eSynapse

July 2013

Editor’s Comments

James Flax, MD, MPH, DFAPA

THATTHANK YOU to all those who have contributed to this issue of eSynapse! Please scroll through everything below as there are many items you will find interesting and useful throughout.

You will find a synopsis of our meetings so all readers will have an idea of district branch business. But, it’s only a synopsis. You have got to come to a meeting to appreciate the rich discussions. PLEASE JOIN US July 26th @ 12 Noon. See below. Dr. Tobe has written of District Branch and statewide issues, Dr. Bark about APA issues and an erudite article on schizophrenia following logically Dr. Abdullah’s new article in his long line of historical articles.

There are ads for jobs, offices for rent in Rockland, Depression Support Groups, research subjects at NKI, and malpractice insurance that may interest you. Please scroll all the way to the end to see it all. And, if you are not receiving the MSSNY eNews, here’s a link where you can read about issues of interest to all of medicine in New York State: http://www.mssny.org.

LIST-SERV

I have written in previous issues about the creation of a list-serv where a member can notify the entire list of a patient needing care, their requirements (location, insurance, expertise, etc) and any one who is a member of the list can reply (on or off list) if they have an opening. Ivan Goldberg, MD (of Psycho-Pharm listserv fame) graciously agreed to host this list at Psycho-pharm.com and we are going to try it out but need enough of our clinicians (private practice and clinics) to participate to make it work. This list-serv could work for other communication as well. So far 12 have indicated an interest. We don’t have a “critical mass” for this list-serv to work well. If you want to be included in this listserv and keep this project alive, please email me at drflax@aol.com.
IT’S A FREE LUNCH!
Next Executive Council Meeting
Il Fresco Restaurant, Orangeburg, NY
Journal Club (15 minutes) PROMPTLY at 12 Noon
Followed immediately by Business Agenda
Date: Friday, July 26th, 2013 @ 12 Noon at Il Fresco in Orangeburg, NY.

Please contact Dr. Russell Tobe, MD (rtobe@NKIRFMH.org) (845) 398-6556 if you are planning to attend.

If you speak to your colleagues who are not members of the APA, remind them to become members. If members, tell them you've received your eSynapnce and ask if they received theirs. If not, tell them to email Liz Burnich at westhudsonpsych@gmail.com with their email address so they can be added to the list.

While some have indicated it is too costly to join the APA, the link below will remind you of the many benefits. The West Hudson Psychiatric Society Membership is one of the least costly in the nation and we hope to keep it that way. The benefits are numerous. http://www.psych.org/Resources/Membership.aspx

PRESIDENT’S COLUMN

Russell H. Tobe, Russell.Tobe@gmail.com

Dear West Hudson Psychiatric Society membership, colleagues, and friends:

Prior to discussing updates, I want to remind everyone that the I-STOP deadline is quickly approaching on August 27. There is information on this through NYSPA including a free webinar on 7/15 at 8PM. But the quick version is that this pertains to any of us who prescribe schedule II, III, and IV medications (including benzodiazepines and stimulants). You are required to have a Health Commerce System (HCS) login to access the registry, which can take around 2 weeks to obtain. Information about this can be obtained at http://www.health.ny.gov/publications/1084.pdf or 1-866-529-1890 (option 2 for those who are newly registering, option 1 for those who have forgotten their login or need a password reset). Procedures for navigating the registry and recommendations on documentation of compliance can be found on the NYSPA site.

Moving on to updates, the West Hudson Psychiatric Society website now exists, at least as a chrysalis www.westhudsonpsych.com waiting to emerge fully developed in the coming weeks. Once released, this new site should improve access to helpful materials, community and patient resources, as well as updated membership information. Our DSM-5 trainings are also being organized for the membership. The first of these will be located at building 57 on the Rockland Psychiatric Center campus on 7/10 (see flyer at the end of the newsletter). There we will be tailoring the didactic to schizophrenia and bipolar disorders. Because there is much to potentially cover in future trainings, WHPS is exceedingly welcoming of recommendations from members interested in establishing additional training sessions regionally on needed DSM-5 training topics. Please contact westhudsonpsych@gmail.com with requests. Finally, we have
started planning for our seasonal seminar series and are in the last stages of finalizing the fall speaker. We have also been quite open to receiving topic requests of interest and continue to welcome suggestions from the membership. Currently, we are actively pursuing expert speakers in already requested areas of adult autism, updates in schizophrenia neurobiology, and advances in neuroimaging.

On a personal note, this has been an exciting transition for me into the Presidency. I continue to be very appreciative of the current executive council and to members who may not hold leadership positions but remain involved with WHPS and offer constructive input and guidance. As always, WHPS continues to welcome involvement of all in the membership at all levels. Feedback and ongoing communication are highly valued, even more so now in this era of so many changes (I-STOP, SAFE act, CPT coding, DSM etc) and advances in understanding of illness and treatments.

