Synapse

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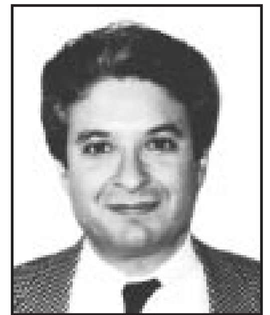
The Next Two Years

Remember 1997? Oxford stock looked invincible, Dr. Harold Eist was in charge and had dubbed managed care the evil empire, and Magellan was still a Portuguese sailor and not a purveyor of low cost psychiatric care. There is much that can change in a relatively short period of time. One thing that hasn't is the commitment and effectiveness of the WHPS. This fine organization has functioned for many years as the center of professional activities for its 150 members, and its range of services continues to expand. I have been pleased and honored to function as the DB president for the last two year and I wish to thank everyone in the organization for the kind support you have shown. My only regret is that my tenure passed so quickly. Good luck to Dr. Les Citrome, our incoming president.

What will psychiatry look like in the West Hudson area, two years from now in 2001? Lots of patients and new medications to be sure. But will we have the physician base to treat them? While the area is thriving economically, the number of psychiatrists locally has not grown appreciably. This is the case both in the private as well as the public sector. The reasons for this are open to speculation. The Pomona Mental Health Center has not kept pace with salaries in the metropolitan area and has not been able to attract and retain new physicians. Certainly, the number of doctors employed by the state system has gone down, as the inpatient population has contracted. Also, there has been the closing of the residency training program in Middletown. Without these centers bringing new psychiatrists into the area, the private sector also suffers, as there are fewer doctors available to set up shingles in the community. Private practice also has the special problem of managed care, which has made the pursuit of a private office less attractive to new physicians, for obvious reasons. Also, there are many insured patients who may be left without psychiatric care, as their carrier may not have contracted with a sufficient number of physicians in the area to meet their needs. This scenario may lead to an artificial scarcity, even before attrition takes its toll. Solution? Better wages for salaried physicians, less onerous managed care control of doctor practices and of course, "market forces" which may bring new psychiatrists to underserved areas. The chances of these changes taking hold? Pick 'em.

Also by 2001, there may be a shortfall of effective membership activity within the WHPS. The organization requires a core of people to devote their efforts to various committee functions, such as CME meetings, public affairs, legislation, ethics, etc. As membership in the APA is no longer universal among psychiatrists, there may be no one available to replace a committee member who needs to end their tenure. Solution? New members to become involved with the nuts and bolts of the organization, who can take over for committee chairs who decide to leave. Prognosis? Good. The sense of professional fulfillment is a sufficient enough inducement for new members to step into these slots when they become vacant.

Finally, what will 2001bring for our ambivalent relationships with the allied professions of psy-chology and social work? For at least the past decade, the trend has continued for psychiatry to relinquish some of its traditional role to these professions with regard to psychotherapy.



Certainly, this has accelerated under the pressures of managed care. When will the pendulum swing back, or is the psychiatrist-psycho-therapist an anachronism? Also, will psychiatry find itself at odds with the physician gatekeeper and generalist, who have been mandated to provide treatment they are often inadequately trained to perform?

Solution? Unclear. Psychiatrist nationwide may be too fragmented on the issue to address it in a cohesive manner, except for some very clear issues of professional boundaries, such as nonphysician prescribing practices. Prognosis? Very good nonetheless, in my opinion. Our training and experience is so unique and so much .▲

Marc Tarle, M.D.

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Abuse of the Post-traumatic Stress Disorder

If one were to quantify the frequency of the use of the PTSD diagnosis in patients, following all types and degrees of trauma, it is a good bet that nearly all of them, (and certainly all litigation claimants, worker's compensation cases and others), would have that diagnosis attributed to their symptomatology. Since its inclusion in DSM III, and the addition of Acute Stress Disorder in DSM IV, no other diagnosis has been used as frequently, and with so much impact as this one.

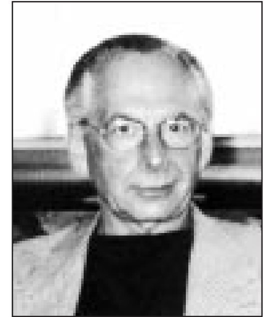
Certainly, if an individual is a victim of a crime, auto accident, or other man-made or nature-produced incident, for which remuneration is sought, and especially if physical injuries are minor or nonexistent, then PTSD becomes the diagnosis to count on.

