Over the past 2 decades in psychiatry, interest in ketamine has grown based upon the potential therapeutic benefit of subanesthetic doses to rapidly improve symptoms of otherwise treatment-resistant depression.

CONTINUED ON PAGE 4

COMMENTARY

I Revealed That I Take Medication for My Mental Health to Millions Online
Here’s What Happened.

On the night of December 5, 2021, I posted the following message on social media: “My name is Dr. Jake. I’m a physician who treats mental illness, and I take meds for my mental health. And by the way, I’m proud of it.” The post was accompanied by a selfie of me in scrubs, holding a pill in my mouth, and an explanation for the photo.

Within 24 hours, the post was seen by millions and shared around the world. Although it received mostly supportive comments from individuals sharing their own struggles with mental health and thanking me for my vulnerability, I also received hate mail and threatening comments. The post struck a nerve.

Many of you reading this may not know who I am, but if you ask a premed or medical student who has TikTok or Instagram, there is a good chance that they do. As one of the most-followed doctors on social

CONTINUED ON PAGE 8
Thursday, March 31
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obody wants to reinvent the wheel, but sometimes we recognize the wheel can be improved. Maybe changing the treading will prevent skidding on a wet surface. Or maybe altering its composition will help it last longer. The same seems to be true in psychiatry, where, according to your colleagues, some systems are not performing as well as they could.

For example, let us consider the DSM. In this month’s Letter From the Editor, John J. Miller, MD, looks ahead to the release of the latest edition of the DSM. Although he was disappointed with DSM-5, he anticipates some positive changes in this new release. Nevertheless, he argues there are still issues with the classification and diagnostic system.

Similar issues can be found in consultation-liaison psychiatry, as Jacob M. Appel, MD, JD, MPH, shares frustrations over inappropriate contacts. He notes that as many as 30% of patients in medical units have psychiatric disorders, so it makes sense that psychiatrists are in-demand—and nobody disagrees that psychiatric expertise can lead to better outcomes for the patient. Yet, inappropriate consultants—regardless of their cause or reason—can be disruptive and wasteful. Dr. Appel shares tips for managing and navigating these situations to refine the process for all.

The potential for improvement also can be found in psychopharmacology. Psychiatric Times® Section Editor Brian Miller, MD, PhD, MPH, examines new research that looks at dose response of antipsychotics to determine how to optimize antipsychotic dosing during acute illness exacerbations. Similarly, David N. Osser, MD, synthesizes research to help make sense of prescribing lithium while monitoring its nephrotoxicity.

The cover stories also share insights into improving status quo. J.J. Rasi, PhD, MD, and Courtney S. Rasimas, MPH, discuss the complexities surrounding excited delirium as well as the controversies that surround it. As they succinctly put it, “The path forward will need to address the many forms of systemic bias embedded in society and the structures of service professions in order to refine the work in a just way.”

Speaking of bias and stigma, Jake Goodman, MD, MBA, pokes holes in the culture of silence and the myth of the superhero clinician in hopes to improve lives for current and future health care professionals. His brave story shines a light on what needs to happen to improve the fields of psychiatry and medicine.

And we are doing the same here at Psychiatric Times®. We are always looking for more ways to share the stories and clinical pearls that matter most to you, our reader. As the voice of psychiatry, we remain steadfast in providing top quality content from cover to cover. If you have ideas or suggestions to help us refine our wheel, please email us at PTEditor@mmhgroup.com.
FROM THE EDITOR

DSM-5-TR... Already?

John J. Miller, MD | Editor in Chief

The American Psychiatric Association is publishing its next iteration of DSM: DSM-5-TR. It feels like a lot less than 9 years since the publication of DSM-5, but I remember how disorienting it was when it came out. I am still grieving the loss of the 5 axes from the previous DSMs, and I would reinstate them in a heartbeat. Maybe this grief is somehow related to the newly added prolonged grief disorder. This term will apply to individuals experiencing a persistent grief response that meets specific criteria and has lasted for at least 12 months for adults and at least 6 months for children and adolescents.

However, to be fair, mood disorder NOS (not otherwise specified) has been resurrected with the DSM-5 congruent name of unspecified mood disorder. This is a big deal. It is challenging and often premature after an initial psychiatric evaluation to have to choose between unipolar major depression and bipolar major depression as the primary diagnosis, as all too often it takes time to tease these apart. Unspecified mood disorder allows us to identify that our treatment is targeting a mood disorder while simultaneously providing us with the clinical flexibility to treat this mood disorder without etching into a patient’s electronic medical record that it is unipolar or bipolar.

Helpful Additions

Two significant additions to the chapter “Other Conditions That May Be a Focus of Clinical Attention” are a history or the current presence of suicidal behavior and nonsuicidal self-injurious behavior. These are welcome additions, as we will now be able to codify the intent of self-injurious behaviors. This will contribute important information in the patient’s medical record to assist in the determination of harm assessment, especially by a clinician who does not know the patient. For some patients, there can be a bidirectional movement between suicidal and nonsuicidal behaviors over time, ultimately resulting in the codification of both descriptors.

Exit the Term Neuroleptic

A welcome change is the almost complete elimination of the term neuroleptic, which was first used in 1955 to describe the effects of the first antipsychotic, chlorpromazine. The term neuroleptic was derived from the Greek words that translate to “take hold of nerves,” and it reflected the observation of adverse effects of early antipsychotics, which included decreased activity, sedation, and impaired motor function. We have always viewed neuroleptic as an archaic term that should have been retired from psychiatric nomenclature decades ago. In DSM-5-TR, it will only remain with the diagnosis neuroleptic malignant syndrome. In its place, 2 different terms are used depending on the disorder: antipsychotic or dopamine receptor blocking agent.

Not Specific Enough

I long for the day when we transition over to neuroscience-based bimellaneous in which a drug is defined by its mechanism of action and not by what disorder it treats. In my opinion, even the term dopamine receptor blocking agent is not specific enough. There are 5 main...
Once again it is time to embrace a new DSM, with the likely accompaniment of burdensome medical record modifications and coding challenges with health care payers.

**DSM Is Inherently Unstable**

One of the benefits of having a DSM of mental disorders—which is updated on a regular basis in an attempt to reflect our evolving understanding of the brain’s functioning, individual variability, and dysfunction—is to share a common diagnostic manual for clinicians and investigators. Having a shared frame of reference for a specific constellation of signs and symptoms allows for a common language that theoretically allows for more rapid advancements in understanding mental disorders, as well as improved guidelines and algorithms for treatment.

The cautionary note is that each DSM edition is only a reflection of the American Psychiatric Association’s agreed-upon opinion at the time a new edition is published and will be in constant flux and revisions for decades to come. There are immense limitations and collateral damage that result from clinicians, insurance companies, and policy makers who impose intrusions into our care of patients based on the mythical belief that the DSM is scientific dogma and fact.

**When the Dx No Longer Exists**

One everyday casualty of this phenomena is the policy of health care payers to only provide reimbursement for treatments that are approved by the FDA. In fact, when a drug is under development by a pharmaceutical company, it must be registered for clinical studies for a specific FDA-approved diagnosis. As DSM has evolved from DSM-I through our newest DSM-5-TR, many diagnoses have surfaced and disappeared as the nosology evolves. Two examples of diagnoses that have come and gone—hence there are drugs with FDA approval for a diagnosis that no longer exists—include symptomatic relief of anxiety and tension associated with psychoneurosis and bipolar I disorder, most recent episode.

In sharp contrast, dopamine receptors 2, 3, and 4 all decrease cAMP synthesis in the postsynaptic neuron and hence are oppositional to D1 and D5. Significantly, dopamine receptor families, each with subsets of variations, Dopamine receptor 1 (D1) and dopamine receptor 5 (D5) both increase the postsynaptic intracellular synthesis of the secondary messenger cyclic adenosine monophosphate (cAMP) when the neurotransmitter dopamine binds to them. In sharp contrast, dopamine receptors 2, 3, and 4 all decrease cAMP synthesis in the postsynaptic neuron and hence are oppositional to D1 and D5. Hence, drugs that are dopamine-2 receptor blocking agents are believed to be involved in psychosis, mania, prolactin levels, tardive dyskinesia, acute dystonias, and drug-induced parkinsonism. The plethora of published research on the dopamine system supports this specific characterization of the D2 receptor. More significantly, most of the diagnoses across all of the DSMs have no FDA-approved drug. A classic article that I often reference, “An Analysis of the High Psychotropic Off-Label Use in Psychiatric Disorders: The Majority of Psychiatric Diagnoses Have No Approved Drugs,” concluded that only 11.8% of DSM-IV-TR diagnoses have an FDA-approved drug.1 With the publication of DSM-5 in 2013, this percentage has likely decreased.

**Concluding Thoughts**

Once again it is time to embrace a new DSM, with the likely accompaniment of burdensome medical record modifications and coding challenges with health care payers. 

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**REFERENCE**

Excited Delirium and Ketamine

Continued from Cover

During roughly the same period, use of the dissociative agent has expanded to emergency medicine and related areas of critical care medicine. In prehospital, emergency department, and intensive care settings, it has become more common to see high doses of parenteral ketamine used to manage agitation that is deemed severe and obstructive to necessary medical evaluation and treatment. Emergency medicine practitioners coined the term “excited delirium syndrome” (ExDS) in an American College of Emergency Physicians (ACEP) white paper to identify a subset of patients whose presenting phenotype correlates with the possibility of having an underlying critical illness.

The authors of this article have lived, learned, and worked in a US urban community in which the expansion of ketamine for such situations has outpaced much of the rest of North America. Based on our combined expertise, we hope to provide useful context for this practice seated in its history with attention to the evolution of nosology and with acknowledgment of changes in the relationship between medicine and society.

Historical Context: Bell’s Mania

The entity ExDS is said to have its earliest roots in the condition of Bell’s mania: exceedingly great overactivity of sudden onset with manifestations of maniac symptoms, delusions, and hallucinations, and the appearance of confusion. In an 1849 article in the American Journal of Insanity, Luther Vose Bell, MD, may have reported the latter because patients were so energetic and difficult to engage in dialogue that clinicians might find it challenging to adequately assess attention, orientation, and other features of mental status to ascertain if they were experiencing a delirial state. In light of that condition, Bell’s mania has also been called delirious mania. Bell, and others following him, noted that without treatment this condition can be fatal; the recommended treatment was “sufficient sedative,” and it was suggested that even large doses might not yield the sleep patients needed to recover. Since medicine conceptualizes delirium not as a psychiatric disorder but rather as a syndromic reflection of the effects of a severe medical condition on the whole body including the central nervous system, there is face validity to the notion that delirious mania could be deadly. If the underlying condition for ExDS might also be life threatening, it would make sense that provision of potent sedation by modern medical means would be the order of the day.

Although it is clinically informative to understand the historical connection between ExDS and Bell’s mania, that connection also highlights aspects that are problematic. Bell indicated that patients in his cohort were able to “suspend the intellectual wanderings long enough to answer correctly as to orientation” if a clinician insisted upon having the mental status questions answered. Although the impairments inherent to delirium may wax and wane, such a description suggests that that historical cohort may have been experiencing psychotic mania, but not delirium. Also, although it was recognized that the condition could be life threatening, his patients died after a 3- to 6-week course of illness, apparently due to cardiovascular collapse secondary to unmitigated overactivity. ExDS is conceptualized as a condition of much more acute danger with an underlying disease process that could result in death rapidly—within minutes to hours of its abrupt onset.

Furthermore, although patients with ExDS may be delirious, the nomenclature more aptly reflects the difficulty in determining whether such agitated patients have delirium rather than accurately indicating that they do. The criteria for ExDS (Table) do not align with the DSM-5 conception of the syndrome of delirium or any previous version thereof. The term excited delirium (sometimes used interchangeably with agitated delirium) is a fusion of a descriptive participle used to communicate something about behavioral energy and a term with a different, preestablished meaning in the nomenclature of psychiatry. And since agitation is used commonly and imprecisely across a variety of medical settings, clarity about the nature and utility of ExDS is elusive. Thus, we point out the historical connection between Bell’s mania and ExDS to indicate how the most important consequence may not be to demonstrate progress in medicine, but instead to allow imprecise thinking and use of language with the potential to stigmatize.

Intoxicating Substances and the History of ExDS

The connection between the history of psychiatry and current practice around ExDS reveals parallels that can be helpful in understanding the evolution of the emergency medicine concept and debates about not only its proper management but also its very existence. ExDS is, as the term indicates, a syndrome. Similar to the whole collection of psychiatric disorders, ExDS is not a diagnosis with a defined pathophysiology. Like our DSM entities, ExDS is defined by criteria set forth by a group of expert practitioners and taken up by its specialty field for use to describe a recognized problem. ExDS has more direct roots within emergency medicine itself, specifically in the subspecialty realm of medical toxicology.

It has been known for decades that patients experiencing the effects of severe intoxication with stimulants, specifically cocaine, are at acute risk of morbidity or death. Massive monoamineergic activity causes autonomic stress on the cardiovascular system and elevates body temperature. Stimulation of motivated behavior along with accompanying perceptual disturbances may drive excessive physical activity that increases anaerobic metabolism and physiologic stress. Cocaine also acts as a sodium channel antagonist, thereby adding to the risk of seizures and fatal cardiac arrhythmias. The established treatment for patients experiencing these toxic effects involves liberal doses of benzodiazepines to provide calm and protect against aberrant conduction, along with fluids, cooling measures, and supportive critical care.

Medical evaluation and testing of these patients will reveal findings consistent with the established pathophysiology that points to a diagnosis of cocaine intoxication. Note, however, that one cannot put this medical knowledge into targeted practice for a given patient without close and ongoing physical interaction with the individual experiencing the condition. And patients experiencing cocaine intoxication generally do not simply present themselves to emergency departments for care because of chest discomfort or hallucinosis. They may be first encountered in the prehospital setting by other members of the community and, next, by law enforcement professionals.

Although difficult to quantify, teaching police about cocaine undoubtedly saved many individuals from dying in squad cars and/or in jail—especially in cases of “body stuffing” where an alleged perpetrator of illegal drug activity quickly ingests the evidence to avoid criminal charges. Even when paramedics arrive and help convert the focus from law to medicine, such individuals do not automatically become patients in the traditional sense by engaging with emergency medical services personnel for assistance and care. Vital signs, physical findings, electrocardiograms, and laboratory results must be gathered and critically evaluated to render a diagnosis of stimulant toxicity. As a result, there must be a process to pursue the proper pathways to serving individuals in the community, identifying those who need to be treated medically and making transitions among locations and personnel.

Enter ExDS. The term excited delirium was first used in medical literature in 1985 to describe a sub-
set of patients who used cocaine and exhibited symptoms of psychosis before suddenly dying. Since the widespread illicit distribution of cocaine in North America during the 1980s and 1990s, the psychoactive drug landscape has become much more complex. Synthetic stimulants, some modeled after therapeutic compounds used in psychiatry and others modified from natural extracts, have toxicity profiles that mimic cocaine with additional effects. Synthetic cannabinoids cause perceptual disturbances and have stimulatory and autonomic effects that overlap with other classes of compounds. Adding to the complexity of patient care is the reality that substances may be used in combination, with ethanol frequently added to the mix.

Clinical presentations involving agitation and prehospital conflict are standably constructed with concern for severe unmitigated agitation and prehospital conflict. In order to minimize that conflict and the circumstances in which it was encountered precluded having any other medically relevant information apart from what could be observed at a distance, patients were categorized as having ExDS as a way to describe the problem. Adopting that nosology led quickly and logically to practice pathways involving the conceptualization of such individuals with the features listed in the Table as patients with potentially life-threatening intoxications. The possibility of other underlying contributory medical conditions exists, but the presence of intoxicating substances—whether older substances such as ethanol, cocaine, and phencyclidine, or new ones such as bath salts and K2—is the sine qua non of ExDS. Insistence was made that patients go for emergency care and, since the effects of substances are potent and the professionals insisting rarely have the interviewing skills of Bell, the result may be physically aggressive as if they do. As we have learned in psychiatry, we label the syndromes we treat intentionally as disorders—not diagnoses—as a way to acknowledge profound lack of certainty about pathophysiology and the corresponding potential for a number of contributing causes and circumstances to give rise to the clusters of signs and symptoms. Previously, however, as reflected in DSM-I and DSM-II, we did tie our diagnostic impressions to ideas about underlying causes—predominantly psychoanalytic ones. Categorization was done without the means to objectively verify etiologies. The result was that, although many patients did improve with our treatments based on assumptions about the underlying psychopathophysiologic processes described by Sigmund Freud and his followers, many others were labeled as having conditions born of mechanisms that did not apply to them. Progress has been made in understanding the many determinants of psychiatric illnesses, but recent iterations of the DSM have largely stuck to refining syndromic descriptions for the purpose of having a common clinical lexicon. Still, there are debates about where to draw diagnostic lines, and the problem of reification drives reductionistic errors that lead to substandard treatment of patients and blind ends in research.

