westchester Medical Center

**January 3, 2017** - Lidia Klepacz, M.D. - Managing Agression & Violence

**January 10, 2017** - Lawrence Kegeles, M.D. - Functional Brain Imaging In Schizophrenia

**January 17, 2017** - Elizabeth Rosenthal, M.D. - "From the Affordable Health Care Act to Universal Health Care in NYS"

**January 24, 2017** - Stephen Billick, M.D. - Dangerous Adolescent Behavior & Electronic Media

**January 31, 2017** - George Alexopoulos, M.D. - Perspectives on Geriatric Psychopharmacology

**All area psychiatrists are welcome to attend Grand Rounds. CME credit is available.**

## Implementing Pharmacogenetic Testing in Psychiatry

### Reported by: Jerry Liebowitz, M.D., PSW Newsletter Editor

Daniel Dowd, Pharm D, Senior Medical Science Liaison at Genomind:East, presented a talk on "Implementing Pharmacogenetic Testing in Psychiatry" at the Psychiatric Society of Westchester's CME Dinner Meeting held at St. Vincent's Hospital on November 9, 2016. He spoke about how to recognize genetic risk factors in mental health, understand the relationship of genetics to pharmacokinetics and pharmacodynamics in psychiatry, recognize how to implement pharmacogenetics into our practices, and manage data to support the utility of pharmacogenetic testing.

**Treatment Resistance in Psychiatry:**

He began by reviewing the topic of "treatment resistance," noting that 30-80% of psychiatric patients have unresolved symptoms. Many have abandoned drug therapy due to inefficiency or side effects. Reviewing the literature, he noted that in MDD 30% were treatment resistant following 4 treatments (STAR-D), in Bipolar Disorder 50-70% relapsed (STEP -BD), in schizophrenia up to 74% discontinue meds due to lack of efficacy or poor side effects after 18 months (CATIE), in GAD there was recurrence in up to 50%, and in OCD the relapse rate was up to 80% in 10-year follow-up.

These NIMH studies converge on the fact that there is significant variance in patient response or remission to psychiatric treatments. For example, up to 40% of anxiety patients still have significant symptoms after their initial treatment, 63% of depressed patients were not in remission, and 73.5% of bipolar patients were not in remission.

This evidence reflects that psychiatric disorders are clinically challenging, hard to diagnose and even harder to treat for clinicians. Psychiatric patients show a higher degree of treatment failure (ranging from 1/3 to 2/3 of the total subjects treated). This, according to Dowd, may be explained by the "treatment as usual" model of psycho-pharmacotherapy. Noting that the Star-D remission rates decreased after each failed antidepressant, he stressed that the goal is to select the right drug during STEP-1, because chances of successful remission decrease with each failed drug. Pharmacogenetic testing using biomarkers, he explained, can help us choose the right drug for the patient.

**What are biomarkers?**

Dowd went on to explain and give examples of each type of BioMarker: 1) **Gene based**: single nucleotide polymorphisms (SNPs), which most of the assays usually ordered measure; 2) **Epigenetics:** Methylation and acetylation, which can turn gene expression OFF or ON, respectively, has been shown to impact genes such as SLC6A4 or COMT; 3) **Proteomics** (gene expression and proteins): BDNF (brain-derived neurotrophic factor) protein is reduced in depressed patients and increased following antidepressant use; and 4) **Brain Imaging**: qEEG or fMRI may be clinically useful in predicting drug outcomes.

**Pharmacogenetic Testing:**

Pharmacogenetic (PGx) testing was introduced commercially in 2010 in psychiatry. Dowd discussed how such gene-based assays can inform treatment decisions for patients. Using a sample PGx testing report from Genomind, he highlighted the difference between Pharmacokinetic versus Pharmacodynamic genes.

He began with 6 pharmacokinetic genes: VYP3A4/5, CYP2D6, CYP2C19, CYP1A2, CYP2B6, and CYP2C9 – all enzymes that metabolize medication in the liver. A large number of psychiatric meds are metabolized by CYP450 enzymes, mutations of which may require dosage adjustment (increase or decrease).

