



Synapse



THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

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Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

"YOUR DISTRICT BRANCH"

Since the last publication the Executive Council has met twice with the next meeting planned for 7/23/06 at the Dellwood Country Club in New City.

One of the most important functions of any group is management of its membership. We learned this as part of our training in group therapy. Only recently has the central office of the APA started doing an efficient job of this, making our job easier. Andy Hornstein has been ably handling the membership duties for about a year, the task having shifted from Madhu Ahluwalia to myself then to Andy. He has created an accurate list that is coordinated with the Central Office and has distributed it to those who need a copy. Andy has shifted his interest and time to Legislative Affairs, quickly getting up to speed by managing arrangements with Senator Tom Morahan's office prior to the last general meeting in June. Now Alan Tuckman will handle membership at least until I'm able to resume the duties next May when Madhu Ahluwalia takes over the presidency.

We have submitted a grant application to the APA for nearly \$13,000 in funding to support our public affairs activities. We directly do public affairs through our information phone line and brochure, handling about 5 calls weekly. We also run the mall screening every October. We have collaborated for years in the many projects run by the Mental Health Coalition. We have provided monies and one of the executive members serve as President of the Mental Health Coalition. The Coalition has projects that include Elementary School education, College Education, a walk, and the well attended Forum every spring.

The following membership changes were reported:

1. Resigned: Young Bae
2. Transfer in: Kathryn Moss, Fabian Tremeau, Lawrence Greenman, Robert Sobel
3. Transfer out: Huon Van Huynh, Bob Sobel, Mona Schneider, Bhati

Palkiwala, Michael Levy, Harlan Kosson, Narendra Patel, Fabian Tremeau, Hoon Hyunh

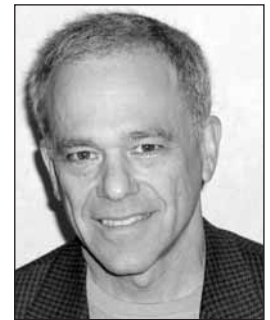
4. Distinguished Fellows: Syed Abdullah
5. Life Member: Young Yoon, Craig Morris
6. Life Fellow: John Fogelman, Joan Berson
7. 50 year Distinguished Life Fellow: Peter Guggenheim, Mary Mercer
8. Dues Waiver rejected: Walter Nieves
9. Advanced to General Member: Shelly Pasternak
10. Application for reinstatement: Pe Wynn paid back dues
11. Dues drops: Lamia Botros, Michael Fruchter, Belle Verkhovsky

Andrew Hornstein, MD reminded us that Tom Morahan is Mental Health Committee Chair, and his committee may be able to provide some funding for our public affairs activities. We hope that NYSIPA lobbyist Richard Gallo will attend our next Executive Counsel meeting to discuss how to pursue this funding.

Nigel Bark, MD is our Assembly representative, attending his first Assembly meeting in Toronto. He reported that there was much energy expended in debating psychiatrists' involvement in torture. The conclusion is that involvement in any individual interrogation is precluded, but a psychiatrist could provide general information. Psychologists will be actively involved in interrogations without compromising their ethical guidelines. There were many issues related to insurance.

The Spring meeting was well organized by Lois Kroplick and Jane Kelman. This is the first meeting in which we charged all those present a nominal fee to attend. This was an experiment to cope with the loss of drug company funding. We learned that it is a viable alternative. We honored Senator Morahan for all of his efforts on behalf of our patients in his role as head of the Senate's mental health committee where he has spear-headed many efforts to improve conditions.

The meeting cost us \$1592 and we received \$800 from the 33 people attending. The DB subsidizes the difference and we could afford continuing this subsidy for future meetings. We hope more of our members will attend future meetings.



The cost was kept low thanks to Dom Ferro who presented a terrific talk on DBT without charge. The October meeting promises to be as exciting with a talk by Leon Balter, M.D. of the NY Psychoanalytic about "The Cult of the Male Musical Performer." Look for an announcement with the details.

The Women's Committee continues to meet every 6 weeks for an interesting discussion. 6 to 7 members attend and there is room for more. Contact Lois Kroplick (362-4215 or drkroplick@AOL.com) or Jane Kelman (638-2626 or jek@icu.com) for details if you'd like to attend.