ExDS has roots in a well-understood problem with a known pathophysiology and established protocols for lifesaving treatment. There are many sound reasons to believe that patients exposed to novel psychoactive substances with pharmacologic mechanisms that overlap with cocaine experience similar toxicity profiles and will benefit from similar treatments. Methamphetamine largely follow that logic. Because of their longer duration of action and tendency to cause more psychiatric symptoms that persist, patients who have taken methamphetamines can be more difficult to evaluate and treat due to their resistance to standard engagement with clinicians. Due to the diagnostic uncertainty that such patients embody (along with those who use novel agents, including mixtures of intoxicants), a syndromic label for their presenting signs and symptoms was understandably constructed with concern for severe underlying pathophysiology in mind. What is not known, however, is whether patients with those presenting characteristics actually have dangerous metabolic derangements and impending cardiovascular collapse. Repeated rounds of circular logic in the ACEP white paper drove home the point that patients with ExDS were critically ill and needed to be treated with “aggressive chemical sedation” to prevent harm befalling them. A more recent review of ExDS is more balanced in acknowledging limitations of the construct and the clinical research underlying it, including the fact that only a small fraction of patients identified as having ExDS have documented acidosis on laboratory testing once blood can be drawn for analysis. The review pointed out that the ExDS criteria are highly subjective and inconsistently applied in practice. Although the original ACEP white paper authors recommended a minimum of 6 of the 10 criteria be present to warrant a diagnosis of ExDS, numerous case series about ExDS involved the presence of fewer than 6 and sometimes as few as 1. Still, the nosology remains in place.

Criteria-based entities such as ExDS are subject to the influences of classism, racism, and a host of systemic biases.

Encountering Agitated Individuals
Further complicating matters is the reality that physicians are not the professionals directly observing the prehospital features of most patients who may meet criteria for ExDS. Patients get to emergency departments based upon the impressions of first responders. Even a brief reading of the list of ExDS criteria makes it clear that they are open to a wide range of interpretations by different observers. For this reason, we have placed the term agitation in italics throughout this article; even in hospitals, use of this word is far from precise and may therefore spark a variety of responses depending upon the situation and the characteristics of the individuals involved.

Efforts have been made to educate those who encounter agitated individuals in the community with attention to the importance of identifying ExDS. With subjective criteria, however, and all the complex factors that bias observation and human decision-making, many patients who do not have a dangerous medical condition may be treated aggressively as if they do. As we have learned in psychiatry with examples such as the overdiagnosis of persons of color with schizophrenia compared with the related condition of bipolar disorder, criteria-based entities such as ExDS are subject to the influences of classism, racism, and a host of systemic biases. In the first large study reviewing psychiatric outcomes after prehospital use of ketamine for severe agitation, the only patient characteristic that predicted treatment with that agent over benzodiazepines was being Black. For these reasons—and citing that the use of the term
ExDS may justify “law enforcement use of excessive force”—the American Medical Association (AMA) recently “oppose[d] the use of excited delirium as a medical diagnosis” after approving a position statement on the matter in December 2020.1

At a Crossroads
Emergency medicine finds itself at the crossroads with ExDS that psychiatry faced after coming to appreciate the pitfalls of DSM-II. Working with the limitations of a list of diagnostic criteria tied to assumptions about underlying pathophysiology, the specialty has employed sedative medications, including ketamine, at increasing rates. Reification has narrowed clinical thinking, and prehospital and emergency department protocols have sometimes become more clinician-centered than patient-centered. Many symptoms of ExDS emerge not only from within the psychosomatic experience of patients, but as a result of how patients are treated by those who first encounter them. It is important to note that a large review of patients identified with ExDS indicated that, despite concerns about an underlying deadly pathophysiology, the patients who die are the patients who are restrained.9

Some emergency medicine practitioners aver that fast-acting sedatives such as ketamine are vital tools that should be used more liberally to minimize injuries and decrease duration of physical restraint. Restraint should be avoided as it may exacerbate the injuries and decrease duration of physical restraint. What should be appreciated and embraced is where this hotly debated entity fits within the range of human experiences. ExDS points to the potential existence of a life-threatening condition that is quite rare. Many of its criteria, however, line up with a wide variety of behavioral presentations that do not correlate with critical illness. Depending upon which criteria are observed in a given individual and how those criteria are ascertained, imminent danger to the individual in question and/or those in the vicinity may not be nearly as high as the ExDS literature would suggest.

On any given day in North America, a lot of individuals exhibit concerning behavior (Figure). A small fraction of those individuals use drugs that, under particular circumstances of interpersonal conflict, ambient temperature, and underlying physical vulnerability, may produce severe somatic illness. Figuring out the best way to approach such individuals in the uncontrolled environments where they are encountered involves practical knowledge of the landscape of all the potential causes of behavioral difficulty, not just the tiny subset of those who may have a serious condition with a verifiable corresponding pathophysiology. Ideally, the large numbers of individuals in crisis with other underlying causes would be treated astutely and humanely by first responders with an ability to intervene without further escalating the situation.

Skills can be taught that allow better care for individuals with histories of trauma, autism spectrum conditions, and psychiatric disorders. Prehospital professionals need more attention to their practical knowledge of the landscape of all the potential causes of behavioral difficulty, not just the tiny subset of those who may have a serious condition with a verifiable corresponding pathophysiology. Ideally, the large numbers of individuals in crisis with other underlying causes would be treated astutely and humanely by first responders with an ability to intervene without further escalating the situation.

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Help More Than Harm
The path forward will need to address the many forms of systemic bias embedded in society and the structures of service professions in order to refine the work in a just way. Because of the dangers and uncertainties inherent to the prehospital setting, we must acknowledge that some larger fraction of individuals than those with genuine deadly toxicity underlying presentation with ExDS criteria will still need to be treated as if they might have it in order to save those who do. Finding our collective range of tolerance for an acceptable range of unavoidable error in the face of such complexity is a task that will involve, among other things, greater tolerance.

It is paramount that the procedures we adopt do not allow the perspectives of medicine to harm more individuals than are helped. Physicians tend to believe that the details of medical science are too difficult for the public we serve to comprehend and thus exclude laypeople from dialogue about the values and actions of our profession. We must resist using that idea as an excuse around the issue of ExDS and instead productively engage the society we serve about the experiences, needs, and expectations of patients and their advocates to help foster real understanding and repair relationships going forward.

Concluding Thoughts
In the end, the situation remains complex, and even widespread implementation of the aforementioned suggestions will not resolve all the potential problems. Outlier cases will still confound ideal management. Expectations for first responders, prehospital emergency medical personnel, and emergency phy-
sicians remain extremely high, and the threat of litigation looms behind each encounter. Emergency medicine regularly ‘hopes for the best but defends against the worst’ in standard practice so that dangerous conditions are not missed and lives are saved. One study of patients who were intoxicated (most cases involved ethanol) demonstrated that 1% had a comorbid underlying critical illness that, had it not been identified, would almost certainly have resulted in a morbid or mortal outcome.12

As previously noted, patients who have such complex conditions do not always find their way to emergency departments for care calmly or without forceful assistance. The threat of violence in a society full of racial and class conflict adds enormous burden to the demands for rapid decision-making in situations that may or may not need to be handled aggressively to prevent harm and/or deliver sick patients to the services they need. Choosing to be less insistent with medical interventions in order to honor human dignity and autonomy may very well lead to more cases of missed diagnosis and poor physical outcome in exchange for attempts at more immediate improvements in psychological and social outcomes. The interface of these choices with protocols of law enforcement demonstrates clearly that asking police officers to function as clinicians is not the answer.

Psychiatry has an opportunity to be helpful. Recognizing the high intensity and acuity of the situations in question and not reacting merely with finger-pointing judgment of colleagues is an essential start. Using the parallels between our specialty’s difficulties with diagnostic uncertainty and evolution as well as lessons from historical nosological missteps to assist our emergency medicine colleagues may come next. We also have opportunities to point out how the behavior of individuals and groups often reflects systemic biases that appear to serve necessary purposes but unconsciously do harm. And we can make ourselves available to assist with reforms by educating other disciplines about the many conditions that manifest abnormal behavior with accompanying methods to distinguish among them and then respond in more nuanced, empathic, and therapeutic fashion. Such collaboration opens up opportunities to remind specialists in emergency and critical care that, for all the advantages of efficiency offered by rapidly administered parenteral ketamine, the psychiatric consequences of having a drug given without consent that causes profound dissociation may be severe—especially for those with a preexisting history of trauma.

Embedding psychiatrists, psychologists, social workers, and other colleagues with mental health expertise in the teams (police units and ambulance services) and locations (the streets and emergency departments) where patients first present with behavioral unrest may decrease this use of ketamine in favor of dialogue and partnership that both protects the public and gets patients the care they need. Early successes with a model that pairs mental health professionals with and/or replaces police depending upon the nature of the emergency situation have been realized in Oregon and Aurora, Colorado—the city in which Elijah McClain was subjected with ketamine and subsequently died.20

Like the AMA, the American Psychiatric Association has put forth a position statement about the term excited delirium.13 Before deciding on one’s opinions about what to make of ExDS and all the relevant historical, medical, ethical, and social concerns, we wish to make 1 direct recommendation for our readers: Call the medical director of emergency medical services in an urban catchment area and ask to ride an evening shift in an ambulance. There is much to see, much to learn, and much to be done.

The psychiatric consequences of having a drug given without consent that causes profound dissociation may be severe.

REFERENCES

Dr Rasimas is medical director of consultation-liaison psychiatry at Hennepin County Medical Center in Minneapolis, Minnesota; professor of psychiatry at the University of Minnesota in Minneapolis; and associate professor of psychiatry and emergency medicine at the Penn State Milton S. Hershey Medical Center in Hershey, Pennsylvania. Ms Rasimas graduated from the University of Virginia with a degree in neuroscience and completed a research fellowship at the National Institutes of Health in Bethesda, Maryland. She received her master’s degree in public health from the University of Minnesota in which she focused on the problems of gun violence and suicide. She is currently a science writer in Saint Paul, Minnesota.
Revelation

Continued from Cover

media, I create content for more than 1.6 million followers, educating them about mental health and demystifying the medical field for future health care professionals.

When I was very young and dreaming of becoming a doctor, I never witnessed a physician open up about their mental health, let alone admit to taking medication for it. Not even on TV shows or movies. Never. I grew up believing that doctors were like superheroes—by working exceedingly long hours in stressful environments, they built up a protective armor that shielded them from mental health issues.

Fast forward a decade or so, and I was in my last year of medical school in the midst of a global pandemic. I was a student in the emergency room the first time I saw someone die of COVID-19 complications. I stood at the foot of the bed during the code, holding my breath while wearing an N95 mask, hot sweat pouring down my face shield, watching a person no older than my parents receive chest compressions, the sounds of cracking ribs exploding in my ears. Then the compressions stopped, someone cursed, the patient pronounced dead, and the team stormed out of the room, leaving me staring at a lifeless body—a human being who was walking, talking, and living their life only days before. There was no process, no roundtable huddle with the care team, no their life only days before. There was no process... I held back tears and tried to remain strong.

Medicine is a demanding and sometimes traumatic profession. Doctors in training know this before entering the field. We know that we will work incredibly long hours, take on hundreds of thousands of dollars in debt, and be with people in their darkest moments. If there is any predisposition for mental health issues, medical training is a pressure cooker that can and will bring it out.

A Culture of Silence

Over the past few years, we have seen the devastat- ing impact that burnout, untreated mental health issues, and a culture of silence have had on medical students and resident physicians in this country.

A recent meta-analysis examined the overall prevalence of depression among medical students found a depression rate of 27.2%, with an overall prevalence of suicidal ideation of 11.1%. Let’s think about this: One in nine future doctors have seriously considered ending their life. What is perhaps even more startling is that only 15.7% of medical students who screened positive for depression pursued mental health treatment. Another meta-analysis that examined the prevalence of depression and depressive symptoms among resident physicians reported the depression rate at 28.8%. Physicinns have one of the highest suicide rates of any profession. Recently, Lorna Breen, MD, medical director of the emergency department at New York Presbyterian Allen Hospital, ended her life after telling loved ones she desperately feared seeking treatment for mental health issues. Despite the staggering statistics about the mental health of doctors and our knowledge of the dire costs of untreated mental illness, we are afraid to ask for help.

Why?

I believe there are 3 main barriers (although others exist) that prevent doctors in training from seeking help:

1. Fear that peers or employers will see us differently and view us as weak or damaged.
2. A culture, beginning in medical school (maybe premed), that physicians must perform at the highest level in the most stressful situations with superhuman strength and composure.
3. Fear that we will be unable to receive medical licenses in states that require doctors to disclose if they have ever received treatment for a mental illness.

According to a study published in 2017, nearly 40% of physicians reported that they would be hesitant to seek treatment for mental health issues due to fear of potential repercussions in obtaining their medical licensure.

We are afraid for social, cultural, and legal/professional reasons.

Why I Shared My Story

I do not have all the answers to fix this crisis. There are many activists who are working tirelessly to reduce the discrimination and stigma and to advocate for legislation to help doctors seek lifesaving treatment. Moving forward, I plan on utilizing my platform to become involved in these legislative efforts. In the meantime, I am using my voice in other ways.

So why did I post this? It would have been easier (with significantly less drama) to continue posting about mental health from a distance, never implicating myself in the messiness. I shared my story to be the doctor I needed to see when I was young, dreaming about what my life would look like as a physician.

I am no superhero—I am a doctor. I am a human being, and I have struggled with mental health issues. Believe it or not, there are many aspiring medical students and doctors who look up to me as my younger self once regarded my pediatrician, our family doctor, and the other doctors I met. I wanted to show them what a real doctor looks like.

Courage is not the absence of fear in a stressful situation; it is doing what you believe even when you are afraid of what might happen or of the resulting criticisms. It is taking the hard road when the easy path would be so much simpler. Real superheroes know when to reach out for help and are not afraid of stigma or discrimination. I hope I showed them that you do not need to be some kind of machine, impervious to pain or doubt or weakness, to be a doctor. I did it for them. I did it for me. I did it to move the culture.

The rest of my post reads: “The stigma is rampant in the medical field. Opening up about your mental health as a medical professional, especially as a doctor who treats mental illness, can be taboo. As a doctor training to be a psychiatrist, most in the field would counsel me to not post this. Some would view it as a risk for my career. But I didn’t join this field to continue the status quo. I am part of a generation of doctors, nurses, and other health care professionals who are not afraid to be vulnerable and discuss mental health. Many consider me a leader in this generation. So here’s me leading by example.”

My name is Dr Jake, I’m a physician who treats mental illness, and I take medication for my mental health. And by the way, I’m proud of it. Medications aren’t for everyone, but they can be a powerful tool in combination with therapy and other self-care techniques to treat mental health issues. If this post helped you, please consider sharing it with a friend or loved one.

Dr Goodman’s views are his own and do not reflect the views of his university or employer.

REFERENCES

The experience of trauma is common for US adults and even more pervasive for patients presenting in psychiatric settings. Estimates of previous experience of traumatic events is 51% to 84% in the general adult population and 76% to 91% in those seen in psychiatric settings. The most prevalent comorbid disorders among adults with serious mental illness (SMI) are substance use disorders (SUDs). Despite trauma symptoms often being underreported, 30% to 60% of individuals seeking treatment for SUD also meet criteria for posttraumatic stress disorder (PTSD). Acknowledgment of “dual diagnosis dates back decades, into the early 1980s; however, the classification of PTSD and SUD as psychiatric comorbidities is inadequate to capture the range of symptoms and impairments of this diverse patient population. Greater understanding of approaches to SUD and related support services may help psychiatric providers provide multifaceted, comprehensive support to patients with SMI, PTSD, and SUD.