He then described 12 pharmacodynamic genes: SLC6A4 (serotonin transporter), a protein responsible for reuptake of serotonin from the synapse; COMT (catechol-o-methyltransferase), an enzyme primarily responsible for the degradation of dopamine in the frontal lobes of the brain; ADRA2A (alpha-2A adrenergic receptor), involved in neurotransmitter release and associated with improved response to stimulant agents; DRD2 (dopamine 2 receptor), affected by dopamine in the brain and blocked by antipsychotic medications; CACNA1C (calcium channel gene), a subunit of the calcium channel, which mediates excitatory signaling; ANK3 (sodium channel), a protein that plays a role in sodium channel function and regulation of excitatory signaling; MC4R (melanocortin 4 receptor), plays a role in the control of food intake; 5HT2C (serotonin receptor 2C), involved in regulation of satiety and blocked by atypical antipsychotics; OPRM1 (mu-opioid receptor), an opioid receptor affected by natural and synthetic compounds; GRIK1 (glutamate receptor), an excitatory neurotransmitter in the brain; MTHFR (methylenetetrahydrofolate reductase), the predominant enzyme that converts folic acid/ folate to its active form (methylfolate) needed for synthesis of

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

By Tony Stern, MD

*(continued from previous issue, Summer 2016)*

**The Place of Pure Meeting**

The psychiatrist Mark Epstein, whom I first got to know back when we were Harvard undergrads together as well as fellow seekers on a spiritual path, provides another lovely example of "signs" near the end of his second book, Going to Pieces without Falling Apart. He takes a walk in the woods after lunch every day during a ten-day Buddhist meditation retreat. In the middle of each hour-long hike, he stops and looks around at his surroundings. Everywhere he ends his walk and watches, there are surprising hints of aliveness, moments of unexpected encounter. Everywhere he turns, life emerges to meet him: first as a windstorm swirling circles of snow around him; the next day as the very first flakes of a new snowfall; on another occasion, as an owl swooping near his head, a single dark wing extended. All of these small meetings suggest to him that these simple stirrings of life are always happening, that it's just a matter of paying attention. He did not have the eyes to see them until this time.

What a blessing, yet such a simple birthright, too: to have eyes of wonder that look out upon the world. Epstein's account discloses a fact about "signs" that Buber surely meant, but that may not be immediately obvious to us: that the magic in life always involves an encounter with an unforeseen and unfamiliar "other." It involves an I-Thou meeting. This "other" is a messenger of the unknown, bringing the unknown to our doorstep. Do we practice hospitality and welcome this stranger? When we hide from signs, we are hiding at the same time from the I- Thou encounter and its peculiar intensity.

The present moment, then, is the place of pure meeting. But most of us often nip our meetings at the bud, refusing to go along with them because there is something unfamiliar and surprising in I-Thou contact, and because the lack of familiarity is sufficiently unsettling. Does this "unsettling lack of familiarity" sound familiar to you? It is the fear of the unknown we spoke of at the start. We hide in the known to maintain a sense of control, and how much poorer are our lives for it.

Again, how often do we welcome the unknown, the strange, or an embodiment of the strange in the form of a stranger? This question includes our own inner experiences. When an unfamiliar feeling or experience knocks on our door, it is good to invite it into our house, as the 13th century Sufi Rumi recommends in a poem named "The Guesthouse." It is the inner equivalent of practicing hospitality to strangers. In fact, if we were alive to such moments and adept at letting them in, we would probably need no other inner practice. Not all such moments are pleasant at first; but all lead to unforeseen depth and richness if we stay with them. Rarely do we realize how often we are shutting out a whole range of our own subtle feelings – feelings that are entranceways into the unknown. Rarely do we realize how routinely we are squelching little experiences in the cradle, before they have had a chance to unfold and grow in all their unforeseen depth and strangeness.

