On April 27, 2011, approximately 50 members gathered at the Quinnipiack Club in New Haven for the CPS Annual Meeting. Outgoing president Charles Dike highlighted the significant changes and improvements made to the organization under his leadership, including increased attendance at council meetings in the new location at the Connecticut Mental Health Center, greater participation of residents and early career psychiatrists, and a mentorship program for psychiatrists applying for APA Fellow or Distinguished Fellow positions. Following Dr. Dike’s remarks, the incoming CPS President, Dr. Christine Naungayan, was introduced. She outlined her background and interest in numerous areas of psychiatry: private practice, inpatient psychiatry, forensic evaluations, and others. She was welcomed warmly by the membership to her new position.

Two awards were given to CPS members for outstanding achievements in the past year. Dr. Paul Desan received the award for Distinguished Service to CPS for his extraordinary efforts as the head of the Committee on Consultation-Liaison Psychiatry and as the CPS liaison to the National Alliance on Mental Illness (NAMI). Dr. Cynthia Conrad received the Service to Patients award, which is presented to a member who has demonstrated exemplary devotion to patient care. Dr. Conrad is the medical director for the Western Connecticut Mental Health Network, a component of the Department of Mental Health and Addiction Services (DMHAS) and a member of the CPS Ethics Committee. She was honored for her work with young adults with prolonged mental illness.

This year’s keynote speaker was Dr. Robert Phillips, a forensic psychiatrist and medical director of the firm Forensic Consultation Associates, Inc., in the Washington, D.C. area. Dr. Phillips completed his psychiatric residency at Yale University, and he then served as director of the Whiting Forensic Institute from 1986 to 1993. During his tenure as director of Whiting, he was credited with many improvements to patient care and to the culture of the maximum-security forensic hospital. He moved to Maryland in 1998, where he started a private forensic practice and has served in several high-profile consultation roles over the years. Most notably, since 1996 he has been a psychiatric consultant to the Protective Intelligence branch of the United States Secret Service, which investigates threats to the President. He is also an adjunct professor at the University of Maryland Schools of Medicine and Law.

Dr. Phillips addressed the topic of stalking in his keynote address, “Inside the Mind of Celebrity Stalkers and Attackers of Public Figures.” He spoke about several infamous stalkers, some of whom he evaluated as a forensic psychiatrist or as a consultant to the Secret Service. He outlined several typologies of stalkers and emphasized that, contrary to the popular myth of the stalker fascinated by a Hollywood celebrity, most stalkers have had a previous relationship with the object of their obsession. He spoke in detail about John Hinckley, the man who attempted to assassinate President Ronald Reagan in 1981, reportedly in order to impress the actress Jodie Foster after seeing her in the film Taxi Driver. Dr. Phillips’ remarks were followed by a robust question and answer session in which CPS members asked about risk assessment and treatment of patients who exhibit stalking behavior. The meeting adjourned, and members were left to enjoy the hospitality of the Quinnipiack Club.
Dr. Cynthia Conrad received the Service to Patients award.

Dr. Paul Desan received the Service to CPS award.

Members enjoy dinner during Dr. Phillips’ keynote address.

Paul Amble, Christine Naungayan, Kevin Trueblood.

Charles Dike and Paul Desan.

Manage Nissanka and John Santopietro.
From the Editor: It’s Not Me, It’s You

Reena Kapoor, M.D.

As physicians, we are taught to approach problem-solving on the level of the individual: one doctor helping one patient at a time. During psychiatric training, we build our skills by working in interdisciplinary teams to identify internal conflicts, defense mechanisms, and neurologic abnormalities, but our focus remains on the individual patient. Once a mainstay of mental health treatment, psychiatrists trained in group and family therapy are quickly becoming relics of the past. As a result, the newest generation of psychiatrists focuses almost exclusively on one-on-one relationships.

This model of problem solving has its limits. What are we to do when insurance companies create impossible barriers to providing good treatment, discuss it with our therapists? When the pharmaceutical industry actively seeks to influence our prescribing practices with skewed data and lavish gifts, should we sit down with each sales representative to discuss our feelings about the matter? Or if legislators pass laws that we believe will be detrimental to our patients, are we to have a good cry? I am being deliberately reductionist in order to make a point (I don't actually believe that psychotherapy is accurately described as crying and chatting), but the point is an important one. Sometimes we need to look beyond individual relationships in order to accomplish our goals.

In this context, consider the CPS. Every month, we gather together to discuss not our individual needs, but rather the agenda of psychiatrists as a group. We have debates about how best to accomplish our goals. We identify our opponents and strategies to defeat them. We do so in the service of better patient care—a truly laudable mission—but I am often struck by how different our approach is from the methods we use with patients. By day, we look inward and ask our patients to do the same, and by night we do battle against all who seek to challenge our fundamental values: the insurance companies, the pharmaceutical industry, overzealous patient advocates, and others. For once, we are allowed to say, “It’s not me, it’s you,” and target our efforts at the external world. Though I can’t speak for all CPS members, I have found the experience rather liberating and a necessary counterpoint to all of the soul-searching that goes on in other aspects of my professional life.

