Connecticut Psychiatrist
A Publication of the Connecticut Psychiatric Society | www.ctpsych.org
Vol. 57, No. 3 Fall 2020

The Next Level of CPS Advocacy

By Steven Madonick, MD, CPS President

The world continues in unprecedented ways. The coronavirus pandemic continues to increase in the United States. Many of us see new opportunities for social justice and for confronting racism, prejudice and inequality and are making our feelings known. There seems to be more "churn" or disruption in the social fabric of the country, sometimes playing out in the streets, than has been seen in at least a generation. Where does this leave psychiatry and our patients in our struggle against stigma and unfairness?

Last year, to considerable fanfare, the Connecticut legislature passed a bill requiring parity of payment between psychiatric services and other medical services. This was the culmination of many years of advocacy by various professional and trade associations, including CPS. This followed up on federal parity legislation passed over 10 years ago. These were positive and groundbreaking pieces of legislative work. Unfortunately, true parity remains elusive. Advocating and legislating require certain skills and connections. The next steps, implementing laws and creating real, lasting change requires access to data, vigilance, organization, hard work and determined commitment by many over an extended time. This is what we must strive for at CPS if we wish to permanently reduce stigma and inequality that allows payers to limit access to treatment and its reimbursement in psychiatry.

We recently succeeded in having the Connecticut State legislature and governor extend access to telepsychiatry and telephonic treatment until March 2021. CPS, other statewide mental health organizations, the Connecticut State Medical Society and consumers drew attention to the importance of these media to mental health treatment during the COVID-19 emergency and beyond. The APA and many medical subspecialty organizations also succeeded in extending the federal emergency measures from the department of Health and Human Services that also include telepsychiatry and telephonic treatment. To permanently develop proper codes, reimbursement and make telepsychiatry and telephonic care a permanent part of our practice will require more than an extension of emergency measures. There will need to be a long-term strategy, ongoing political pressure and lasting legislation.

In the past several months, our country and members of our profession have been looking harder at the consequences of racism on our society. Demonstrations, media coverage and responses by politicians and officials have

(Continued on page 3)

The Protection of Feeling Young

By Sheila Cooperman, MD

"May you always be courageous, stand upright and be strong, may you stay forever young…"
- Bob Dylan

As I read through professional journals, news articles, newsletters and reports these past months of the pandemic, the enormity of the stressors that everyone is facing cannot be ignored. There is the loss of friends and family to COVID-19, increased suicides and drug overdoses. There is rising racial tension, unemployment, loss of health insurance and financial blows, just to mention a few.

There were pre-COVID articles describing how alone, alienated, and disconnected a growing number of Americans reported feeling. Then the pandemic hit with lock downs, rising infection and death rates. The senior population has had the highest death rate. How could seniors emotionally and physically survive this? One piece to the answer came from the Journal Digest column in the APA's Newsletter of August 7 written by Nick Zagorski entitled "Feeling Young May Protect Seniors from Loneliness During Pandemic." He referenced the study, "COVID Related Loneliness and Psychiatric Symptoms Among Older Adults: The Buffering Role of Subjective Age" by Shrira A, Hoffman Y, Bodner E, Palgi Y in the American Journal of Geriatric Psychiatry, May 27, 2020.

This Israeli study was conducted online by 277 adults, 69% of whom were women, with a mean age of 69.58 who responded to questions on the following surveys about their symptoms and feelings due to the COVID-19 crisis: (a) a 4-item subjective age scale referring to mental, physical, behavioral and appearance-related aspects of aging that provided a 5 point scale from feeling much younger than their age to feeling much older than their age, with higher scores indicating

(Continued on page 2)

Assistant Editor Column: Which Person are You?

By Amanda Calhoun, MD, MPH, PGY-1
Yale Psychiatry Resident, Albert J. Solnit track

"What do you think of when you hear the word, 'doctor'?" I asked. I was speaking in an online career panel for Black high schoolers. Responses began to populate the zoom chat. Hero. Medicine. Caretaker. *Death.* I did a quick double-take. "Tell me more about that," I asked.