To drive home our awareness of the strangeness inherent in I-Thou meetings, let's turn to a film, Robert Zemeckis's "Contact" (1997), based on Carl Sagan's novel of the same name. The Jodie Foster character, Ellie Arroway, dreads I-Thou intimacy even as she yearns for it. Near the end of the story, she has the experience of awesome contact she has been reaching and working toward for most of her life. She stands on a beach, and the starry night sky is far closer than it seems. Every time she reaches toward it, she actually touches its invisible border, and each times she does, a chiming sound rings. Rilke's beautiful words come to mind: "Don't you sense me, ready to break into being at your touch?"

Indeed, the starlit heavens are nearer than we think. The entire cosmos is close at hand, right here and right now. But Ellie had to go through a few rather intense wormholes to come to this simple point. And so do we. The experience of extraordinary contact she has had remains a mystery to her at the end of the film. As our own I-Thou encounters do for us. Finally, this contact frees her to open to greater intimacy in her everyday world. And the same kind of freeing occurs in our own lives.

**How and Now**

Let's return now to where we began, with the interesting dilemma of "How?" How can we enter where we already are?

Many teachings can help, by encouraging us to enter wherever we are, wherever our present concrete situation happens to be, right here and right now. Thus, for instance, Buber contrasts the question, "What is one to do?" with the less abstract and more heartfelt question, "What have I to do?" "One cannot help himself, with one there is nothing to begin, with one it is all over…. But he who poses the question with the earnestness of his soul on his lips and means,

'What have I to do?' – he is taken by the hand by comrades he does not know but whom he will soon become familiar with, and they answer (he listens to their wonderful reply and marvels when only this follows): 'You shall not withhold yourself' …'You, imprisoned in the shells in which society, state, church, school, economy, public opinion, and your own pride have stuck you, indirect one among indirect ones,

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# THE NARROW RIDGE:

## Insights from Zen, Judaism, and Psychoanalysis

*(Continued from page 10)*

break through your shells, become direct; man, have contact with men!'" Today, of course, he would have said, "Man and woman, have contact with men and women!"

Among the many teachings that may help, the Serenity Prayer, originally written by Buber's friend Reinhold Niebuhr, has been quite central in our time. It has been one way countless people have earnestly asked, "What have I to do?" It provides one simple entry point into breaking through our shells and emerging from hiding. Its wisdom is in essence the same as a core teaching of Krishna in the beloved Hindu scripture, the Bhagavad Gita. Both this prayer and the Gita remind us that we are compelled to act, but the results of our actions are out of our hands.

Sooner or later on the inner path, we discover both the courage to act, even the necessity to act, and the serenity to accept what our own action cannot change. This dynamic of courage and acceptance relates to the question, "Is it me, or is it a power beyond me, which brings the needed energy on the path of transformation?" To ask the same question more practically, "Do I need to act now, or do I need to wait for a power beyond me to act?" "Action" here includes the simple act of paying attention: do I need to bring attention to something within me, or will "something" find me? Will something find me if I give it a chance? Even this "giving it a chance" is a sort of action. Do I need to rely on my own effort, or do I need to depend on grace?

Paradoxically, both self-reliance and the surrender of effort have a key role to play. My first spiritual teacher, Rudi, made one practical point about this paradox. He likened the process of inner practice to the activity of a skater. Imagine yourself skating alone on a beautiful mountain pond in the dead of winter, surrounded by snowy hills and frost-covered trees. You are gliding along, having a grand old time. But then you find yourself slowing down. Naturally, without really thinking, you push off at this point with one foot. As your momentum slows again, you push off with the other foot. And that's how it goes. You push off, you make an effort, whenever you find yourself slowing down, but otherwise you relax and let yourself enjoy the ride. Push, and glide; push, and glide.

The narrow ridge, as we have said, is a ridge of paradox. It includes this paradox, too: the critical need for both active assertion and passive receptivity. The one hand clapping of the present moment is the meeting point between doing and non-doing, between the certainty of action and the uncertainty of where it leads, between working for change and accepting what is. When we blend the concrete focus of courageous action with serenity, the relaxation of acceptance, then we are off to a very good start.

