Southern California

PSYCHIATRIST

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President's Column

Integrative Psychiatry - The Wave of the Future?

Heather Silverman, M.D.

With all the attention to the gyrations in the politics and economics of health care that inevitably filter down to the working psychiatrist, it might be easy to overlook another kind of revolution that is, and will continue to affect the direction of research and clinical practice.

I am talking about new conceptualizations of what constitutes comprehensive psychiatric care. Consider the recent APA annual meeting titled "Integrating Body and Mind, Heart and Soul" which included a conversation with 1960's guru Ram Dass. How about a keynote presentation titled "The Medicine of Music " in the educational offerings of the upcoming US Psychiatric and Mental Health Congress.

Inflammation is a hot topic in medicine these days, including psychiatry. Will anti-inflammatories become antidepressants? What about the gut biome and its interaction with metabolism, body and brain? Will psychiatrists eventually be prescribing probiotics and fecal transplants?

"Wellness " based practices include an emphasis on exercise, nutrition, sleep connectedness, meditation and mindfulness. "Positive Psychiatry" suggests that factors such as resilience, optimism and social engagement are associated with better outcomes and lower morbidity.

It is my impression that we are looking at indicators of a shift amongst psychiatric clinicians towards a more integrated approach to psychiatric care, incorporating many different approaches along with more conventional medications and psychotherapy. How these expansions of the therapeutic arsenal will play out remains to be seen, but for now ideas about what constitutes treatments are undergoing profound changes.

For those of you curious to learn more, the SCPS program committee is working to include some of these topics in our upcoming educational meetings. Have a good summer!

In This Issue...

Letter from the Editor

Vaccine Fever

Colleen Copelan, M.D.

On June 30, Governor Brown signed SB 277, legislation that ended the Personal Belief Exemption in California's vaccination program. The increasingly liberal use of the PBE had created gaps in our "herd immunity," posing the risk of new epidemics such as hinted by the recent Disneyland measles outbreak. It seemed like a reasonable proposal.

But the legislation drew vociferous opposition at every stage of review in the Legislature, mostly from groups of parents who brought along their exempted children. Celebrities testified as to the dangers of vaccination. Voices and tempers rose. Curses and death threats were made on the author, Senator Richard Pan, MD, a pediatrician.

The opposition included Robert F Kennedy, Jr, comedian Jim Carey (no joke) and the California Chiropractic Association.

The fight isn't over yet. Senator Pan is now facing a recall election, assuming he survives the curses and death threats. And despite their minority status, the anti-vaccine coalition is looking for a majority vote on a forthcoming ballot initiative.

We hope the fever is not contagious. cocopelan@aol.com

Letter to the Editor

Dear SCPS Members, June 22, 2015

I wish to respond to the Letter to the Editor published by Dr. Ron Milestone in the June 2015 issue of the Southern California Psychiatrist, as I found several arguments therein highly concerning. While I was pleased to see him state the view that people have the right to end their own lives, and that the presence of depression should not automatically negate that right, I was perturbed by the following arguments, which I will address in turn: firstly, that it is easy for able-bodied individuals to commit suicide alone; secondly, that a risky, painful, and lonely death is an acceptable end to a life of unbearable suffering; thirdly, that the suicidal wish is de facto evidence that an individual is not in his right mind; and fourthly, the implication that people disabled in such a way as to be unable to commit suicide should be forced to carry on suffering when able-bodied people are not, in a legal system that requires interminably suffering individuals to end their own lives without help.

In terms of the ease with which suicide can be committed, I beg to differ with the following statement: "Given the availability of guns, cars, and drugs in our society it seems obvious that no individual needs any assistance in killing him or herself unless a sudden loss of motor capacity makes it impossible for the person to carry out the necessary actions." How many of us have encountered patients in the ICU who are either in a vegetative state or severely and permanently disabled – with quality of life much worse than prior to the attempt - as a result of a failed suicide attempt? I have certainly encountered many. Suicide is not easy: a first-time self-inflicted gunshot to the head can lead to brain damage, quadriplegia, and serious disfigurement; an overdose, even on the appropriate drugs or medications, can end in organ damage, excruciating pain, and sometimes inter-

minable ICU admission; an intentional car crash can result in all of the above, plus potential serious harm to others; and so on, and so on. Not to mention that these attempts mostly occur in fear, secrecy, and isolation. Please recall that family members and friends are not allowed to assist. It reminds me of the botched abortions performed before abortion was legalized.