"Well," she typed, "I think about the family members I've lost to the medical system, a system that failed to treat them with dignity or respect."

Another student chimed in. "And doctors don't think Black people feel pain the same as white people do, so they give us less medicine."

"Yeah," typed a third student. "I really want to be a doctor, but I'm terrified to be a patient."

"It is inaccurate — and frankly, a slap in the face — to explain away racial health disparities by citing poverty and lack of healthcare access without acknowledgement of the impact of racism."

It is important to understand that mistrust of the medicine is not only driven by historical atrocities in the distant past. It is also due to current racism in the medical system. A myriad of studies validate the statements made by those students. Black patients, including Black children, are given less pain medications compared to white patients with comparable diagnoses or complaints.

It is inaccurate — and frankly, a slap in the face — to explain away racial health disparities by citing poverty and lack of healthcare access without acknowledgement of the impact of racism. Because this suggests that education and income protect Black women from racial inequities. Because this suggests that Black people are just poor without acknowledgement of the centuries of barriers intentionally put our way.

How many attendings know that the gap between Black and white infant mortality rates is wider than it was in 1850, when most Black women were viewed as chattel? How many residents know that a Black woman with an advanced degree is more likely to lose her baby than a white woman with an eighth grade education, in part due to racial neglect and the chronic stress of racism? It is far from surprising that a recent NPR survey showed that over one third of Black women say that they have been discriminated against in the hospital by healthcare providers.

How many psychiatrists know about "protest psychosis," a term used to conflate Black men advocating for basic civil rights with schizophrenia? This led to schizophrenia being viewed as a Black disease, with advertisements for haloperidol showing Black men portrayed as cartoonish, hostile figures. These beliefs persist today, with Black Americans being more likely to be diagnosed with schizophrenia and other psychotic disorders than white Americans with comparable presentations.

My work in systemic racism is synonymous with my work to become a great psychiatrist. I refuse to separate the two, because I believe that rectifying systemic racism is not a matter of interest, but of necessity. Not a matter of politics, but a matter of human rights. I have been doing this work long before the modernized lynching of George Floyd. Long before it was trendy to hashtag Black Lives Matter. Racism inside and outside of the medical system is not new. Unlawful killings of Black Americans are not new. We, as Black Americans, have been telling society that racism is killing us, for centuries. I hope now, society is finally listening.

Clinically, I see and experience

(Continued on page 6)

The Protection of Feeling Young

(continued from page 1)

identification with an older age; (b) a-3 item UCLA Loneliness Scale; (c) the Generalized Anxiety Scale (GAD-7); (d) the 9-question Patient Health Questionnaire; and (e) the Peritraumatic Distress Inventory. None of the respondents had been diagnosed with COVID. When controlled for demographics and COVID-19 variables, those who reported feeling older and those feeling lonely reported higher psychiatric symptoms at a level of significance. The researchers noted that in previous studies, subjective age was a moderator for the outcomes of stress. They acknowledge that one limitation of the study was the availability and ability for those older adults to have and use digital technology and that they had not compared these responses to pre-COVID experiences of the respondents. What they did recommend is using subjective age as one screening area that can help identify those older adults at high risk to the consequences of loneliness and that therapeutic efforts aimed at age identity and loneliness such as telephone or online interventions may serve to improve outcome.

The challenge for us as psychiatrists is how to make use of this information and apply it to our range of treatment interventions for this vulnerable population. In training we were taught to assess if a patient appeared younger, older or their stated age. Now it would be important to include how they feel in relation to their stated age.

CPS
Connecticut Psychiatric Society

Toward Allyship

By John Santopietro, MD

Immediately after George Floyd's death, I knew that I needed to stand up as a white leader but quite literally couldn't find the words. I decided (or was compelled) to lean in without them. I found the words by meeting with people. By bumbling through in public. By inviting feedback. By listening to those who *did* have the words. I knew there was a "reading list" – in fact I thought I'd done my share — but I didn't realize what a drop in the bucket that was. I took an online course on African American history. Twice. And read more books (including, this time, White Fragility), watched movies and documentaries, listened to podcasts, and listened to my friends and colleagues. One of my most powerful new awakenings was to realize that people I live and work with – right next to me — have had so entirely different an experience of life in what we think of as the same country. When I looked at the picture of my graduating high school class that sits in my office, I noticed there wasn't one Black face in it — for the *first time*. I found my way by doing my best to show up and be present. I realized how important language is. Realized how tentative we are to use terms like racism, anti-racism, anti-Black racism, and even white supremacy.