In this issue of the newsletter, I have invited our contributors to reflect upon our roles as psychiatrists outside of the usual doctor-patient relationship. We are fortunate to have many examples of psychiatrists who are engaged in societal pursuits that extend far beyond the traditional boundaries of medicine. Dr. Robert Phillips, the keynote speaker at the Annual Meeting, is the quintessential example: a psychiatrist who consults to the US Secret Service about the mental state of those who threaten the President. Drs. Shaukat Khan and Maya Prabhu write of their experiences with disaster psychiatry training and evaluations of refugees seeking asylum in the US. The profile of Dr. Robert Trestman describes a rare creature: a man who is both a psychologist and a psychiatrist. Dr. Charles Dike muses on the topic of retirement, entertaining the idea that psychiatrists can have a life after psychiatry, not just outside of it. Finally, Dr. Victor Altshul reminds us that psychiatrists need not look beyond the couch to find a sense of importance in their work. However, he did indulge me by contributing a poem to the newsletter (printed on back page), which clearly demonstrates that he, too, does occasionally stray from the analytic couch.

The end result is an issue of the newsletter that celebrates the diversity of modern psychiatric practice. I hope you enjoy this opportunity to examine the interface between psychiatry and the wider world. Then go forth and fight!
Let’s Make a Commitment

Christine Naungayan, M.D.

One of the principles I have come to appreciate these past four years on the executive committee for the Connecticut Psychiatric Society is that ninety percent of the discussions generated in CPS stem directly from the members who are actually present during each meeting. If a particular meeting, for example, is comprised mostly of psychiatrists in private practice, then the concerns, questions, focus, and general concessions and motives raised during that meeting were comprised of—you guessed it—mostly issues facing those members of CPS in private practice. If this seems simplistic, then I am on the right track, because one of the best contributions of our former CPS President, Charles Dike, was to generate renewed interest in CPS amongst an array of psychiatric specialists and members at various levels of academic training, including those members in residency and fellowships. It can be difficult initially to recruit new members to CPS or to encourage current members to attend CPS meetings. Most of us are creatures of habit, and, if a CPS meeting is not a usually attended event, it means making an additional commitment outside of our already overburdened schedules. But please know how crucial attendance is for the breath that is infused into the life of each meeting, and how each meeting shapes the momentum for the entire year.

So while I would like to reassure members reading this newsletter that CPS does extend tremendous efforts to represent the interests of all members, regardless of meeting attendance, I am simultaneously imploring you to please make a personal commitment to attend at least one meeting during this 2011-2012 year. If you have attended a CPS meeting in the past, you will be pleasantly reminded of how revitalizing it can be to participate actively in discussions with your colleagues and co-practitioners on matters that directly impact your practice of psychiatry day to day. If you have never attended a CPS meeting, you will be surprised at how connected you feel to your colleagues when working cohesively on CPS policy formation or in collaboration with our state’s legislative members, who are more than happy to educate our members about current or future statute developments.

Ultimately, all members will experience how incredibly satisfying it can be to be directly involved in heated and lively dialogues about the very issues that affect and shape the future of how psychiatry is practiced in Connecticut. Please do not discount or underestimate how vital your opinion is to CPS. We want to hear your concerns, answer your questions, and help you to feel as if your membership in CPS is an integral piece of a cohesive whole. Because in reality, it is.....and your voice is as important as any voice in our wonderfully diverse and active community of psychiatrists. Please help us to make a difference in CPS, for you and for all of your colleagues, by making a commitment to attend at least one meeting this year. The rewards are both immediate and incredibly far-reaching. I look forward to seeing you soon!

How They Do Vex My Spirit

Ezra E. H. Griffith, M.D.

It has been a good summer. The grass in Connecticut has stayed green, which is testimony to the balance of rainy and dry spells. And the fashions have been up, leaving the young and the strong of heart to be adventurous in their choice of attire. All the while, the usual outdoor concerts and the other signs of summer life have been present and contributing to the cheeriness that characterizes our interactions at this time of year. But Bob Dylan warned us long ago that this cheeriness can’t define the state of affairs for everybody all the time. And if he didn’t say it, then I did.

Still, part of my summer has been vexing. Not profoundly so. But there still has been a sustained element to the irritability. This vexation developed after I read two essays that commented on books written about psychotropic medications. The author of the commentaries is a distinguished physician with an established reputation. And because of her style and national status, her articles always attract considerable attention. This time, however, she outdid herself. She raised two matters at length: the medications we prescribe don’t give as much benefit to patients as we claim; and we are caught in a strategic plot by pharmaceutical companies to have us think that medications represent our only therapeutic option in psychiatry.

I, of course, heard the first point put differently. In the less subtle version, self-styled patient advocates say that we psychiatrists prescribe poison. At least in that version, wrapped in its concentrated political formula, I can see the objective of the speakers. They seem to believe that an effective approach to defending their patients’ interests is to sully the character and intentions of psychiatrists, to undermine all we do. We have strayed far from medicine’s ethics base and we should not be trusted.

It is this point that links us so firmly to the second matter – the business of being caught up in a pharmaceutical plot that is tawdry and unprofessional. Yes, I grasp the coercion that may occur when physicians’ interests are intertwined with those of industry. But, I have never seen it as obviously possible in the professional life that I lead.

I’ve had several opportunities to participate in collegial discussions about the points made by the book reviewer and by patient advocates. The debates have been stimulating but devoid of any clear resolution. They generally tend to return inexorably to the perceptions we have of our individual professional activities. I have never thought that I prescribe...continued on page 5
The Importance of What We Do
Victor Altshul, M.D.