My fundamental question here is this: should someone who has suffered for a lifetime, for years, or even for months with a terminal and incurable illness truly be required to die alone in fear and in pain? Is that good medicine?

Is it really true that suffering and debilitated patients "can kill themselves without your help and have whatever death they want, good or bad?" How can a death by suicide – unassisted – be "good?"

As I have covered my first two points above, I will now move on to the third: Dr. Milestone's assertion that a suicidal wish can only be the product of a disordered mind. Let's imagine that Ms. X, who has endured a painful ten-year fight with metastatic breast cancer and is now crippled with bone metastases, paralyzed from multiple brain tumours, plagued by chronic, severe neuropathic pain, and covered with chemotherapy- and radiation-induced wounds, finally wishes to end this fight and die. I actually find it hard to imagine that anyone would call her mentally ill due to this wish. Let's also imagine an individual who has lost all of his personhood due to chronic and severe illness – all of the abilities and qualities that make him who he is – and let's say he has no living family, no companionship, and no such prospects. Would his wish imply that he is "not in his right mind?" When life is worse than death, is the desire to die really, truly insane?

Finally, I would like to address the assertion that "a person who is in a treatment relationship to stop feeling suicidal should have the courtesy to end that relationship once he/she makes up his/her mind to die. If the person remains in the relationship it is presumed that he/she continues to want help in dealing with this issue."

One: not everyone enters a treatment relationship for the purpose of ceasing to feel suicidal. Two: let us take a moment to examine the subjective experience of suicidality and suicide. Most suicidal people are suffering in a way that is, to them, unbearable and ceaseless. Many of those individuals have tried and failed most available treatments, and are also in a state of isolation, whether that be a subjective sense of aloneness or an objective life situation, in which there are no meaningful relationships. For many such people, the only meaningful relationship is that with the physician or therapist, and here Dr. Milestone is asking that those terribly unfortunate few actually leave this one relationship before the final act of suicide. And to protect the physician? (ie "have the courtesy to end that relationship" implies the patient is capable of and should be focusing on the physician's needs rather than his/her own.) Since when is it a patient's job to protect his physician, therapist, or psychiatrist? This seems an inhumane role-reversal. Three: I would argue that not every suicidal person seeking a therapeutic relationship is looking to live longer; what if that relationship is a kind of palliation? What if that individual wishes not to be alone in death, just as he has been in life? We would be committing a harm, as physicians, in allowing or forcing suffering to increase prior to a painful, lonely, and frightening death by suicide, by withdrawing our care. If we are to "do no harm," then surely this is in fact a contradiction of the principle of non-maleficence, which we all learn in medical school is one of the four pillars of medical ethics. Here, then, is an answer to Dr. Milestone's question of why a physician would "want to aid someone in dying:" what if a physician wants to relieve suffering? Does that sound so preposterous, if in some cases the only way to end suffering is through death?

The final concept I wish to address is the inequality proposed in Dr. Milestone's letter: the idea that it is ethical to deny the severely disabled access to suicide, by maintaining a law that does not allow physicians to assist. If, as he implies, death is a fundamental human right, then surely it is immoral to propose a law that discriminates against people who are not able-bodied enough to commit suicide.

I, like most other psychiatrists, am passionate about caring for my patients, and determined to relieve suffering in any way that is ethical. My request to my colleagues is simply to consider the implications of Dr. Milestone's thesis and to recall the internal experiences of your own suffering patients in doing so.