Alan Tuckman reported on the new annotations to our ethics guidelines that have two significant changes:

1. Torture is unethical, as discussed above
2. There is now an educational option for response to ethics complaints

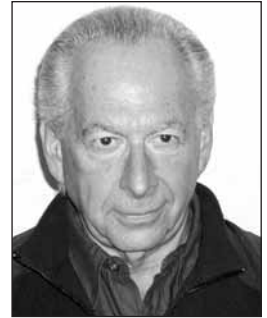
Again, I welcome your interest and participation. Please call me at 362-2557 or email (DrFlax@aol.com) if you would like to discuss any district branch activities, attend

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Understanding Dissociative Disorders and Memory



In my Forensic Psychiatry work, I often come upon psychiatrists and non-psychiatric physicians (as well as attorneys), who seem to attribute various memory problems, as well as behaviors, to one of the Dissociative Disorders when the "problem" bears no resemblance to the definition of Dissociative Disorders. Of course, this frequently comes up in the context of a criminal case, where an individual is charged with a crime and claims that he or she suffered from "amnesia," a "fugue," or "multiple

personality disorder" as a justification and explanation for their misbehavior.

While I have frequently thought of addressing this topic, in this column my current thoughts were triggered by the recent article in *Clinical Psychiatry News* (June 2006) under "Reel Life: The Allure of Amnesia," Dr. Roland Atkinson describes the documentary "Unknown White Male," a story about a young man who "apparently experienced a Dissociative Fugue State that lasted for at least several hours. "... He came to his senses... and realized that he had no memory whatsoever for his past and his personal history. He bore no wallet or no identification..." Dr. Atkinson quotes "Dr. Daniel Schacter, a Harvard psychology professor and memory researcher, in describing the different components of memory. He explained that memory comes in several "parts": "Episodic (Personal identity and life events), "Semantic" (Information about the world), and "Procedural" (for example, language skills, how to ride a bike) Memory."

Psychogenic Retrograde Amnesia is one in which an individual, following a severe, emotionally traumatic event, appears to lose memory for a period of time in the very recent past. While alcoholic blackouts are probably organic in nature, they do present in a manner similar to psychogenic amnesia. In both, an individual, currently well-functioning and with intact cognitive abilities, appears to "lose memory" of a specific time period in the very recent past. But, if one can speak with individuals who were with that person during that time period, the person is described as having been functioning well and having appeared to be cognitively intact. In an alcoholic blackout, similarly, an individual may be drinking (at times not excessively), then go to sleep and the next day have no memory of the evening's "festivities". Yet, when others are questioned, the individual, while appearing somewhat intoxicated, functioned cognitively well. Psychogenic amnesia is used as an explanation for an individual's not being "criminally responsible" for their behavior during a criminal act, if they "do not remember the act." This is false and does not explain their behavior during that time period, simply because they could not remember it. An individual may commit a serious crime, such as murder, and then claim that they have no memory for the events of the murder, utilizing that as a defense for

criminal responsibility.

Fugue states have a very different quality to them. An individual suffering from a "dissociative fugue" leaves his or her familiar environment, seems to appear in another setting, assuming behavior and possibly a new identity, with no memory of their actual life and identity. If they're discovered shortly after the beginning of the fugue state, the individual may not have assumed a new identity, but may simply be confused about their actual identity. When criminal behavior occurs, prior to the onset of the fugue state, the individual's culpability and criminal responsibility are assessed, based upon their functioning prior to the onset of the fugue state. If the criminal behavior occurs after the supposed onset of the fugue state, then their culpability and criminal responsibility are assessed utilizing information from events during that time period. But simply claiming a "fugue", does not automatically absolve an individual of criminal behavior. One must look to the individual's actions and statements at the time of the crime.

Dissociative Identity Disorder (Multiple Personality Disorder) is a much more complex process. In assessing an individual's criminal responsibility at the time of the crime, simply claiming that they had a "Multiple Personality Disorder," is certainly not adequate to justify or exculpate one from criminal responsibility. First, of course, there should be a documented past history of other episodes of Dissociative Identify Disorder. In addition, in order to evaluate that person's criminal responsibility or lack thereof, forensic psychiatrists evaluate the "alter" or distinct identity who was active at the time of the crime. It must also be remembered that there must include ...two or more personality states (each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self)..." in order to make the diagnosis.