Evidence-based treatments exist for both PTSD and SUD; however, the approaches are rarely integrated, despite recognition of frequent cooccurrence. There are trends to further integrate trauma-informed care (TIC) in both SUD and psychiatric settings, but these services are seldom cohesive. To combat the SUD epidemic, availability of medication-assisted treatment/recovery has focused on primary care and the treatment of SUD as a chronic health condition. There is also greater opportunity for psychiatric providers to strengthen their care of patients with comorbid SMI, PTSD, and SUD by continually linking emergent evidence with clinical care. As the SUD epidemic has further intensified during the COVID-19 pandemic, the need for trauma-informed psychiatric care addressing SMI and SUD is even greater.

Treatment of SMI-related distress or symptomatology in isolation from SUD fails to address the whole person and is likely to result in suboptimal outcomes. Without integration of SUD and SMI care, providers risk inappropriately generalizing diagnoses without recognizing the context and lens of SMI symptoms. Addressing an epidemic requires the responsiveness of all providers. As SUD services, treatment, and research have advanced, we highlight 5 practices that are useful in supporting psychiatric clinicians as they effectively integrate trauma-informed SUD and SMI treatment.

Integrate TIC and Substance Use Care

There is substantial evidence that clinicians do not routinely ask patients about trauma history in clinical settings. Despite growing recognition of the impact of adverse childhood experiences on individuals and awareness of trauma prevalence, both institutional and intrinsic barriers interfere with provider inquiries about patient trauma. Although a psychiatric history often includes inquiries about traumatic experiences, TIC requires routine attention to symptomatology and reactions to trauma. Documentation of a single question within an initial evaluation is inconsistent with TIC, but consistently attending to previous experiences with and responses to trauma throughout care is imperative. Trauma assessments at initial visits may underreport traumatic experiences, as patients may not feel comfortable disclosing these at a first-time
Appointment.

Similarly, inquiring about substance use and recurrence of substance use must be an ongoing practice. Patients may not disclose substance use right away for a multitude of reasons. As the provider learns this information, the trajectory of care may change, much like when we are asking about trauma. Assessment around SUD also requires being trauma-informed, as increased PTSD symptom severity is related to substance craving. Patient omission of disclosing a substance use recurrence is common in psychiatric care, often related to fears of losing care or prescription medication. To mitigate this risk and develop space for honest disclosure, clinicians can share their policies or practices related to substance use and foster open discussions—discussions that acknowledge cravings and recurrence are likely to increase with stress and trauma.

**Recognize Trauma as a Primary Pathway to Substance Use**

For decades, the pervasive narrative around substance use was the “gateway hypothesis,” which has now been widely refuted. The gateway hypothesis—that consumption of a particular substance will lead to or increase the likelihood of progressive substance use—came to prominence after publication by Kandel in 1975. The 4-stage sequence of drug consumption—from beer and wine, to tobacco and hard liquor, to cannabis, to other illicit drugs—indicates that only individuals who use 1 drug have a chance of progressing through the sequence. Although substance use is associated with use of other substances, a causal relationship where alcohol and/or cannabis are gateway drugs has been disproven. Conversely, marijuana use has been associated with reductions in opioid use in states with medical cannabis use. One notable evidence-based approach is integrated treatment for cooccurring disorders (ITCOD). Integrating treatment approaches for mental illness and SUDs requires looking at combining efficacious existing treatments while modifying interventions that may be outdated or lack reliable benefit. ITCOD is a multifaceted approach to treatment and care that captures the importance of individual therapy, assertive outreach, social support interventions, and long-range perspective via a patient-centered framework.

As we unlearn the non–evidence-based “gateway hypothesis,” a deeper dive into traumatic experiences and their relation to substance use is likely to serve both provider and patient. Often, substance use initiation is related to seeking relief from pain as well as traumatic events and symptoms. Providers can more fully explore events preceding substance use initiation or transition to nonprescribed medication with compassionate understanding, recognizing that substance use may have been the only accessible and available coping tool at that time.

When we sit in the office with a 40-year-old patient, for example, imagine, as they are sharing memories of their traumatic upbringing with you, that they are 12 years old and not in your office, but in their home—terrified of the trauma there. They have no resources or outlets. A substance is introduced, and it temporarily provides some relief of the awful feelings that they are experiencing. That is not a moral weakness or deficiency. One can imagine what one would do in that situation, but the context and the patient’s experience are of utmost importance, and we need to remove our own opinions from the equation. Intergenerational trauma is another prevalent reality, and the cycle perpetuates. When someone comes to see us for help, it is our job to use our expertise and understanding to facilitate their healing and recovery.

**Partner With Patients Across Multiple Pathways to Recovery**

Substance-specific 12-step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous are often considered synonymous with peer-led recovery. These programs have benefited millions of people over the course of decades. However, these models are based on an abstinence-only philosophy with religious/spiritual elements, wherein sobriety is the explicit goal for group members. These programs have provided effective support for countless individuals and families, but they do not fit all people seeking or maintaining recovery.

Abstinence-only models are not a panacea. Many individuals suffering from SUD are not able or ready to totally discontinue use or are turned off by the religious basis of these groups, resulting in disengagement from these services. Alternatives to spiritually based and abstinence-only peer-led mutual support groups exist and should be considered viable recovery pathways for patients. They include SMART Recovery, Secular Organizations for Sobriety, Moderation Management, LifeRing, Women for Sobriety, and Celebrate Recovery, among others.

In addition to these peer-led groups, harm reduction services—including peer-led groups and/or syringe services programs—can be a critical low-barrier access point to engage patients with SUD who are not interested in abstinence. Abstinence and harm reduction are often conceptualized as diametrically opposed; in reality, they serve as different engagement points on a continuum.

Appropriate service or program recommendations are dynamic, contingent upon individual differences in needs and desires surrounding treatment and recovery.

Instead of referring patients to treatments that are not well suited to the individual, acknowledging the multiple pathways to treatment and recovery is imperative. We have heard of the challenging routes patients have faced on their journey to treatment and recovery, such as a provider telling them they could not be seen “until they go to AA and stop drinking.” This advice is as good as telling your patient to leave your office and never come back again. Supporting multiple pathways helps meet patients where they are, learn where patients are in their willingness to engage in treatment, and determine which modalities may be the best fit for them. It is important to engage in a shared decision-making process and provide options, rather than providing a paternalistic recommendation that does not take patient preference or prior experiences into consideration.

**Approach With Unconditional Positive Regard**

When assessing patients, the longstanding OLDCARTS (onset, location/radiation, duration, character, aggravating factors, relieving factors, timing, severity) acronym utilized in general medicine can be adapted for psychiatric evaluation and assessment. Information gathering in a psychiatric evaluation is not a rigid, linear, “check off the boxes” process—there is, of course, an art to facilitating an informative interview. Asking our patients when the symptom or trauma started or occurred and ascertaining what was going on in their life around the time that they started using substances are crucial to assembling the pieces of the puzzle each of our patients presents. Often, a silent “Aha!”
moment occurs when these connections are made, relating the timing of trauma to the onset of substance use or to an increase in one’s patterns of use.

There are peer-facilitated learning opportunities, as well as the PACT-MAT ECHO model, which is an all-teach, all-learn approach. These sessions have many benefits, especially since comorbidity of a psychiatric disorder along with a SUD is often an area where clinicians appreciate feedback and recommendations for ongoing care. It is also an excellent opportunity for network and for clinicians to become familiar with other area resources and referral locations.

Concluding Thoughts

As psychiatric care providers amid a challenging health care landscape and a global pandemic, we are tasked with providing optimal care to our patients and meeting their needs. The evidence, as we have noted, continues to evolve, and this provides all of us with the opportunity to self-reflect and continue adapting in our own practice and methods. Opportunities for collaboration and growing our knowledge base abound, and within the field we are lucky to have colleagues and mentors to support us along this journey.

Mrs Robinson is a psychiatric-mental health nurse practitioner in the Seacoast, New Hampshire, area, and a clinical assistant professor and program director of the Post-Masters Psychiatric-Mental Health Nurse Practitioner Certificate Program, Department of Nursing, University of New Hampshire, Durham. Ms Apicelli serves as the project manager for the Harm Reduction Education and Technical Assistance project, a multiorganization collaboration dedicated to reducing drug-related harms, based at the Department of Nursing, University of New Hampshire. She is also an adjunct professor in the university’s Department of Social Work. Dr Nolte is a family nurse practitioner in community health and an assistant professor of nursing at the University of New Hampshire. Dr Nolte’s research focus is reducing drug-related harms.

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RESEARCH ROUNDUP

Psychiatric Comorbidities in the News

» Leah Kuntz and Erin O’Brien

Psychiatric and medical comorbidities can complicate the differential diagnosis and hamper treatment success. Thus, investigators around the globe continue to examine how these comorbidities interact with each other. In this Research Roundup, Psychiatric Times™ looks at clinical issues and implications of comorbidities associated with depression, eating disorders, COVID-19, and more.

Depression, Bipolar Disorder, and Sleep in Children and Adolescents

Recently, investigators conducted a narrative literature review of affective disorders and sleep difficulties in children and young people, seeking to understand the relationship between sleep and both depression and bipolar disorder.

Monica Comsa, FRACP, of the Child and Adolescent Mental Health Service at Cumbria Northumberland, Tyne and Wear NHS Foundation Trust in the United Kingdom, and colleagues found that parasomnias, narcolepsy, and sleep-related movement disorders are associated with depression in children and adolescents. Additionally, children and adolescents with depression can present with a number of sleep difficulties, which are also associated with several other issues such as more severe depression, greater fatigue, suicidal ideation, physical complaints, pain, and decreased concentration.

On the other hand, insomnia, obstructive sleep apnea, and circadian rhythm disorders are associated with both depression and bipolar disorder in children and adolescents. Sleep difficulties can occur before, during, and after an episode of depression or bipolar disorder.

“Sleep disturbances among adolescents with BD can affect the severity of depressive and manic symptoms, are a poor prognostic indicator, and have been associated with social and academic impairment.”

These sleep difficulties may be the result of medication. According to the investigators, antidepressants and antipsychotics can directly affect sleep architecture, and clinicians should be cognizant of this problem when prescribing and might instead consider non-pharmacological interventions. These interventions for sleep problems might minimize the risk of relapse in affective disorders.

Investigators suggested that a multimodal approach to target both the affective and specific sleep disorders is the ideal treatment plan. “Psychoeducation, consistent sleep-wake schedules, and tailored interventions for addressing sleep problems should play an important role in the prevention and treatment of mental health difficulties, at any age,” they wrote. “Concomitantly addressing sleep problems can lead to an increased remission rate of depression.”

More research is required to understand the impact of combined interventions on clinical outcomes, concluded investigators.

“Of most importance is the impact of specific treatment for sleep disorders on the long-term outcome of affective disorders. Clinicians need to know if better nights reliably lead to better days.”—LMK

REFERENCE

Impulse Control Disorders and Behavioral Addictions in Patients With Eating Disorders

There is a moderate prevalence of impulse control disorder (ICD) and behavioral addiction (BA) comorbidities in individuals with eating disorders (EDs), investigators have found in a first-of-its-kind meta-analysis.

Because the prevalence has never been systematically examined, Daniel J. Devoe, PhD, MSc, and colleagues performed a series of random effects meta-analyses of peer-reviewed literature reporting prevalence of ICDs or BAs in individuals with EDs. The investigators included 35 studies with a total of 9646 individuals who had an ED and analyzed the prevalence of different behavioral addictions among these individuals. The mean age of participants was 25.5 years (range, 16.7-43.9), and 97.7% were female.

Results showed that stealing/shoplifting behaviors were the most common form of behavioral addictions in individuals with EDs, with a prevalence of 30%. Devoe et al also noted prevalence of pathological/compulsive buying at 19%, kleptomania at 18%, and pathological internet use at 12%. Intermittent explosive disorder, trichotillomania, and gambling had prevalence rates of 5%, 3%, and 2%, respectively.

ICDs are more closely associated with bulimia nervosa and binge-purge subtype than other ED diagnoses and behaviors, the investigators noted. This finding supports previous research indicating that individuals with binge-purge subtypes are more likely to have ICDs, partly due to impulse control difficulties and greater emotion regulation. The investigators also noted that certain personality traits (eg, perfectionism, impulsivity), psychiatric comorbidity, age of onset (eg, early age of onset may worsen prognoses), and concurrent substance use disorders may also play a role in deteriorating ED prognoses. They suggested that future research explore common underlying pathomechanisms.

Although causal inferences cannot be drawn, the numbers strongly suggest that clinical screening/monitoring of ICDs/BAs should be part of the clinical routine in cohorts with EDs,” Devoe et al concluded.—EAO

REFERENCE

First-of-Its-Kind Study of Antidepressant Use in Patients With Depression and Type 2 Diabetes

Although treatment guidelines do not provide specific prescribing recommendations for antidepressants in individuals with diabetes, effective treatment of depression in patients with comorbid depression and type 2 diabetes is important for both conditions.

In a first-of-its-kind study looking at the prevalence of antidepressant prescribing and associated patient characteristics, Jeffrey et al searched 7 databases using terms related to depression, type 2 diabetes, and antidepressant medication. From the 9 utilized reports, the investigators determined that the prevalence of antidepressant prescribing varied considerably between studies—from 18% to 87%.

“This review has highlighted the gap in our knowledge about which antidepressant agents are being used in adults with comorbid depression and [type 2 diabetes], and alongside which concurrent medications and comorbidities. Thus, we are unaware of the extent to which such individuals are at risk from the risks associated with polypharmacy and other adverse effects,” wrote the study authors.

Investigators also found that women with type 2 diabetes are more likely to be prescribed antidepressants versus men; however, the difference is less than in the general population. Additionally, individuals with more advanced type 2 diabetes mellitus who use insulin were as likely to be prescribed antidepressants as those who did not use insulin.

“This is the first systematic review to our knowledge that investigates the prevalence and characteristics of antidepressant prescribing in adults with comorbid depression and [type 2 diabetes],” the study authors wrote. They added that, “There is an urgent need for longitudinal studies to inform guidelines on the long-term safety and effectiveness of antidepressant prescription in persons with comorbid depression and [type 2 diabetes].”

With a lack of evidence to support the long-term use of antidepressants in individuals with type 2 diabetes, special care should be taken when prescribing antidepressants—especially in more complex patients who have higher risks of potential adverse events.—LMK

REFERENCE
COVID-19 Mortality Risk in Patients With Psychiatric Disorders

Patients with psychiatric disorders who were hospitalized for COVID-19 experienced higher mortality rates, but not due to their underlying psychiatric disorders, study results show.

The study, led by Nicolas Hoertel, MD, PhD, MPH, of Paris University and Corentin-Celton Hospital in Issy-les-Moulineaux, France, explored previous research indicating a connection between psychiatric disorders and increased mortality in patients with COVID-19. Hoertel et al conducted an observational multicenter retrospective cohort study of patients who had received a laboratory-confirmed diagnosis of COVID-19. The study included 15,168 patients who were hospitalized with COVID-19, of whom 857 also had received a diagnosis of a psychiatric disorder. Of this population, 59.6% had a substance- or illness-induced psychiatric disorder; 46.4% had a primary psychiatric disorder; and 6.1% had both types of disorders.1

The investigators found that across a mean follow-up period of 14.6 days (SD = 17.9 days) 38% of patients with a psychiatric disorder died, compared with 8.9% of patients without a psychiatric disorder (odds ratio [OR] = 6.27; 95% CI: 5.40-7.28; \( P < 0.01 \)). Individuals with a psychiatric disorder had a 6-fold higher risk of mortality than those without a psychiatric disorder, and this risk remained higher when adjusting for factors such as sex, age, and current smoking status in individual psychiatric diagnoses (adjusted OR [AOR] = 3.27; 95% CI: 2.78-3.85; \( P < 0.01 \)). However, when adjusting for obesity and other medical comorbidities, the investigators found no statistically significant association with increased mortality in individuals with psychiatric disorders compared with individuals without psychiatric disorders (AOR = 1.02; 95% CI: 0.84-1.23; \( P = 0.86 \)). Notably, diagnosis of a mood disorder was associated with reduced mortality, which the investigators suggested could be related to the use of certain antidepressants such as fluvoxamine and fluoxetine, which may have anti-inflammatory or antiviral effects.1

The investigators concluded that the risk of COVID-19-related mortality may be higher in individuals with psychiatric disorders due to the overall higher prevalence of obesity and medical conditions in this population—which also increases the risk of developing severe cases of COVID-19—rather than factors related to the psychiatric disorders themselves.1

“Future studies including data on outpatients and inpatients with and without psychiatric disorders and COVID-19 and taking into account main medical risk factors of severe COVID-19 (ie, age, medical comorbidities, and obesity) will be important to determine whether the risk of hospitalization and mortality due to SARS-CoV-2 infection is similar or different across psychiatric diagnoses and psychotropic medications prescribed,” Hoertel et al concluded.—EAO

REFERENCE

Psychiatric Comorbidities Affect Psychotic Depression Outcomes

Results of a recent study on gender and psychiatric comorbidities in individuals with psychotic depression (PD) found that comorbidities have significant implications for PD age of onset and outcomes.