This talk of doing and non-doing brings to mind some of the central clinical insights of Leston Havens and James P. Gustafson, drawing from the earlier work of Harry Stack Sullivan. Havens has enriched the original meaning of "analytic neutrality" by carefully describing the need for therapists to be quietly passive yet active through making room for the patient's own space yet remaining a tangible presence to the patient. Gustafson has suggested that patients need to learn to find a balance between passivity and aggression, by getting beyond three stories in which they are trapped: subservience (passivity), delay (more passivity), and overpowering (aggression).

While it is beyond our scope to explore now, it should be mentioned that these human tendencies to be caught in passivity and assertiveness are in turn intimately connected to the dynamics of idealization and devaluation. In addition, please also note that the distinction between the sacred and the mundane that Zen teachers and Jews like Buber fundamentally call into question is itself an expression of the idealizing and devaluing dynamic. In any case, Zen, Hasidism, and psychoanalysis are all opposed to rigid black-and-white thinking, where the tendency to idealize another person or oneself is not well-integrated with the devaluing tendency.

Krishnamurti entered this same discussion by talking about the acceptance of "what is". With this kind of non-judgmental awareness, we do not get nearly so lost in favorable or unfavorable impressions of situations and other people and ourselves.

When we accept "what is," does all become easy? Not exactly, because the "what is" of the present often contains sorrow and other difficult emotions. One of our human tasks is to learn to bear the sorrow and pain of the present hour. This present "what is" brings forward all the dimness of the past. We have referred to this dimension earlier by mentioning the reservoir of pain we all carry. In other words, the cup of the past oftentimes contains a bitter and confusing brew; we need to drink it as well as digest it before we can move more wholeheartedly into the new life of the present.

The "what is" is not an isolated moment. It opens into the past and the future. It contains all. In "Four Quartets," T.S. Eliot writes, "Not the intense moment/ Isolated, with no before and after, /But a lifetime burning in every moment/ And not the lifetime of one man only/ But of old stones that cannot be deciphered." And the nineteenth century rabbi Zusya suggests that only when we have overcome the dimness we have inflicted on ourselves as well as the

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## Fall 2016 APA Assembly Meeting

### Reported by: Richard Altesman, MD, Our DB Assembly Representative

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modal treatment of distinct Mental Health disorders.

**Report of the CEO/Medical Director of the APA- Saul Levin, MD, MPA:**

Dr. Levin presented his report, much of which can also be found in the Assembly packet. At the APA Annual Meeting, the White House Task Force on Mental Health Parity heard testimony from several leaders and members of the APA, who voiced concerns and ideas to ensure full implementation of the law. Current initiatives include: health plan network adequacy, funding to audit health plans, public reporting on parity investigations, and producing a consumer guide to disclosure rights. APA is making MACRA implementation for Medicare providers as user-friendly as possible. See here: www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/macra-101?ga=1.161216830.2057838146. This includes reporting exemptions for practices treating less than 100 Medicare beneficiaries, decreasing and making reporting requirements more flexible, and developing a registry – called PsychPRO – to facilitate MACRA reporting for members. With the rapidly changing political climate, Dr. Levin encouraged members who can advise the president-elect and newly elected members of Congress to reach out to their transitional teams. APA is using their TCPI-SAN (Transforming Clinical Practice Initiative – Support and Alignment Network) Grant to facilitate over 500 psychiatrists to date in Integrated Health Care, and plans to train several hundred more. Also, kudos goes to APA member Peter Yellowlees, M.D, recently elected president of the American Telemedicine Association. APA will be taking occupancy of its recently purchased new office space in 2018, after completion of construction and renovation.

**Assembly Nominating Committee - Glenn Martin, MD:**

Dr. Martin announced the candidates nominated for Assembly office. For Speaker-elect: Bob Batterson, MD from Area 4 and James Polo, MD from Area 7. For Recorder: Steven Daviss, MD from Area 3 and Paul O'Leary, MD from Area 5. Hearing no other nominations from the floor, the nominations were closed. Best of luck to all nominees.

