



Synapse



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When Not to Keep a Secret

In 1998, the APA Alliance initiated a valuable high school essay contest entitled "When Not to Keep A Secret." The contest designed for ninth and tenth grade high school students, is an effort by the APA to decrease violence and suicide in the schools as well as dealing with bullies. I believe this would be a worthwhile project for WHPS members to get involved with this year.

This project gives students permission to break a confidence, trust a significant adult, and understand that violent talk can lead to violent behavior. In their essays, the students tell their truths about situations that have hurt or frightened them or others. This essay has become a tool of awareness, responsibility, education, and discussion. It is a proactive non-threatening way to create awareness about suicide, violence, depression, substance abuse, or sexual behavior that results in unplanned pregnancies and sexually transmitted diseases.

"When Not to Keep a Secret" is a creative project in response to the Surgeon General's call to action to prevent suicide and violence in children.

This project has received national recognition and the APA gives prizes to the winners of the essay contest (round trip to the APA convention, a computer and a bond). The consequences of keeping silent can be devastating. In fact, most of the kids who are taunted suffer in silence. Some of them seriously contemplate taking their own lives. Some lash out

towards their fellow students, almost randomly as evidenced by the shooting in Santana High School, California. In this case, a 15-year-old boy killed two fellow students. His friends said he had bullied throughout his young life. In addition, the shooter at Santana High School told several of his friends about his violent plan weeks before he carried it out. A recent federal report on school shootings shows that friends know about the incidence.

I recently had the painful experience of being the parent of a child who was being bullied not by a child, but rather by an adult- my son's Little League coach. In response to making an error in the field during the game, the coach yelled at my son in front of the team and nearby spectators "I don't know where to hide you. Just fall on the ball when it is hit to you" as well as "Your playing is despicable." This was clearly verbal abuse and intimidation, which is a form of bullying. Thankfully, my son felt comfortable confiding in his parents instead of suffering in silence by withdrawing and becoming depressed or by taking out his anger by picking up a firearm.

Just like in schools, people in the community do not speak out about adult bullies because they are intimidated and fear the risk of retaliation, just as an abused battered wife is afraid to speak up.

However, the rewards of speaking up and not keeping a secret can be so gratifying. In my own case, speaking up to the Little League allowed us to confront the coach and change

coaches, which set a new precedence in the history of our local Little League.

As Psychiatrists, we have been trained that no human being, child or adult should be abused verbally or physically. Now is the time to introduce this project into our community so we can break our code of silence and be proactive in our campaign to allow our children to open up and learn healthier ways to cope with stress in our society.

I welcome your comments and feelings about this project. Anyone, who has a 9th or 10th grade class they would like to get involved in the project, please let me know.

My telephone number is 845-364-2428 and my e-mail address is drkroplick@aol.com. ▲



Lois Kroplick, D.O.
President

In This Issue...

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Psychiatry

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"Involuntary" Intoxication and Criminal Responsibility

We frequently hear of or are treating individuals with alcohol or substance abuse problems who are arrested and charged with a crime, whether it is driving while intoxicated or a crime of another type. Generally, courts hold that when an individual "voluntarily" imbibes alcohol or other drugs and then commits a crime, they cannot raise an insanity

defense. The law believes that when an intoxication is voluntary, the individual cannot then make use of that intoxication for their benefit. But a court may decide that an individual was too intoxicated to form a specific intent, for example, to commit a murder, but still may find that individual guilty of a lesser crime of manslaughter. Thus, voluntary intoxication is considered a potential "partial defense" to a crime.

There is though, a situation in which an individual may claim that the intoxication was "involuntary" and that in contrast, can be utilized as a complete defense to a criminal charge. If that is the case, the individual must prove (a) that he was intoxicated at the time of the criminal act, (b) that the intoxication was involuntarily created and (c) that his mental state at the time met the jurisdiction's test for insanity.