Yet in my experience, no other diagnosis is more misunderstood and misused as PTSD. It would appear that attorneys and mental health professionals, had either not bothered to consult the relevant DSM or ignored it completely when making this diagnosis. The DSM was formulated, following extensive field trials, in a manner that requires specific symptoms, stressors, and behaviors to make the diagnosis and to avoid the vague, slipshod approach to diagnosis which was the practice prior to its inception. Its primary purpose was to add a measure of scientific accuracy to a hitherto amorphous field.

Take, for example, the following case:

A 34 year old woman, with a history of daily marijuana use, longterm anxiety and serious marital problems, is working an a bartender in a a neighborhood bar. One evening, a police raid occurs, during which she is questioned, and, subsequently taken to police headquarters, where a strip search is conducted (no body cavity search) by female officers. Nothing is found on her and she is released, angry and indignant.

The following day she returns to the bar, continues to work regular shifts (including nights), begins school which she does well in, takes a second job and re-enters therapy (which she had been in previously), to attempt to stop her marijuana use and to improve her marriage. In addition, discussions were held (intermittently) about the police raid and search.



She described few additional symptoms, other than"feeling anxious and wary" during police encoun-ters, and "angry" that she was ac-cused of having drugs and having been treated "like a common criminal".

Some months later, she initiated a civil action against the police department and the town, claiming that as a result of this "illegal search, she was severely traumatized and suffers from PTSD. Her therapist and an "expert" she hired, concurred in this diagnosis after reading to her the symptoms of PTSD, and then asking her which of them she had encountered since the raid.

In order for one to make a diagnosis of PTSD, one must find, on examination, the following:

a) Symptoms follow experiencing, witnessing or being confronted with events involving actual or threatened death, physical injury, or other threats to the physical integrity of the self or others, the stressor.

b) In addition, to meet the definition of an appropriate stressor, the person's response has to involve intense fear, helplessness or horror.

c) For Acute Stress Disorder, at least three dissociative symptoms must be present, and the Criteria-C (re-experiencing), D-(avoidance), and E-(arousal), require that at least one symptom of each be persistent (a

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SYNAPSE designed by Lydia Dmitrieff

May is Mental Health Month

Yes, it's here again. May is Mental Health Month! It's time once again to get involved in the community to destigmatize mental illness and promote mental health.

On May 11, 1999 at the Fire Training Center in Pomona, NY, the Mental Health Coalition will present a seminar for the police entitled Mental Illness- What You Need to Know. This program is our first educational seminar for the police. The goal is to promote the important liaison between police, mental health providers, and advocacy groups. This program includes:

1) Introduction:
Mary Ann Walsh-Tozer, CSW, Commissioner Rockland County Department of Mental Health

2) A Brief Overview of Mental Illness:
Les Citrome, MD, MPH, Director Clinical Research and Evaluation Facility, Nathan Kline Institute for Psychiatric Research

3) Brief Presentations:

a) Legal Issues:
Marc Tarle, MD

b) Dealing with Alzheimer's Client:
Karen Hanusik. BSN

c) Crisis Intervention:
Mary Pesner, RNC

4) A Personal Story:
Gerry Trautz

5) A Family's Story:
NAMI FAMILYA presentation

6) Case Discussion/Questions

This should be an excellent program! If you are interested in attending,please, contact Dr. Kroplick at 914-364-2428. We want Psychiatrists to be visible, and show our leadership in the community. Here is a unique opportunity for us to achieve this goal! The last part of this program is an informal question and answer session and we could use the participation of WHPS psychiatrists from 11:00 am to 12 noon.The coalition is also joining other mental health groups in the Second Annual Picnic for Parity. This picnic will be located at Rockland Lake. Last year's picnic was a great success and was attended by over 400 people. Many of our district branch psychiatrists attended and this was well received by the Mental Health Community and the public. Let's see if we can beat the number of psychiatrists who attended last year's picnic. (Last year attended by Drs. Abdullah, Flax, Gerber, Harris, Kroplick, and Tarle.There will be two college programs this spring at RCC and St. Thomas Aquinas.A family member, mental health professional, and consumer will present to a psychology class- "A First Hand Look at Mental Illness from 3 Different Perspectives."The Mental Health Coalition and West Hudson Psychiatric Society continues to receive tremendous recognition and praise from the APA's central public affairs office in Washington, D.C. Dr. Nada Stotland congratulated us for our enthusiasm and hard work. She says we are an inspiration to APA public affairs representatives across the rest of the country. ▲