Finally, I think it an interesting though directly unrelated coincidence that one month following the release of the latest edition of DSM (which, as we know, once characterized homosexuality, in of itself, as a disorder until DSM-III in 1980, ICD 302.0), the Defense of Marriage Act was rejected by the Supreme Court. I take it as a reminder that our field (at times criticized for intellectual stagnation and lack of ‘science’) faces unique factors of diagnosis unshared by most other disciplines of medicine. Society is constantly developing in technology, scientific data, and ideology. Psychiatry must continue to maintain a capacity to change and refine its concepts of illness accordingly. While DSM-5 has many quirks, numerous criticisms, and is by no means perfect, I find it long overdue after nearly 15 years without revision.

SUMMARY FROM EXECUTIVE COUNCIL MEETING
Friday June 21, 2013

Attendees Present: Russ Tobe, Mary Mavromatis, Raj Mehta, Nigel Bark, Mona Begum, Jim Flax, Dom Ferro, Nnamdi Maduekwe and Liz Burnich.

Journal Club – Dr. Mona Begum presented a recap of a psychopharmacology conference that she attended on Depression Treatment with Medications: the Benefits and Limitations.

President’s Address – Dr. Russell Tobe thanked Dr. Monowara Begum for accepting the nomination of President-Elect. The formal vote will take place at our General Membership Meeting at the Fall Educational Meeting. Because of a perceived outside conflict, it was decided that we should nominate a new Treasurer. We also still need to fill the position of Secretary. Russ nominated Dr. Mary Mavromatis for the Treasurer position and Dr. Dominic Ferro for the Secretary position. Both accepted and we will also hold a vote for these positions at the Fall Educational Meeting. Lastly, Russ gave everyone a recap of the meetings he attended at the APA Annual Conference in May.

DSM-5 Workshop/RPC Ground Rounds – We discussed the final logistics and planning of our DSM-5 workshop that we are doing on Wednesday, July 10 from 1:30-3pm as part of the Rockland Psychiatric Center Grand Rounds. Liz will email and mail flyers to all members as well as order the food for the luncheon. We will plan for 60
attendees and the luncheon will take place from 12:30-1:30pm that afternoon. Raj suggested that Liz meet with Kia Watson at RPC ahead of time to tour the meeting facility and finalize the details. All costs associated with this event will be funded by the APA grant that was awarded to us in the beginning of 2013 to help our district branch membership growth and retention projects.

Additional DSM-5 Trainings – we applied for a grant from the APA for money to use for additional DSM-5 trainings. We discussed doing a workshop at Orange Regional Medical Center or Mid-Hudson Psychiatric Center. We will revisit this after our initial workshop at RPC and if we get this grant from the APA.

Fall Educational Meeting – Dr. Jim Flax advised that Pat Bloom is not available on the topic of ‘Mindfulness’ Meditation. Dr. Russ Tobe advised that he has several contacts at Nathan Kline Institute that would be great speakers on relevant psychiatric topics. It was discussed that he would ask Bennett Leventhal to speak on the topic of Autism on a tentative date of November 1. Russ will try to finalize the details of this meeting.

Depression Screening Day – Dr. Mary Mavromatis advised that National Depression Day is the first Thursday in October. We will hold our own Depression Screening Day at the Nyack Street Fair on Sunday, October 13, 2013. Liz will order the kit from Screening for Mental Health, Inc. Mary will sign us up to get a table/booth at the Street Fair – hopefully at the same location as last year which was right in front of Starbucks. Russ will have some flyers available for those who screen positive and Liz will try to have the new WHPS Informational Brochure complete by then. It was suggested that maybe the new Shoppes at Nanuet could be a possible new location for future Depression Screenings.

Private Practice Update - Dr. Jim Flax advised that he has gotten 58 calls since December to the WHPS answering machine with referrals of approximately 2/week.

Women’s Group – Dr. Mona Begum advised that the Women’s Group has been well attended with 7-8 attendees at each meeting. The next meeting is scheduled for August 2nd at Mona’s office. Mona also advised that she attended a recent Depression and Bi-Polar Support Group meeting and that they have a picnic scheduled for July 9th.

NYPSA – Dr. Nigel Bark advised that the next NYPSA meeting is scheduled for October 26 in Queens. He will also put a recap in the next issue of eSynapase about the recent Assembly Meeting that he attended in May.

Next Executive Council Meeting - Friday, July 26, 2013 at 12 noon at Il Fresco, Orangeburg, NY. Dr. Mary Mavromatis will present for our Journal Club.