Courts generally recognize involuntary intoxication if it occurs under any of the following conditions: (1) coercion or duress, (2) "pathological intoxication," (3) a drug prescribed by a physician, and (4) resulting from an innocent mistake (where an individual innocently ingests a substance without knowledge of the foreseeable intoxicating potential of that substance. The "innocent mistake" can occur with or without the trickery or connivance of another individual. We periodically have heard about this entity, in which an individual claims that they went to a bar or party, was drinking and someone else "slipped a drug into the drink." These "drugs" have variously been called "knock-out drops" or "a Mickey Finn." Certainly the individual must prove that they were involuntarily intoxicated by a substance being placed in their drink without their knowledge. This may be proven by a blood analysis, which reveals an intoxicating substance, and evidence of an acute delirium.

In New York State, a finding of

involuntary intoxication does not lead to an insanity plea and defense, but instead leads to an outright acquittal. In essence, the defendant had drugs administered to him against his will or by deception, thereby depriving him "of the ability to act consciously and to exercise his own independent judgement and volition, because criminal liability requires at the very least, a voluntary act." Commonly used drugs for this purpose include chloral hydrate, scopolamine and other belladonna alkaloids related to atropine. We have read in the public press periodically of women who claimed that they were raped following a date, during which they believed that a drug was "slipped into their drink" and, during an altered state of consciousness, they were subjected to involuntary sexual activity. Interestingly, scopolamine and related drugs frequently produce total amnesia that develops for events that occurred while the individual was under the influence of the drug. Many other drugs can produce a similar effect, such as drugs used for colds, allergies, motion sickness, and peptic ulcer, ophthalmologic conditions and Parkinson's Disease.

Certainly, when presented with this fact pattern by an individual, specific information must be acquired about the individual's state of mind, level of alcohol consumption, likelihood of having been involuntarily intoxicated, onset of the delirium (30-60 minutes after consuming the unknown substance), and evidence of a delirium. It is not uncommon for individuals charged with crimes who were intoxicated at the time of the crime, to claim that their behavior was produced



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SYNAPSE designed by Lydia Dmitrieff

Intoxication, cont'd.

by a substance that was either involuntarily given to them or prescribed for them by a physician, and that they had no knowledge or awareness that the substance, mixed with alcohol, could produce this altered state of consciousness and most importantly, could then result in the commission of a crime.

This last element is critical to an understanding of the involuntary intoxication defense. Simply because an individual consumes an intoxicant does not automatically absolve him or her of responsibility for the commission of a crime. The character of the crime is relevant to his or her level of culpability. Where an individual, after allegedly ingesting a substance, drives a vehicle and is stopped for a DWI, the involuntary intoxication may well be appropriate. Where an individual then proceeds to attempt to rape a woman, it might

well be much more difficult to prove that they were not responsible for their behavior, simply because of this intoxicant. In another scenario, an involuntarily intoxicated individual, who then attacks another person, may well be held not responsible if it can certainly be shown that their violent behavior was significantly out of proportion to any potential provocation (or the absence of provocation).

Involuntary intoxication is a rarely used and an extremely difficult defense to prove and be successful at. It is incumbent upon psychiatrists evaluating individuals claiming this defense to have all available material and information before rendering an opinion. (Goldstein-JAAPL, 20, 2 1992). ▲

Alan J. Tuckman, M.D.

A Note From the President

On June 3, 2001, despite the threat of thunderstorms and a morning of showers, at least two hundred people attended the Picnic for Parity at Rockland Lake. Consumers, family members, mental health professionals, and the general public all came out to support parity for mental illness.

Petitions were signed and letters written to State Senator Bruno advocating parity. Senator Morahan, Assemblyman Gromack, and Commissioner Maryann Walsh-Tozer attended the picnic. Thank you to all the WHPS members who attended the picnic. In addition, the organizing committee should be recognized for doing an outstanding job.

We look forward to the year we can run a Picnic to Celebrate Parity!