Lois Kroplick, DO,
Chair, Public Affairs

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higher level of intensity).

d) For PTSD, while the dissociative criteria requirement is less (one or more), the other criteria require more than those of Acute Stress Disorder; C-three, D-two. But, in addition, the "disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning or impairs the individual's ability to pursue some necessary task".

It certainly appears that if a patient or someone being evaluated after a traumatic event has anxiety when passing the site of the trauma, or thinks about the event frequently, or has nightmares of the event, or is anxious in a car, irrespective of the low level or type of trauma, absence of all the other symptoms and lack of impairment in functioning, this person receives the PTSD diagnosis.

Yet a number of authors have stated that individual post-traumatic symptoms, including dissociative symptoms appear to be common, during or after a traumatic event and are not necessarily pathological.

If we are to have respect for the DSM and for its scientific basis, we must conform our assessments with its requirements. That is the only way psychiatry will be recognized as a scientific discipline. Because of the added aspect of sympathy for victims of crimes and disasters, there is too great a tendency to identify with the patient, and want to help him/her by stretching the diagnostic criteria (or ignoring them altogether). This isn't good for psychiatry. ▲

Alan J. Tuckman, M.D.
Chairman, Ethics Committee

Should Psychologist's Prescribe? One Psychologist's View

Dr. Safran is a psychologist with the Rockland County Mental Health Clinic. He also resides and practices with his wife Marsha Safran, PhD, in South. Nyack, NY. He has a PhD in Clinical psychology from St. John's University. and a Post-doctoral Certificate in psychoanalysis/psychotherapy from NYU. He is former editor & publisher of Projective Drawing (a bulletin on psychological assessment).

Recently, a new controversy has erupted in the on-going territorial struggle between psychiatry and clinical psychology--- the right of psychologists, appropriately trained on the post-doctoral level, to independently prescribe a regimen of psychotropic medication for their patients. To understand this controversy, one must first realize that there is a major schism within the ranks of psychologists about whether or not to be involved in this arena, traditionally ascribed to the medical profession.A distinction must also be made for those psychologists who wish further training in psychopharmacology in order to understand the effects of medication on behavior and disease processes in order to better serve their clients, but have no interest in actually prescribing medications. Examples of this are knowing the effects of psychostimulants on the attention span of an ADHD child or a side-effect, such as sedation, on a patient's behavior.I believe the Prescription (Rx) Privilege movement within psychology has been prompted by a number of pressures such as Managed Care's endorsement of medication as the most cost-effective treatment. What about the further erosion of our role in treating mental illness by the increasing number of clinical social workers and the likelihood that other master's-level professionals will soon be certified to practice independently in N.Y. State under the "Mental Health Counselor" title. In fact, Mental .Health. Counselors will probably be able to do "psychometric" testing which cuts into the psychologist's traditional role.Another issue is that in N.Y. State there is no inherent right for a psychologist to do anything-- only the title is protected by the certification law. Current legislative reports indicate a move by "organized psychiatry & medicine to further restrict the ability of psychologists to practice by limiting their authority to diagnose and treat mental illness". A statement from one proposed bill is as follows -" Such diagnostic privilege is non-medical and is distinct from a medical diagnosis" (Northman, 1998). The reported likely effect of such a bill would be "to restrict the practice of psychology to disorders that have no biological connection or basis." Northman further speculates it could eventually prevent psychologists from using the DSM-IV because it is a "medical" diagnostic tool. Without belaboring the point, it is not difficult to see such threats as contributing to the will of a segment of psychology to advance their scope of practice (the best defense is a good offense?).