As I engaged the system I lead, I started to see the stages a group goes through in this process – in my case, via the lens of the DEI (diversity, equity, and inclusion) framework we'd been building the last few years in our behavioral health network. First, there is getting over the awkwardness of not wanting to say the wrong thing. Next, there is opening up to implicit bias – our desire to see ourselves as good can be our worst enemy. Then, structural and institutional racism comes into view – realizing that if we waved a wand and eliminated interpersonal racism in an instant, we would still face all that is baked into the system. And, eventually, opening up 'brave spaces' where people (if authentically invited) start speaking up - sometimes with each other, sometimes on behalf of the group, sometimes for themselves, sometimes for the first time.

If we can create an environment where acknowledging one's own bias isn't seen as a failure but as an achievement, where we can be truly humble and curious about each other's experience, where we question the stereotypes that blind us to the truth, and where honest expression by someone of color is not assumed to be anger until proven otherwise…then we may be moving forward.

In the first grand rounds for a series on racism we stood up this summer, the speaker said working on anti-racism requires a combination of "being" and "doing." I've focused so far on finding the words, on a way of being. However, the work requires much more than words. We must…particularly as leaders we must…support this work with resources. We must un-bake and re-bake the infrastructure so that it endures. The test of our success won't be in the next 3 months. It will be in the next 3 years. In the next 30 years.

A word on allyship. I think it's good for people to want to be allies. We live in a country that remains segregated both geographically and in life experience. By working together on common issues, emphasizing shared goals and values and supporting the same goals, we can work towards being allies. But allyship is a journey, not a destination.

Embrace the awkward. Racism is human-made. We can change it.

IOL summer grand rounds on racism videos: *https://instituteofliving.org/health-professionals/training-education/grand-rounds*

Open Yale Courses: African American History: From Emancipation to the Present: https://oyc.yale.edu/african-american-studies/afam-162

The Next Level of CPS Advocacy

(continued from Page 1)

drawn attention to the long-standing problem of racism that been a plague upon our country. Both the APA and CPS have started a discussion about racism in psychiatry and how to combat it. Unfortunately, news coverage is inconsistent and public officials are easily distracted by other concerns. A comprehensive strategy will be necessary to push for meaningful, lasting change in structural racism as it affects our country and its many institutions.

CPS has done some important initial work on parity, telehealth, improved access to mental health care and calling out racism in organized psychiatry. **We need to do more.** Some of this work by CPS has been accomplished by the CPS executive committee and its subcommittees. These efforts have only involved a small minority of members, probably 25-30 individuals. CPS has over 700 active members and we will need many more to work with us if we are to get to the next level of creating permanent, robust changes in these important areas so we can practice with greater freedom, dignity and effectiveness.

Psychiatry on the Front Lines of Racism

By AZA Stephen Allsop, MD, PhD

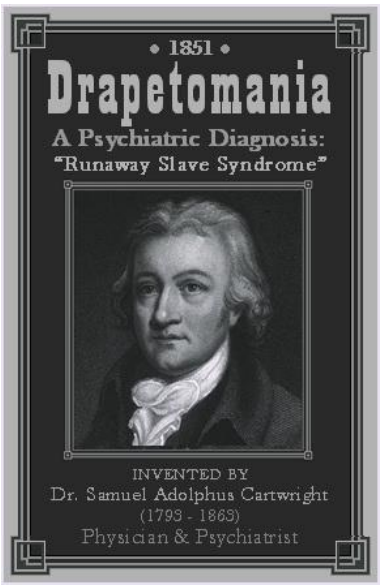
The recent police killings of George Floyd, Ahmaud Arbery, and Breonna Taylor have once again sparked a national conversation about the role of race in America and its continuing legacy and impact on People of African Descent (PAD). As a PAD trainee in psychiatry at this time, I especially think about ways psychiatry has been historically used as a tool of oppression for those who look like me while imagining ways we can be uniquely equipped to lead the intellectual and political charge against racism through innovating what this field looks like and how it interfaces with society.