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The Changing Face of American Psychiatry in the 21st Century: Part 1 of 2

John Graham, MD is a clinical associate professor of psychiatry at the NYU School of Medicine and is in full time private practice in New York City. Dr. Graham is originally from Capetown and during the course of his career ran the E.R. and an inpatient unit at Bellevue.

THE BEGINNING

Psychiatric illness goes back in history - as long as there have been people on earth.

The understanding of illness was by theories of black and yellow bile, blood, phlegm and vapors. Psychiatric illness was viewed with fear and superstition, with ideas about demons and witchcraft.

Philippe Pinel was the early 19th century Parisian psychiatrist who abolished the chaining of the unfortunates at the Salpêtrière. He taught that the mentally ill could be spoken to in a kindly manner and that

they might even get better.

Esquirol, a follower of Pinel's, was a pioneer of social psychiatry who put some of Pinel's ideas into practice. This man brought humanity to psychiatry.

The world of general medicine was every bit as full of superstition and ignorance as the world of psychiatry.

The death of our first President would illustrate that point.

Washington had taken a cold, had resultant mild hoarseness and thereafter difficulty in breathing. He was febrile, increasingly uncomfortable, constantly shifting position and spoke with difficulty. Three physicians were in attendance (James Craik and Gustavus Richard Brown - both trained in Edinburgh, Scotland, and Elisha Cullen Dick, trained in Pennsylvania). A bloodletter, George Rawlins, was called and over the next twelve hours four bloodlettings were carried out.

This was the theory of "heroic depletion". 80 ounces (2365 ml) of blood was removed, approximately half of his total blood volume. At the end, it is described that Washington's blood became viscous and flowed slowly.

During this time various other treatments were carried out. Wheat-bran poultices were applied to his throat and blisters of cantharides to his feet, arms and legs.

The hypovolemic shock which Washington suffered at the hands of his doctors would likely have made him more comfortable, but surely contributed in a major way to his death. Tracheostomy was known at the time, but was not resorted to. It would probably have saved his life.

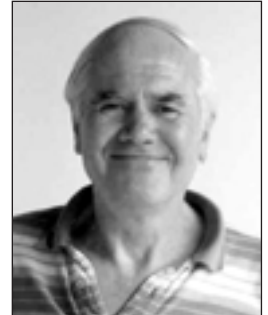
In 1747 a wonderful clinical experiment was carried out that pointed the way to where medicine should aim in the future.

James Lind, a 28 year old British naval physician, treated twelve scorbatic ship's passengers. Two were given a quart of cider per day, two an elixir of vitriol, two were given vinegar, two seawater and two the juice of two oranges and a lemon. These last two were cures and the word "Limey" came into being. Countless lives were saved.

In medicine treatment has always gone ahead of understanding and so it was here.

THE FIRST BIOLOGICAL PSYCHIATRY

There were doctors - early scientists - who attempted to study and more clearly understand these devastating



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and baffling psychiatric illnesses. Much of this work was carried out by German-speaking psychiatrists, with contributions made by Franz Nissl, Aloys Alzheimer, Wernicke, Meynert and Griesinger.

Microscopic studies were extensively done, but the equipment was primitive and the results were meager. In 1882 Paul Flechsig in Leipzig did pioneering work on cerebral localization and in 1885 Eduard Hitzig established that the brain responds to electrical stimulation. Wernicke set out to establish that specific symptoms could be associated with specific areas of the brain.

Kraepelin gave first definition to the two great functional psychoses - Manic-depressive illness and Schizophrenia.

Shorter in his *A History of Psychiatry* states that Kraepelin is truly psychiatry's father figure and not Freud.

The dictum resulting from all these efforts was that if you see something under the microscope, it is neurology and if you see nothing, it is psychiatry.

The unfortunates with severe illness were sent to psychiatric hospitals, which became large custodial warehouses.