Report from the APA Assembly and Annual Meeting
May 2013

Nigel Bark, MD, West Hudson Representative also representing Mid-Hudson Psychiatric Society
Two very important things happened at the APA this year, one with global implications and one internal to the APA. The one with global implications was of course the publication of DSM-5. The other was the announcement of the appointment of a new Medical Director – more of that later.

DSM-5 was published the first day of the Assembly, May 17 2013 and had sold 150,000 copies by the next day. By the third day of the APA meeting it was sixth on Amazon’s best-seller list: rather remarkable for a specialized book the cheapest version of which is about $70. It was a source of much self-congratulation in both the Assembly and the APA; of vigorous defense by the leaders of APA and the leaders of the DSM-5 process, against the public criticism by particularly the head of NIH and the chair of DSM IV, which some saw as harmful to psychiatry and psychiatrists, others as beneficial to the field as a whole with discussion of the issues in the major news media; others again seeing it as beneficial to the APA as it tries to recoup its $15 million investment. There was criticism, and defense, in many of the sessions, as I will mention.

Of course I am not a disinterested reporter having expressed my views to the Psychosis committee, and in public, and I attended the meeting to be an approved District Branch trainer. The strongest criticism that I heard at a session was by Nassir Ghaemi, of the Major Depression diagnosis that had combined the recurrent depression from the former Manic-Depressive illness with other depression including Reactive Depression that can be mainly anxiety, but of course this was not a DSM-5 decision. The defense from the Vice-Chair of the DSM-5 Task Force, Darrel Regier, was that they agreed with the problems but firstly there are no biomarkers yet to better classify Depression and the attempt to separate anxiety depression totally failed in the field trials. But there are dimensions in section III which it is hoped will be used to find better categories (or to use only as dimensions) by the time of the first update (not revision) in about four years time.

The changes in DSM-5 are conservative. That is the major proposed changes were put in Section III for further research and for people to get used to them. Section III also contains “cross-cutting” symptom measures (for patient, parent or clinician) that can be used with any diagnosis; the World Health Organization Disability Schedule (WHODAS) to replace the GAF; the alternative DSM-5 model of Personality Disorders which is probably much more logical; and conditions for further study including the much criticized Attenuated Psychosis Syndrome, (which actually has good reliability and may lead to less antipsychotic treatment because there is evidence of psychological treatments preventing progress to schizophrenia and most people with any psychotic symptoms are now being treated with antipsychotics).

I personally support most of the changes. Axes have been dropped, mainly because insurance companies were using (mis-using) GAF scores as criteria for admission or discharge from hospital or as a measure of treatment response. The subtypes of schizophrenia have been dropped because they changed frequently in any individual and did not have treatment implications. (Catatonia is defined separately and diagnosed in association with another disorder, because it occurs more often in conditions other than schizophrenia.)

The term dependence has been dropped, thank goodness, because in previous editions it was conflated with addiction (as if caffeine dependence was the same as heroin addiction): now there are Substance Use Disorders with measures of severity.
The evidence, I believe, strongly supports Autism Spectrum Disorder and although some States support services for Aspergers’, others do not. If services are based on severity of the Spectrum it may be beneficial for all.

Dropping the grief exclusion is logical as it is Major Depression that is the disorder not grief. Obsessive Compulsive Disorder has been taken out of the Anxiety Disorders Chapter and has its own Chapter along with related disorders and the new Hoarding Disorder.

The Chapters have been reorganized to try and bring related conditions together or adjacent and are arranged in a loosely developmental sequence.

It was interesting to hear that the leaders of DSM-5 and of the APA had visited the Editorial Offices of many of the leading newspapers and magazines to explain and discuss it – it seems successfully.

(For more on DSM-5 see www.psychiatry.org/dsm5)

Dr Jay Scully is retiring in the fall and his contributions to the APA in his ten and a half years as Medical Director and CEO were acknowledged and recognized by the Assembly by making him an Honorary Speaker, with about 20 former speakers giving him an oversize gavel. Dr Scully took over when the APA was very nearly broke and had no reserves. He has turned the APA around financially (it now has over $70 million in reserves). He led the APA staff through the hard times when there had been a lot of layoffs. He has been very successful in increasing the strength and credibility of the APA as a medical specialty society by representing the APA before Congress, in the media, at the AMA and elsewhere. He has been Chair of the Directors of all Specialty Societies.

Dr Scully reported that membership is up slightly for the first time in a few years and the pre-registration for the APA was also considerably higher than the past few years. He reported on the continuous battle in state legislatures against psychologists’ prescribing in which the APA works closely with State Psychiatric Associations; and on the battle to ensure insurance companies pay as they should for the new CPT codes: this has involved both discussions with various companies (United Healthcare and ValueOptions) and litigation (against Anthem/Wellpoint) and in Vermont to ensure parity – with a favorable judgment.