**Report from the APA President-elect - Anita Everett, MD:**

Dr. Everett presented her report as chair of the JRC, including upcoming new business for the Assembly of a position statement on psychiatrist participation in euthanasia, an Autism Spectrum Disorder medication guide for parents, and increasing psychiatrist participation in treatment of persons with mental illness in prisons. She then outlined an agenda of initiatives for her upcoming presidency, including increasing access to psychiatric care, making the APA a "go to" place for psychiatrists everywhere, improving treatment of first-episode psychosis, and addressing physician burnout and improving resilience.

**Treasurer's Report - Bruce Schwartz, MD:**

Dr. Schwartz reported on the APAF and the APA. APA is generally on target with the forecasted budget. Key points include better than expected revenue from DSM licensing and royalty fees, along with lower than expected overall book sales, lower than expected Annual Meeting attendance, some cost reductions due to personnel vacancies, and excellent investment portfolio performance. All detailed information can be found in the Treasurer's Report available in the Assembly Packet.

**American Psychiatric Association Foundation - Saul Levin, MD, MPA, Chairperson/Chief Executive Officer and Medical Director, and Dan Gilleson, Executive Director:**

APF, APIRE, and APPI have all now been combined into APAF. Daniel GIlleson is the APAF's new Executive Director, who promises to bring great enthusiasm and passion to his job. The APAF wants to increase relevance to members and increase efforts at education and fundraising. The APAF has been partnering with other organizations around the country to increase visibility of programs important to these efforts, including "Typical or Troubled" – called out by Hillary Clinton during her campaign, and partnering with "Sandy Hook Promise", Partnership for Workplace Mental Health, which produces a Mental Health Works newsletter, and Stepping Up Summit – partnering with SAMHSA and state and county agencies to improve awareness of mental health needs of prison and jail inmates. Member contributions have increased in 2016 relative to 2015. The APAF will be hosting a reception in San Diego at the Wine and Cultural Event Center at the 2017 APA Annual Meeting. Please contribute generously to the APA

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# Fall 2016 APA Assembly Meeting

## Reported by: Richard Altesman, MD, Our DB Assembly Representative

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Foundation for all the good work they do: www.americanpsychiatricfoundation.org/get-involved/donate

**Report from APA-PAC - Paul O'Leary, MD:**

Dr. O'Leary described the work the APA-PAC has done over the past year. The PAC has contributed $410K to various federal candidates and committees, with about 54% going to GOP and 46% to DNC projects. In addition, the APA-CAN (Congressional Advocacy Network) remains strong and active. With the results of this year's presidential and congressional elections, psychiatrists can play an influential role in the upcoming lame duck session of Congress.

**REPORTS AND NEXT STEPS FROM THE ASSEMBLY WORK GROUPS/COMMITTEES:**

This year's Assembly Agenda placed greater priority on meeting time for Workgroups.

**Psychiatric Diagnosis and DSM** - Efforts to harmonize DSM and ICD-10CM continue, as does efforts to evolve the DSM into a "living document". The long awaited DSM portal website to accept suggestions and recommendations for future changes should be available in a matter of weeks.

**Access to Care** - This task force has evolved into a standing committee of the Assembly. Initiatives include fostering better communication between APA and its constituent DBs/SAs to support state and local efforts at expanding access to care. Also, this committee continues to provide a repository for colleagues and patients to share their anecdotes of problems with access.

**Assembly/Foundation Initiatives** - The APAF report underscores the importance of maintaining strong liaison with the Assembly.

**MOC** - Identified concerns include cost to diplomates of MOC, testing reform, and the importance of keeping an open dialogue with the ABPN.

**Metrics** - Current and proposed metrics projects include studying the Assembly's role as a conduit/incubator for APA leaders, and Assembly reps as a resource for increasing membership engagement.

**Liaison to the Steering Committee on Practice Guidelines** - It will be important to bring published guidelines up to date and making them more user friendly, as well as making the updating process more nimble.