Lothar Kalinowsky said of this that, until the end of the 1930s, little could be done for these hospital patients other than to keep them safe, stay in touch with their families and to release them in the event of a spontaneous remission. The 1949 movie *The Snake Pit* sought to depict the horrors of these underserved and overcrowded hospitals.

THE AVAILABLE TREATMENTS

Von Wagner-Jauregg discovered the malarial fever cure in 1917. The blood from a malarial patient was injected into the bloodstream of a patient with neurosyphilis. It was a case of fighting fire with fire.

He was awarded a Nobel prize for this work in 1927.

Hydrotherapy was used from the 1920s onwards. Here the patient would be hosed down or wrapped up in wet sheets when acutely psychotic.

Insulin coma therapy was discovered by Manfred Sakel in 1933 and Metrazol convulsion therapy in 1934 by Ladislav Von Meduna, a Budapest psychiatrist.

Electroconvulsive therapy - a treatment now much better understood and still in use today, was discovered by the Italians, Cerletti and Bini in 1936.

Egas Moniz, a Lisbon neurologist, discovered the lobotomy as a surgical treatment. He was awarded a Nobel Prize for his discovery.

Walter Freeman, a neurologist at George Washington University, popularized lobotomies in the United States. Over five thousand were performed in 1949.

The advances of psychopharmacology caused the demise of this "treatment".

A doctor, Henry Cotton, had a theory of auto-intoxication as the cause of mental illness. The treatment for this led to the unfortunate having his teeth pulled and/or colon resected.

Shakespeare has truly written that "desperate diseases lead to desperate measures".

AND THEN CAME FREUD

We must recollect that all of our provisional ideas in Psychology will presumably one day be based on an organic substructure.

Sigmund Freud "On Narcissism"

The deficiencies in our description would probably vanish if we were already in a position to replace the psychological terms with physiological or chemical ones...We may expect [physiology and chemistry] to give the most surprising information and we cannot guess what answers it will return in a few dozen years of

questions we have put to it. They may be of a kind that will blow away the whole of our artificial structure of hypothesis.

Sigmund Freud "Beyond the Pleasure Principle"

Medical scientific approaches had little to offer suffering mankind. Freud - a man of restless curiosity, a fine and seductive writer, with a brilliant mind - developed a theory of the mind and mental illness that offered a way out of the asylum and the hope of treatment for the mentally ill.

A number of Freud's ideas were taken from the philosopher Schopenhauer "who conceived of the world as an illusion with an upside and an underside. He was a pioneer in the mysterious land of the underside, the concealed, the masked, the unadmitted. Behind the mask was sex above all, the main content of the unconscious". (Freud's Answer: Martin Wain).

Freud's theories as developed were passed into psychoanalysis as science.

He once said of himself that he was "not actually a man of science, not an experimenter, not a thinker. I am by temperament a conquistador - an adventurer, if you want it translated, with all the curiosity, daring and tenacity characteristic of a man of this sort".

By a confluence of circumstances, Freud's theories were to become a popularized and highly influential movement.

The Nazi regime banned psychoanalysis as a decadent movement and many of the early practitioners fled Germany and Austria. Freud went to London, but the majority came to the United States, with most of those coming to New York City. They were prominent people and "brought glamour and heft" (Shorter).

Analysts were learned doctors with

Continued on next page 

Changing Face, cont'd.

practices on Park Avenue and Central Park West (which was once called "Spooks' Row"). So if one could afford it for oneself or the ailing loved one, analysis was available and was practised by kindly and thoughtful practitioners. The ailment shouldn't be too severe, for there were conditions where analysis did not seem to have much success. Even in such cases, there were many in the analytic movement who believed and taught that analysis in the hands of the truly skillful and experienced could bring about cures in conditions such as schizophrenia. Frieda Fromm-Reichmann and Harry Stack Sullivan were said to be of such skill.