For this edition our editor has enjoined her columnists to write something outside the one-to-one clinical situation—“psychiatry beyond the couch”, in her felicitous phrasing. A worthy undertaking, no doubt, and I wish its spokespeople well.

Alas, I have spent a professional lifetime far from the madding crowd, sealed behind closed doors with one other person and the couch—well, all right, chair—and I know little about what goes on out there in the real world. I would have little but skepticism to contribute to the dialogue, and I would prefer, at least for this issue, not to draw my colleagues’ fire or ire.

Instead I would like to offer a perspective that took shape in my mind as my three-week vacation in Vermont was drawing to a close. I had expected to encounter the usual reentry problems—vexation about the reassumption of professional responsibility. Surprisingly, these familiar feelings were somewhat muted. Instead I found myself invigorated by the return to work and by the recognition of the extreme, one might even say sacred, importance of what we do.

I don’t know why I should have felt so startled by a thought I have had numerous times in the past. It is after all a message that I preach with tiresome frequency to my supervisees. But this time it felt almost like a new insight, and there is no way of conveying it here without its sounding tired and trite: what we have to offer our patients, what we uniquely offer them with the highest seriousness, is the gift, the responsibility, of listening to them. And I mean really listening, with every pore of our being open to what is being offered us and to what has been caused to reverberate within us.

Often we hear from colleagues that our responsibility is to understand our patients. I think this is a critical misconception, and it speaks to a destructive grandiosity we sometimes fall prey to. We cannot “understand” our patients, and it is misleading and dishonest to imply that we can. What we can and must do is to listen to them with the highest respect, offering them a conversation and a relationship safe enough to allow them to begin to experience themselves as they really are. Whatever “understanding” comes is tentative and uncertain; it follows this developing relationship and is experienced more or less simultaneously by both participants.

In recent years a type of psychiatry has been developing that regrettably deemphasizes the importance of listening, and we learn from the newspapers and our own observations that it is fast becoming standard practice. I refer to the 15-minute “medication maintenance” appointment. Its practitioners will tell you that they have to listen too; but what they are listening to is not what deeply concerns the patient, but what they need to know to make what they consider a safe and rational decision about medication. It’s not the same kind of listening, and it is very important that all of us understand the difference.

So this is what my vacation did for me: it reinvigorated me professionally; it fostered a joyous reedition to my work and a renewed understanding of its importance; it inspired me. I remember that feeling of inspiration from my earliest days in medical school, and it is wonderful to keep feeling it 55 years later.

Should lengthy August vacations be mandatory for all psychiatrists?

Vex My Spirit
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poison to my patients. And I’ve never imagined myself as a physician who would intentionally cause harm to those who trust in my medical acts. Such an idea strikes forcefully at the heart of the healing relationship between me and a patient – a relationship that is based on trust and that assures the patient that I respect his autonomy.

But back to my irritability. I am not pleased that the anti-psychiatrist political constituencies are spouting their foolishness. These groups have set out to define who physicians are and how they should do their work. The examples are numerous: assess only the strengths of your patient – as though you could ever properly conceptualize a treatment plan without balancing effectively the patient’s strengths and deficits; the treatment plan should reflect only the goals and objectives of the patient – as though the physician has no medical expertise to offer that the patient would be wise at least to consider.

One of my less temperate and considerably suspicious colleagues told me the other day that the anti-physician movement is just another plan to decrease health care to minority groups. The colleague assured me that all the well-educated advocates have their doctors and make good use of them – including taking their medications once the doctor has explained the benefits and the side effects. I’m not yet able to accept such an obviously paranoid position. But my colleague told me that he had a summer free of worry and vexation.

Private Practice Opportunity
Well established group psychology practice seeks a child psychiatrist to provide medication management and psychiatric evaluations for children and adolescents. Great opportunity for an early career psychiatrist to establish a practice from the high volume of referrals from the psychologists in the practice. Opportunity also exists to establish an affiliation with Connecticut Behavioral Health, LLC in a newly renovated office space within the psychology practice.

Send letter of interest and vita to Connecticut Behavioral Health, LLC
C/O Dr. Jonathan Pedro or Dr. Ryan Loss, 673 South Main Street, Cheshire, CT 06410. Fax: 203-271-1800.
Disaster Response: What Psychiatrists Can Do
Shaukat A. Khan, M.D.

Facing disaster is a part of mankind. Descriptions of disasters and their psychological impact on humans appear in ancient literature and various religious texts. The historian Herodotus, in the 6th century BC, described a soldier who suffered from permanent blindness after he witnessed the death of a fellow soldier. Soldiers who fought in the civil war suffered from a set of physical and emotional symptoms known as “Soldier’s Heart” or DaCosta’s syndrome, a predecessor of what we now call Posttraumatic Stress Disorder (PTSD). Depending on their intensity and severity, disasters are associated with a varying degree of emotional problems for survivors. Although disaster-related emotional traumas have been known for years, the clinical evaluation and treatment for these traumas within the disaster situation (or immediately afterward) are relatively recent developments.