**Assembly Committee on Procedures** - A. David Axelrad, MD:

The Committee on Procedures brought several proposed changes to the Procedures Code of the Assembly. Approved changes included:

- Allowing Deputy Representatives to vote in matters before the Assembly.
- Incorporating liaison language for the Committees on Access to Care and Public and Community Psychiatry.
- Incorporating the Committee on MOC into the Procedural Code.

The proposed change to the Procedures Code to allow election of Assembly officers by a simple majority of individual voters, rather than vote by strength, based on Action Paper 12T (2015), postponed in the last Assembly until this meeting, narrowly failed to achieve the required 2/3 majority of Assembly approval on a vote by strength.

**Action Papers/Items:**

Among the more notable Actions taken during this session, the Assembly voted to:

- Approve (on consent) proposed APA Position Statements on Out-of-Network Restriction of Psychiatrists, Location of Civil Commitment Hearings, Mental Health and Climate Change - all based on previous Assembly Action Papers;
- Approve the improved communication between outpatient and inpatient (hospitalist) physicians;
- Explore (with AMA) models for single payer and universal healthcare access delivery;
- Ensure privacy of protected health information in access of PDMP databases by law enforcement;
- Urge APA develop Position Statements on Screening and Treatment of MH Disorders during Pregnancy and Post-Partum and increase Parity of MH Care for persons with Intellectual and Developmental Disabilities;

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serotonin, dopamine, and norepinephrine; and BDNF (brain-derived neurotrophic factor), important for proper neuronal development and neural plasticity.

He went on to point out how PGx testing is valuable for almost all mental health conditions: in Depression/Anxiety/OCD (SLC6A4, BDNF, MTHFR, CACNA1C, CYP450); in ADHD (COMT, ADRA2A, CYP450); in Pain/Substance Abuse (OPRM1, GRIK1, COMT, DRD2, CYP450); In bipolar/schizophrenia (SLC6A4, CACNA1C, ANK3, MTHFR, BDNF, DRD2, MC4R, 5HT2C, CYP450), In PTSD (SLC6A4, BDNF, COMT, CYP450); and in Autism (MTHFR, CACNA1C, DRD2, MC4R, 5HT2C, CYP450).

Explaining that real world patients don't easily fall into DSM-V discrete category "buckets," since real world diagnoses are "fuzzy at the borders," Dowd proposed "Psychiatric Disease Pathways" as a better approach to treatment, utilizing pharmacogenetic testing as an component. He illustrated this with slides that show the diagnostic category (like "Depression") surrounded by a circle of pathways (like inflammation, neuron signaling, and sleep-related) connected by enzyme-related processes (e.g., catecholamine, folate, cortisol, and methylation) and neuroplasticity.

**Genetic 101:**

Dowd briefly explained the science behind genetic testing. Our chromosomes (23 autosomal) are long strands of DNA, which is composed of 4 nucleotide base pairs: adenine (A), thymine (T), guanine (G), and cytosine(C). Genes are sections of DNA that code for proteins. Each person has approximately 20,500 different genes, which are 99.9% identical between all individuals. The 0.1% variance can help clinicians understand how a patient will respond to treatment. A change in a single nucleotide can have a clinical impact.

He then discussed Nature vs Nurture (how genes + environment = phenotype). In psychiatry, we do a good job of determining what environmental factors have contributed to a particular disorder. Until now, we have not had access to a large component of our phenotype – genetic factors. The use of a PGx plus the patient's history can lead to a more personalized treatment, he explained. Our genes are not deterministic. Environmental factors impact the expression of genes, and clinicians should be careful to always include clinical/ environmental patient history when making clinical decisions. He illustrated how the genes in Genomind's "Genecept Assay," for example, present risk factors for some drug therapies and should be used as supplemental data to all other clinical information.