Dr Scully then introduced his successor, Dr Saul Levin, originally from South Africa, who has been a delegate representing psychiatry at the AMA for 25 years. Dr. Levin most recently has been Interim Director of the District of Columbia Department of Health. He will work with Dr Scully until Dr Scully’s retirement. Dr. Scully asked for input from the Assembly and all members and noted that it will be important for psychiatrists to lead in the application and modification of the Affordable Care Act (ACA).

Of note, the President-Elect of the APA is now Dr Paul Summergrad, an expert on the development of health care systems, and Chair of the APA’s Ad Hoc Workgroup on the Role of Psychiatry in Healthcare Reform, who had spoken to the Assembly last November. His knowledge and role are going to be very important.

A very important Position Paper on “Firearm access, Acts of Violence and Relationship to Mental Illness and Mental Health Services” was passed unanimously. There were five Action
Papers on this topic, developed out of the Sandy Hook Elementary School tragedy, submitted for the Assembly’s consideration. It was decided that a better alternative might be to combine these with a number of other documents: the AMA letter on gun violence to the President that the APA had signed on to, a previous APA Position Statement opposing laws limiting physicians ability to discuss with patients issues related to firearms, previous Policy statements on guns and the conclusion of the Board of Trustees-Assembly ad hoc workgroup on gun violence. Dr Debra Pinels President of AAPL and AAPL representative in the Assembly did a remarkable job in combining these into a three page (with references) statement. It remained for the reference committee (of which I was a member) assigned to review the five action papers and the statement to decide whether to recommend the statement over the action papers and to alter the wording and order slightly. The reference committees hear the arguments from the writers of action papers and of anyone else interested for or against and then have their own discussion of what to do. There was a lively discussion with representatives from, especially mid-western states, opposing some aspects of the statement, worried that they would not be able to use a Statement that started with limiting access to guns in their approach to legislators seeking earlier and improved access to mental health care.

The reference committee agreed that the Position Statement was better than the series of Action Papers and the authors of those action papers also agreed. The wording and order were changed slightly and one unnecessary piece about liability insurance was removed. The Assembly approved this document unanimously without anyone speaking against any part of it. It can be accessed at www.psych.org/assembly/assembly_archives/2013May/section14 (That section is titled new business but it has only this Position Paper (14A))

Other Action Papers that were passed included: endorsing a vigorous program to revitalize the APA’s public relations efforts to address the importance of Mental Health and the removal of barriers to treatment; to support the AllTrials petition to insist that the data from all clinical trials be made available; to apply to the UN to be a Non-Governmental Organization (NGO) with Consultative Status that can provide input to the UN on issues of importance to psychiatry; to reinstate the Committee on Persons with Mental Illness in the Criminal Justice system; a position statement on detained immigrants with mental illness with recommendation for screening and treatment; a position statement opposing the use of medical marijuana for PTSD as there is no evidence of its benefit; a resource document on human trafficking; and more.

Dr Jeremy Lazarus, President of the AMA (and the third Psychiatrist in this position- but the last one was in 1939) spoke of the rather dramatic change in the AMA’s attitude towards and support for psychiatry in the past 30 years or so; almost certainly related to the increasing number of active members of the APA in the AMA: there are 38 psychiatrists delegates to the AMA (the best specialty delegation) and active on the AMA councils – but we need more – he said! He talked of the ACA, 30% more people will have coverage, 60% will have increased coverage for mental illness, but the Supreme Court’s ruling on Medicaid means that many poor (especially in Southern States) will have no insurance or coverage. But he (and others) spoke of the major problem of a shortage of doctors to provide the care. They are pushing for an increase in residents by 15,000 but even then there is a need for new models of care and he mentioned the very successful “integrated care” in the Minnesota Diamond Initiative.

Lots more happened at the Assembly but this report is already too long. I do want to close by noting the opening sessions of the APA were very exciting: Dilip Jeste had a fascinating – and very moving and very funny - interview with Elyn Saks and her husband. (Elyn Saks, author of “the Center cannot hold”, Professor of Law, Psychology, Psychiatry and Behavioral Sciences at
USC and a person on continued clozapine and psychoanalysis for schizophrenia.) Former 
President Bill Clinton, disappointingly, was forbidden to fly by his doctors but was present on 
the big screen, speaking and answering questions with great knowledge, insight and wit. Our 
new APA President, Jeff Lieberman spoke powerfully of the need to defend and advance 
psychiatry for our profession and our patients. The rest of the meeting was both very interesting 
and very enjoyable with lots going on, plenty of social activities and meeting old friends from 
around the world.