I recently had an opportunity to be consulted by an attorney who believed that his client suffered from a "Fugue State and

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Telephone (845) 638-6992

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SYNAPSE designed by Lydia Dmitrieff

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West Hudson Psychiatric Society Spring Dinner

Dr. Dominic Ferro gave a lively presentation entitled "What's So Special About DBT" on June 9, 2006 at LaTerrazza Restaurant in New City for our spring dinner. Thirty five people attended the dinner and lecture which included members of WHPS, their spouses, members of the Mental Health Coalition of Rockland County, Richard Gallo and State Senator Thomas Morahan.

Dr. Ferro's valuable presentation presented information about DBT, which is used to treat borderline personality disorders. He spoke about the importance of the team approach in order to achieve success with



this therapy. He taught the audience how to use techniques of "validation" through his special sound techniques of mimicking monkeys in a forest! His sound effects, jokes and invaluable information added to the liveliness of the talk. He had to contend not only with a small crowded room, but had to deal with waitresses yelling "who ordered chicken parmigiana" in the middle of his presentation. Dr. Ferro was able to skillfully multitask to give the lecture amidst the chaos!

In addition to Dr. Ferro's excellent lecture, Richard Gallo, our lobbyist from Albany spoke about the importance of contributing to the PAC and supporting Timothy's Law. Senator Thomas Morahan was presented an award from WHPS for outstanding work in the field of Mental Health. He is the head of the committee on mental health in the NY Senate! He spoke about getting parity for mental illness.

Dr. Jim Flax, our President was unable to



attend the lecture due to the flu. Dr. Madhu Ahluwalia ran the meeting and did a great job!!! Thanks, Madhu!!

For those of you who couldn't make the meeting, please try and attend our fall meeting which will probably occur the end of October or early November. It is always great to reconnect with colleagues and to hear such outstanding lectures!

Many thanks to Dom Ferro for volunteering his time and effort in making this such a great night. ▲

Lois Kroplick, D.O.

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Galen: the Scientist and Ethicist

Let us briefly glance over the time-lines of Greek history:

- 700 BC Homer writes of Appolo, the bringer and reliever of plagues in the Illiad
- 600 BC Rise of Greek science and philosophy. Thales begins inquiries about nature and physics.
- 500 BC Pythagoras founds a scientific and philosophical cult.
- 480 BC Empedocles advents as a philosopher and physician.
- 460 BC Hippocrates begins compiling his Corpus.
- 384 BC Aristotle was born and grew up to be a philosopher and scientist.
- 334 BC Alexander invades Egypt, the Mid-East, Western India, brings Greek culture and learning.
- 300 BC Alexandria becomes the center of Greek scholarship including medicine.
- 146 BC Greece becomes a Roman protectorate.
- 129 AD Galen was born in Pergamum which is modern day Bergama, Turkey.
- 476 AD The western Roman empire falls, western scientists lose contact with Greek scholars. Greek texts and learning faced a fast decline in Europe.

Ancient Greece included, from time to time, parts of modern day Greece, Turkey, Italy and Egypt. In 632 AD onwards Arab medical scholars took an interest in Greek physicians' methods and texts which were translated in Arabic thus preserving them from the ravages of the Dark Ages; during which they were virtually banned in Europe.

As noted above, Galen was born in 129 AD in Pergamum. His father, Aelius Nicon, was an architect. Galen was initially interested in the pursuit of agriculture, architecture, astronomy, astrology, philosophy until he became focused on medicine. By the age of 20 he had become a therapeutes (attendant or associate) of the god Asclepius in the local temple for four years. After his father's death in 184 AD he left to study abroad. He studied in Symrna and Corinth and at Alexandria in Egypt. His medical studies extended to a total of twelve years.

In 157 AD he returned to Pergamum where he worked as a physician in the Gladiator school for three or four years. During this time he gained experience of trauma and wound treatment. He later regarded wounds as "windows into the body".

Galen performed many daring operations on people. These surgeries were not practiced again for about two thousand years. They included brain and eye surgeries. To remove cataract he would insert a long needle like instrument into the eye behind the lens and then pull it back and dislodge the cataract. The slightest slip could cause permanent blindness. Galen had set the standard for modern medicine in many different ways.