Genotype contributes to phenotype, he noted. Alleles are different variants of a gene. Humans are diploid organisms and receive one allele from each parent. One's genotype is a representation of those two alleles. They can be either homozygous or heterozygous or have insertions or deletions for any specific gene. Often, having two copies of a risk gene has more of an impact compared to one copy.

**Genes in Detail:**

**Pharmacokinetic gene variants** associated with altered liver enzyme metabolism activity may lead to side effects and toxicity. There are 4 possible phenotypes for CYP450: **Poor metabolizers or inhibitors (PM)**, with low activity, may have increased drug serum levels and adverse events. **Intermediate metabolizers or inhibitors (IM)** also may have increased drug serum levels and adverse events. **Extensive metabolizers (EM)** (the common state) metabolize substrates normally. **Ultra-rapid metabolizers or inducers (UM)** may have reduced drug serum levels and poor efficacy. PM and UM are your highest risk populations.

He discussed the major psychotropic substrates (CYP2D6, CYP3A4, CYP2C19, CYP1A2, CYP2C9, and CYP2B6) and some of the drugs metabolized by each group. He also showed how CYP1A2 is highly induced by certain environmental factors, such as tobacco smoke (and not nicotine patches, gum, etc.), cruciferous vegetables, and char-grilled meats.

He then discussed some of the **pharmacodynamic genes** in detail, explaining, for example, how patients containing certain alleles of the serotonin reuptake transporter gene (SLC6A4) are at higher risk for side effects and lack of response to SSRIs.

He also discussed ion channels in the brain in various psychiatric disorders. Neurons communicate electrically within themselves. This electrical charge is carried by ions, which enter the cell via

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specific channels. Activating glutamate receptors leads to depolarization as sodium enters the cell. Depolarization opens calcium channels, which are responsible for neurotransmitter release. Thus, calcium and sodium are excitatory to cells. Homozygotes of the ANK3 "T" allele or the CACNA1C "A" allele are at higher risk of altered neuronal signaling. Therapeutic options include agents that reduce neuronal signaling, such as mood stabilizers, atypical antipsychotics, and omega-3 fatty acids.

He went on to describe the genetics of atypical antipsychotic medications' metabolic effects. The regulation of feeding behavior and energy balance is highly complex and controlled mainly in the hypothalamus. Serotonin signaling regulates satiety through activation of 5HT2C receptors. 5HT2C antagonists inhibit satiety and can lead to increase feeding behaviors. Drugs that have a high binding affinity to 5HT2C, and therefore are associated with weight gain, include olanzapine, clozapine, risperidone, and mirtazapine. Mutations here suggest that atypical antipsychotics should be used with caution. However, the T mutation confers a protective effect against weight gain. A deficiency of MC4R, a receptor protein that regulates energy balance in the hypothalamus, may cause hyperphagia, hyperinsulinemia, as well as increased fat mass, fat-free mass, and bone mineral density. Activation of MC4R leads to satiety and energy expenditure, while inhibition promotes energy intake. Atypical antipsychotics exacerbate the risk for weight gain for A allele carriers of this gene.

Discussing the dopamine and antipsychotics, Dowd noted how clinical efficacy is highly correlated with the binding affinity to the DRD2 receptor. Deletions in the DRD2 gene can alter binding affinity and receptor density, leading to poorer outcomes with atypical and typical antipsychotics – lower efficacy and increased side effects. Deletions may also be associated with increased risk of opiate abuse.

He also discussed briefly how response rates to methylphenidate can be predicted by the various alleles of COMT and the ADRA2A gene; how folate metabolism is affected by the different alleles of MTHFR; how one of the alleles of BDNF is linked to impaired cellular secretion and transport, which may indirectly affect expression levels, and how BDNF may be a "candidate gene" for many psychiatric disorders; how one allele of OPRM1 is associated with decreased response to opioids and increased risk of addiction; and how different alleles of GRIK1, a glutamate receptor, are associated with alcohol dependence and topiramate response for alcohol abuse.