Using the Northern Finland Birth Cohort 1966 and other national registers, Miika Nietola et al from the Department of Psychiatry at the University of Turku and colleagues analyzed 12,058 individuals who had been followed since they were in utero for lifetime psychiatric diagnoses, age of illness onset, hospitalizations, disability pension rate, and mortality. Fifty-eight individuals in the sample had received a lifetime diagnosis of PD (male, \( n = 23 \); female, \( n = 35 \)); the lifetime prevalence of PD in the participants was 0.5%; and the median age of PD onset for participants was 40.2 years.1

In comparing outcome variables in subgroups for gender and comorbid PD or alcohol use disorder (AUD), the investigators identified the prevalence of comorbid personality disorders at 38% and comorbid AUDs at 41%. Results showed that psychiatric hospitalization was more strongly associated with male gender (\( P = .03 \)), personality disorder (\( P < .01 \)), and comorbid AUD (\( P < .01 \)). Comorbid PD also was associated with earlier onset (\( P < .01 \)) and higher mortality (\( P = .03 \)) and was more common in men than women at 61% and 29% (\( P = .03 \)), respectively. However, Nietola et al found no statistical difference related to gender in the disability pension rate for individuals with PD.1

Since little is known about the effects of gender and comorbid psychopathologies on PD prognoses, the investigators stated that this study’s findings highlight a need for further research on these effects in individuals with PD and on PD in general—especially since comorbid personality disorders have been associated with poorer outcomes in individuals with nonsympathetic depression. They also suggested that clinicians control the effects of gender and comorbidity as confounding factors in PD trajectories.1

“Clinical implications of high alcohol use and personality disorder comorbidity in PD include rigorous assessment of these disorders in everyday practice and active implementation of effective treatments,” Nietola et al wrote. “There are potential possibilities to improve outcomes of PD by focusing more on those detrimental comorbidities that appear to associate with a malignant course of illness.”—EAO

REFERENCE
Book Review

Optogenetics and Piercing the Professional Armor

Reviewed by Barbara Schildkrout, MD

Projections: A Story of Human Emotions by Karl Deisseroth, MD, PhD; Random House, 2021

256 pages; $28.00 (hardcover)

Deisseroth, who is now the D.H. Chen Professor and a professor of bioengineering, psychiatry, and behavioral sciences at Stanford University and a Howard Hughes Medical Institute investigator, had always been interested in words. Here, in this encounter, it became clear to him that psychiatric illness was manifested through a patient’s emotional communication. Everything came together for Deisseroth and reset the course of his career. He writes, “What, in fact, are those feelings, in a physical sense, down to the level of cells and their connections?” This struck me as perhaps the most profound mystery in the universe—vailed only by the question of the universe’s origin, its reason for being.”

Deisseroth’s encounters with patients become opportunities for self-reflection, curiosity, and keen observation; they also provide the grounding for discussions about the neural underpinnings of behavior. Deisseroth’s descriptions of neuronal functioning are lucid and vivid; they have narrative life. Far from the dry, rote lessons about neuroscience to which we have become accustomed, Deisseroth’s deep understanding makes his explanations of brain function entirely lively and memorable.

Throughout, Deisseroth appreciates and captures the full breadth of psychiatry—from the astonishment he felt upon hearing a thought disorder (a first glimpse at the multitude of extraordinary ways that mental functioning can go awry), to the counterintuitive behaviors of someone afflicted with an eating disorder, to the power of human connection and the magic of creativity. Deisseroth reminds us of the profound mysteries of human behavior that called many of us to pursue careers in psychiatry.

On September 27, 2021, the prestigious Lasker Award was presented to Deisseroth for his work with colleagues in pioneering a revolutionary approach to studying individual neurons in living mammals—a technique known as optogenetics. Deisseroth’s book makes the fundamental concepts of optogenetics easy to understand.

Algae contain proteins that transform light into energy; this is how these organisms produce energy for survival. Optogenetics takes the genes that code for these proteins and transfers them into mouse neuronal DNA. This makes it possible for a researcher to turn individual mouse neurons “on” or “off” by exposing them to light delivered through fiber optics that have been inserted into the mouse brain. Switch “on” the light—switch “on” a neuron. This can be used, for example, while simultaneously observing the animal’s behavior and thereby discerning the specific neuron’s function.

This methodology has proven to be extraordinarily powerful as an investigative tool. In 2009, 25 papers were listed in PubMed under the search term optogenetics; by 2016, there were more than 900, and more than 1000 have appeared thus far in 2021.

In his book, Deisseroth shows us how his work with patients and his curiosity led to important scientific questions. These questions, in turn, fueled his prolific neuroscience research and have influenced scientific work around the world.

Projections, the book’s title, refers to a defense mechanism, well known to psychiatrists, in which aspects of the self are experienced by the individual as residing outside the self. But Projections also are the ultimate destination of a neuron—the anatomical site to which a neuron extends its axon and exercises its synaptic influence.

Deisseroth is a model and an inspiration for all of us in the field of psychiatry, and Projections is a work of true biopsychosocial integration. The book is not only a joy to read, but also a compelling, educational experience. I recommend it to every 21st-century psychiatrist.

Dr Schildkrout is an assistant professor of psychiatry, part-time, at Harvard Medical School in the Department of Psychiatry at Brigham and Women’s Hospital. She is the author of several books and a blog.

REFERENCES
NOW APPROVED for adults with BIPOLAR DEPRESSION: BIPOLAR I OR II

CAPLYTA is the first and only bipolar depression treatment indicated for both bipolar type I or II as monotherapy and adjunctive therapy with lithium or valproate

Clinical studies evaluating adults with a depressive episode associated with bipolar disorder (bipolar depression)\(^1,2\)

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There are no head-to-head clinical studies comparing the safety and efficacy of these products. This chart is descriptive of the FDA-approved indications.

CAPLYTA is also indicated for schizophrenia in adults\(^3\)

CAPLYTA is indicated in adults for the treatment of schizophrenia and depressive episodes associated with bipolar I or II disorder (bipolar depression), as monotherapy and as adjunctive therapy with lithium or valproate.

Important Safety Information

Boxed Warnings:
- Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. CAPLYTA is not approved for the treatment of patients with dementia-related psychosis.
- Antidepressants increased the risk of suicidal thoughts and behaviors in pediatric and young adults in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors. The safety and effectiveness of CAPLYTA have not been established in pediatric patients.
- Contraindications: CAPLYTA is contraindicated in patients with known hypersensitivity to lumateperone or any components of CAPLYTA. Reactions have included pruritus, rash (e.g., allergic dermatitis, papular rash, and generalized rash), and urticaria.

Warnings & Precautions: Antipsychotic drugs have been reported to cause:
- Neuroleptic Malignant Syndrome, which is a potentially fatal reaction. Signs and symptoms include hyperpyrexia, muscle rigidity, delirium, autonomic instability, elevated creatinine phosphokinase, myoglobinuria (and/or rhabdomyolysis), and acute renal failure. Manage with immediate discontinuation of CAPLYTA and provide intensive symptomatic treatment and monitoring.
- Tardive Dyskinesia (TD), a syndrome of potentially irreversible, dyskinetic, and involuntary movements which may increase as the duration of treatment and total cumulative dose increases. The syndrome can develop after a relatively brief treatment period, even at low doses, or after treatment discontinuation. Given these considerations, CAPLYTA should be prescribed in a manner most likely to reduce the risk of TD. Discontinue CAPLYTA if clinically appropriate.
- Metabolic Changes, including hyperglycemia, diabetes mellitus, dyslipidemia, and weight gain. Hyperglycemia, in some cases extreme and associated with ketoacidosis, hyperosmolar coma or death, has been reported in patients treated with antipsychotics. Measure weight and assess fasting plasma glucose and lipids when initiating CAPLYTA and monitor periodically during long-term treatment.
- Leukopenia, Neutropenia, and Agranulocytosis (including fatal cases). Perform complete blood counts in patients with pre-existing low white blood cell count (WBC) or history of leukopenia or neutropenia. Discontinue CAPLYTA if clinically significant decline in WBC occurs in absence of other causative factors.
NEW INDICATIONS

Warnings & Precautions:

- Contraindications:
  - Antidepressants increased the risk of suicidal thoughts and behaviors in pediatric and young adults in short-term studies.

- Elderly patients with dementia-related psychosis treated with antidepressants may be at an increased risk for worsening and for emergence of suicidal thoughts and behaviors.

- Worsening, and for emergence of suicidal thoughts and behaviors in pediatric and young adults in short-term studies.

- Antipsychotic drugs have been reported to cause:
  - Neuroleptic Malignant Syndrome, which is a potentially fatal syndrome of potentially irreversible, hyperpyrexia, muscle rigidity, and/or withdrawal symptoms following delivery. Breastfeeding is not recommended. Avoid use in patients with moderate or severe hepatic impairment.

- Seizures. Use CAPLYTA cautiously in patients with a history of seizures or with conditions that lower seizure threshold.

- Falls. CAPLYTA may cause somnolence, postural hypotension, and motor and/or sensory instability, which may lead to falls and, consequently, fractures and other injuries. Assess patients for risk when using CAPLYTA.

- Potential for Cognitive and Motor Impairment. Advise patients to use caution when operating machinery or motor vehicles until they know how CAPLYTA affects them.

- Body Temperature Dysregulation. Use CAPLYTA with caution in patients who may experience conditions that may increase core body temperature such as strenuous exercise, extreme heat, dehydration, or concomitant anticholinergics.

- Dysphagia. Use CAPLYTA with caution in patients at risk for aspiration.

Drug Interactions: Avoid concomitant use with CYP3A4 inducers and moderate or strong CYP3A4 inhibitors.

References:


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12/2021 US-CAP-2100528
INDICATIONS AND USAGE
CAPLYTA is indicated for the treatment of schizophrenia in adults and depressive episodes associated with bipolar I or II disorder (bipolar depression), as monotherapy and as an adjunctive therapy with lithium or valproate.

DOSAGE AND ADMINISTRATION
Recommended Dose: The recommended dosage of CAPLYTA is 14 mg administered once daily with or without food. Dose titration is not recommended.

Dosage Adjustments: Avoid concomitant use with CYP3A4 Inducers or Moderate or Strong CYP3A4 Inhibitors. Co-administration with CYP3A4 inducers. Avoid concomitant use of CAPLYTA with moderate or strong CYP3A4 inhibitors.

Dosage Recommendations for Patients with Hepatic Impairment: Avoid use of CAPLYTA in patients with moderate or severe hepatic impairment (Child-Pugh B or C).

CONTRAINDICATIONS
CAPLYTA is contraindicated in patients with history of hypersensitivity reaction to lumateperone. Reactions have included pruritis, rash (e.g. allergic dermatitis, papular rash, and generalized rash), and urticaria.

WARNINGS AND PRECAUTIONS
Increased Mortality in Elderly Patients with Dementia-Related Psychosis:
Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. CAPLYTA is not approved for the treatment of patients with dementia-related psychosis.

Suicidal Thoughts and Behaviors
Antidepressants increased the risk of suicidal thoughts and behaviors in children, adolescents, and young adults (<18 years old) in short-term studies (i.e., <4 months) of depression, anxiety, and other conditions in the previously mentioned trials (modal duration of 10 weeks) of short-term use of antidepressants. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in the drug-treated patients of 1.6 to 1.8 times that in placebo-treated patients. Over the course of a typical 10-week clinical trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in placebo-treated patients. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infections (e.g., pneumonitis) in nature. CAPLYTA is not approved for the treatment of patients with dementia-related psychosis.

Suicidal Thoughts and Behaviors in Children, Adolescents, and Young Adults: In pooled analyses of placebo-controlled trials of antidepressant drugs (SSRIs and other antidepressant classes) that included approximately 7,700 adult patients and 4,500 pediatric patients, the incidence of suicidal thoughts and behaviors in patients treated with antidepressants was no higher than in placebo-treated patients. However, there was an increased rate of suicidal ideation and behavior in young adults and patients with both depression and anxiety. There were differences in absolute risk of suicidal thoughts and behaviors across the different index diagnoses, with the highest incidence in patients with MDD (major depressive disorder). The risk increases were generally seen in pediatric studies, with more frequent reports of suicidal ideation and behavior in patients on psychiatric medications, compared to those on placebo. In subset analyses of MDD trials, the incidence of suicidal ideation and behavior was found to be similar to that seen in placebo trials. In the bipolar depression trials, the incidence of suicidal ideation and behavior in placebo-treated patients was not statistically different from that in CAPLYTA-treated patients.

Weight Loss:
CAPLYTA does not contain an active ingredient known to cause weight loss. Monitor weight at baseline and frequently thereafter.

Effects on Lipid Levels:
CAPLYTA may cause patients to have greater than normal levels of fasting glucose and insulin in patients treated with CAPLYTA were similar to those in patients treated with placebo.

No specific antidotes for CAPLYTA are known. In managing overdose, provide supportive care, including close monitoring of vital signs and Somatic: In general, patients should be monitored closely for adverse reactions and withdrawal symptoms, particularly those taking CAPLYTA. The use of CAPLYTA should be discontinued, if needed, to prevent these adverse reactions.

In the 6-week adjunctive therapy bipolar depression trial, the mean changes from baseline and the proportion of patients with shifts from normal to greater than normal levels of fasting glucose in patients treated with CAPLYTA were similar to those in patients treated with placebo.

In an open-unlabeled open-label trial of CAPLYTA for up to 1 year in patients with stable schizophrenia, the percentages of patients with a shift from normal to higher levels of fasting total cholesterol and triglycerides were similar in patients treated with CAPLYTA and placebo.

In an open-unlabeled open-label trial of CAPLYTA for up to 6 months in patients with bipolar depression, the proportion of patients with a shift from normal to high were 10%, 5%, and 4% for total cholesterol, triglycerides, and LDL cholesterol, respectively.

Leukopenia, Neutropenia, and Agranulocytosis:
Leukopenia and neutropenia have been reported during treatment with antipsychotics, including CAPLYTA. Agranulocytosis (including fatal cases) has been reported with other agents in the class.

Possible risk factors for leukopenia and neutropenia include pre-existing low white blood cell count (WBC) or absolute neutrophil count (ANC) and history of drug-induced leukopenia or neutropenia. In patients with a pre-existing low WBC or ANC or a history of drug-induced leukopenia or neutropenia, perform a complete blood count (CBC) frequently during the first few months of therapy. In such patients, consider discontinuation of CAPLYTA at the first sign of a clinically significant decline in WBC in the absence of other causative factors.

Monitor patients with clinically significant neutropenia for fever or other symptoms or signs of infection and report promptly if such symptoms or signs occur. Discontinue CAPLYTA in patients with absolute neutrophil count < 1000/mm3 and follow their WBC until recovery.

Orthostatic Hypotension and Syncope:
Atypical antipsychotics cause orthostatic hypotension and syncope. Antipsychotic medications are associated with increased risk of mortality especially in the elderly population who are vulnerable to hypotension (e.g., elderly patients, patients with dehydration, hypokalemia, and concomitant treatment with antiparkinsonian medications), patients with known cardiovascular disease (history of myocardial infarction, unstable angina, cerebrovascular disease, or cerebrovascular disease, patients who have recently had a heart attack). Efficacy and safety of CAPLYTA in these patient populations have not been established.