Part of this innovation requires honestly confronting what psychiatry has been. The field is generally agreed to have its formal beginnings in the mid 1800s and from its beginning was explicitly Eurocentric in its philosophical underpinnings and became institutionalized at a time when racist thought was being widely integrated and legislated into European and American culture. As a result, by the late 19th century, well known psychiatrists and psychologists held explicit and implicit racist beliefs. This allowed the field to be used as another socio-political tool to justify the oppression of PADs and includes examples such as "drapetomania," a mental illness which caused slaves to want to run away to Clennon W. King, Jr being arrested and kept in a mental hospital for 12 days in 1958 because "any nigger who tried to enter Ole Miss *must* be crazy" (Tucker). Today, racism still manifests in modern psychiatry in diagnostic and prescription patterns and mental health access and outcomes.

"...psychiatry is a powerful tool to analyze and understand racism."

Yet despite this history and current practice, psychiatry is a powerful tool to analyze and understand racism. Frantz Fanon and Chester Pierce, two giants of this practice, are readily accessible examples of this. Fanon understood how racism alienated groups of people and viewed the social structures of white supremacy as causative for the mental illnesses seen in his colonial setting. He fought against a racist framework that normalized adjusting to a vicious social system. Chester Pierce, the originator of the now common word "microaggression," used the psychiatric lens to define racism as "a mental and public health illness in which skin color determines whether or not one is expected to operate from an inferior or superior vantage point." Among other insights, he was critical of the role of TV and the media in shaping and upholding racist ideology and produced data validating the racist portrayal of blacks in media and how this would inherently shape children's development of normative ideas.

Psychiatrists today must now embrace this lineage of the field as the intellectual foundation for crafting lasting solutions to racism. We must be intentional about using our field to create solutions for the race problem. This can take two general forms. First, psychiatry is equipped with the tools for changing the ways that individuals think and behave and must be utilized to address racist ideology in this country. Modern ideas of race came into existence as an ideology meant to justify an oppressive system in which humans from Europe intentionally dehumanized humans from Africa for economic gain. However, previous solutions have been largely aimed at legislative and economic actions that do not address the deeply entrenched ideology. Thus, every few years the country is forced to confront the reality that Black lives still do not matter in the ideology of the socio-political system. Secondly, the legacy of racism and slavery is inherently traumatic and the generational effects of this trauma are apparent and have never been addressed in an intentional way. Psychiatry must be systemically at the forefront of any reparative action in order to heal the trauma of racism. Only when psychiatry has been transformed from its current practice to intentionally confront racism in society, can the legislative and economic solutions truly be effective. This is a necessary step in the progression to what Pierce calls "the mature society," in which we have achieved "true integration" and a system that "works for the mutual advancement and comfort of all its subjects."



Coard M. Drapetomania: Compliant Blacks sane, resisting Blacks insane. The Philadelphia Tribune. March 15, 2019.

CPS
Connecticut Psychiatric Society

Legislative Update

By Jacquelyn T. Coleman, CAE, Executive Director

With all the seats in the General Assembly up for election this November, campaigning doesn't look like it used to. Candidates have to get their names and faces in front of the voting public in a way that maintains safety. For many that means no door-to-door visits, no standing in front of supermarkets, no large gatherings. And incumbents with an opponent can't take their constituents for granted. There are also over 20 empty seats, which would usually involve more spirited contests.

When the dust settles, there will be a need for new leadership as well. Of 4 leadership positions, Senate Majority and Minority and House Majority and Minority, three will need to be filled. These seats are filled by election by the party caucuses, so campaigning for those positions will start right after the elections.

After that, Committee chairs will be appointed and legislators will be assigned to Committees.