He concluded by describing a prospective naturalistic open label study to determine the **effectiveness of genetic testing** based on clinician-rated and patient-rated measures and to assess its influence on clinical treatment decisions. In that study, 91% of treatment-resistant patients showed clinically-measurable improvement, with 64% of treatment-resistant patients demonstrating significant clinical improvement. "This is a strong signal for us to continue to seek funding for randomized trials," he urged, noting that a benefit has been demonstrated, "but we need to better understand the magnitude of the benefit." ■

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## Fall 2016 APA Assembly Meeting

### Reported by: Richard Altesman, MD, Our DB Assembly Representative

*(Continued from page 13)*

- Urge APA to improve liaison between APA fellowship applicants and recipients and their local DBs;
- Urge APA to support smart-gun technology as part of an effort to reduce gun violence as a public health concern;
- Urge APA to advocate for improved quality and access to medical and psychiatric care in correctional and institutional settings;
- Urge the APA to collaborate with other state and national groups to combat the consequences of childhood poverty and to end this public health problem;
- Have the BOT from a Task Force on combatting Discrimination and its MH consequences;
- Reaffirm the requirement of medical training for anyone who prescribes psychotropic medications;
- Develop a fund with APAF help to pay costs of consumer speakers who present at APA meetings;
- Reaffirm several current APA Position Statements, which can be found in the Assembly Packet;
- Approve the proposed Position Statement opposing Psychiatrist prescribing or administering any euthanizing intervention to a non-terminally ill person;
- Refer a Position Statement on Confidentiality of Medical Records of Physicians who have previously been in treatment back to JRC for revision to address practices of state Medical Boards publicly posting such information on their websites.

Final Action Papers can be found by going to http://ait.psychiatry.org/. ■

## THE NARROW RIDGE:

### Insights from Zen, Judaism, and Psychoanalysis

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dimness our mother and our father have inflicted on us, can we open to what the Divine Mystery has in store for us.

One of the well-known stories in the Chinese Zen tradition tells of the eighth century student Joshu. He travels a long way and asks Nansen, a great Zen master of the day, "What is the way?" Nansen replies, "Everyday mind is the way." Starting from where we are truly does suffice.

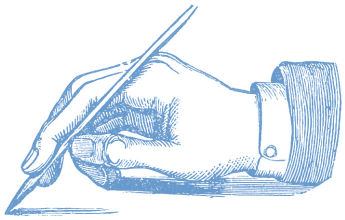
We began by suggesting that the "How" is misled. We also said that it was inevitable. It is more than both of these descriptions; it is also crucial. It is the raw intentional power of the search expressing itself in each of us. It is where each of us begins. It cannot be done away with, and it would be a disaster if it were, embodied perhaps most poignantly in the withdrawal of a person afflicted with undifferentiated schizophrenia. (Such withdrawal is an expression of great hopelessness, and it involves such a shut-down of desire and drive, the raw material of the search, that it leads to a nearly hopeless situation. The will to avoid all pain leads to an eventual draining of the will to interact and engage.)

This "How" is inevitable and crucial because it is the central feature of restless seeking in our everyday minds. In other words, this "How" is not only a place where we hide. It is also a place where our very life is hiding. It is also our raw material, the grist of where we are for the mill of what can be. It is one outer expression of the "sense of uneasiness" that the psychologist William James discerned as the nucleus of the religious search.

When diffuse seeking becomes clearer intention, and when intention then joins hands with attention, this "How" finds its proper home. For the fun of it, we could put the optimal situation this way: it is when the power of "How" connects with the power of "Now." "How Now."

**Bone-level Wisdom**

As we near the end of this dissertation, let us re-visit a central point and ask together, is the here and now ordinary or extraordinary? Is it made up of common old stuff or ever-new, amazing spirit? This is essentially identical to a question the ninth century Zen master Rinzai put to two soldiers. They were standing next to a wooden gate pole in front of an army camp, and as he approached, he asked them, is this pole worldly or transcendent? In other words, is it basically within this world or beyond this world? As our minds scramble for an answer, our bones already know what our minds cannot grasp: that reality cuts clean through these categories. ■



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