The 1942 “Cocanut Grove” nightclub fire in Boston killed 492 people and left many relatives grieving the deaths of their young. The papers based on observation of psychiatric complications, symptomatology, and the management of acute grief related to this event by Erich Lindemann¹, Stanley Cobb², and Alexandra Adler³ are considered the beginning of modern disaster psychiatry. During the past two decades, the American Psychiatric Association (APA) has taken a leadership role in disaster preparedness and, in some situations, disaster response. In 1993 the Committee on Psychiatric Dimensions of Disaster was founded “to work toward the APA’s strategic goals of advocating for patients, supporting education, training and career development in the area of disaster psychiatry, and enhancing the scientific basis of psychiatric care for the victims of disaster”⁴.

There are several definitions of disaster. The definition offered by World Health Organization (WHO) is as follows: a “severe disruption, ecological and psychosocial, which greatly exceeds the coping capacity of the affected community”. There are different categories of disasters based on how they are caused. Disaster may be caused by natural occurrences, “Acts of God” (e.g., earthquakes, hurricanes, floods); man-made accidents or technological malfunctions (e.g., aircraft crash or power plant explosion); or willful human acts (e.g., atrocities or terrorism).

Psychiatrists are becoming increasingly active within disaster response. More than 700 psychiatrists responded to the 9/11 attacks⁵. Following the earthquake and tsunami in the Indian Ocean in 2004, Hurricane Katrina in 2005, and the earthquake in Haiti in 2010, psychiatrists continued to volunteer in disaster relief. Psychiatrists can play important roles in various areas, and as such, their participation in disaster relief should be encouraged. However, they should be aware that disaster psychiatry is not same as trauma psychiatry, particularly in the disaster’s immediate aftermath. It is not an office-based practice, and those impacted are not generally defined as patients. Though disasters can lead to decompensation in established psychiatric patients, many individuals who might benefit from mental health support are experiencing normal reactions to extraordinary circumstances. Often the psychiatric presentations in disaster survivors do not reach the threshold of psychiatric diagnostic criteria. The skills required early in disaster response therefore differ from those used in traditional trauma treatment. In addition, a psychiatrist volunteer in a disaster may be asked to play roles other than that of emotional healer, such as administrative, consultative, educational, and general medical roles.

Before committing to the relief efforts, psychiatrists should be affiliated with a recognized organization, aware of major issues impacting those affected by disasters, and knowledgeable about appropriate intervention. There should be a clear understanding of the concerted purpose and of one’s own motivation for responding. Psychiatrists themselves should be in good health to operate in a variety of circumstances and should take care not to become a burden to the relief effort.

Phases of Disaster Management
It is generally accepted that disaster management has three different phases: Pre-disaster, the acute phase, and post-acute phase. Each phase has its own specific set of requirements and interventions.

In the pre-disaster phase, prospective disaster-relief mental health workers should devote themselves to understanding the logistical issues related to disaster response and relief activities. They should be aware of the roles of different disaster response organizations, as well as the roles of the persons within an organization’s hierarchy of response. They should assist their hospital or clinic in disaster planning, make others aware of possible mental health consequences of the victims, and consider the welfare of individuals with serious mental illnesses in case of a disaster. Knowing the characteristics of the affected community, including its strengths, weaknesses, and cultural characteristics is vital. In addition, it is important to have a plan for self-care.

Phases of response and recovery after a disaster hits a community are:
1. Impact: first 24-48 hours of the acute phase (hours to days)
2. Acute: Extends up to 2 months after the event
3. Post-acute: Approximately 2 months and beyond (weeks to months years)

The rest of the article will discuss the management of the first two phases, based on the presentations and course materials at the APA disaster psychiatry course⁶. Information provided is included only to encourage further study, and certainly is not intended as a complete clinical guide to patient care.

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Disaster Response
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Assessment of Victims
In the acute phase, intervention begins with assessment of the victims, which includes assessment of exposure and assessment of needs.

Assessment of exposure should include:
1. Scope, Proximity and duration of event
2. Personal loss and injury
3. Ongoing insecurity or threat
4. Demographic data
5. Medical injury or exposure
6. Past psychiatric and substance abuse history
7. Pre-event problems with living and social support

The most important aspect of the assessment of needs is the identification of survivors who need immediate treatment, either medical or psychiatric. The following (psychiatric) situations need urgent triage:
1. Suicidal
2. Homicidal/harm to others
3. Inability to care for self
4. Acute exacerbation/recurrence of psychiatric symptoms
5. Substance relapse/acute intoxication
6. Past psychiatric and substance abuse history
7. Pre-event problems with living and social support

Common Symptoms and Syndromes
The psychological impact of a disaster on its victims requires careful assessment and knowledge about common physical, emotional, cognitive, behavioral, and spiritual reactions to disaster. Psychiatrists also need to distinguish between symptoms and syndromes, distress and diagnosis. Common initial psychiatric symptoms include anxiety, insomnia, mood dysregulation, and irritability. Less common symptoms include agitation, psychosis, dissociation, medically unexplained somatic complaints, and relapse with substance abuse.