From 162 to 166 AD he lived in Rome where he wrote extensively, lectured and

publicly demonstrated his knowledge of anatomy. His reputation as an experienced physician was soon established, resulting in wide spread clientele. Among them was the consul Slavius Boethius who introduced him to the court where he became a physician to Marcus Aurelius. Later he also treated Lucius Verus, Commodus and Sepeimius Severus. Galen spoke mostly Greek which was a more prestigious language of medicine than Latin at that time. He briefly returned to Pergamum from 166 to 169 AD.

Galen spent the rest of his life in the Imperial court, writing and experimenting. He performed vivisections on numerous animals to study the functions of kidneys and the spinal cord. His favorite subject was the Barbary ape. He employed twenty scribes to record his words. In 191, fire in the Temple of Peace destroyed part of his records. He died around the year 200 AD.

Galen transmitted Hippocratic medicine all the way to the Renaissance. In his book "On the Elements According to Hippocrates" he describes the philosopher's four bodily humors, blood, yellow bile, black bile and phlegm. These correspond to the four elements and in turn with the seasons. Galen created his own theories based on these principals. Much of his work can be seen as built on Hippocratic theories of the body. He rejected the Latin writings of Celsius but built on the ancient works of Asclepiades.

Amongst Galen's major works is a seventeen volume "On the Usefulness of the Parts of the Human Body." He also wrote on philosophy, philology and, extensively, on anatomy. His collected works total 22 volumes.

Galen's own theories in accord with

Plato's, emphasize purposeful creation by a single Creator, a major reason why later Christian and Muslim scholars could accept his views. His fundamental principal of life was Pneuma (air, breath) that later became connected with the soul. His writings on philosophy were a product of Galen's well rounded education, and throughout his life he was keen to emphasize the philosophical element in medicine. Pneuma physicon (animal spirit) in the brain took care of movement, perception, and senses. Pneuma zoticon (vital spirit) in the heart controlled blood and body temperature. "Natural spirit" in the liver handled nutrition and metabolism.

Galen expanded his knowledge partly by experimenting with live animals. One of his methods was to dissect a living pig, cutting its nerve bundles one at a time. Eventually he would cut a laryngeal nerve (now also known as Galen's nerve) and the pig would stop squealing. He also tied the ureters of living animals to show that urine comes from the kidneys, and severed spinal cords to demonstrate paralysis.

In addition to working with pigs, Galen also experimented with Barbary apes, goats and pigs, he emphasized the fact that, in some respects, they are quite anatomically similar to humans. Public dissections were also a valuable way of disputing and disproving others' biological theories. This was the main method of academic medical learning in Rome. Large numbers of medical students attended these public gatherings, which would sometimes turn into debates.

Galen's theories were partially correct, partially flawed. He demonstrated that arteries carried blood not air and made first studies about nerve functions and the brain and heart. He argued that the mind was in the brain, not in the heart as Aristotle had claimed.

However much of his findings were flawed: He did not recognize blood circulation and thought that venous and arterial systems are separate. Since most of his knowledge of anatomy was based on dissection of pigs, dogs and Barbary apes, he made



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Galen, cont'd.

erroneous conclusions about the locations of blood vessels in humans. He resisted the idea of tourniquets to stop bleeding and vigorously propagated blood-letting as a treatment. In spite of Galen's mistakes and mis-perceptions, the wealth of accurate details in his writings is astonishing.

Galen's authority dominated medicine all the way to the sixteenth century. Scientists did not bother to experiment, as studies of physiology and anatomy stopped. Galen had already written about it. Blood letting became a standard medical procedure.

Ethics: Training in philosophy is, in Galen's view, an essential part of the training of a physician. The profit motive says Galen, is incompatible with a serious

devotion to medicine. The doctor should despise avarice. He played down the motive of financial gain in becoming a doctor. He declared that the body was an instrument of the soul.

Much of medieval Islamic medicine drew on the works of Galen, such as his expanded humoral theory. Most of Galen's writings were first translated to the Syriac language by Nestorian monks in the University of Gundishapur, Persia. Muslim scholars, primarily in Baghdad, translated the Syriac manuscripts into Arabic, along with many other Greek classics. They became the main source for

Arabic scholars like Avicenna, Rhazes and Maimonides. Galen is called Jalinus in Arabic, many people with that name today are considered to be descendants from

him.