CORRESPONDENCE

(Editors note: I vowed when I started this publication to publish anything sent to me. 
Please send me announcements, news, notices, rumor, recipes, innuendo, ads etc).

From Bedlam To Asylum

Syed Abdullah, MD

In the year 1800, an American citizen, Mr. James Norris, was admitted into London’s infamous 
mental hospital, Bethlem. There he stayed for the next ten years sleeping in a straw bed, 
restrained in an iron harness that was chained into an upright pole. He stayed in that condition, as 
an insane person, for more than 10 years. In 1814 his case became known to the reformers who 
were campaigning for more humane treatment for those ‘deprived of their reason’. In 1815 Mr. 
Norris was released from Bethlem only to die a year later of a pulmonary disease contracted in 
the asylum.

In the later part of the 18th century, the French physician, Philippe Pinel had started advocating 
reform in the care of the mentally ill. He advocated the breaking of the chains and the provision 
of humane treatment. He emphasized the psychological and emotional antecedents of mental 
illness. Pinel’s writings were well disseminated in England and the United States. The case of 
Mr. Norris specially hit home and fueled a movement for reform in the way we looked at and 
treated the mentally ill.

The humane, or moral treatment, entailed some simple basic principles: treat the insane with 
dignity and kindness, provide them with the basic needs of the body and spirit and provide it in a 
friendly, clean environment of a Retreat. Mr. William Tuke of Yorkshire, was instrumental in the 
establishment of such a Retreat in 1776 following the death of a Quaker woman, Hannah Mills, 

The treatment meted out at the Retreat run by the ‘Friends’ excluded the practice of frequent 
blood letting and purging of the patients. Instead, regular exercise, work and amusements were 
instituted as the new treatment modalities. It was assumed that the mad persons retained their 
spiritual worth and a semblance of their reason. ‘The inner light was dimmed but not 
extinguished’ on this contention they tried to resurrect the essential humanity of the patients. We 
therefore see that just a few years before the incarceration of Mr. Norris the beginnings of a vital 
reform movement was already in place.

The earliest American Asylum, opened partly in response to these events, was the nonprofit
private Connecticut Retreat for the Insane in Hartford in 1817, known as the Hartford Retreat. Massachusetts General Hospital opened the McLean Hospital for the Insane in 1818. New York Hospital opened the Bloomingdale Asylum in 1824. The Pennsylvania Hospital had opened a new wing for the mentally ill in 1796 and eventually opened a separate asylum, called the Pennsylvania Hospital for the Insane, in 1841.

There was much optimism about the curative power of the moral treatment. Exaggerated and unsubstantiated claims of cures were made. The Hartford Retreat claimed a 91% cure rate. The Ohio Lunatic Asylum improved on these statistics by claiming a 100% cure rate! The reports from every Asylum, albeit published by their own staff, presented the glowing picture of the idyllic life in these private Asylums that catered mostly to the rich and the well-connected patients.

A glimpse into the workings of these private Asylums will give us an idea of how the humane/moral treatment worked for the privileged few:

At the Pennsylvania Hospital for the Insane, for example, the patients woke up at 6 in the morning to be served breakfast. After this the physicians made the ward rounds to talk with the patients after which the patients were taken outside for a walk, weather permitting. Otherwise they engaged in reading books or playing parlor games. There was a bowling alley, a calisthenium, a miniature railroad and a little museum of ‘natural curiosities’ for their amusement. Lunch was served in a well appointed dining room after which another round of light and leisurely activities were made available for them. Carriage rides around Philadelphia and the city parks were regularly arranged. The attendants entertained the patients with exercise classes, music and sports. At night, patients attended lectures, lantern slide shows, concerts and dances popularly called the ‘lunatic balls’.

What about those mentally ill patients who could not afford to check into these prestigious institutions? Well most of them languished in the almshouses poorly run by the counties, and in jails, and on the streets of large cities (the early homeless). It was only a matter of time that the compassionate and concerned citizens would start a movement for the provision of Asylums for the poor.