Falls:
Antipsychotics, including CAPLYTA, may cause somnolence, postural hypotension, and motor and sensory instability, which may lead to falls and, consequently, fractures and other injuries. For patients with diseases, conditions or medications that could exacerbate these effects, complete fall risk assessments when initiating antipsychotic treatment and periodically during long-term treatment.

Seizures:
Like other antipsychotic drugs, CAPLYTA may cause seizures. The risk is greater in patients with a history of seizures or with conditions that lower the seizure threshold. Conditions that lower the seizure threshold may be more prevalent in older patients.

Potential for Cognitive and Motor Impairment:
CAPLYTA, like other antipsychotics, may cause somnolence and have the potential to impair judgment, thinking, and motor skills. Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with CAPLYTA does not affect them adversely.

Schizophrenia: In short-term (i.e., 4 to 6-week), placebo-controlled clinical trials of patients with schizophrenia, somnolence and sedation were reported in 24% of CAPLYTA-treated patients, compared to 10% of placebo-treated patients.

Bipolar Depression: In short-term (6-week), placebo-controlled monotherapy and adjunctive therapy bipolar depression clinical trials, somnolence and sedation were reported in 13% of CAPLYTA-treated patients, compared to 3% of placebo-treated patients.

Body Temperature Dysregulation:
Atypical antipsychotics may disrupt the body’s ability to reduce core body temperature during intense exercise, exposure to extreme heat, dehydration, or antipsychotic medications that may contribute to an elevation in core body temperature; use CAPLYTA with caution in patients who may experience these conditions.
**Dysphagia**: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Antipsychotic drugs, including CAPLYTA, should be used cautiously in patients at risk for aspiration.

**ADVERSE REACTIONS**

**Clinical Trials Experience**: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety of CAPLYTA has been evaluated in placebo-controlled clinical trials in 2661 adult patients with schizophrenia or bipolar I disorder. A total of 462 CAPLYTA-treated patients had at least 6 months of exposure and 108 had at least 1 year of exposure to the 42-mg dose of CAPLYTA.

**Schizophrenia** - The following findings are based on the pooled short-term (4- to 6-week), placebo-controlled schizophrenia trials in which the drug was administered at a daily dose of 42 mg (N=406).

There was no single adverse reaction leading to discontinuation that occurred at a rate of ≤2% in CAPLYTA-treated patients.

The most common adverse reactions (incidence of at least 5% of patients exposed to CAPLYTA and greater than twice the rate of placebo) are somnolence/sedation, dry mouth, and dizziness.

Adverse reactions associated with CAPLYTA (incidence of at least 2% in patients exposed to CAPLYTA and greater than placebo) were as follows (adverse reaction is followed by percentage of patients treated with CAPLYTA 42 mg (n=406) and patients treated with placebo (n=422) in parentheses): Headache (14%, 8%); Somnolence/Sedation (13%, 9%); Dizziness (8%, 4%); Nausea (8%, 3%); Dry Mouth (5%, 1%); Diarrhea (4%, 2%); Vomiting (4%, 0%); Abnormal weight gain (2%, 1%); Hyperhidrosis (1%, 0%); Dizziness, dizziness postural; ALT, AST, “hepatic enzymes” increased, or low function test abnormal.

**Bipolar Depresion - Monotherapy**

The following findings are based on the pooled short-term (6-week), placebo-controlled monotherapy bipolar depression studies in adults treated with CAPLYTA administered at a daily dose of 42 mg (N=327).

There was no single adverse reaction leading to discontinuation that occurred at a rate of ≤2% in CAPLYTA-treated patients.

The most common adverse reactions (incidence of at least 5% of patients exposed to CAPLYTA and greater than twice the rate of placebo) are somnolence/sedation, dry mouth, and dizziness.

Adverse reactions associated with CAPLYTA (incidence of at least 2% in patients exposed to CAPLYTA and greater than placebo) were as follows (adverse reaction is followed by percentage of patients treated with CAPLYTA 42 mg (n=327) and patients treated with placebo (n=435) in parentheses): Headache (14%, 8%); Somnolence/Sedation (13%, 9%); Dizziness (8%, 4%); Nausea (8%, 3%); Dry Mouth (5%, 1%); Diarrhea (4%, 2%); Vomiting (4%, 0%); Abnormal weight gain (2%, 1%); Hyperhidrosis (1%, 0%); Dizziness, dizziness postural; Abdominal discomfort, abdominal pain, abdominal pain upper and lower.

**Bipolar Depresion - Adjutative Therapy with Lithium or Valproate** - The following findings are based on a 6-week, double-blind, placebo-controlled, add-on treatment bipolar depression study in adult patients treated with CAPLYTA administered at a daily dose of 42 mg (N=177).

There was no single adverse reaction leading to discontinuation that occurred at a rate of ≤2% in CAPLYTA-treated patients.

The most common adverse reactions (incidence of at least 5% of patients exposed to CAPLYTA and greater than twice the rate of placebo) are somnolence/sedation, nausea, and dry mouth.

Adverse reactions associated with CAPLYTA (incidence of at least 2% in patients exposed to CAPLYTA and greater than placebo) were as follows (adverse reaction is followed by percentage of patients treated with CAPLYTA 42 mg (n=175) and patients treated with placebo (n=175) in parentheses): Somnolence/Sedation (13%, 3%); Dizziness (11%, 2%); Nausea (6%, 4%); Dry Mouth (5%, 1%); Vomiting (4%, 0%); Abnormal weight gain (2%, 1%); Hyperhidrosis (1%, 0%); Dizziness, dizziness postural.

**Dystonia** - Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first few days or treatment. Dystonic symptoms include: spasm of the neck muscles, sometimes progressing to tightness of the throat, swallowing difficulty, difficulty breathing, and/or protrusion of the tongue. Although these symptoms can occur at low doses, they occur more frequently and with greater severity with high potency and higher doses of first-generation antipsychotic drugs. An elevated risk of acute dystonia has been observed in males and younger age groups.

**Extrapyramidal Symptoms (EPS)** - In the short-term, placebo-controlled schizophrenia and bipolar depression studies (see Clinical Trials Experience), EPS (see Clinical Trials Experience) were reported.

**Increased Mortality in Elderly Patients with Dementia-Related Psychosis**

In elderly patients with dementia-related psychosis treated with antipsychotic drugs, overall mortality was increased. The causes of death were generally unknown, but observers noted that some deaths appeared to be drug related.

**Antipsychotic Use in Dementia**

Antipsychotic drugs are approved for the treatment of dementia-related psychosis in adults with Alzheimer’s disease with moderate to severe dementia. However, the risk-benefit ratio of antipsychotic drug treatment for this indication may not justify the use of antipsychotics in all patients with dementia-related psychosis.

**Suicidal Thoughts and Behaviors**

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death compared to placebo.\(^1\)\(^2\)\(^3\).

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The Benefits of Collaborative Care: A Social-Relational Healing Tool

» Carli A. Genet, MSW, LICSW

During a particularly difficult session talking about chronic low mood, pain, and difficulty sleeping, “Molly” made a heartbreaking confession: “I cannot bear the thought of one more practitioner telling me they think they have the answer for me.” What she meant was that after hearing so many individuals say, in so many different ways, that they believed they could help her, her nervous system, her diet, her sleep habits, her neurotransmitters, her thoughts, her ability to emotionally regulate ... all of it was broken.

It was so difficult to watch Molly go through this. The part of me shaped by solution-focused and efficient care wanted to jump up and say, “But have you tried X, Y, and Z?” Instead, I called on curiosity and attunement. I slowed down, and we talked about her frustration and her hopelessness. About how, although her team meant well, we were making it worse. About how, with every solution that did not work, came another wave of believing she was unfixable. I saw hope begin to re-grow as we sat through the pain of the hopelessness.

We started talking about what should happen next (because honestly, even the best-laid plans still often need some level of goal setting), but this time the conversation was different. I was looking to her to tell me what she needed from her entire team. I was asking her what she needed relationally.

I may not have had the answer that would solve all her ailments, but I did have the knowledge and ability to share with her team what I believed she needed from us: a willingness to reach a common goal and a common belief in her ability to heal. I was lucky enough to be working alongside practitioners who were willing to slow down and step away from having the answer. Rather than seeking information that validated our professional opinions, we sought to listen to the ways the client was experiencing her therapeutic experience with each of us (and I mean that in the sense of her entire being, not simply her mental health).

I would love to say that within months all of this patient’s symptoms miraculously improved, but we are still all actively working to help get her to where she wants to be. What did change, however, was the belief she had in herself and her hope that things would improve. When an individual believes in their ability to heal and feels they have an honest stake in their treatment, they are more likely to engage in their own care, thus improving treatment outcomes.1 With Molly, the shift to focusing on her experiences within relationships with her team allowed this to happen.

Finding Answers

Sue Johnson, EdD, an investigator and clinician who has taken Bowlby’s attachment theory and molded it into emotionally focused therapy, one of the most well-researched relational modalities of today, elaborates on Bowlby’s belief that “the human psyche, like human bones, is strongly inclined towards self-healing.”2 She says that, although this is true, validation and an environment that feels safe allow self-healing to take place.3 Similarly, the application of polyvagal theory to clinical settings by Deb Dana, LCSW, has shown that providing emotional connection and safety for our patients means improved physiological and psychological health outcomes.4

Unfortunately, as the third, fourth, and now fifth waves of therapy have studied and encouraged this importance of relationship and safety to promote healing, the systems that push for efficient and solution-focused care have put pressures on providers to do the very opposite. These systems put pressure on providers to have answers as quickly as possible, which does not leave time for honest inquiry or dialogue. This means little to no opportunity to explore beyond measurable outcomes and desired goals, or to talk with the patient’s other team members about how they experience this individual, their areas of difficulty, or their hopes for the patient’s healing. It means that even with the best of intention, the relational experience often stops at the door.

Commitment to relationally focused care opens the door for us to move beyond the confines of efficiency and into “a state of connection [where] health, growth, and restoration are possible.”

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CLINICAL REFLECTIONS
Typically, when a patient leaves our office, we have little to no control over what they do with their time and our recommendations after or between sessions. Although our well-thought-out clinical opinion is offered with the intention of encouraging growth and change, the exchange of information can only go so far. The current system of care encourages individuals to come to us because of our knowledge, skills, and the answers we have for them—answers that we hope will lessen their pain and enhance their ability to live the life they want. Unfortunately, it is the idea that we, as mental health providers, have all the answers that can hinder the development of relationships necessary for meaningful healing, thus eroding effectiveness of support.4,5

Quality of Relationships
In Molly’s case, it was my responsibility to share my knowledge and the responsibility of my team members to value my knowledge as we navigated this case. This exchange, in practice, models and encourages a similar exchange in our patients. It provides them with the opportunity to learn to believe in themselves and in their team. Emphasis on the relationships between providers, between providers and patients, within the patients themselves, and among the entire team and the community is referred to as relationship-centered care (RCC), which conceptualizes health care by the quality of these relationships.6 The 4 principles of RCC go beyond the technicalities of providing care (Figure).

Even in settings in which there may be opportunity for RCC, emphasis on measurable outcomes can hinder collective conversation. Data obtained as part of an action research study aiming to understand how professionals navigate discord and decision-making in a team-based format highlight these hindrances.3 The study showed that socioemotional concerns are introduced to team discussion far less frequently than task-oriented concerns, thus limiting cross-discussion between disciplines and even among mental health team members.6 Here we see, once more, the necessity of valuing and making space for conversation and exploration over efficiency.

Commitment to relationally focused care opens the door for us to move beyond the confines of efficiency and into “a state of connection [where] health, growth, and restoration are possible.”7 It is our job, as practitioners and team members, to create an environment and experience that encourages our patients to make the choices that will improve their overall health and healing, mirroring the very environments and experiences Johnson and Dana wrote about. In order to do this, we have to believe that our patients are more than a system of pulleys and chains—we have to believe that they are a single integrated system, thus requiring relationally oriented and integrated care.

When individuals come to us looking for an answer, we also may be fooled by the expectation that we should be able to give it to them. As professionals, it is up to us to model for our patients that their whole story and experience with us in the moment matters, not just the measurable outcomes. We need to begin to move away from the idea that we, as any particular type of practitioner, are the best, most knowledgeable, or only option. This means valuing our role while also valuing the roles and knowledge of others. John Shotter discussed the danger of generalizability, which he defined as “continual recovery of sameness.”8 He posited that as soon as we place a label on someone, it narrows what we have the ability to discover and thus help to heal that person.9 In a field in which we are encouraged to silo, to find a specialty, we are ripe to fall into this risk of generalizability.10 If we instead permit ourselves, and encourage one another, to remain open to the answers, we open ourselves up to endless options for potential healing for our patients.

As a therapist who focuses much of her work on complex trauma, I am no stranger to the pull to have an answer for a client in pain. I also fall victim to the pressure to fix. Sometimes it takes the honesty of a patient’s experience to remind us of the bigger picture, and that is exactly what happened with Molly.

Collaboration and Connection
Whether we are talking about changing the way we collaborate individually as health care professionals with our patients, with our colleagues, or with the team supporting our patients, perhaps the place we ought to begin is with ourselves. Understanding what drives us to seek answers instead of exploration, be it societal, cultural, or internal forces, is a necessary step toward RCC. Becoming aware of our relational tendencies can help navigate intentionally toward connection. Becoming self-informed through tools such as The Attachment Project’s Attachment Quiz is a great place to start.11 Beyond understanding ourselves, we can start to become curious about our colleagues’ experiences, all in an effort to prioritize relationship.

The evidence is clear that relationship, dialogue, and connection affect patient experience,5,9,12 and the more positive the experience, the more likely treatment is to have the desired effects of healing, growth, and change.7 RCC contributes to the development of a safe environment, encourages open dialogue, and creates a shared experience of goal development and attainment.13 The idea that mental health care professionals should be able to care or heal our patients by ourselves is an outdated and limiting model of treatment. If we do the work to understand our own selves relationally and the beliefs that may contribute to our need for success, we provide an opportunity to shift the focus to where it belongs: to the relationship.

We need one another, and our patients need us to model connection and belief in one another so that they can believe in the possibility of their healing.3

Ms Genet is a licensed independent clinical social worker in New Hampshire and a therapist and owner of Soul’s Nest Counseling & Wellness LLC in Newington.

REFERENCES
Alan A. Stone, MD, was born in Boston, Massachusetts and was the son of Jewish-Lithuanian parents. His father was a lawyer, and Dr Stone later became an expert on the law as it relates to psychiatry, although he did not have a law degree. He taught classes with the well-known lawyer Alan Dershowitz for many years at Harvard University in Cambridge, Massachusetts. Dershowitz said that for Dr Stone, “the world was never right or wrong. It was always why.” What could be more psychiatric than the emphasis on why? I had a father and sisters who were lawyers and toyed with a similar idea, but I never followed up on it, instead focusing on psychiatric ethics. Despite his knowledge base, Dr Stone refused to be an expert witness; I tried to avoid that, too, sensing we were “hired guns” by one side, but I succumbed at times when I thought my knowledge base was useful.

Dr Stone studied medicine at Yale University in New Haven, Connecticut, and graduated in 1955. Yale encouraged free thinking, reflected in the policy of our times of no testing. Dr Stone’s psychiatry residency was at McLean Hospital in Boston, and he went on to train in psychoanalysis at the Boston Psychoanalytic Society and Institute.

When I came to know Dr Stone in the 1990s, I was involved as a participant/observer with managed care at a time when ethical dilemmas and personal morality were becoming paramount. In many ways, this was a major turning point for psychiatry and medicine. My view of managed care was published in the book The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare. Essentially, I concluded that managed care could help improve quality of care, but only if it was not for profit. Unfortunately, the for-profit organizations have won out, and business ethics come before health care ethics. Although the term managed care is not spoken much anymore, we are left with systems of care that seem to put profits over quality of care, putting obstacles and limitations on physicians, thus leading to our epidemic rate of burnout.