The most common acute phase psychiatric diagnoses include:
1. Acute Stress Disorder
2. Major Depression
3. Reactivated Post-Traumatic Stress Disorder
4. Acute Bereavement
5. Adjustment Disorder
6. Panic Attacks
7. Exacerbation of Personality Disorder
8. Brief Psychotic Disorder
9. Substance abuse
10. Delirium

Psychological First Aid
Acute mental health interventions can be psychological or pharmacological. Key goals of acute phase intervention are to assure safety, reduce symptom burden, reduce anxiety and distress, and improve functioning. Acute psychological interventions should be empathic, supportive, and practical. They should be directed towards enhancing resilience and addressing current impairment.

Psychological First Aid (PFA) is a very helpful tool, and every disaster psychiatrist should be aware of it. PFA was developed by the National Child Traumatic Stress Network (NCTSN) and the National Center for PTSD (NCPTSD). The first and second editions of the PFA operation guide were released in 2005 and 2006, respectively, and the guide is now available online. PFA has received widespread acceptance, including adoption by the American Red Cross, public health agencies, the military, and state and local government. It has been translated into several different languages. The elements and goals of Psychological First Aid are as follows:
1. Contact and engagement
2. Safety and Comfort
3. Stabilization
4. Information gathering- current needs and concerns
5. Practical Assistance
6. Connection with social supports
7. Information on coping
8. Linkage with collaborative services

Although PFA is a very effective intervention tool for mental health workers, it does have some social, religious and cultural limitations. In cases where PFA is not applicable, short-term cognitive behavioral therapies can be effective.

Pharmacological Treatment
In the acute disaster setting, treatment is directed at symptoms rather than specific syndromes or disorders. There are no FDA-approved medications for acute stress disorder (ASD). The standard clinical practice, however, is to prescribe anxiolytic, sedative, or antipsychotic medications for “off-label” use to treat anxiety, insomnia, or agitation, similar to such practice in emergency psychiatry or primary care settings. Much of the current psychopharmacological intervention in the acute phase of disaster targets the postulated disease mechanism of ASD and PTSD, including dysregulation of the hypothalamic-pituitary-adrenal axis and of the norepinephrine, glutamate and serotonin systems. However, one must remember that not all ASD lead to PTSD, and PTSD may occur without ASD.

Medications, if prescribed, are usually done so on a short-term basis to reduce target symptoms, usually guided by prior clinical experience in disasters and research on other acutely stressed populations. A complete discussion of treatment of every disaster-related psychiatric syndrome is beyond the scope of this article, but the following is a list of medications which may prove helpful in a disaster psychiatrist’s tool box: lorazepam or clonazepam (though it is important to remember that benzodiazepines are contraindicated in traumatic brain injury), diphenhydramine, hydroxyzine, zolpidem, eszopiclone, trazodone, citalopram, mirtazapine, fluoxetine, risperidone, olanzapine, and quetiapine.

Conclusion
In the last few years, we have been affected by several natural and man-made disasters. Mental health workers have played important roles in the relief efforts following these disasters, and it is expected that their involvement will continue to increase in the future. Armed with adequate pre-disaster preparations and knowledge about the management of acute and post-acute phases of disaster, psychiatrists will be able to act more effectively as clinicians and humanitarian relief workers. The American Psychiatric Association (APA) is playing a crucial role in preparing the psychiatrists for this dual role in response to disastrous situations. Many district branches, including Massachusetts, New York, and California, are already supporting the APA’s efforts. Others—particularly Connecticut psychiatrists—should come forward, too.

References:
In the winter of 2011, as a forensic psychiatry fellow, I accompanied a team of law students and professors to the Middle East to conduct forensic psychiatric consultations of Iraqi refugees. The team was assembled by IRAP, the Iraqi Refugee Assistance Project, a clinic at Yale Law School which provides legal representation to Iraqis seeking resettlement in safe countries. The Yale forensics fellowship has had a longstanding relationship with many of the Yale Law School clinics – Immigration, Criminal, Veterans, Complex Federal Litigation. As part of our training, fellows work with law students and supervising attorneys in a variety of ways, including educating them on mental illness, advising them on interviewing techniques, and teaching them coping skills. But this was the first time fellowship work had taken us abroad on a kind of “global mental health elective.” And, according to IRAP, it was the first time that psychiatric evidence was going to be considered for use in refugee resettlement proceedings.

The story of how IRAP came to be is, to me, as interesting as the stories of its clients. IRAP was founded, almost accidentally, by two Yale law students (now lawyers), after one, Becca Heller, made an impromptu trip to Jordan over summer break. There, she was introduced to Tamara Daghistani, a prominent Iraqi exile, who arranged for Heller to meet displaced Iraqi families. Daghistani, her husband and their children themselves fled Iraq after Daghistani became a critic of the Baathist regime’s violence. “They took my neighbor’s boy, they took my friends, it was only a matter of time before they came for me too.” Asked what it was like to leave her whole life behind, Daghistani said it was very simple—“The only thing that matters are the people in the car with you.”

Daghistani was one of the first wave of expat Iraqis who swept back into Baghdad after American invasion, hoping to rebuild the country. Now utterly disillusioned with the current Iraqi political process, she is focusing on helping Iraqis who also fled, just as she did thirty years ago. She persuaded Heller to do anything possible for the hundreds of thousands of refugees living in limbo mostly in Syria and Jordan. Heller was surprised by her meetings with the Iraqis. She had expected to hear pleas for money and necessities; instead, the families requested help with the byzantine refugee hearing process. Upon returning to law school, she joined forces with Jonathan Finer, who had been a correspondent with the Washington Post in Iraq. Over 150 students responded to a handwritten poster-board requesting volunteers. Three years later, IRAP has chapters in law schools across the US and dozens of professional attorneys providing pro bono advice. IRAP estimates it has helped 450 families.