With the advent of the first psychotropic medications, there were many analysts who believed and taught that using such medications was the sign of the failed analyst. The medications were really to assuage the doctor's sense of fallibility and anxiety.

It is probably still being taught by some that medication use interferes with the transference. It was certainly so in the 1980s. After the 1930s, the world's center of psychiatry moved to the United States, and psychoanalysis took over the profession for more than three decades. In the 1970s, this was starting to reverse.

By the entry of the United States into WW II, analysis had captured the basics of training in psychiatry at the undergraduate and graduate levels. It was a period of anti-science.

With the advent of the many internationally acclaimed German analysts (such as Nunberg, Felix and Helene Deutsch, Paul Federn, Heinz Hartmann, Franz Alexander and Sandor Rado), came a stifling orthodoxy. What had been the relaxed and free debating atmosphere of the psychoanalytic coffee houses in Berlin and Vienna became "a

frighteningly standardized American product".

When I began my residency in 1968 at NYU/Bellevue, the Chairman of the department was Dr. Bernard Wortis. He had undergone a four month analysis with Freud, a thing unheard of once the orthodox took over.

"American psychiatry before WW II was biological psychiatry and within a few years after the war was largely a psychoanalytical psychiatry".

Seymour Sarason.

The American Psychoanalytic Association grew from 92 members in 1932 to almost 1300 in 1968, with an unremitting mandate to extend Freud's domain to all of psychiatry. New York City in 1940 had one third of the analysts.

At this time and subsequently, almost every prestigious psychiatric chair in the country was held by an analyst. The analysts wrote the textbooks, had taken charge of residents' training and controlled the examination boards.

Eric Kandel, the second psychiatrist to be awarded the Nobel prize - and totally deserving - writes of his

residency in 1960 at Harvard that there was no reading list, there were no grand rounds and they had to go searching high and low to find someone to give them a lecture on genetics. One was supposed to listen and listen to the patient and by one's empathy bring about healing. "It takes a person to heal a person" (Menninger). There is the famous or infamous quote "There are those who care about people and those who care about research".


The language of analysis could be highly imaginative. Mania = triad of Bertram Lewin "A wish to eat, a wish to be eaten and a wish to go to sleep". Depression was "A despairing cry for love" as per Sandor Rado. The ego tries to punish itself to forestall punishment by the parent. The term "schizophrenogenic mother" accused many mothers by the benign and dedicated Frieda Fromm-Reichmann.

Bruno Bettelheim said "The precipitating factor in infantile autism is the parent's wish that his child should not exist. He could become expansive in his accusations.

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Freud on paranoia: "Unable to acknowledge the proposition "I love him" the paranoiac protects too much and insists instead "I hate him". This proposition in him is unacceptable because it forces the patient to see himself as poisoned by hate and so is transformed by one final twist into "He hates me".

A young woman's fear that a ticking clock might disturb her sleep was interpreted as "The ticking of a clock may be compared with the knocking or throbbing in the clitoris during sexual excitement".

Medication use was the sign of the failed analyst, and classification of psychiatric illnesses was pointless. Karl Menninger once told Lothar

Kalinowsky "I consider you to be an intelligent individual and cannot understand why you are interested in questions of classification". The analyst would undo the psychogenic cause of the illness - interpretation would be central - thus bringing about the cure. Any doubters were dismissively criticized.

Ralph Greenson spoke of the aim of psychoanalytic therapy - different from all other therapies - "In that we aim for structural, that is, permanent changes in the relationship between the id, ego and superego, and the external world".

I believe this would be possible, as learning and teaching, in a proper setting. How about some scanning of

the analyzed brain? So far this has not happened. The equipment is available.

Al-Ghazali (1058-1111):

He who does not doubt does not investigate and he who does not investigate does not perceive, and he who does not perceive remains in blindness and error.

John Graham, M.D.