Dr Stone saw all of this coming. He warned early on that greed would come to dominate psychiatry, and he foresaw how managed care could adversely control the doctor-patient relationship and decrease the role of psychiatrists.

Dr Stone was on the editorial board of Psychiatric Times for many years, and Psychiatric Times covered his perspectives on managed care. Anthony M. D’agostino, MD, wrote the article “Managed Care: The New Colonialism” in 1998, which covered the 1997 annual meeting of the American Psychiatric Association. I clearly recall the many emotional presentations about managed care: that it was evil and unethical, that psychiatrists who refused to participate in managed care were freedom fighters, and that maintaining the moral high ground would ultimately lead to victory. Dr Stone recognized that we were losing, partly because not enough colleagues and psychiatric organizations joined the cause.

In the Psychiatric Times article “The Humanities and Psychiatry: The Rebirth of Mind,” James L. Knoll IV, MD, discussed Dr Stone’s involvement in “an important historical moment of transition in modern psychiatry.” This historical moment had to do with Dr Stone’s debate with Gerald Klerman, MD, in 1990 for The American Journal of Psychiatry about Osheroff v Chestnut Lodge, a famous legal case suit. Klerman emphasized the need for randomized controlled trials to justify the use of any form of treatment, whereas Dr Stone wanted to leave room for the freedom to use treatments that were more difficult to research than medication, such as psychodynamic psychotherapies. Paradoxically, although they were not talking about managed care, for-profit managed care grabbed onto Klerman’s argument and basically limited psychiatrists to using brief medication treatment. From my perspective, the most successful clinical psychiatrists often merged both points of view and knowledge, which was where Dr Stone rested his case back then.

Of course, there is much more for which Dr Stone is renowned. For instance, when he was president of the American Psychiatric Association in 1979, he guided the decision to remove homosexuality from the list of mental disorders. He was a film critic for the Boston Review. He protested the use of psychiatric treatment of oppressed minorities such as Soviet Jews and Falan Gong. He taught courses about Shakespeare and the law.

How we psychiatrists combine our personal morality values, professional ethical principles, and the law as it pertains to psychiatry (which includes codified ethics) is inevitably reflected in how we live our lives. Dr Stone seemed to lead a very important life.

May his memory be a blessing.

Dr Moffic is an award-winning psychiatrist who has specialized in the cultural and ethical aspects of psychiatry. A prolific writer and speaker, he received the one-time designation of Hero of Public Psychiatry from the Assembly of the American Psychiatric Association in 2002. He is an advocate for mental health issues related to climate instability, burnout, Islamophobia, and anti-Semitism for a better world. He serves on the Editorial Board of Psychiatric Times.

REFERENCES
The treatment of psychiatric disease is evolving with advances in imaging and genomic profiling and the emergence of investigational molecules as potential new treatments for prevalent psychiatric disorders. With these advancements it is important that psychiatrists, along with members of the multidisciplinary care team, understand the latest clinical developments and how to best apply that knowledge in clinical practice.

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- Hear about strategies for early diagnosis and intervention to improve outcomes
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Disease burden and disability among patients with schizophrenia is largely determined by the negative symptoms, which include blunted affect, alogia, avolition, asociality, and anhedonia. In addition, it has been estimated that about 60% of patients with schizophrenia have prominent negative symptoms that require treatment. These symptoms are challenging to treat and often persistent. Although studies have observed a reduction of negative symptoms in the acute phase of trials, these have been unspcific or reflect reductions in secondary negative symptoms. Thus, negative symptom reduction is not considered a relevant outcome in acute phase trials. Similarly, much has been written on the issue of designing clinical trials to assess response for negative symptoms. A previous meta-analysis investigated the dose-response relationship between antipsychotics and total symptoms in acute-phase schizophrenia. However, data on the dose-response relationship between antipsychotics and negative (versus positive) symptoms are lacking. Identification of near-maximum effective doses would help guide clinical decision-making.

To gain a better understanding, Michel Sabe, MD, and colleagues conducted a systematic review and dose-response meta-analysis of double-blind randomized controlled trials (RCTs) of fixed antipsychotic doses for negative and positive symptoms in acute exacerbations of (chronic) schizophrenia or schizoaffective disorder. The investigators included all fixed-dose double blind, parallel group RCTs of antipsychotic versus placebo with a duration of at least 3 weeks. The primary outcome was the intent-to-treat score change from baseline for negative symptoms assessed with either the Positive and Negative Syndrome Scale (PANSS) negative subscale or the Scale for Assessment of Negative Symptoms (SANS). The secondary outcome was the intent-to-treat score change from baseline for positive symptoms assessed with either the PANSS positive subscale or the Scale for Assessment of Positive Symptoms (SAPS). Sabe et al estimated flexible dose-response models from sets of correlated mean differences, which were combined into pooled dose-response curves. From these curves, they estimated 50% (ED50) and 95% (ED95) effective doses for each antipsychotic. The ED50 is the mean dose that produces half of the maximum reduction of symptoms, and the ED95 is the near-maximal effective dose.

From 4398 articles, the authors identified 612 articles for full-text review, of which 40 met the inclusion/exclusion criteria. These 40 trials included 15,689 patients with a mean illness duration of 14 years, and investigated 13 oral and 3 long-acting injectable antipsychotics. The median study duration was 6 weeks (range, 4-13). The Table provides resulting data on the ED50 and ED95 for negative and positive symptoms for various antipsychotics.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Negative symptoms</th>
<th>Positive symptoms</th>
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<tbody>
<tr>
<td></td>
<td>ED50 (mg/day)</td>
<td>ED95 (mg/day)</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>2.7</td>
<td>6.3</td>
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<tr>
<td>Aripiprazole</td>
<td>4.9</td>
<td>11.9</td>
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<td>Asenapine</td>
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<td>4</td>
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<td>Lurasidone</td>
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<td>Olanzapine</td>
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<td>Olanzapine LAI</td>
<td>9.7</td>
<td>15.7</td>
</tr>
<tr>
<td>Paliperidone</td>
<td>2.9</td>
<td>7.2</td>
</tr>
<tr>
<td>Paliperidone LAI</td>
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<td>Risperidone</td>
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<tr>
<td>Ziprasidone</td>
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Based on this data, the resulting dose-response curve types could be trichotomized into: (1) plateau after an initial increase, (2) still increasing at the maximum dose, and (3) bell-shaped. Most of the dose-response curves suggested that the ED95 was lower for negative than positive symptoms, except for aripiprazole and asenapine. For olanzapine and quetiapine ER (for negative symptoms) and ziprasidone (for positive symptoms), the dose-response curves were still increasing at the upper end of the investigated dose range, raising the possibility that higher doses could be more efficacious.

Sabe et al acknowledged that the primary limitations of their analyses were the small number of RCTs and limited dose range investigated for some antipsychotics. Another limitation of the study was the absence of RCTs of clozapine. Furthermore, findings do not permit inferences on effects of longer durations of treatment beyond the acute phase of illness.

**The Bottom Line**

Findings can help clinicians optimize antipsychotic dosing during acute illness exacerbations. Antipsychotic doses above the ED95 may not confer additional efficacy for most agents.

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**While Listening to Annie Lamott Give Tim Ferriss Her Advice for Writers**

**Richard Berlin, MD**

“Step 1: put your butt in a chair for 45 minutes every day and get down a shitty draft.”

Which is exactly what I’ve started doing after sharpening pencils for three minutes, and I’m thinking, Annie, I know this drill from keeping my butt in a chair for 45-minute sessions with patients before I shift gears and spend fifteen more as a doctor-poet, compressing their stories and sighs into progress note poems I season with blood work and brain scans. And now, Annie, at minute 16, I’m writing about the way professional standards make me gaze into my crystal ball to predict suicide risk, and I’m wondering if imagining the future makes me a sci-fi writer whose words could be used as time machines for patients to board and rearrange their past: a doomed marriage derailed before wedding; the pathology report changed from malignant to benign; making a full stop at the warning light. Hitting minute 33 I’m pausing to read what I’ve written, my inner critic screaming, Don’t sign off on a shitty draft like this one, even though Annie’s Step 2 says: Perfectionism blocks playfulness and creativity.

But hey, I only write for an audience of three: the clear lens of my professional eye, that bureaucrat who authorizes my payments, and a malpractice attorney, years from now, who will read my progress note poems while she weighs her case against me. The clock just ticked minute 41, and Annie, just as you predict my attention is wandering, even if I haven’t hit Step 3: Make the reader feel something is at stake, which I’ll have to focus on in my revision. But I do understand your words about The holiness of the writer’s craft, because my other profession asked me to swear the sacred Hippocratic oath, To Apollo Healer and before all the gods and goddesses... getting these words down just as my alarm signals minute 45. I put down my pen. “Shitty Draft Number One.” Thanks, Annie, I had fun.

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*Dr Berlin* has been writing a poem about his experience as a doctor every month for the past 24 years in *Psychiatric Times™*. He is instructor in psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts. His latest book is *Freud on My Couch*.
BIPOLAR UPDATE

Chronic Kidney Disease and Lithium—A New Perspective

David N. Osser, MD

ephrotoxicity is a well-known adverse effect of lithium. Monitoring for nephrotoxicity and using lithium with great caution in patients with renal impairment are standards of care.1 The estimated glomerular filtration rate (eGFR) has become an easily available routine measure for baseline and periodic monitoring of kidney function in patients on lithium.2 Laboratories report eGFRs of less than 60 mL/minute/1.73 m² as abnormal and indicating risk of chronic kidney disease (CKD). Stage 3 CKD, associated with an eGFR of 45 plus minus 14 mL/minute/1.73 m², is defined as a level of impairment with significant potential for kidney failure and death during a 5-year period. One would usually want to avoid lithium, or consider reducing or discontinuing it, if the eGFR is between 45 and 59 mL/minute/1.73 m².

In a recent Psychiatric Times™ Bipolar Update, we discussed ways of dosing lithium and maintaining levels of lithium to minimize risk of kidney harm.3 These included using the immediate-release formulation (rather than long-acting versions), prescribing the full dose at night, keeping maintenance levels no higher than 0.6 to 0.8 mEq/L, and avoiding levels higher than 1.0 mEq/L at any time. GFR decreases with age, so not all reductions of eGFR during long-term lithium use are due to lithium. Questions have been raised about the longstanding adoption of a fixed threshold of less than 60 mL/minute/1.73 m² for an abnormal eGFR for patients of all ages. It has been proposed that the thresholds should be 75 mL/minute/1.73 m² for patients under age 40, 60 mL/minute/1.73 m² for those aged 40 to 65 years, and 45 mL/minute/1.73 m² for patients 65 years and older.4

In a recent study, investigators evaluated outcomes associated with CKD when defined by a fixed (< 60) threshold vs these age-adapted eGFR thresholds.5 Utilizing a population-based cohort of patients in the province of Alberta, Canada, investigators found, as expected, that CKD was diagnosed much more often in older adults using the standard threshold of less than 60 compared with using a 45 mL/minute/1.73 m² threshold. There were 2356 new cases per 100,000 person-years with the 60 mL/minute/1.73 m² threshold vs 714 with the 45 mL/minute/1.73 m² threshold. However, 75% of patients with eGFRs from 45 to 59 mL/minute/1.73 m² were aged 65 or older and had normal or only mild albuminuria. The 5-year risks of kidney failure and deaths among these older adults were similar to those of a control group of non-CKD elderly patients with eGFRs from 60 to 89 mL/minute/1.73 m². The absolute risk of kidney failure was 0.12% in both groups. The investigators concluded that the current fixed eGFR criterion seems to result in overdiagnosis of CKD in this aging population. They likely suffered unnecessary evaluations and interventions when their problem was only age-related reduction in eGFR.

The implications for treating with lithium would seem to be that older adults and some other patients with eGFRs of 45 to 59 mL/minute/1.73 m² do not necessarily have CKD. Clinicians should evaluate these patients for proteinuria before making that diagnosis. Of course, close consultation with a kidney specialist would be advised regarding decisions about lithium use. However, it may be reasonable to start or continue to use lithium in more patients than was done prior to the emergence of this new perspective on the meaning of eGFRs.

Younger patients, in contrast, were often underdiagnosed with CKD using the 60 mL/minute/1.73 m² threshold. The study found 14 vs 91 new cases per 100,000 person-years with the 60 and 75 mL/minute/1.73 m² thresholds, respectively. The absolute rate of CKD was low. Still, it would seem prudent to remember the Alberta data and consult with a renal specialist if the eGFR is below 75 mL/minute/1.73 m² in younger patients. Notably, however, studies of lithium maintenance in younger patients with bipolar disorder have not found declining eGFRs.6

Dr Osser is an associate professor of psychiatry at Harvard Medical School and codirector of the US Department of Veterans Affairs’ National Bipolar Disorder Telehealth Program in Brockton, Massachusetts. The author reports no conflicts of interest concerning the subject matter of this article.

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“Inappropriate” Consults: Taxonomy and Strategy

>> Jacob M. Appel, MD, JD, MPH

Consultation-liaison psychiatrists wear 2 hats in the hospital setting. The consultation function, similar to consultants in other medical specialties, offers colleagues guidance on the diagnosis and management of medical or surgical patients with psychiatric comorbidities. In contrast, the liaison function—often less clearly defined and too often afforded short shrift—involves educating nonpsychiatric physicians and other clinicians about psychiatric illness, as well as serving as an intermediary between other medical teams and mental health providers.

The subspecialty evolved from its psychoanalytically informed forebearer, psychosomatic medicine, starting in the 1930s and more rapidly in the 1960s and 1970s in conjunction with the widespread embrace of George Engel, MD’s biopsychosocial model, although the formal transition to the term consultation-liaison psychiatry dates only to 2018. Estimates are that up to 30% of patients in general medical units have psychiatric disorders. As a result, consultation-liaison psychiatrists and teams remain in high demand. In that context, consult requests that psychiatrists believe to be inappropriate—for a range of reasons—can prove burdensome and pose a challenge to interservice rapport. Filtering out inappropriate consults detracts from the time and energy that psychiatrists might devote to appropriate consultations.

As early as the 1970s, Anastasia Kucharski, MD, and James Groves, MD, described the challenge of consult requests that “superficially appear…to the consultant as covert, manipulative, illogical, [or] ill-timed” and seemed “to represent a dysfunction in the medical or surgical staff caused by arousal of conflicted aggressive, sexual, or depressive feelings.” Nearly 50 years later, a cursory review of social media sites (eg, Reddit, Student Doctor Network forums) reveals that gripes about inappropriate consults remain intense. Of course, one physician’s inappropriate consult may be another physician’s good-faith, legitimate effort to secure better care for a patient.

As the medical profession becomes increasingly specialized, consultants may mistakenly consider their knowledge to be common sense and therefore resent physicians in other specialties who lack their expertise. For the psychiatric consultant, managing requests for consults that may be inappropriate—without offending colleagues in other specialties—is a crucial and underappreciated skill.

Unnecessary consultation calls may prove delusional in multiple ways beyond the burden that they place upon already overtaxed consultants. For instance, summoning a psychiatrist might lead a patient to believe their credibility or sanity is being questioned, causing ruptures in the relationship with that patient’s primary care team. Because certain types of consults inherently may raise questions about a patient’s psychiatric stability or decisional capacity, this impact should be minimized by avoiding unnecessary calls. In particular, surplus decisional capacity consults that are conducted when no reasonable question exists regarding the patient’s ability to render decisions—because they are either grossly impaired or not impaired at all—implicate the autonomy of patients and may be perceived as threatening.

At the same time, exploring with the primary team the circumstances and motives behind a consultation request initially deemed inappropriate may reveal details that render the consult justified or even essential to patient welfare. Unfortunately, no effort to establish a taxonomy for inappropriate consults has occurred in nearly 50 years, whereas earlier classification schemes reflect largely outdated approaches to psychiatric pathology. What follows is a review of 7 common reasons for which consults may appear inappropriate, as well as strategies for addressing these calls for assistance.