Although IRAP also advocates for broader policy reform, the core of its work is still individual legal support. Like asylum-seekers (who are physically present on US soil), refugees must provide evidence of significant persecution or a well-founded fear of persecution should they be returned to their country of origin. Unlike asylum-seekers, refugees do not have the right to legal counsel, nor are medical or psychiatric evaluations routinely incorporated into the refugee process as they are in asylum proceedings. This is significant because studies have shown that asylum applicants who have any sort of legal help are almost three-times more likely to be granted asylum as those without.¹ Not surprisingly, many refugees and asylum-seekers suffer from mental illness in reaction to the violence and persecution that caused them to leave. Opinions about the client’s mental state, which could reflect on their ability to convey a credible, coherent story, as well as explanations of culturally informed emotional expression, can be helpful. As a result, IRAP was eager to pilot this project to incorporate forensic psychiatric opinions in its refugee submissions, especially for clients who had pre-existing histories of psychiatric treatment.

IRAP’s caravan-like trip to several countries in Middle East, during which the legal advocates met their clients for the first time face-to-face, was both exhilarating and grueling. The “Arab Spring” was just beginning to make itself felt. And, as so often happens when traveling, we were the grateful recipients of much local hospitality, including mental health workers who provided access to ongoing care for the clients and activists who helped translate the babel of languages – psychiatric, legal and linguistic. However, were it not for the relentless good humor of the law students, it would have been easy to be overwhelmed by the magnitude of the traumas we heard—torture, self-immolation, rape. Of special note to all of us were the stories of Iraqi translators who had worked with Western news organizations or the American military and were then targeted for their “collaboration.” At a mental health training session we gave at a local United Nations office, the aid workers rapidly shifted the conversation from refugee symptomatology to their own stories about burnout and compassion fatigue. It is easy to understand why: the Iraqi refugees have been described as the “most documented” refugees in the world. Their stories are both uniquely shocking yet familiar. For the most part, the refugees were not sanguine about their prospects.

For the majority of the refugees we met, their lives continue to be “in abeyance,” unable to return or settle permanently in their host countries. It is also unclear whether further trips to provide such consultations will be possible given the security situation in the region; for refugees in certain of the countries we visited, a meeting with a foreigner at this time would lead to certain arrest. One option we are considering for the future is whether telepsychiatry can be valid and reliable consultative tool in lieu of face-to-face meetings. I feel very appreciative for the experience to have worked with such creative and dedicated legal activists, just as I was glad for a safe place to which I could return where I do not fear a midnight “knock on the door” for me.

Reference:

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“Thus was the first time that fellowship work had taken us abroad on a type of ‘global mental health elective.’”
Retirement: Aspiration vs. Reality

Charles C. Dike, M.D., MPH, MRCPsych

Retirement: An interesting word that is never too far away from the mind of most workers. What would retirement be like? Where would I retire to – country, climate, etc.? How would I spend my retirement – touring the world? Yes, every worker thinks about retirement once in a while, but some are more consumed by it than others.

But, how many people actually retire, if retirement is defined as a point where a person stops employment completely? Perhaps, retirement should be qualified – retirement from a specific job or activity – knowing full well that the higher chances are that the individual would continue to work, but, at a different job or location.

I remember attending a retirement party for one of my co-workers just weeks after I started working at the state maximum security psychiatric hospital; the staff member was retiring at 45! I was amazed and intrigued all at once. How was that possible? Wasn’t retirement what one did when he/she was old? I found an opening and cornered the staff member; I had questions for him. He told me he could have retired at 43, but extended it because he wanted to improve his pension by “working like a dog” for three years - the state would pay him the average of his 3 best years, for the rest of his life. He apparently started working at the facility at 21, and, being a hazardous duty environment, he could retire after 20 years. He had no student loans to pay off and had a vacation home off the coast of Maine!

I thought of my physician colleagues; what were they doing at 21, and at 30? Even if they were to start working at the same facility right after residency, would they be able to retire at 50? With student loans currently running in the hundreds of thousands of dollars, home mortgages of the same amount or higher, and kids in private schools or colleges, I doubt that retirement will come knocking on the door of most doctors until much later in life. A sad prospect indeed. Of course, I know that given a choice, most doctors love their jobs so much that they would not retire, at least, not completely. The problem is, there is often no choice in the matter.

It is this lack of choice is troubling to me, not that I would ever retire for I have never really embraced the concept; I will work until I am too frail to move (don’t tell my wife). However, it would be nice to know that I could if and when I wanted. As often happens to me at times like this, the voice of one of my lecturers in medical school echoes in my head - “For those of you entering this profession because of grand ideas of being rich, I beg you to reconsider your decision; it is not too late to change careers…”

Perhaps the word retirement is always in the consciousness of most people who work in my state hospital (and in fact, all of state government, recently) – even the newest employee seems to know the date continued on page 11

Connecticut Residents’ Day 2011

Remy Sirkin, M.D.