Galen is so venerated in the Arabic world that in 1977 the Peoples' Democratic Republic of Yemen issued a postage stamp celebrating him. If the work of Hippocrates represents the foundation of Greek medicine, the work of Galen, who lived six centuries later, is the apex of that tradition. Galen crystallized all the best works of Greek medical schools which had preceded his own time. Galen's work remained the unchallenged authority for well over a thousand years. It is essentially in the form of Galenism that Greek medicine was transmitted to the Renaissance scholars. ▲

Syed Abdullah, M.D.

Dissociative Disorder and Memory, cont'd.

Amnesia or Multiple Personality Disorder," when on the street, he threatened with a knife, two completely innocent black men. Apparently this white man's wife had been brutally assaulted by two strange black men some weeks before, when she was on her way home. Our defendant, disturbed by this event, seemed to maintain control and focused, primarily, on allowing the police to "do their work to apprehend the two people who assaulted his wife." But, after the two men were apprehended, they were released for lack of evidence. Our defendant was very troubled by the two supposed assailants of his wife having been released from custody. Some weeks after the release of these men, he, apparently, left his home, approached two black men, well dressed, carrying attaché cases, on their way to

work, and threatened them with a knife. He did not speak with them. He simply brandished the knife at them, turned and walked away. The two men immediately called the police and gave them the description of their assailant as well as his license plate number. He was tracked down and arrested. Subsequently, he claimed that he had no memory of having committed that crime. His attorney, as well as his family doctor, were convinced that he was not criminally responsible and believed that he was suffering from one of the above-mentioned Dissociative Disorders. After investigating this case, it became evident to me, given additional information that I acquired, that his actions did not, at all, fit with any of the Dissociative Disorders. It appears that he was "harboring significant

repressed anger," and like in "road rage" situations, exploded, acting inappropriately. Since the inclusion of "Dissociative Disorders" in the DSM-IV, attorneys have attempted to utilize these disorders as excuses and explanations for criminal behavior. Certainly, there are situations in which people do act criminally and also suffer from one of these disorders. Only a thorough exploration of the individual's actions, with other data, can elucidate the actual cause of the behavior. Much of the time it is not directly caused by the Dissociative Disorder, but may occur concurrent with it. ▲

Alan J. Tuckman, M.D.

District Branch, cont'd.

an executive council meeting or volunteer to participate. I encourage any members or prospective members to join us. You'll get to see what we talk about, to network with your colleagues, and to hear about matters of relevance to psychiatrists from different geographic areas and from different institutions or private practice. We will try to involve you in district branch activities.

On a more national scale and with reference to our local scene, I have written in the past about phantom managed care provider lists. Either the list is inaccurate or the provider does not have time. From my perspective running the information service

for WHPS, most of the calls are from people who cannot find a psychiatrist that takes their insurance, including Medicare and especially Medicaid. With Medicare again set to lower rates, I suspect even fewer private psychiatrists will have open time for patients with Medicare.

A recent post to the Psycho-Pharm list-serv by a social worker in California addressed this problem: And on a more practical level, I practice in San Francisco and one of the biggest problems for myself is not trying to prescribe or even figure out the answers only by myself. I would love to use psychopharmacologists much more often

but can't. Why? Because, while there are a huge number of psychiatrists here, few of them are available. Most accept only cash which rules out the majority of clients. The costs are huge. Insurance in this area is primarily managed care and few psychiatrists will actually accept managed care, despite being on many lists. The most frequent response is that they're full. Even the most basic psychiatric care for those with government medical coverage is hard to come by. That leaves only a few medication mills or med school clinics.

A recent headline article in the Minneapolis

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Psychiatrists and Interrogation, etc:

by Nigel Bark, West Hudson Psychiatric Society Representative

Report of APA Assembly meeting, Toronto, May 2006

In my last report (*Synapse*, Winter 2005) I described the workings of the Assembly and in particular the passage of a Position Paper stating that psychiatrists should have no part in torture and coercive interrogation. As it turned out that was not the end of the story. The APA Board of Trustees did not approve the Assembly's position because they felt psychiatrists should have no part in any interrogations, even in advising interrogators of the signs of mental illness (because the information could be used against the subject). There was no disagreement about the strong condemnation of torture. The two Papers were sent to a committee to produce a compromise Paper to be discussed at this Assembly.

