Everyone,

Times have changed. At last week's Institute of Psychiatric Services in New Orleans, of two dozen exhibits, only one was sponsored by a pharmaceutical firm. Of the 79 sessions, the only ones focused on specific meds were two on clozapine and two on buprenorphine. As to psychotherapy, one on brief psychotherapy and one on motivational interviewing.

In opmed.doxemity.com, "Why Psychotherapy Training Shouldn't Be Part of Psychiatric Residency" suggests that the only reason psychotherapy continues to be required is "mostly nostalgia for a bygone era of couch-bound patients and bearded psychiatrists supposedly expert in all aspects of human behavior, still trumpeted by depictions in movies and television." Author says 11% continue to practice psychotherapy extensively after residency. The result, the author claims is "woefully undertrained psychiatric diagnosticians and psychopharmacologists."

When responsible for training psychiatrists at St Es, I supported some psychotherapy training on two grounds:

1] After saying "Hello," even if focused on psychopharm, one wants to communicate elements of supportive psychotherapy.

2] Even if only 15 minutes, it is important to be sensitive to transferences and countertransferences that arise.

One might argue, however, that supportive psychotherapy be THE requirement.

From the lakphy desk:

Studies are claiming that exercise does not prevent or reduce the size of arterial plaques; thus, the logic allows, back to the couch to watch TV. In July's J of Amer College of Cardiology, an article warns against such thinking, as exercise may not prevent plaques but can help prevent them from breaking off arterial walls and going to the heart. Bottom line: the article champions exercise.

An editorial in 10 Oct 2017 JAMA points out that cognitive behavioral therapy has the most empirical studies, but warns against thinking that because it has the most studies, it is the gold standard for psychotherapy. It goes on to say that all evidence-based therapies -- be the focus on cognition, emotional, interpersonal or unconscious processes -- have value clinically and in research.

In this month's AJP, an article suggests that ADHD may not exist in adults without a history of another disorder. The article suggests that other conditions, especially substance abuse, will be found when getting a history.

An editorial today in the NEMJ on the mass shooting in Las Vegas argues for better gun control. It also argues that tighter background checks can keep war weapons out of the hands of those who are known to be mentally ill.

In Sentinel #173, we listed 10 actions that may help one's memory. We have some more for your patients and you to consider [from a Mass Gen Hosp's, Mind, Mood and Memory]:

11] Help the patient to strengthen their social support system.

12] Help the patient avoid chronic stress. Note, "chronic."

13] Work out your mind with mentally challenging puzzles or games.

14] Have a diet of vegetables, fruits, nuts, dark chocolate.

15] Keep a written scheduler that allows for details such as what to bring to that event.

16] When acute stresses do occur, suggest techniques to diminished negative impact:

A] Have the patient decide what are happy remembrances, then suggest recalling them after an unpleasant event or thought.

B] Learn and use relaxation techniques. Three choices:

i] meditation [eyes closed, inhale deeply and slowly for a count of ten, then exhale slowly for a count of ten for 10 to 20 minutes. Think about the breath going through the nose.]

iiI tai chi

iii] yoga

Roger