The official start of the session is Wednesday, January 6. Legislators can start submitting bills in December.

In the first year of the two-year session, all legislators can submit bills, and they will, since they all ran to accomplish things and make changes to the status quo.

It's not clear how the legislature will conduct business. The Capitol complex has been closed since March. Any necessary meetings have been held by Zoom. It's hard to tell how Committees will meet and hearings will be held. Face to face contact with your legislator would seem like an impossibility.

That all said, we will have work to do. Our most important task will be to make telepsychiatry practice, including telephonic contact, permanent. We all have to train ourselves to mention telephonic contact when we mention telepsychiatry, as there are many studies showing good outcomes with treatment by telephone. It improves compliance and lessens the burden on patients with no or poor internet who have transportation, childcare and underlying health problems.

Although that will be our priority, we will also look for opportunities to improve access to care and defend against discrimination against those with mental illness.

Although many things are unknown, each legislator has one vote – that hasn't changed – and our task as advocates will still be to get their attention.

News from the APA

APA Presidential Task Force to Address Structural Racism Throughout Psychiatry Begins Its Work

The American Psychiatric Association today announced the members and charge of its Presidential Task Force to Address Structural Racism Throughout Psychiatry. The Task Force was initially described at an APA Town Hall on June 15 amidst rising calls from psychiatrists for action on racism. It held its first meeting on June 27, and efforts, including the planning of future town halls, surveys and the establishment of related committees, are underway.

APA Praises CMS Action to Increase Telehealth Access via Phones

The American Psychiatric Association (APA) today praises action taken this week by the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services to increase access to telehealth for Americans who lack the required video technology or live in areas without reliable broadband access. The APA has pushed for this increased, audio-only access for patients who have older phones that do not have a camera or lack internet access.

APA Applauds Dr. Patrice Harris for Her Tenure as President of the American Medical Association

The American Psychiatric Association (APA) today issued the following statements to mark the end of Dr. Patrice Harris' one-year tenure as president of the American Medical Association (AMA), the nation's largest medical society with roughly 250,000 members. Dr. Harris is a Fellow of the APA and is a practicing psychiatrist, trained in child/adolescent psychiatry and forensic psychiatry.

APA Foundation Joins NIH Public-Private Partnership To Advance Early Interventions for Schizophrenia

The American Psychiatric Association Foundation (APAF), the philanthropic and educational arm of APA, joins a new public-private partnership launched today by the National Institute of Health (NIH) that is aimed at meeting the urgent need for early therapeutic interventions for people at risk of developing schizophrenia. It is part of the Accelerating Medicines Partnership (AMP) that promotes development of effective, targeted treatments.

Which Person are You?

(continued from page 2)

Metzl, J. The protest psychosis: how schizophrenia became a Black disease. (Beacon Press, 2010).

racism all the time and in every single rotation. I deal with attendings who confuse me with other Black residents, and don't bother to rectify their mistake when I point it out. I deal with medical students asking me if I am a physician assistant student, even though I am wearing a long white coat. I watch staff describe Black psychiatric patients as "nightmares" and describe white patients with similar behaviors as "struggling." I watch my Black patients labeled as "paranoid" at their mere suggestion that they are experiencing differential treatment based on race.

Non-Black Americans sometimes tell me that they were unaware of the impact of anti-Black racism until recently. I have trouble fully believing that. And if that is true, what will you do with this newfound awareness? How will you act? There are many people, like me, who speak up on behalf of our Black patients and call out racism when they see it, but we are often silenced and ignored, instead of supported and amplified. Anti-Black racism continues to occur, not just because of racist beliefs, actions, and policies, but because of the vast number of non-Black people who hush us, instead of helping us. People who send us empathetic text messages after the fact, instead of emphatically defending us in the moment, in front of the medical team. Which person are you?

Connecticut Psychiatric Society

Connecticut Psychiatrist

Newsletter of the Connecticut Psychiatric Society

PO Box 30
Bloomfield, CT 06002

Phone: 860-234-6463
Fax: 860-286-0787

Email: cps@ssmgt.com

Vol. 57 • Issue 3

Fall 2020