The whole issue was complicated, so I was told, by the long standing rivalry between the Trustees and the Assembly and a feeling in the Assembly that it represents those psychiatrists in the real world working in the courts and prisons and armed services. The compromise Paper was apparently nearer the Trustees position and President Scharfstein was known to support it: it proscribed any direct involvement by psychiatrists with an individual interrogation inside or outside the interrogation room. But it did allow psychiatrists to be involved in the general education of investigators and law enforcement personnel on recognizing mental illness and the effects of particular techniques and conditions of interrogation. It was known that some Army psychiatrists and some forensic psychiatrists felt that this was too restrictive; some members saw it as restricting the country's ability to protect itself from terrorists; and there was a feeling that the Board of Trustees was (once again) unnecessarily opposing an Assembly's action. There was an extensive, passionate, well argued debate moderated with remarkable skill by the speaker, Jo Rubin, and the paper was approved with a voice vote, that was then questioned; so also by an individual vote of delegates and then, because that too was questioned, by "vote by strength" where the number of

members each delegate represented were counted. The Paper was then approved by 1958 votes to 889 with 1008 abstentions. I spoke and voted for the Paper.

This version was approved by the Board of Trustees the next day because it was felt too important and urgent to wait for their next working meeting. On June 7th it was reported in the New York Times that the Pentagon "would try to use only psychologists, and not psychiatrists, to help interrogators devise strategies to get information from detainees at places like Guantanamo Bay, Cuba" because "of differing positions taken by their respective professional groups"... specifically the policy adopted overwhelmingly by the American Psychiatric Association in May "unequivocally stating that its members should not be part of the [interrogation] teams".

The other issue that is a major concern to many psychiatrists in New York fizzled out at the Assembly. This is the question of sexually violent predator (SVP) offenders without mental illness being certified into Psychiatric Hospitals. There was a Position Paper on this but it was rejected because it was not clearly written and confused the issue with Antisocial Personality Disorder. I am sure there will be a clarified Paper at the next meeting. The APA has published an excellent summation of the clinical information available.

This issue is particularly pertinent in New York because, as reported at the Spring Meeting of New York Psychiatric Association (NYSPA) (which I also attended), there are two SVP confinement bills before the New York State Legislature. NYSPA opposes both but the Assembly bill, having more alternatives for placement, would be preferable to the Senate bill. NYSPA's Position Statement, opposing civil confinement on the basis of criminal behavior alone, and model letters to send to legislators are available on the website. A motion was approved to authorize the NYSPA representative to the MSSNY House of Delegates to submit a resolution proposing the MSSNY prepare a similar position statement: that any SVP program should be placed under the auspices of the Department of Corrections not under the Office of Mental Health and that funding

should not come at the expense of OMH.

At the Assembly meeting in Toronto there were an additional 26 Action Papers discussed and 24 Reports heard covering everything important to psychiatrists, from Medicare Part D, Insurance companies unreasonable demands, Katrina, to Bipolar practice guidelines etc and awards, farewells and welcomes such as to a group of Iraqi psychiatrists (90 for 29 million people last year, 70 this year). It was a very full couple of days, busy, interesting and social but clear evidence that the APA is actively working for us and wants to know our problems and can help us with many.

One final comment: ours is the only District Branch without a Deputy Representative. Any volunteers? ▲

WHPS Has Its Own Legacy Collection

by Leslie Citrome, MD, MPH

You may have heard about the American Psychiatric Publishing, Inc.'s *Psychiatry Legacy Collection*, where all issues of *The American Journal of Psychiatry* from volume 1 (published in 1844) to present are available on-line at the journal's website. All issues of *Psychiatric Services* from 1950 are also available. The complete run of these two titles are available free of charge to APA members. The *Legacy Collection* includes other journals available to APA members by separate subscription.

Not to be outdone, the West Hudson Psychiatric Society now has available all issues of *Synapse* at our website, www.rfmh.org/whps <<http://www.rfmh.org/whps>>. Pay the site a visit and download PDF versions of *Synapse* dating from September 1989 to present.