Justine Dembo, M.D., FRCP(C), dembojs@hotmail.com

Is Love All You Need? A Review of Joseph Natterson's "The Loving Self"

by Arsalan Malik, MD

Psychotherapy is a labor of love. This is a trope as old as psychoanalysis itself. Freud himself famously wrote in a letter to Jung that psychoanalysis is "essentially a cure through love." So, what do these analysts from Freud to Natterson mean when they use the word "love" in the context of psychotherapy? They don't mean an erotic or physical love. Nor do they mean verbal flirtation. It's not the kind of selfish, mean, grasping, egotistical thing that people often mistake for love but which only uses love for self importance. Nor does it take the form of romantic interchanges, no matter how much either party may so desire.

Dr. Natterson, in his protean way, draws on Jurgen Habermas' and Axel Honneth's analysis of love as a "struggle for recognition." It is in the search for this recognition that human beings relate to each other. Mentally ill or not, we are all primarily motivated by a yearning to be recognized and understood, to "see ourselves in another." In the intimate transaction of psychotherapy there is a reciprocal searching, in the course of which a mutual and transformative identification occurs for both the therapist and the patient. Seeing oneself in another and the other in oneself is the core of love out of which emerges not only self respect but a respect for others, and their rights. The unfolding of the loving self is thus essentially an intersubjective and eventually a communal phenomenon. This is the scaffolding upon which Dr. Natterson builds his concept of love in the therapeutic situation.

What makes the psychotherapeutic situation especially suitable for this unfolding is the searching and "subordinated subjectivity" of the therapist. There is an asymmetery in the patient-therapist relationship that does not exist in a person's relationships outside therapy. The patient is seeking help and must be able to express his neediness candidly, urgently and clamorously. The therapists subjectivity must be active to the extent that she should be able to identify with the patient's dependence and vulnerability, his guilt, his shame and his fears, but in a mellow, controlled fashion. The therapists "subordinated subjectivity" in this sense is the gift he brings to the therapy, because he has been there and done that. This subordinated subjectivity, is actively and empathically attuned to the patient's pain and suffering. The therapist feels with and for the patient but in a way that she can analyse it and use it for the benefit of the patient without being swamped by her own emotions in her identification with the patient.

Dr. Natterson gives some powerful examples of vividly reliving his own childhood relational themes, emotions and images evoked contrapuntally in therapy with certain patients. With the skill of a master composer he is able to momentarily subdue his own pain, long enough to use this relational music to make poignant, intense and "loving" interpretations about his patient's emotional experiences, making them aware of hidden, neurotically suppressed, and loving aspects of themselves. The psychotherapist's offering of this love to the patient is what encourages, stimulates and enables the patient to gradually reciprocate in kind. To open up to love. To tolerate love's anxiety and ambiguity. To risk letting love happen, to experience it, to allow the vulnerability of intimacy. To relinquish control and be more receptive to love.

Dr. Natterson also gives clinical examples to emphasize how it is that a person's immature aggression and inability to reconcile the angry and destructive parts of themselves with their loving self, blocks their willingness to open their hearts, and commit to and care deeply for another. The notion of love as something pure, as a given in social terms, is a sentimental fallacy. We can only love or be kind by an exhaustive, honest, endeavor to acknowledge understand and embrace our aggression. Without that we don't achieve the synthesis called kindness or love that is the cornerstone of a mature relational life. There is no way to have a "purified love", or a love free from ambivalence. The trick it is to recognize the ambivalence and achieve a synthesis.

In the end, Dr. Natterson has done a stellar job of articulating in easy, accessible language what we already do intuitively as therapists, whether we are psychiatrists, psychologists, social workers, mental health counselors, neophyte or experienced therapists. No matter what one's theoretical orientation, we should all aspire to this way of being with our patients.

Maybe Surgery Would Have Been Easier

by Walter T. Haessler, MD

I think I did one of the last rotating internships. I had started out as straight surgery in the summer of 1970, but after deciding on psychiatry, and being accepted into that program, I was able to trade my last two surgery rotations for internal medicine. The other guy, who had wanted straight surgery in the first place, was thrilled. I was too.