Indeed that is what happened. The reformers started petitioning the state legislators to build public asylums for those who could not afford to receive the expensive treatment provided at the private institutions. The case for moral treatment was promoted on economic as well as humanitarian grounds. Dorothy Dix was the most prominent and forceful exponent for such a measure. She was a visionary, religious woman who herself suffered from recurrent depression. She made the cause of the mentally ill poor her life’s mission. In 1843 she sent a moving message to the Massachusetts legislature which read in part: “I come as an advocate of helpless, forgotten, insane, idiotic men and women; of beings sunk to a condition from which the most unconcerned would start with real horror; of beings wretched in our prisons, and more wretched in our almshouses.” This was a time when state governments spent very little on public welfare. But the force of the reform movement was such that the first public state asylum was opened at Worcester in Massachusetts in 1833. It was named the Massachusetts State Lunatic Hospital. Other states followed suite and soon there were state hospitals being founded all over the country. Augusta, Maine in 1840 and the New York State Lunatic Asylum, in Utica in 1843. Thus a new era in the care of the mentally ill was ushered in. Huge stately buildings were constructed when such architectures were not common in the country.
In the following years we witnessed the filling up of these institutions with an unending stream of individuals in need of treatment and refuge. They came from the prisons, from the almshouses and from the streets and homes. As the asylums filled up and became overcrowded, new ones were built. The doctors and the administrators of these hospitals were mostly trained on the job, as the teaching of psychiatry was practically non-existent in the medical schools of the time. As the overcrowding increased, it became more difficult to keep up the high ideals of the moral treatment being practiced in the private institutions.

Despite this, the staff in these public institutions continued to provide the opportunities of work, entertainments, sports and other leisure time activities. Some of the patients worked in the farms and gardens that surrounded the buildings, which were usually situated in rural or semi rural locations.

Although the patients were much better off in the state asylums than in the almshouses and jails, there was not much evidence of real ‘cures’ as was initially hoped. The search for such cures went on, and every new technique was given an enthusiastic try. These included the tranquilizing chair invented by Benjamin Rush, M.D. and a variety of water treatments or hydrotherapy. The drugs in use in general medicine were gradually introduced in the state hospitals. These included Potassium Bromide, Chloral Hydrate, Paraldehyde and Barbiturates. But the treatment of the major mental illnesses remained elusive for decades to come, while the mentally ill were being sheltered and cared for in these crowded, under staffed, state hospitals.

In the late 19th and early twentieth century, news about the advent of ‘talk therapy’ created some guarded optimism in the more elite establishments of American psychiatry. Pierre Janet lectured at Harvard Medical School in 1906. Freud and Jung visited the USA in 1909. Freud gave a series of lectures on psychoanalysis that aroused much interest in the academic circles, and helped spur the teaching of psychiatry and mental illness in medical schools. But Freud quite frankly, downplayed the therapeutic role of analysis for those who suffered from schizophrenia. Despite this, American psychiatrists used modified forms of psychoanalysis in private practice, and in the psychoanalytic institutes.

Alas, this important development in psychiatry did not have a direct effect on the dismal overcrowding in the State hospitals across the country. In Rockland County, by a law passed in 1926, the Rockland State Hospital was built to relieve the extreme overcrowding in the city hospitals. The hospital opened its doors to patients in 1931 and bus loads of patients were brought in from the city, filling up its 5000 planned capacity and exceeding it as the years went by, until by 1953, 9700 patients were being taken care of at this state facility.
At Rockland, as in other State Hospitals, every new treatment was tried with the hope of reducing census and improving the quality of life for the patients. Continuous bath treatment, in which patients were kept immersed in water circulating at body temperature, was an old standby, and was liked by the patients as a calming and restful experience. But there were others that were much harsher, and bordered on the punitive. One of them the ‘Utica Crib’, was developed at Utica, but never gained favor at Rockland. Insulin Coma Therapy, Metrazole Seizure Therapy, and Electric Shock Therapy, had their advocates, and were practiced with varying levels of enthusiasm, but did little to effect sizeable number of patients.

Then came the lobotomies, practiced by Egas Moniz, clinical professor of neurology at the university of Lisbon. Psychosurgery was advocated during the 40's for patients with intractable psychoses. Patients subjected to this procedure became docile ‘zombies’, more manageable but lacking ambition, tact and imagination, and bereft of their personalities. Many of them developed
seizure disorders and other neurological problems. There were loud protests made against this dangerously crippling surgery with little evidence of cure. Rockland Psychiatric Center had the dubious distinction of being one of the centers where lobotomies were performed. In 1949 the Noble Prize in Medicine was given to Dr. Egas Moniz for developing the lobotomy!

It was only with the discovery and use of Chlorpromazine in the early and middle fifties that a reversal in the pattern of the burgeoning population in the Mental hospitals started. We shall take a look at this phenomenon, and the local contribution to it in a subsequent article.

What’s new (or not?) in Schizophrenia?
A report from the 14th International Congress on Schizophrenia Research, 21-25 April 2013
Orlando, Florida

Nigel Bark, MD

This meeting, which occurs alternate years is one of the most interesting and enjoyable meetings that I go to; and I have been going since 1993. It was started by Charles Schultz and Carol Taminga and they have run it every year since. It is usually in a big old style hotel like the Broadmoor in Colorado Springs. This year it was at the JWMarriott, not similar except the grounds were beautiful and full of exotic birds like cranes, storks and limpkins. This meeting always has a full evening’s opening reception and a party another evening; breakfast and lunch, morning and afternoon coffee and tea are included for everyone so you can meet lots of people.