The quest continues: If anyone has any newsletters from the West Hudson District Branch dated prior to September 1989, please send them on to Les Citrome for scanning and inclusion on the website. Materials will be returned if desired. Mailing address: Leslie Citrome, MD, Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962. ▲

Electro-Convulsive Therapy: An Effective Treatment

Part 1: Brief History:

It has been nearly three quarters of a century since Dr. Ladislav Meduna, a Hungarian neuropsychiatrist, introduced a repeated and medically induced convulsive therapy for a catatonic patient in January, 1934. It was about the same time that other somatic treatment modalities were introduced: insulin coma (in 1933), leucotomy (in 1935) and lobotomy (in 1935). The methodology of medically induced convulsive therapy evolved quickly. It began with intramuscular injections of Camphor (in Oil), then to Pentylentetrazol (Cardiazol, Metrazol) until the modification to electrical induction was introduced in 1938. The evolution to electrical stimulation was initiated by Italian investigators due to unpleasant side effects and experiences with Cardiazol treatments. The first case of treatment with an electrically induced seizure was in April, 1938 during which a 39 year-old man was treated and responded well. One of the important findings was that the introduction of an epileptic-like seizure, no matter how it was obtained, had an antagonistic effect on the schizophrenic process, or dementia praecox, as it was called at the time.

Since the introduction of electrically induced convulsive therapy in 1938, the methodology has undergone many changes. The clinical findings from scientific studies and observational studies were quickly published and the efficacy of convulsive therapy was quickly validated by the middle of last century. The muscle-paralytic and muscle relaxing agents were used to prevent fractures, first with curare in 1940 and then Succinyl-choline in 1952. The evolution of electrode placements and types of electrical waves used followed, together with proliferation of clinical, scientific and observational publications demonstrating the efficacy of Electro-convulsive therapy (ECT).

In and around 1953, a new somatic therapy (psychotropic medication) was introduced. The use of psychotropic medications had a great impact on other available somatic treatments at that time. The leucotomy and insulin coma therapy were largely replaced by the convenience and efficacy of psychotropic medications. The use of convulsive therapy also markedly declined, but it survived the challenge of psychotropic medications over time.

Public Image Problems:

Despite its survival as one of somatic therapies for treating psychiatric conditions, convulsive therapy remains a lightning rod for controversy among some professionals, legislative leaders and the public. The controversy has been fueled by the media. "Shock Treatment" - the name itself was frightening. As convulsive therapy spread quickly in popularity as a treatment for various psychiatric conditions, the use of the term "shock treatment" was common in many published articles in public and professionals journals. The negative public image of ECT was increased by a systematic campaign of anti-psychiatry organizations. The negative campaigning against ECT greatly influenced public perception towards the treatment. Public negativism towards ECT was greatest in the 1970s and 1980s. Public misperceptions of ECT were fueled by portrayals of ECT in several movies. In 1974, California legislature introduced a law against ECT.

The dramatization and portrayals of ECT influenced public attitude towards the treatment. Among the major psychiatric films, the following popular movies have prominent convulsive therapy scenes and have probably had major negative impacts on ECT - The Snake Pit (1948), One Flew Over the Cuckoo's Nest (1975), Frances (1982) and Shine (1996). The movies portray ECT as cruel and barbaric treatment, ineffectual and punitive, used for antisocial behavior and as a mean of social control. The negative depiction of ECT in motion pictures overshadowed the positive reports of ECT in scientific studies at the time.

Struggles among professionals:

The 1974 California legislation added a chill for the American Psychiatric Association (APA) which assigned a working group on ECT in 1975. The endorsement by the APA was half-hearted, but admitted a role for ECT in clinical practice. A major turn around for the reemergence of ECT was a consensus conference, organized by the Office of Medical Applications of Research of the National Institute of Health (NIH). The revival of ECT was initiated by subsequent publications for efficacy of ECT in the short-term management of severe depression resulting from the consensus conference in following years. ECT has

evolved from a first-line treatment for depression in the 1940s and 1950s, to use for treatment-resistant depression in the 1990s, then as a last-resort treatment in severe life-threatening and treatment resistant cases in today.