Shortly after all that was settled, at the squash courts in the college gymnasium, I encountered an attending general surgeon from the program. I had known him from the first year of medical school, when he would mentor students in the anatomy lab. He was a kind, friendly, soft-spoken man, and I liked him immensely.

So it was a little hard for me to respond when he asked how the surgery program was going. I told him about the switch to psychiatry, and right away sensed his disappointment. He asked why, and the answer that came to me was that I didn't want to be wedded to a hospital, as surgeons seemed to me to be.

I think if I had had time to prepare a response, to rehearse. my answer would have been more complete, and would perhaps have sounded less self-centered. But right then, as an off-the-cuff response, it was heartfelt and accurate.

He responded that it didn't necessarily have to be like that, as though wanting me to reconsider a decision that already had been made. I don't remember what else was said — it was a brief conversation — but I remember his being cordial, as he always was, and I remember sensing his disappointment.

A more complete and polished answer would have gone into the fact that I found human psychology more interesting than human anatomy. (Remember, in those days the psychiatric 50-minute hour was not yet extinct, although the director of our program, Dr. Gary J. Tucker, repeatedly cautioned us that it was indeed endangered because of changes in insurance coverage that he saw coming. He was a smart fellow.)

And, had I the courage, I would have told him maybe the biggest reason: that despite your best efforts surgical patients may dehisce, bleed. get infected, or find other ways to die. And then you get to talk to the family. In short, I didn't have the stomach for it.

(Somehow that reminds me of on old, politically incorrect joke that doesn't even make sense anymore, now that as many "girls" as "boys" become doctors, and other demographics have changed. Q: What is the definition of a lawyer? A: A lawyer is a nice Jewish boy who can't stand the sight of blood.)

Anyway, I suppose there were other reasons, but those would have been the big three for me.

And it worked for me for nearly 20 years: an office, a telephone, an answering service, and my wife was the bookkeeper. I never scheduled sessions shorter than 50 minutes. About half of my patients were on no medications. I got to know them.

It turned out, of course, that Gary was right, and by 1993 managed care was taking over in my area. The psychiatrists were receiving semiannual printouts from the dominant MCO as to our prescribing practices — basically, how expensive we were to them. And they announced they would be heading toward a primary care gatekeeper system, with Medicare-level fees for outpatient psychiatry (assuming they approved our periodic requests to continue funding treatment).

No thanks.

Instead, I accepted locum tenens assignments for several years — outpatient clinics, state hospitals, jails and prisons — and ended up working for Corrections until 2010. I seem to resist using the word "retired," and keep up my license, but doubt I will go back to work.

And here's why.

Let's say you're on a locum tenens assignment at an outpatient clinic in South Carolina. This is one of the better clinics to work at, so you have an hour to review the intake form, greet the patient, conduct the interview, discuss the risks and benefits of medication, obtain informed consent, order lab work, write prescriptions, schedule a follow-up appointment, and dictate a note in multi-axial format. (Actually, since this is 2015, I suppose you are required to enter an electronic record.) So, of necessity, the interview must be disturbingly brief.

The patient is a sullen 21-year-old white man who is accompanied by his father, who had insisted that his son get help. (I'm making all this up, by the way, but wondering how it might have gone had this contact occurred.) The patient has little to say, and most of the history is from the father.

The father reports that he and his son's mother are separated, and he and his son have kind of an off-and-on relationship. Friendly as a child, and a good student, the boy had dropped out of 9th-grade classes after the second try. The father was not sure how hard the boy had tried. He said the young man stayed with him at times, seemed to have no interests beyond video games and the internet, and had few acquaintances. There had been some drug use. He felt his son lacked direction. He recently insisted that his son seek employment, and thought some efforts were being made in that direction. He had, for some reason, just bought his son a .45-cal semi-automatic pistol for his birthday.

You ask the patient if he wants to speak privately, but he declines.You ask if he has anything to add, but he does not. You ask if he feels depressed, and he replies, "Not really." You ask about his sleep pattern, and he replies, "OK…I wake up late." You ask specific questions about psychotic symptoms and about thoughts of homicide or suicide, and he responds in the negative.