Each year residents from Connecticut psychiatry residency programs come together to take part in Connecticut Residents’ Day. This day is dedicated to learning, reaching out, and strengthening ties between residents. The event is generously sponsored each year by the Connecticut Psychiatric Society (CPS). Generally, it is tied in with the annual CPS meeting to promote resident involvement with the organization and events.

This past year’s Connecticut Residents’ Day was held on April 27, 2011, at Luce Restaurant in Middletown, CT. Approximately 40 residents and fellows from the University of Connecticut Health Center, the Institute of Living/Hartford Hospital Program, and Yale University School of Medicine attended the event. A luncheon was followed by three distinguished presentations, with time for questions and discussion after each presentation.

Dr. Paul Amble gave the first talk. He is Assistant Clinical Professor at Yale and also the Chief Forensic Psychiatrist for the Department of Mental Health and Addiction Services. Dr. Amble has spoken numerous times on the topic of risk assessment and has provided expert testimony on some of the most high profile forensic cases in the state. His talk exploring family dynamics and the death penalty blended well with discussion about his own experiences in the field of forensic psychiatry.

Dr. Amble’s presentation was followed by Dr. Ross J. Baldessarini. Dr. Baldessarini has been very active in the education of medical trainees and psychiatrists in psychopharmacology and other biological aspects of psychiatry. He is a tenured Professor of Psychiatry and in Neuroscience at Harvard Medical School and Senior Consulting Psychiatrist at Massachusetts General Hospital. Among his many awards and appointments, he is the current Director of the International Society for CNS Drug Trials Methodology, and he is Director of the Psychopharmacology Program and the International Consortium for Bipolar Disorder Research, Mailman Research Center at the McLean Division of Massachusetts General Hospital. Dr. Baldessarini gave a presentation on recent research and treatment of bipolar disorder and his work in the field.

The final presentation was given by Dr. Earl Giller. Dr. Giller has received grant support from the VA, NIMH and the pharmaceutical industry for research in biological assessments and pharmacological treatment of schizophrenia, bipolar disorder, depression, anxiety disorders and post-traumatic stress disorder. He is currently an independent consultant on CNS drug development and is Associate Professor Adjunct of Psychiatry at Yale School of Medicine. His talk, “Molecules to Medicine,” gave residents a clear idea about how the medications we prescribe make it onto the market.

This past Connecticut Residents’ Day was thought provoking and sparked curiosity among the residents. This event was organized by Institute of Living residents. Each year, one of the three residency programs takes charge of organizing the event. The University of Connecticut will organize Connecticut Residents’ Day 2012.
The 2011 legislative session ended and, despite being dominated by the state’s economic woes and Governor Malloy’s ongoing negotiations with the unions, several pieces of health care legislation were acted on. The following is a brief report of some of those issues. If you have any questions, please contact the CPS office at 860-243-3977.

Riverview Hospital
In a cost saving measure, some legislators called for the closing of Riverview Hospital. Senate Minority Leader John McKinney and House Minority Leader Larry Cafero argued that Riverview, the only state-run psychiatric hospital for children in Connecticut, costs $1 million per child per year and that children should be treated in less costly, smaller, community-based settings. While Jeanne Millstein, Connecticut’s Child Advocate, agreed with the Republican sponsored bill, she cautioned that closing Riverview prematurely without alternatives in place would be disastrous. Given the concerns about immediately closing Riverview without any alternatives, the bill introduced by McKinney and Cafero was changed to require the Department of Children and Families to submit a plan that would address key aspects of a potential closure—alternative placements for children, cost savings, etc. In the end, the bill was not acted on during the session.

Mental Health Parity
A bill requiring large group health insurance policies (those with more than 50 members) to comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHParEA, P. L. 110-343) died during the session when no action was taken on it by the House and the Senate. The bill applied to large group health insurance policies (including those that are self-insured) delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Under the bill, a fully-insured large group health insurance policy would have been subjected to both federal and state law.

APRNs as Primary Care Providers
Public Act 11-199 – An Act Concerning the Listing of Advanced Practice Registered Nurses in Managed Care Organization (MCO) Provider Listings, and Primary Care Provider Designations currently awaits the Governor’s signature. It requires a MCO’s annual list of participating providers to include, under a separate category or heading, participating advanced practice registered nurses (APRNs). In addition, the act will allow an enrollee of a managed care plan that requires selection of a primary care provider to instead choose a participating, in-network APRN.

Preauthorization Standards
A bill that would have established uniform standards for health care providers and health insurers for the preauthorization, precertification and predetermination of an admission, service, procedure or extension of stay was not acted on by the Insurance and Real Estate Committee. As physicians are aware, the current system of different criteria and standards among the multiple health insurers make it a guessing game trying to figure out which criteria need to be met to get treatment authorized. This is quite labor intensive for staff and frustrating for physicians and patients who are at the mercy of individual health insurance plans each requiring different criteria to be met.

Standards in Contracting
A big victory for medicine came in the form of standards in contracting. While Public Act 11-58 was not signed into law by the Governor due to scheduling conflicts, it will still become law. The act includes timely payments for electronic claims; network adequacy provisions; a ban on future product clauses; and standards for denying previously authorized services.

Psychoanalytic Psychiatrist
The Hospital of Central Connecticut is a 414-bed acute care teaching hospital affiliated with Hartford HealthCare, the largest health care system in the state. We have an outstanding full time or part time opportunity for a BC/BE Psychiatrist to join our talented psychiatry division.