Proponents of Rx privileges believe that formalized psychopharmacology education "significantly advances the statutory recognition of the bio-behavioral basis of our scope of practice." They believe the Rx privilege agenda has the capacity to " dramatically accelerate the evolution of professional psychology, and to move us closer to fulfilling our potential of being the premier behavioral healthcare profession" (Levant, 1998). Others continue to believe, somewhat more modestly, that "psychological assessment is the core aspect of our unique identity" (Reed, 1998) in addition to our knowledge of research methodology.

In fact, a survey of psychologists in N.Y. State did not support the Rx Privilege initiative of the American Psychological Association: The majority view of the respondents is best reflected by "I am interested in the information [about psychopharmacology] - but, not in prescribing"(Nevin & Fishbein, 1998).

Another perspective outlined by Lester (1998), who is pro-Rx privileges, suggests that "if we encroach into pyschiatry's territory and are able to prescribe, then other mental health professionals should be able to get trained in what we do and be able to offer it. This is called free-market competition." In Texas, licensed professional counselors made a bid to do projective testing [e.g., Rorschach]. The psychology community banded together and got "government intervention to prevent this scurrilous crime from coming to pass." Dr. Lester goes on to say, "Well, you can't have it both ways. If we can be trained to prescribe, they can be trained to test."

It is apparent that given the Ph.D.'s (or Psy.D.'s) intellectual ability that they could, with additional post-doctoral training and supervision (estimated at more than 2 years), competently prescribe a limited repertoire of

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psychotropic meds. The question remains... why would they want to? Do they really want to be junior-level psychiatrists? Would the possible increase in income [power or status?] be offset by the time and focus on purely medical issues, not to mention the increased liability risks and malpractice insurance costs?

In my personal experience, I have often detected a medical issue that my psychiatrist-colleague may have overlooked because of my particular relationship to the client (e.g., more frequent contact), but it is also true that, by far, the M.D. has been better equipped to diagnose and provide liaison with the patient's other physicians about the numerous medical disorders that they are subject to.

There are benefits to not blurring the traditional roles in the "medical model" as it relates to a team approach within a mental health center context (In-patient, Day Hospital, Out Patient Clinic). Specialists such as psychiatrist, psychologist, clinical social worker, psychiatric nurse, occupational therapist, and art therapist have much to contribute toward a thorough and effective treatment plan. Although a lack of flexibility in these roles can cause dissension or even burn-out-- e.g., the psychiatrist restricted to the role of treatment management, diagnosis, and treatment (medications only) who misses the opportunity to do counseling.

I, personally, have found a very rewarding niche within the Mental Health Center as Primary Psychological Evaluator, a part-time role which supplements my work as a clinic psychotherapist. This allows me to consult with psychiatrists and other Mental Health professionals on the clarification of diagnostic dilemmas, neuropsychological deficits, personality/emotional factors; and intellectual functioning through the medium of psychological assessment.

So, if you haven't guessed by now... I have no interest in prescribing ! ▲

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Lewy Body Disorder: A Challenge For Psychiatry

Lewy body disease, also known as Lewy body dementia or diffuse Lewy body dementia is an uncommonly diagnosed condition. This might be partly explained by the fact that this syndrome lies at the interface of neurology and psychiatry. The patient, usually in his 60s, comes to the psychiatrist with symptoms of depression mixed with some psychotic features. The depression is moderate to severe often leading to social and occupational withdrawal, low energy and a general slowing down of the cognitive faculties. The psychotic features include some delusional thoughts and fleeting visual hallucinations which later become persistent.

Clinically there are some tell tale signs which include a fluctuating pattern in the cognitive deficit, and the lack of response to the antidepressants and most of the antipsychotic medications. As a matter of fact the symptoms of depression as well as of psychosis worsen on these medications. Patient and relatives usually mention that his memory is no longer what it used to be and wonder if he has Alzheimer's disease. The relatives and care givers report that there are periods of time when his memory and intellectual functions return to near normal. This fluctuation in the cognitive process leads the psychiatrist to rule out dementia and think more in terms of severe recurrent depression.