It starts each morning with a “plenary” lecture by some world expert, not necessarily directly related to schizophrenia and then breaks into concurrent sessions. The rest of the morning and afternoons have five to eight concurrent sessions. So, although there were numerous presentations on genetics, biochemistry and imaging, I did not go to those. And there were more informal evening sessions. Lunch is with posters, 300-400 each day, from 12 to 3pm followed by further concurrent sessions, with more informal sessions in the evening. Everyone who goes has a presentation or poster.

I also attended two “satellite” programs: a Clinical Update on Advances in Treatment and the International Congress Prodromal Satellite Meeting.

The overall impression from the meeting was the very strong evidence for the effectiveness of Cognitive Remediation, even for the most severely ill; and the persistent – and curious – evidence for the importance of infection and inflammation in schizophrenia. I report more on these below and on the increasingly specific knowledge of the dangers of cannabis - and a few other things that interested me.

Outcome: not new but Philip Harvey reported (from the Hillside first episode psychosis (FEP) study and elsewhere) that 90% of people treated with first episode schizophrenia remit but at 5 years only 18% recover. In Bipolar 98% remit and 40% recover at 5 years. Successive relapses take longer to remit: 1st: 4 weeks, 2nd: 7 weeks, 3rd: 24 weeks. And the more episodes in the first five years, the greater loss of brain volume. Larry Alphs said “there is enormous danger in stopping medication after the first episode”.
The same cognitive deficits predict disability in schizophrenia, bipolar and major depression and can be assessed in a seven-minute test. Treatment with cognitive remediation is also the same for each condition: using computerized delivery, feedback on performance and dynamic difficulty titration. It is cheap (e.g. $170 unlimited use) and effective.

For example a randomized control trial of cognitive remediation with supportive employment resulted in an 1100% improvement in income, time worked and sustained. Other trials showed normalization of BDNF in the brain, less grey matter loss in first episode patients and evidence of brain repair. Several studies showed that cognitive remediation is much more effective if used with psychosocial treatment – 18-25 combined sessions were as good as 50-100 alone. And Jean-Pierre Lindenmayer has demonstrated that it is just as effective in the very chronic inpatients in Manhattan Psychiatric Center as first episode patients. However, he also showed that those who were younger and with more education and less severe cognitive deficits to start with did better. And interestingly those with Met/Met or Met/Val alleles of the COMT gene did better than those with Val/Val.

A review of medication for the cognitive deficits of schizophrenia are mostly negative. Cholinesterase inhibitors make them worse. Trials of davunetide, a neuroactive peptide, and of a nicotine α7 partial agonist were negative but underpowered and maybe show some signal of improvement. The CATIE trial results showed no improvement in cognition but switching was encouraged in that trial. When those who did not switch medication were examined there was significant improvement. In a four-year trial comparing ziprasidone with haloperidol there was significant improvement in cognition in those on ziprasidone.

Forty years ago Fuller Torrey, in the Lancet, talked of slow viruses causing schizophrenia and he has talked and written provocatively of the feline schizo-virus. Infection during pregnancy and early life is well demonstrated as a risk factor for schizophrenia – ‘flu, CMV, rubella and the feline-related toxoplasmosis (which we heard from Alan Brown is also associated with Bipolar Disorder with psychosis but not without psychosis) – but the evidence for an effect in the adult is much less. But here was Fuller Torrey chairing the session on “the long search for the inflammatory component in schizophrenia.”

His long time collaborator Robert Tolken spoke of the other genome we have beside the human genome: the microbial metagenome, organisms at mucosal sites inherited from our mothers during birth (unless we were born by cesarean) and from the environment. It is ten times larger than the human genome. With 300,000,000 sequence reads of DNA and RNA from throat, skin and blood in people with schizophrenia and controls over 4000 species were identified. There were about 200 species in people with schizophrenia that were not found in controls and these were nearly all lactic acid bacteria (lactobacillus, lactococci and pediococci). These microbes in the intestinal tract do alter behavior and cognition and the immune system. They in turn can be modified by probiotics and there is such a double blind trial going on at Shepherd Pratt now! Studies in Finland and elsewhere show the same similarities and differences are found across continents and in first onset and chronic schizophrenia.