In a perfect world, you would get a thorough work-up by internal medicine and rather extensive psychological testing. But this world is not perfect. In a semi-perfect world, his case would come up at a staffing conference, and there would be ample time for discussion. But this world is not semi-perfect, either. And so you schedule a second appointment, suggesting that he come in alone. And you make a mental note to yourself to speak with his case manager (and his therapist, if he has one) as time permits. And then you hurriedly dictate the note, or enter an electronic record. And it's time for the next appointment.

Don't read the paper, or watch the evening news.

When you do, you learn that young men like that do very bad things. You also hear things like these two actual examples of stories on the evening news in Los Angeles from several years ago.

1) A woman was charged with murder in the death of her 12-year-old daughter. The woman's brother was interviewed, and regarding his sister said: "They wouldn't give her the help she needed."
2) A man was charged with the serial murders of several women. The man's brother was interviewed about him, and regarding is brother said: "They had him so full of medications that he didn't know what he was doing."

Maybe surgery would have been easier.

Dates to Save:

September 25-27, 2015 - CPA Annual Meeting

October 3, 2015 - LA NAMIWalk

October 18, 2015 - SCPS Career Day

November 7, 2015- Inland Empire NAMIWalk

November 7, 2015 - Women's Tea

January 30, 2016 - Psychopharmacology Update 27

CLASSIFIED ADVERTISEMENTS

Positions Available

PSYCHIATRIST - SANTA BARBARA

Outpatient psychiatric practice opportunity at Santa Barbara Behavioral Health (SBBH). SBBH manages the practices of psychiatrists and allied behavioral health professionals by generating patient referrals, and giving providers all the support services possible. Psychiatrists at SBBH are independent contractors and each determines their own hours, time off, and style of practice. SBBH provides guaranteed compensation for services rendered for SBBH contracted insurance work, and withholds an administrative fee for private pay work. As a result of continued growth, we have sufficient referral requests to add an additional full or part-time Adult and/or Child/Adolescent psychiatrist. Earnings for psychiatrists working at SBBH are high compared with salaried positions in the community. We have an affiliation of wonderful providers and support staff, with six psychiatrists, eight psychologists and masters level clinicians, and nine dedicated front and back office staff. The staff and Co-Directors provide an unusually high level of practice management and support to the psychiatrists, enabling them to focus on their clinical work, while tailoring their practices to maximize meeting their own needs and desires.
To confidentially explore this opportunity, please call or email:

Richard Steinberg, Co-Director, SBBH, 805-682-5777, rds1@impulse.net

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Community Research Foundation is seeking the services of a Licensed Psychiatrist to work with our Heartland Wellness and Recovery Center in San Diego, CA. Hours for services can range from 16-32 hours per week. There is Nursing support available and there are no afterhours coverage associated with this contract. CA Board Certified Psychiatrist with experience working with serious mental illness and co-occurring disorders and experience in a community health center preferred.

Interested parties are requested to submit their letter of interest, CV and service rate to James (Diego) Rogers PsyD by fax at (619) 275-1422 or by email at JRogers@comresearch.org. Please visit our website at www.comresearch.org.

Providence Health & Services and a large multi-specialty group that is part of its medical foundation are seeking a California-licensed BC/BE Psychiatrist to serve the community. Group has a strong reputation and collaborative history with Providence Holy Cross Medical Center. Competitive salary supplemented with a full benefit package and very generous pension plan. Shareholdership available after three years. Not accepting visa candidates.

For more information or to apply, send your CV to:

Rachelle Hobson, rachelle.hobson@providence.org; 503-203-0808

Miscellaneous Opportunities

Intensive Short-Term Dynamic Psychotherapy Core Training Group: John Rathauser, Ph.D. and David Wolff, M.D. are forming an ISTDP core training group in LA. The group is open to licensed therapists at all levels of experience with ISTDP. For more information visit www.davidwolffmd.com or contact Dr. Wolff at 310-273-5689 or dr@davidwolffmd.com.

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