**THE CHALLENGES AND STRATEGIES**

**CHALLENGE: Premature Consult**
Among the most common sources of frustration for consultation-liaison psychiatrists are consults that are called in prematurely. Often these requests will occur under the guise of “getting psychiatry on board early”—so early that it remains unclear whether a psychiatry consult would be indicated. In many cases, a medical work-up that should precede the psychiatric evaluation is incomplete. For instance, the psychiatry team may be asked to assess a patient for new-onset primary psychosis before head imaging or a urine toxicology screen has been obtained. At the extreme, a psychiatrist may be asked to address a functional disorder or suspected malingering before the primary team has ruled out other medical causes of illness.

**MANAGEMENT STRATEGY:** Whether a formal consult will eventually be required can be difficult to predict. When consultation appears premature, the psychiatrist may wish to thank the primary team for alerting them to the patient’s presence in the hospital. However, rather than consult immediately, the psychiatrist should lay out specifically what steps ought to be taken before a formal psychiatric consult is indicated— the more detail in this regard, the better. “Please call back when you have the results of the head CT and the urine toxicology. If these results are negative or if the patient’s symptoms persist, I will be happy to evaluate the patient” is liable to generate a far more positive response than the much less precise, “Can you call back when your work-up is done and the patient is medically cleared?”

**CHALLENGE: No Specific Question**
When calling a consult, the physician seeking guidance should pose a focused question to the consultant. Unfortunately, many requests, at least initially, lack such a core inquiry. Rather, they are phrased as broad calls for assistance or, even more challenging, broad requests for assistance shrouded in vague, sometimes tangential questions. For example, a clinician might say, “We need help treating the patient, and they might be depressed or psychotic.” In essence, the primary team is asking the consultant to assume responsibility for the patient, rather than soliciting guidance with regard to specific aspects of their presentation. Needless to say, such broad management is generally not the role of the con-
Consultant in the hospital setting and is an abrogation of duty by the admitting service.

**MANAGEMENT STRATEGY:** The key to consultation requests where the requesting physician appears to lack a clear question is to investigate whether the request is for general management or whether the barrier is merely in how the core question is formulated. Often, the primary team does have legitimate questions but has not yet precisely honed them. In other words, the challenge is with interprofessional communication—not the need for a consult itself. An important part of the psychiatrist’s liaison function in such cases is to help the primary team formulate their question(s).

**CHALLENGE:** No Active Question

In contrast to vague questions, sometimes no active question exists at all. These cases arise most frequently when the patient has a history of psychiatric illness or behavioral disturbance but no active symptomatology. The primary team may say, “When the patient was hospitalized last year, he was suicidal, so we want to make sure he is not now.” Sometimes this is referred to as a request to “treat the chart,” rather than the patient.

**MANAGEMENT STRATEGY:** Consultants should generally not evaluate patients without active or recent signs or symptoms of illness. In addition to a burden on resources, systematic billing for such consults may rise to the level of fraud. At the same time, declining such consultations outright without offering any assistance does not build rapport. Rather, the psychiatrist might inquire whether the patient is in ongoing outpatient psychiatric care. If so, the psychiatrist should urge the primary team to contact the outpatient psychiatrist or other clinician to ascertain whether the patient is off their baseline, agreeing to see the patient if the primary team still believes such a consult is indicated after discussing the case with the patient’s outside provider.

Often, the primary team seeks reassurance from the ongoing treating clinician, rather than a formal consult, and a brief phone conversation with the patient’s psychiatrist or psychotherapist can meet this need. Such collateral information is a foundation of good medical care. If the patient is not already in outpatient care, the psychiatrist might offer “curbside” suggestions of potential referrals. Alternatively, outpatient services might be arranged by a discharge planning social worker. To build additional goodwill, consultation psychiatrists might make themselves available to offer “curbside” suggestions to the discharge planning team as well.

**CHALLENGE:** Consultation Will Not Change Management

Consults should be thought of as interventions, not merely tools, with their own potential sets of adverse effects and negative consequences—exhausting patients, damaging therapeutic relationships between patients and primary teams, and increasing medical error as a result of chart clutter. Consultation should occur only when it serves a clinical purpose. For instance, a decisional capacity consult for a patient who refuses a medical intervention should take place only if the primary team is willing and able to force that intervention upon a nonconsenting patient who lacks capacity to refuse.

Of particular concern are potential biases in requests for so-called nonactionable consultations—where the risk that they are more likely to be called on patients with less social capital or from historically marginalized communities. For example, physicians may be driven by unconscious, implicit biases to assume falsely that certain patients, such as those from low-income communities or communities of color, have less understanding of proposed interventions than these patients actually do—resulting in surplus decisional capacity consultations that would not be called upon white patients in similar medical circumstances.

However, on rare occasions, such as direct patient request, the reassurance of having a psychiatrist on board may justify a nonactionable consultation. The value of such assistance should be discussed with the primary team. It is important to emphasize to the primary team that consenting to such requests is not the norm or standard of care, but it might be justified in some instances where concrete evidence indicates that the patient’s adherence to care will improve with such a consultation. For instance, a patient with a long history of previous psychiatric hospitalizations might request reassurance from a psychiatrist that signing a consent form for medical care will not lead to another involuntary commitment. Needless to say, psychiatrists agreeing to see such cases run the risk of sliding down a slippery slope, so discretion is highly advised to manage future expectations.

**MANAGEMENT STRATEGY:** Nonactionable consultations can usually be preempted if the psychiatrist clarifies the purpose of the consultation with the primary team. In requests related to decisional capacity, the refusal of care, or efforts to leave against medical advice, the potential consultant should routinely ask the question, “How will you change your treatment plan based upon my recommendations?” Frequently, explaining to the primary team that a consult will delay treatment or disposition without changing the outcome is sufficient advice for the primary team to retract a formal request for consultation.

**CHALLENGE:** Wrong Specialty Consulted

In some cases, the primary team does require guidance, but the psychiatric team is the wrong source of expertise. Such requests may arise when the primary team does not require a clinical consultation but rather the support of nonmedical professionals such as patient representatives, an ethics committee, risk management officers, or even hospital attorneys. In other cases, the history and symptomology may strongly suggest a condition best managed by another medical service, such as neurology or pain medicine.

**MANAGEMENT STRATEGY:** The liaison function of the consult-liaison psychiatrist is valuable in cases where a psychiatrist is consulted for nonpsychiatric help. But steering the primary team elsewhere may be seen as an effort to wash one’s hands of a case. Rather, the psychiatrist should suggest that the primary team consult the appropriate specialist or authority first and may even assist them in doing so with the reassurance that, if psychiatric help is still required after that consultation, psychiatry will follow up with a consult of its own. In some cases, the psychiatrist might also emphasize that obtaining a different consult first will enable the psychiatric consultation to prove more helpful. For example, having the neurology consultant confirm a diagnosis of Parkinson disease prior to a psychiatric consultation might guide the latter in choice or medication and course of treatment.

**CHALLENGE:** Issue Best Addressed as an Outpatient

Few consults frustrate the busy psychiatric consultant more than being called in to address a problem better suited for outpatient management. For instance, such requests might occur in cases of simple phobias, for help with smoking cessation, or for decisional capacity assessments to execute financial documents. On some services, when patients stay in the hospital for lengthy periods of time (eg, after an allogeneic stem cell transplant), these may take the form of the patient requesting psychiatric assistance under the guise of, “While I’m here anyway…”

**MANAGEMENT STRATEGY:** Many interventions are best offered in the outpatient setting for reasons of efficacy and logistics that transcend the mere inconvenience of providing them during hospitalization. For example, one might not wish to begin treatment with a time-limited, manualized psychotherapy (eg, interpersonal therapy) if the patient’s planned discharge from the hospital halfway through the course of treatment would disrupt continuity of care. Explaining to the primary team (and, when appropriate, the patient) why the patient is better served by commencing treatment in the outpatient setting and providing the name and contact information for a psychiatrist who can offer such treatment upon discharge will resolve the need for further inpatient management.

**CHALLENGE:** Question Previously Answered

One of the situations that damages interprofessional rapport is when the consultant has answered a consult question, but the primary team continues to request guidance. Occasionally, this may prove to be a communication error, with the primary team overlooking guidance that has already been documented. At other times, the primary team may simply be unhappy with the suggestions offered and expect a change in opinion.

**MANAGEMENT STRATEGY:** The easiest path in such cases, although far from the most effective, is either to decline further consultation or to repeat the consult with a brief follow-up note affirming the original recommendations. Of course, if the recommen-
EHRs May Enhance, Prolong Racial Bias in Clinical Settings, Study Results Show

**Jeffrey Bendix**

Language used to describe patients in electronic health records (EHRs) may be perpetuating racial bias and other negative stereotypes in health care, according to results of a new study.1

Using machine learning techniques, investigators analyzed potentially stigmatizing language in more than 40,000 history and physical notes in EHRs from 18,459 adult patients at an academic medical center in Chicago, Illinois. Sun et al found the odds of Black patients having 1 or more negative descriptors such as “refused,” “not adherent,” “(not) compliant,” or “agitated” noted in their EHRs were more than twice (2.54; 95% CI, 1.99-3.24) the odds of white patients, even after adjusting for sociodemographic and health characteristics.

The differences were not solely based on race. Medicare and Medicaid beneficiaries, for example, were more likely to have negative descriptors applied to them than were patients with commercial or employer-based insurance, as were unmarried patients compared with patients who were married, the study results showed.

The findings are especially troubling, Sun and colleagues wrote, given that other studies have found that less than 20% of text in inpatient progress notes is original, with much of the information imported from prior documentation. As a result, “subsequent providers may read, be affected by, and perpetuate the negative descriptors, reinforcing stigma to other health care teams,” Sun et al wrote. The investigators found that notes written for outpatient visits were less likely to have negative descriptors in the patient’s EHR than inpatient encounters. They theorized this resulted from inpatient settings being inherently more stressful, thereby increasing the risk of doctors using stereotypes as cognitive shortcuts.

Sun et al also found that race-based differences in the use of negative descriptors narrowed after March 1, 2020. They theorized this was due to the stark racial differences in care and outcomes highlighted by the COVID-19 pandemic and the pandemic’s overlap with “a historically defining moment of national response to racialized state violence” created by the killings of George Floyd and other Black Americans.

“These social pressures may have sensitized providers to racism and increased empathy for the experiences of racially minoritized communities,” Sun et al wrote.

The authors further noted it is imperative that medical institutions better address the issue of implicit racial bias and institute provider training. For example, they noted a physician’s use of the term aggressive may reflect the physician’s personal bias regarding Black men, adding that once a negative label becomes part of the patient’s record, “it potentially affects the perceptions and decisions of future providers regardless of whether future providers hold a bias about Black men being aggressive.” Similarly, they recommended “people first” language (eg, saying a patient has an alcohol use disorder instead of labeling them an alchoholic) be used in interprofessional communication.

Similarly, Sun et al also suggested that regulatory bodies such as the Accreditation Council for Graduate Medical Education develop specific recommendations for the use of nonstigmatizing, patient-centered language to prevent the transmission of bias.

The need is especially important, they wrote, in light of the OpenNotes policies adopted by medical institutions. These policies allow patients full access to their EHRs, including chart notes. Sun et al added that inappropriate and negative language used to describe patients may risk “harmonizing the patient-provider relationship with downstream effects on patient satisfaction, trust, and even potential litigation.”

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**FROM THE PAGES OF**

Psychiatric Communities

**Dr Appel is director of ethics education in psychiatry and assistant director of the Academy for Medicine & the Humanities at the Icahn School of Medicine and an emergency department psychiatrist in the Mount Sinai Health System in New York, New York.**

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TALES FROM THE CLINIC: THE ART OF PSYCHIATRY  
SERIES EDITOR NIDAL MOUKADDAM, MD, PHD

“There’s No Point”  
Alcohol Use Disorder Relapses

Hira Hanif, MD; Christie Aldrich, MD; Kim Parks, MD

In this installment of Tales From the Clinic: The Art of Psychiatry, we discuss alcohol use disorder (AUD) with difficult relapses. AUD is one of the most prevalent mental health disorders worldwide. This discussion examines comorbidities and barriers to treatment.

**CASE STUDY**

“Ms Frank” is a young woman with a history of alcohol use disorder (AUD), cocaine use disorder, posttraumatic stress disorder (PTSD), and bipolar disorder who is receiving psychiatric care at an outpatient program. She has a severe trauma history that has never been fully discussed with a therapist or psychiatrist, despite years of treatment. She has chronic suicidal thoughts after multiple previous attempts by overdose. Suicidality is increased in times of intoxication, and suicidal thoughts have never completely gone away even with the switch to lithium. She has failed more than 15 medications and is often sensitive to adverse effects.

After a significant suicide attempt and inpatient rehabilitation for 90 days, Ms Frank achieved and maintained sobriety for almost 2 years before being put into a supervisory role at her sober living facility. Some of her duties included expelling individuals who had relapsed, including those who had become her friends. She felt that “everyone relapses, anyway” and “there’s no point,” and subsequently relapsed herself with successive suicide attempts and psychiatric hospitalizations. She has since regained sobriety and gone through another 30-day rehab program. She continues to have persistent suicidal thoughts and difficulty engaging with therapy. How- ever, she has again achieved and maintained sobriety for more than a month with a medication regimen including naltrexone monthly injectable, which reportedly helped with her cravings. She previously tried and failed naltrexone by mouth, acamprosate, and disulfiram due to adverse effects. She regularly attends Alcoholics Anonymous meetings and therapy.

Ms Frank’s history is significant for a pervasive pattern of instability in personal relationships; impulsivity; affective instability; difficulty controlling anger; and recurrent suicidal behavior, gestures, and threats that may indicate an underlying cluster B personality disorder. As she deals with these issues, she maintains a close circle of friends and is able to maintain a consistent job.

**The Most Prevalent Mental Health Disorder**

AUD is known to be one of the most prevalent mental health disorders worldwide. As seen in Table 1, according to the 2019 National Survey on Drug Use and Health (NSDUH), 7.6% of men and 4.1% of women 18 years and older have AUD.\(^\text{1}\) As the prevalence of AUD cases has continued to rise, various methods of detection have been recommended. The Alcohol Use Disorder Identification Test (AUDIT) is recommended by the World Health Organization as a screening tool to detect alcohol problems. Different AUDIT scoring thresholds are required for men and women, as research has shown that AUD in women has distinctive social and biological characteristics.

For the same amount of alcohol, women develop a higher blood alcohol concentration than men. Therefore, the Centers for Disease Control and Prevention (CDC) provides distinctive cutoffs for alcohol use and binge drinking in women vs men (Table 2). Women are more susceptible to the toxic effects of alcohol such as cognitive disorders, heart disease, and liver cirrhosis. Women also differ in their approach to the health care system, which may influence their performance on self-reported screening tests. Women also often display a shorter trajectory from onset of alcohol use to when they receive a diagnosis of AUD. The prevalence of AUD has steadily increased in women, resulting in a narrower gender gap in AUD diagnoses.\(^\text{2}\) These are a few of the many reasons it is imperative to utilize a lower screening threshold when assessing female patients for AUD.

**Treatment Options and Barriers to Care for AUDs**

Despite the increasing prevalence of AUD and the multitude of services available, national surveys consistently demonstrate low utilization of treatments (Table 3). Gender disparities in the utilization of treatment are long-standing and significant. Women have approximately one-third to one-half the odds of utilizing treatment when compared with men.\(^\text{3}\) Fears of stigmatization and beliefs that treatment is ineffective seem to play a large role across the board. In a recent study, women were found to be more likely than men to report attitudinal barriers to treatment. These barriers consisted of shame, fear of others finding out, belief that no one can help, and belief that the problem is not serious enough.\(^\text{4}\) Because women are less likely to seek help, tailored interventions are warranted. Although underutilized, effective and safe treatment for AUD is available through psychosocial and pharmacological interventions.\(^\text{5}\) The combination of pharmacotherapy and psychotherapy (cognitive behavioral therapy, individual and group drug coun-

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**Table 1. Alcohol Use Disorder Among Individuals 18 Years or Older, by Gender: 2019**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Alcohol Use Disorder (AUD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>7.6%</td>
</tr>
<tr>
<td>Female</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

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**Table 2. CDC Guidelines for Alcohol Use**

<table>
<thead>
<tr>
<th>Category</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of maximum daily alcoholic drinks</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Minimum alcoholic drinks for a binge</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

CDC, Centers for Disease Control and Prevention.