Private Practice: Referral Program Update

In a separate mailing, you will soon be receiving an invitation to once again become part of the private practice referral directory or to update your listing in the directory. This has become one of the most successful programs your district branch runs. We distribute about 1000 of these manuals yearly. It is now also available on the internet at our Website.

We feel this has contributed immeasurably to our public image, has reduced stigma and offers a direct service to patients and their families who are looking for psychiatric care but don't know how to go about it. This program serves you and the community at large.

Over the past year we have continued to answer FIVE calls PER WEEK for referral information. These calls come from our advertising in the Yellow Pages of Rockland County and Middletown. When the request is specific enough to narrow the number to 3 - 5 psychiatrists who meet the patients' requirements, these names and

numbers are provided over the phone and a copy of our referral directory is mailed out. If the request is too general (for example, someone requests a psychiatrist who treats "anxiety" and is located in Rockland County - a description applying to most of those currently listed in the referral manual) their questions are answered and a copy of the referral directory is mailed to them.

WE ARE MAKING ABOUT 260 REFERRALS PER YEAR over the phone and another 100 or more through the Depression Screenings we run. If you have not received any referrals from us, it is because:

YOU ARE NOT LISTED

Many of the callers have insurance coverage requiring that they see an approved provider only and no one on our list fits the bill.

The callers request a psychiatrist who accepts Medicaid and no one on our list takes Medicaid.

Your listing does not fully describe you or your practice. For example, if

you are board certified in Child but haven't indicated so, a prospective patient looking for a board certified Child Psychiatrist would not pick you. Or, if you indicate "yes" to insurance accepted without specifying which ones you participate in, I wouldn't be giving your name to someone who is looking for a VBH provider even though you might be. If you don't indicate you have any special interest areas or services, then your name would not stand out to someone looking for a psychiatrist who has experience with the pharmacological management of adult ADHD.

Your listing does not advertise anything unique about you or your practice, which distinguishes you from all the others who are listed in



Continued on last page

the manual. Review the manual through the eyes of a prospective patient to see how they might make a choice. See if there is anything you can say in describing your training, interests, special services or credentials which might differentiate you from your colleagues.

WHAT YOU CAN DO TO INCREASE REFERRALS FROM THE LIST

BE LISTED. I know there are many psychiatrists in private practice that are not. You are missing out on a potential source of referrals and failing to participate in an important public service.

Review your listing and edit it again to **ACCURATELY AND COMPLETELY REPRESENT YOU** in a way which will appeal to a prospective patient seeking care.

Add to your credentials, skills and experience. Then call or write me to insure these are included in your listing.

I will be sending out notices shortly to revise and update the manual

once again. If you are not participating now and have a private practice, please consider adding your name to the list. If you are participating and have not received referrals, review your listing and see how you can more fully and accurately describe what sets you apart from others and might pique the interest of prospective patients.

This program is one of the more expensive we offer to our members. The printing of the manual alone is over \$1000. Advertising, phones and mailing add over another \$1000. While the program serves the public, we again must charge those practitioners who stand to benefit directly from referrals in order to make up some of the costs of what has turned out to be an extremely successful program. We are asking for \$50 to be listed in the next edition of the Referral Manual. (One referral to you will more than offset the \$50). This will cover some of the total costs. You will also be listed at our website for no additional cost. Remember that your District Branch dues are the lowest in the country. You receive

dinner meetings with scintillating speakers, public advocacy, the award winning newsletter Synapse and public relations efforts like the Depression Screenings, the creation of a mental health coalition with psychiatric leadership, etc. The Referral Manual is an important part of our efforts. Patients, other practitioners, professional organizations all find it useful and think of us when deciding what to do about a psychological or psychiatric problem.

Please participate in the Referral Manual. Review the materials mailed to you. If you are already listed, go over the description in the manual and edit it so it includes everything that might help a patient deciding where to seek help. If you are not listed and have a private practice, please consider participating in this important public relations effort. It benefits patients, psychiatry and potentially YOU.

Thank you,

Jim Flax, MD

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