ECT remains a scientifically mysterious treatment modality among medical professionals. Questions about the long-term effects, structural changes and mechanism of actions always come up during discussions of ECT. Though there are many scientific articles demonstrating considerable efficacy in the treatment of major depressive disorders, catatonia, mania, psychosis and other psychiatric disorders, the idea of using ECT for psychiatric conditions still causes concerns among many patients, families and medical professionals including psychiatrists. ECT is still considered as a treatment of last resort, rather than a first line treatment. This is hard to understand. Why not use the full range of available treatment and current scientific and evidence-based medicine for people suffering from severe mental illnesses?

ECT has come a long way. ECT was introduced before psychodynamic / psychoanalytical therapies and revolutionized somatic and effective psychopharmacologic treatments; it remained effective and acceptable treatment until today. The dramatization and portrayals of ECT in movies like "One Flew Over the Cuckoo's Nest" bear no similarity to modern ECT, which is neither painful nor used as a punishment. Survey data shows that it is no worse than going to the dentist. Many patients find ECT less stressful.

Procedure, use of ECT, and indications:

For ECT to be administered, patients must give their consent or, if a patient lacks capacity, court authorization is required. Patients and families are fully informed about what to expect; informational booklets and video tapes are available explaining the procedure and its side effects.



Continued on back page 

Therapy, cont'd.

During treatment, an intravenous line for medications is placed. The patient is put under general anesthesia, receiving muscle relaxants and oxygen. The electrodes are placed based on clinical indication to obtain the desired therapeutic response. Then, the patient is given a brief electrical stimulation which lasts a few seconds. The total response time is generally under one minute. Because muscle relaxants are administered, the convulsion is rarely seen. The patient recovers after a few minutes of treatment. The post-ECT condition is continuously monitored in a recovery room for about one hour. The most common adverse effect is a brief memory loss of recent events, but it is generally temporary and is modifiable by different electrode placements.

Primary use of ECT is considered when a rapid recovery of severe medical and psychiatric conditions is needed, or the risk of other somatic treatments outweighs the risk of ECT. It can be used as an initial treatment of choice if there is a previous positive response or, if the patient prefers it. The secondary use of ECT is considered in situations where there are treatment failures after adequate medication trials, the adverse effects of medications are unavoidable and medically dangerous, or there is a deterioration of the patient's condition despite other somatic treatments.

ECT is effective for major depressive

disorders (single and recurrent), bipolar disorders (mania, depressive and mixed), schizophrenia, and schizoaffective disorder. It is also effective in catatonic conditions secondary to the schizophrenic process. Other medical conditions where ECT is indicated include neuroleptic malignant syndrome, intractable seizures and Parkinson's disease.

The benefits of ECT may be seen as early as a few sessions in mood disorders, but a therapeutic response for psychotic disorders requires a much longer treatment duration. ECT is proven safe for patients with pace-makers and patients during pregnancy.

Future of ECT:

Recently, many research studies have been focusing on Repetitive transcranial magnetic stimulation (rTMS), which is new, exciting and revolutionary. While awaiting approval by the FDA, scientists and clinician are working on the efficacy and safety of rTMS. Vagal Nerve Stimulation (VNS) was approved by the FDA in 2005 for treatment resistant depressive disorder.

Until alternative methods of brain stimulation for induction of controlled seizure are found, ECT remains an effective treatment for patients with severe psychiatric disorders. Until new and more effective therapy is introduced, we should continue our efforts to train professionals and educate our patients, their families,

and the general public. We should continue to help our patients with established treatments of proven efficacy while embracing new treatment approaches. ▲

Pe Shein Wynn, M.D., M.P.H.

District Branch, cont'd.

Star & Tribune was titled "Sick of insurers, psychiatrists opt out of the system". It goes on to detail the experiences of several psychiatrists who have stopped participating in any insurance system. It chronicled how these individuals proudly are able to practice as they see fit without anyone else dictating the practice parameters for those individuals who can afford to pay directly and receive reimbursement from their insurer.

If this is a national trend, and if I may be optimistic, it may eventually influence the insurance industry to loosen their counter-productive tight control of the care we provide. If we all started to bill for the time we spend complying with paperwork and regulations, the insurance industry might also be forced to change. In the meantime, impossible access to care is a significant and relatively underground problem. ▲

James Flax, MD, President

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