Other evidence of inflammation in schizophrenia are the finding of CRP (a reliable marker of chronic inflammation) and of herpes simplex virus both related to cognitive deficit in schizophrenia, increased density and activation of microglia which release cytokines and macrophages, and an increased number of inflammatory biomarkers associated with schizophrenia.
There have been many double blind studies of augmentation with anti-inflammatory drugs: aspirin two studies, celecoxib five, minocycline four, EPA fatty acid which is mildly anti-inflammatory six studies and davunetide. A few were positive but most negative or neutral. Iris Sommer who presented this evidence described it as “fragile” – “not ready for practice but deserving further investigation”. And it may help cognitive deficits more than symptoms.

There’s more evidence of the dangers of cannabis in adolescents. In further analysis of the Dunedin, New Zealand, birth cohort by Madeline Meier those who started using cannabis in adolescence and continued to use it for years lost an average of eight IQ points, with more persistent use associated with greater decline. If they quit there was no recovery. Those who started later and then quit did recover.

There was confirmation by Marta Di Forti in Camberwell, London (where the cannabis used is the high potency ‘skunk’ kind) of the Dunedin finding of increased risk in cannabis users of having the Val/Val COMT alleles, with a four-fold increase. Likewise there was a two-fold increase when cannabis was used with the C/C alleles of AKT1, a gene associated with striatal dopamine. There was a much higher rate among the heavy users and those having both alleles: an odds ratio of 11.6 in daily skunk users and 6 in less than daily users. Interestingly those with these same alleles and no cannabis use had lower rates of schizophrenia than the general population.

There are two components of cannabis: THC and CBD. CBD is anxiolytic, neuroprotective and not psychoactive and prevents the reduction in cognition and increase in symptoms caused by THC. The problem in London and elsewhere is that as well as cannabis use increasing enormously, the levels of THC in the cannabis have increased enormously. This partly accounts for the increasing rates of schizophrenia in South London. Hashish has low levels of THC – it was suggested that that should be legalized, but the pain relief seems to be from THC.

The other contribution to high rates in South London is the very high rates in Afro-Caribbean’s – nine times that of British whites. Robin Murray summarized studies showing that racism and ethnic isolation significantly contributed to these high rates. An example from history is the rates of schizophrenia among British immigrants to Vancouver in the gold rush of the early 1900s were low initially when immigrants were welcomed but when the gold was no longer found and there was economic adversity immigrants were no longer welcomed and the rates of schizophrenia in this group increased.

A study (reported by Dana March of the California Birth Cohort and Kaiser Permanente records) of racial differences in rates in Northern California where there had been the largest internal immigration in the US around the Second World War showed the rate of schizophrenia to be about three times higher in blacks, reduced to just less than twice when adjusted for socio-economic status. The rates were significantly lower when the neighborhood was mixed with 18-43% black; these were areas of racial cohesion and epicenters of the civil rights movement. But still biological factors could contribute: flu vaccination was much lower in black neighborhoods despite the “socialized medicine” of Kaiser Permanente.

It remains surprising that all our antipsychotic medication works in exactly the same way as chlorpromazine, the first one introduced 60 years ago. That is by dopamine antagonism. The NMDA receptors have been a focus of interest for 20 years so far without success. Bruce Kinon reported that Lilly’s selective mGluR2/3 agonist failed in two large trials but surprisingly they
have not given up on it. They found that in a subpopulation with the T/T alleles of the rs7330461 gene in the serotonin 2A receptor, mGluR2/3 was significantly more effective than placebo. The other long studied NMDA co-agonist is glycine. Daniel Umbricht reported on a potent glycine re-uptake inhibitor, bitopertin, which was found in a placebo controlled trial with 231 subjects to significantly improve the negative symptom dimension of avolition and to a lesser extent expressive deficits.

The nearest new drug to introduction is still a dopamine agonist, Cariprazine, albeit with a main effect on D3 as partial agonist which, it is thought, makes it pro-cognition and anti-anhedonia.

There was much more but no dramatic breakthroughs. In the last twenty-five years we have gained an enormous body of knowledge about schizophrenia that is fascinating and increases our understanding but very little has so far been translated into treatment or prevention.

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**Depression Support Group**

Depression support group meets 2 times a month in Pomona, NY. We are inviting new members at this time. We are moderated by a clinical social worker. This is not a therapy group but social support for people fighting depression. Call Kathy for more information (914) 714-2837.

**Rockland County Depression and Bipolar Support Alliance**

is a peer-to-peer run support group for people with depression, bipolar disorder, anxiety disorder or any related mood disorder and their friends and family. The support group meets every Thursday night from 6:30 - 8:30 at St. John’s Episcopal Church, located at 365 Strawtown Road in New City. Reservations are not required; you just need to show up. There is no fee for attending the support group meetings. This is a very warm and welcoming group run by people who have been there and can help. Any questions please call Leslie or Leonard at 845-837-1182.
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NYU Langone Medical Center
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