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- A rewarding and challenging patient mix
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Interested candidates please send a current CV to Patricia Lowicki, Director of Physician Recruitment, at email plowicki@thohc.org or call 860-224-5576. We are Affirmative Action/Equal Opportunity Employer, M/F/V/D.
CPS Member Profile: Robert Trestman, Ph.D., M.D.

Dr. Robert Trestman is Professor of Medicine, Psychiatry, and Nursing at the University of Connecticut School of Medicine and Executive Director of Correctional Managed Health Care (CMHC).

CPS: Dr. Trestman, where did you grow up?

RT: New Orleans.

CPS: And was it your childhood dream to become an expert in prison mental health care?

RT: Yes, of course.

CPS: Can you say a little about how you made your dreams come true?

RT: When I was in graduate school [for psychology], I wrote my dissertation on stress management in cancer patients, and I was interested in the mind-body connection. I looked at whether modalities such as psychotherapy and self-hypnosis could improve outcomes in cancer treatment. During that process, it became clear that I didn’t understand much about cancer itself, so I had a choice. Either I could do a post-doctoral program in physiology, or I could go to medical school. I went to medical school.

CPS: And then?

RT: I chose to do my residency in psychiatry at Mt. Sinai Medical Center because they had an active program in psycho-immunology. After residency, I completed a research fellowship in neuro-immunology with my mentor, Dr. Marvin Stein, who was the chairman of the psychiatry department at Mt. Sinai. Although our work was productive, I always wondered why it was so, after all, I don’t hear of Supreme Court Justices or members of the US congress jumping into retirement – they often have to be dragged into it kicking and screaming. Retirement: An increasingly elusive concept that may not be worth all the hoopla.

CPS: How did you accomplish that?

RT: I spent 5 or 6 years researching the neurobiology of severe mood and personality disorders with another mentor, Dr. Larry Siever, at the Bronx VA Hospital. We studied impulsivity, aggression, and suicidality. Again, while the research was important, I found it difficult to have a direct impact on patient care. In 1995 I accepted a position as the Deputy Clinical Chairman of Psychiatry at Mt. Sinai, which gave me an opportunity to make the psychiatry department more competitive in a managed care environment. I stayed in this position until 1999, when my family decided to move away from New York City to a more rural environment.

CPS: And so Connecticut was the logical choice.

RT: I came to UConn Health Center in 1999 as the Vice Chairman of Psychiatry. Shortly after I arrived, I was asked to also assume responsibility as Director of Mental Health in the Correctional Managed Health Care (CMHC) contract, and agreed. Given my background in research related to impulsivity and aggression, I worked to build up the research component of CMHC by securing funding, in collaboration with others, first from the National Institute of Justice, and subsequently from the National Institute of Corrections. From 2005-2007, I stepped away from that position to focus more on research. I also worked with a group throughout the University of Connecticut to develop the Center for Public Health and Health Policy at UConn during that time period. Eventually I returned to CMHC, where I have remained ever since. In addition to providing clinical care to almost 20,000 people each day, we are currently working on research related to medication compliance, HIV, therapies for impulsive and aggressive patients, and collaborations with DMHAS.

CPS: Has working in the Department of Corrections been very different from working in academia?

RT: The skills required to be successful as a researcher in corrections are no different from the skills required to be successful in any other environment. One needs to

CPS: Any advice for young psychiatrists who are interested in a research career?

RT: I would advise them to join a well-established research group initially. Eventually, if they enter an area that is not as crowded with established research groups, but bring the same skills that they previously learned, they can rise to national prominence quickly.

CPS: Thank you!

Reference:

Disaster Response

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Retirement

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sometimes to the second) he/she will become eligible for retirement. I have always wondered why it was so, after all, I don’t hear of Supreme Court Justices or members of the US congress jumping into retirement – they often have to be dragged into it kicking and screaming.
The Department of Psychiatry at UMass Memorial Health Care is currently seeking a BC/BE Attending Psychiatrist for its adult inpatient unit at UMass Memorial Medical Center, the academic teaching hospital and clinical partner of The University of Massachusetts Medical School. Primary duties involve direct clinical care and support of the academic mission of the Department and the Medical Center including educational responsibilities and the opportunity to participate in research. The position provides the opportunity for involvement in a full range of clinical and academic pursuits. A faculty appointment, commensurate with experience, is also available.

Come join Dr. Alan Brown, Vice Chairman of Clinical Services, Dr. Douglas Ziedonis, Department Chair, and other prominent members of the Psychiatry Department in their ongoing pursuit of clinical and academic excellence. Interested candidates are encouraged to submit CVs and cover letters to: psychiatryrecruitment@umassmemorial.org.

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Synesthesia
Victor Altshul, M.D.
I would not sip manhattans in rounded goblets
Or Meursault in martini glasses.
Only a ballet dancer should conduct the Jupiter,
And the fugue from the C-sharp minor quartet
Must be played by angels in evening dress.
The old-world aromas from the children
In their formal dress, and their parents and dog,
Waft delicately across the centuries, and silently
Into the gray stone room in Madrid,
Where later, outside, I shall hear
The hum of a velvet Rioja, and savor
A longed-for caress, and I shall taste
All the splendid colors in the world.