The slowing down of movements and speech, which might become almost a whisper,is usually interpreted as a sign of deepening depression. On physical examination there is early evidence of mild stiffness in the joints but there is usually no noticeable tremors at this stage. As the disease progresses and treatments for depression and the concomitant psychosis remain ineffective,despite repeated changes and dosage adjustments, the search for the etiology leads to neurological consultation and such sophisticated investigations as CT scan and MRI, which are usually inconclusive.

The following case report of a patient who was followed for many years is typical of the progress of this condition: Mr. NT a 65 year old married man,became depressed following some business reverses. When first seen, he was obviously depressed and had some memory deficits. The family reported that he had lately been making some poor business decisions and had become irritable,weepy and at times confused. They wondered if he was developing Alzheimer's dementia. However there were periods of time when he would seem to come out of the mental morass and resume his business activities. This fact lead to the diagnosis of severe recurrent depression as Alzheimers is usually assumed tobe a progressive condition with a steady unrelenting decline in the cognitive functions. He did not present overt psychotic symptoms other than a paranoid suspicion of his close relatives, who he thought were after his money. There were no hallucinations until much later in the progress of the condition, when he would see the battle scenes of his youthful years.

Treatment with a variety of antidepressants and antipsychotics proved to be of no help; they only made the target symptoms worse. As the slowness of movements, appearance of slight tremors and slurring of speech worsened, the diagnosis of Parkinson's disease was made. The use of dopamine agonists exacerbated hallucinations and produced states of confusion and disorientation. After several trials and errors he was finally tried on a very small dose of Clozapine. The initial dose of 12.5 mg brought about a dramatic improvement in his condition. He was able to gradually resume some of his business and social activities and became much easier to get along with. The dose of Clozapine was never increased as the patient argued against the risks of higher doses. He has continued to do well for the last two years with only a very slow worsening of his motor symptoms. With the slowing down of the process of dementia and the extra-pyramidal symptoms he has perhaps added several fruitful years to his life.

The above case illustrates the challenges of a treatment resistant case of depression in an elderly patient who also has minimal evidence of an underlying neurological condition. The use of a small dose of Clozapine went along way in this otherwise difficult to treat condition. For the treating psychiatrist it is necessary to consider this neurobehavioral and neuropsychiatric disorder about which much controversy rages among the neurologists. Is the Lewy body disease a variant of Parkinsonism, or is it a variant of Alzheimer's dementia, or an independent disorder? These questions remain unresolved. Pathologically, Lewy body shows multiple neuritic plaques like those of Alzheimer's disease as well as the typical Lewy body inclusions in the cortex and the brainstem but there are few neurofibrillary tangles found. A recent publication, Dementia With Lewy Bodies: Clinical, Pathological and Treatment Issues, edited by Robert

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Perry et al, deals exhaustively with this condition. In the meantime it is heartening to know that this complex syndrome is treatable with a medication that is presently available.

Historical Note:

60 years after the death of Sir James Parkinson who described the shaking palsy, Friederich Heinrich Lewy was born in Berlin, on January 28, 1885. Lewy contributed to the pathology of Parkinson's disease by describing the eosinophilic intracellular inclusion bodies in the brain that we now call Lewy bodies. The term "Lewy bodies" was first used by Tretiakoff at the University of Paris in 1919.

Lewy's father was an internist in Berlin, he was related to Paul Ehrlich who discovered the Salvarsan treatment of syphilis. In Zurich, Lewy studied neuroanatomy with von Monakow, and graduated in 1910 from the University of Berlin. From 1910 to 1912 he trained with outstanding teachers: Nissl,Alzheimer, and Spielmeyer in Munich; clinical neurology with Oppenheim; and psychiatry with Kraeplin in Berlin. He carried forward the rich tradition of these pioneers in medicine.

In 1913 at the seventh convention of the German Society of Neurologists held in Breslau, Poland, Lewy described in detail the inclusion bodies which bear his name. He described intra- and extracellular bodies free in the tissue and around arterial walls, which he thought to be breakdown products. These bodies were found in the dorsal motor nucleus of the vagus, in the nucleus basalis of Meynert, the nucleus lateralis thalami and the paraventricular nucleus. The bodies were described by him as elongated or circular structures, which stained with eosin.

At the outbreak of World War I he became a major in the German army in charge of field hospitals in France, Russia and Turkey.

In 1926 he was nominated Director of the Institute of Neurology of Berlin,which he had to leave in 1933 when the Nazis came to power. He then spent one year in Britain and was afterwards invited to the Medical School of the University of Pennsylvania in Philadelphia, USA.

In Philadelphia he was a Professor of Neurophysiology, Neuropathology and a consultant Neurosurgeon at the University of Pennsylvania. During World War II he joined the armed services and became Chief of Neurology in the Army hospital at Framingham, Massachusetts. After the war he returned to the University of Pennsylvania.

F. H.. Lewy died in Pennsburg Pennsylvania, aged 65, on October 5,1950. ▲

Syed Abdullah, MD

Statement of the American Psychiatric Association on Patient Protection Legislation House Commerce Health Subcommittee Hearing

March 24, 1999

The American Psychiatric Association (APA) is the medical specialty society representing more than 42,000 psychiatric physicians nationwide. APA commends Chairman Bilirakis and the Health and Environment Subcommittee for holding this hearing on much needed patient protection legislation.

APA members and, most important, their patients, strongly support Federal legislation to end abusive managed care practices. Psychiatric patients are entitled to the medically necessary care they require. Neither patients nor psychiatrists should have to fight with a health plan clerk to ensure such care is available. We believe that the “marketplace” cannot work if health plans are not accountable for their actions and are not held to basic standards of practice.

Members of the Commerce Committee have made very helpful contributions to the patient protection debate. These include bills sponsored in the current Congress by Representatives Ganske, Norwood, and Dingell. We urge the Subcommittee to take favorable action on comprehensive patient protection principles embodied in these bills.

APA-sponsored patients’ rights principles are as follows: Point-of-Service: Patients should be allowed to seek care — at a reasonable additional negotiated cost to them — outside the provider network via a “point-of-service” option. There should be no loopholes to the point-of -service feature (e.g., no 1 percent cost exemption).

Utilization Review: Plans should be required to disclose their utilization review (UR) criteria. Plans should also be required to use UR personnel who are appropriately trained & credentialed to review the services in question.

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Appeals: Plans should be required to establish an independent appeals procedure for denial of care. Dollar thresholds for external review, if any, should not be so high as to exclude most diagnostic tests and treatments.

Liability: The Employee Retirement Income Security Act (ERISA) should be amended so managed care organizations and health plans are liable for damages under state laws for their decisions to limit or withhold medically necessary care.

Gag Rules: Plans should be barred from requiring physicians to sign "gag rule" clauses which interfere with the full disclosure of all treatment options, whether or not covered by the plan.

Access to Specialty Care: Plans should be required to establish clear-cut procedures to ensure access to specialty care, including direct access to specialists without repetitive "gatekeeping" authorization when necessitated by a patients medical condition.

Incentive Clauses: Plans should be barred from using incentive contracts in which compensation is linked to denial or limiting of medically necessary services.

Termination without Cause: Plans should be barred from "termination without cause" clauses which allow them to immediately terminate participation by a physician without written notice of the reason for termination and an established independent appeals process of the termination.

Full Disclosure: Plans should be required to provide all prospective enrollees with a Plain English description of key plan features including: limitation on coverage, co-payments, qualifications of providers, what its quality assurance program consists of, etc.

Confidentiality: Health plans must protect the confidentiality of patient medical records. In particular, plans should be prohibited from using or disclosing individually identifiable health information unless authorized by the individual patient. ▲

APA Seeking Nominees for Journalism Awards -- $1,000 Honorarium

APA recognizes excellence in media coverage of mental illness and psychiatric treatment by journalists, editors, newspapers, producers, radio and television programs with two annual awards. Examples of outstanding work in print and broadcast journalism may be submitted by the journalists themselves, colleagues, or professional organizations. The entries are judged separately in the categories of print and broadcast. Winners will receive $1,000 and a plaque from the APA. If an award is presented to both a radio and television nominee in the broadcast category, the prize will be evenly divided into two $500 awards. Please submit entries to the APA Department of Pub-lic Affairs, 1400 K Street, NW, Washington, DC 20005. Please contact Erin Murphy with questions (202) 682-6324. Deadline for receipt of mailed or faxed entries for year 2000 winners are due July 31, 1999.

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