\(^\text{1}\) Binge drinking is defined as having a certain number of drinks in 1 sitting (approximately 2 hours) in the past 30 days.
When formulating treatment plans for patients with cooccurring disorders, it is imperative to determine the chronology of onset of the diseases. The clinical course tends to be determined by the primary diagnosis. Comorbidity has particularly important clinical implications in cases where psychiatric symptoms increase the risk for suicide. AUD in patients with depressive disorder is associated with increased suicidality.11 Personality traits that are often associated with increased risk for alcohol abuse (impulsivity, negative emotionality, and antagonism) are also characteristics of borderline personality disorder (BPD) and antisocial personality disorder (ASPD).12

Although these disorders are highly comorbid and result in poorer prognosis when they occur together, there are limited treatments that target the symptoms of both BPD and AUD. There is promising evidence that some anticonvulsants (eg, topiramate, lamotrigine) and second-generation antipsychotics (eg, aripiprazole, olanzapine) may reduce the anger, impulsivity, and mood lability present in BPD. Similarly, there are also studies suggesting that these same medications may also reduce alcohol craving and consumption.13 It should be noted that these medications are not FDA approved for BPD or AUD.

Modified psychotherapies (eg, dynamic deconstructive therapy, dialectical behavior therapy, dual focus schema therapy) have been developed for the treatment of comorbid AUD and BPD; however, there is limited evidence to support the efficacy of these modalities on treating symptoms of both disorders concurrently. Only dynamic deconstructive psychotherapy has been specifically tested on patients with both AUD and BPD. Evidence shows that although this therapy may be successful in treating symptoms of BPD, its efficacy in reducing alcohol consumption may not be sustained long term.

The efficacy of the other 2 of the 6 models in the treatment of AUD has not yet been established.14 Due to the lack of sufficient evidence, psychotherapies for ASDP are limited.15 Although there is sparse evidence to support pharmacotherapy for AUD, medications can be used to treat symptoms of the disease such as aggression and impulsivity.16

Concluding Thoughts

In order to effectively treat AUD, an awareness and utilization of evidence-based treatment options is imperative. Furthermore, barriers to seeking care in this particular population require special consideration when formulating treatment plans.

**Table 3. Alcohol Use Treatment in Past Year Among Individuals 18 Years or Older: 2019**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.4%</td>
</tr>
<tr>
<td>Female</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

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**Figure. Treatment Patterns of AUD in Individuals Aged 18 and Older**

AUD, alcohol use disorder.
REEL INSIGHTS

Best Recent Screen Portrayals of Mental Health Issues

» Christopher Magoon, MD; and David A. Sasso, MD, MPH, for the Group for the Advancement of Psychiatry Committee on Arts and Humanities

Recent years have seen a remarkable increase in public discourse about mental health issues, with representations of mental illness in popular culture becoming increasingly varied, nuanced, and abundant. Each artist brings their own mental health experiences to their work; however, depictions of mental illness and the mental health care system are often demonizing, sensationalized, or grossly inaccurate. Such misfires can further stigmatize patients with psychiatric disorders. As such, it is important to celebrate accurate representations of psychiatric issues and treatment. As members of the Group for the Advancement of Psychiatry Committee on Arts and Humanities, we wanted to share some excellent representations of mental health issues in film and television over the past year.

Memories and Misperceptions in The Father

Christopher Magoon, MD

When perception diverges from reality, terror ensues. In The Father, the viewer experiences the disorienting decline of Anthony (played by Anthony Hopkins) as he grapples with dementia. Anthony struggles to understand where he is, who he is, and who is around him. Director Florian Zeller deftly places the viewer into Anthony’s frame of mind as he experiences the horror of mistrusting his memories and perceptions. There is no overdramatization or embellishment. Zeller trusts that the stakes of this proud man—a well-off retired engineer—losing his faculties are high enough. As a result, the viewer is left feeling profound empathy. When a nurse hugs a crying and confused Anthony in the final scene, it feels genuinely cathartic to know he is comforted by human touch. The end of the film comes as a relief, as it does for many families with someone suffering with dementia. The Father, an honest portrayal of the fragility of the mind, is well worth experiencing.

Cultural Snapshots of Mental Illness in Shtisel

David A. Sasso, MD, MPH

Shtisel, an Israeli drama about a Haredi (ultraorthodox) family in Jerusalem, began streaming its third season in March 2021, with Hebrew and Yiddish dialogue subtitled in English. This thoughtful series centers on Akiva Shtisel (portrayed by Michael Aloni), an endearing but hapless son, brother, and father. Akiva is an oddity in his family and his insular religious community because of his artistic pursuits—he is a painter—and for his serial failures in love. In this season, we meet Racheli, a new love interest for Akiva, recently widowed and now a single father. Racheli, we learn, quietly suffers from what appears to be bipolar disorder. The touchingly human telling of their love story weaves Racheli’s psychiatric illness into the story seamlessly, neither glamorizing nor minimizing it, neither stigmatizing it nor ignoring its inherent cultural stigma.

Other subplots touch upon mental health themes. Akiva’s sister and brother-in-law navigate their fragile marriage while watching their children strive to build families of their own. Akiva’s niece silently and courageously endures a complicated pregnancy. Through it all, Akiva’s father, widower Shulem, tries desperately to keep his family under his thumb while searching for companionship. Shtisel gives viewers a fascinating glimpse into a world foreign to most, yet somehow simultaneously familiar. Although our day-to-day culture often either silences mental illness or sensationalizes it, Shtisel’s fictional portrayal seems to bring us closer to reality than real life. That’s good TV.

Compelling Reality in Love on the Spectrum

Kenneth J. Weiss, MD

Love on the Spectrum is an Australian documentary series that streamed its second season on Netflix in 2021. It is about young men and women with autism spectrum disorder who are looking for love. The episodes are without commentary and with minimal intervention from the filmmakers and crew who chaperone dates. The otherwise
The Power of Positivity in Ted Lasso
Andrew Lustbader, MD

An American football coach, Ted Lasso (Jason Su-deikis), is hired to run an English Premier League soccer team without any knowledge of how to play the game. He has tremendous confidence and an optimistic attitude toward the human condition. He evokes a positive response in others—undaunted by their negative responses to him—bringing them along to elevate their own personal experiences. Happily, a new star player, Danny, appears, whose credo is “football is life.” When Danny accidentally kills the team’s mascot dog with a penalty kick, he is traumatized and becomes quite depressed. His new motto becomes “football is death.”

When the coach is not able to help pull Danny out of his depression, the team brings in a therapist who helps him move forward. After seeing the therapist’s success with Danny, many other, often macho, members of the team engage her services. They realize that by simply talking about what is on their minds, they are able to feel better and move on in their lives. Ted also reluctantly seeks her services when he has to leave the sidelines because of a panic attack during a critical match. When knowledge of Ted’s panic disorder becomes public, he challenges the media to look at the treatment of mental health in sports.

Although the show later depicts unrealistic boundary violations after the therapist suffers from a hiking accident, the two agents of change, Ted Lasso and the therapist, are complementary in advancing the inner lives of the team members. Much of the success of the series is due to the viewer also being exposed to the possibility that positive change can occur with optimism, self-confidence, and good therapy.

Human Connections in Pig
Fernando Espí Forcén, MD, PhD

Pig stars Nicholas Cage as Rob Feldman, a former chef who makes a solitary living by truffle foraging with his beloved and talented pig. From the beginning, it is hinted that Rob is coping with tragedy, and as a result, he is no longer interested in engaging in society. From time to time, Bob receives visits from Amir, who supplies truffles to high-end restaurants. One day, Rob’s pig is stolen by unidentified assailants. Rob, blaming Amir because he had spread word in town about the pig’s abilities, asks Amir to accompany him to Portland and find his pig. The duo goes through an odyssey with the hope of rescuing Rob’s lost love. The portrayal of Rob, who shows traits of autism spectrum disorder, such as impaired social skills and a restrictive pattern of interests, is laudable. His fixation on cooking and food makes him the best chef and truffle forager in town. Rob copes with his loss with support from an unlikely friend. Despite being very different, like Rob, Amir is also coping with the loss of an important figure in his life. As such, a peculiar bond and attachment is formed between the two, and this human connection across differences has a healing power.

Lies, Suicide, and Growing Up in Dear Evan Hansen
Donald Fidler, MD

The movie version of this Broadway musical, Dear Evan Hansen, is populated with mental health issues. In this story, both teenagers and adult parents present their guarded, inauthentic selves to the world. As often happens in worthwhile musicals and operas, when characters sing, their true selves burst out of mental shackles. “Why should I play this game of pretend?” asks Evan, the protagonist, played by young actor Ben Platt, who originated the Broadway role. He painfully stutters incoherent phrases, retracting and contradicting every word, avoiding eye contact with his world. He is on a trio of psychiatric medications. His single-parent mother unconsciously imprisons him by considering him “sick.”

A schoolmate’s mother embraces the pathologically shy Evan, mistakenly believing he was close friends with her son, Connor, who recently died by suicide. In fact, the only moment of contact between the boys was when Connor bullied Evan. However, Evan not only perpetuates the lie, but develops a fantasy of his and Connor’s friendship, using Connor as an idealized transitional object, a teddy-bear of warmth. As long as Evan is immersed in the lie, Connor’s family welcomes Evan into an accepting family he never had, and his awkwardness fades. Eventually, his lie thrusts him onto the world stage as an icon for adolescent mental health. Evan appears a star, but inevitably, the lie is revealed and Evan’s world crashes. Will traumatized Evan fall from grace or transform into maturity? Can real-world actions and emotions match truths that once were only sung in songs? Sometimes in therapy and the outside clinical world, disillusionment leads to growth.

Coming of Age in Never Have I Ever
Christopher Snowdy, MD

Never Have I Ever is a coming-of-age comedy whose second season launched this past July. Never’s central protagonist, Devi Vishwakumar (played by Mauliery Ramakrishnan), is a 15-year-old Indian-American girl. Less than 5 minutes into the first episode, narrator John McEnroe (yes, that John McEnroe) tells us that Devi’s parents immigrated to the United States in September 2001 (“Not a super-chill time to be a brown person in America”); her father died of a sudden heart attack during her freshman year; she developed functional paralysis in her legs shortly thereafter; and the paralysis resolved suddenly 3 months later while she was stretching to get a look at her crush. Devi is an overwhelming nerd struggling with the unprocessed grief of her father’s death, her complicated relationship with her mother, and her cultural identity. The conflict of the show hinges on Devi’s vows to improve her social status and experience “normal” American teenage life.

The show’s pacing and occasionally over-the-top performances set the tone for its comedic content, but they also mirror aspects of the adolescent experience that can be confusing, chaotic, clumsy, and replete with drama. While not all the psychiatric themes feel authentic (eg, the paralysis resolution), the underlying struggles of the teens generally do, and the show tackles issues including grief, coming out, family dynamics, and, briefly, anorexia. Similarly, Devi’s exchanges with her therapist (played by Niecy Nash) are often too compressed and laden with wit to serve as a how-to for supportive therapy, but, far more important, they do provide a positive, destigmatizing depiction of a helpful therapeutic relationship. On its surface, Never Have I Ever is a typical teen rom-com, but at its core, it has a lot of heart.

Dr Magno is a fellow of the Group for the Advancement of Psychiatry Committee on Arts and Humanities. Dr Sasso is chair of the Group for the Advancement of Psychiatry Committee on Arts and Humanities. Other committee members include Anish Ranjan Dube, MD, MPH; Fernando Espí Forcén, MD, PhD; Donald C. Fidler, MD; Andrew Lustbader, MD; Christopher Snowdy, MD; Kenneth J. Weiss, MD; and Helena Winston, MD, MPH, MS.
The Assessment of Depression Among Older Adults

Rajesh R. Tampi, MD, MS, DFAPA, DFAQG; Deena J. Tampi, MSN, MBA-HCA, RN, DFAQG

According to the DSM-5, major depressive disorder (MDD) is a condition that is characterized by the presence of depressed mood or marked loss of interest or pleasure in activities. Other symptoms associated with MDD include changes in sleep, energy, concentration, appetite, weight (changes in 5% of total body weight), and psychomotor activity. Additionally, individuals present with feelings of inappropriate guilt or worthlessness and recurrent thoughts of death or suicide. Furthermore, these symptoms should cause clinically significant distress or impairments in social, occupational, or other areas of functioning. Also, these episodes of depression should not be attributable to the psychological effects of substances or medical conditions. To meet the criteria for an MDD, an individual should have depressed mood or marked loss of interest or pleasure in activities, plus 4 associated symptoms. These symptoms should have occurred during the same 2-week period.

The term late-life depression (LLD) is specifically used to describe depression that occurs among individuals 65 years or older who do not have a previous history of depression. Table 1 describes the prevalence rates for depression among older adults.1

Table 1. Prevalence Rates for Depression Among Older Adults

<table>
<thead>
<tr>
<th>Type</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive symptoms</td>
<td>30% and 45%5,6</td>
</tr>
<tr>
<td>MDD among community-dwelling older adults</td>
<td>Approximately 2%3,5</td>
</tr>
<tr>
<td>MDD among older adults who attend primary care clinics</td>
<td>6% to 9%4</td>
</tr>
<tr>
<td>MDD among older adults who are admitted to acute care hospitals</td>
<td>10% to 12%6</td>
</tr>
<tr>
<td>MDD among older adults who live at nursing homes</td>
<td>12% to 14%2</td>
</tr>
</tbody>
</table>

MDD, major depressive disorder.

**ACTIVITY GOAL**
The goal of this activity is to review the epidemiology, risk factors, and evidence-based assessment of depression among older adults.

**LEARNING OBJECTIVES**
1. To describe the epidemiology and risk factors for depression among older adults
2. To discuss the assessment of depression among older adults

**TARGET AUDIENCE**
This accredited continuing education (CE) activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals seeking to improve the care of patients with mental health disorders.

**ACCREDITATION/CREDIT DESIGNATION/FINANCIAL SUPPORT**
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Presentation

The presentation of MDD in older adults differs from the presentation of MDD among younger adults.13-15 Table 2 highlights the differences between MDD in older adults vs younger adults.13-15

**Psychotic Depression**

MDD with psychotic symptoms accounts for approximately 25% to 50% of admissions to inpatient geriatric psychiatry units.10 Nihilistic, somatic, or poverty-based delusions are often seen among older adults with MDD. These individuals also have greater rates of insomnia, somatic symptoms, diurnal variation of mood, and poor insight into their illness.13,15 Among older individuals with MDD, hallucinations appear to occur less frequently than delusions.

The risk factors for the development of psychotic symptoms among older adults with MDD include being single, widowed, or living alone.10 The presence of psychotic symptoms in older patients with MDD is a poor prognostic factor. These individuals present with frequent recurrences of symptoms that result in hospitalizations.12 Age-related deterioration of the cortical areas of the brain, neurochemical changes commonly seen with aging, comorbid medical conditions, social isolation, sensory deficits, cognitive decline, and polypharmacy are all considered possible reasons for the occurrence of psychotic symptoms among older adults with MDD.13

**Relationship Between Depression and Dementia**

Depression and dementia in older adults have a similar presentation and share an important relationship.11,12 Older adults with MDD are more likely to develop cognitive deficits when compared with their age- and education-matched counterparts without depression.13,14 Approximately 20% to 50% of older adults with depression develop cognitive deficits, including executive dysfunction and deficits in information processing and visuospatial functioning.13,14 Depressive pseudodementia or depression-associated dementia are the reversible cognitive deficits that are often seen during an episode of depression and that tend to improve with the treatment of the depressive episode.13

Often, the occurrence of depressive symptoms can be the presenting symptom of dementia in this patient population. It is still unclear from available evidence whether an episode of depression is a prodrome for the onset of dementia, a risk factor for dementia, or an independent event.10 Table 3 describes the symptoms that primarily occur among individuals with depression-associated dementia when compared with a primary dementia.17

**Neurobiology**

Current evidence indicates that LLD occurs due to the complex interactions among the various biological, psychological, and sociological factors seen among older adults.14 Table 4 describes the various biological, psychological, and sociological factors that result in the development of depression among older adults.19-26

Table 2. Differences Between MDD in Older Adults vs Younger Adults

<table>
<thead>
<tr>
<th>MDD in older adults</th>
<th>MDD in younger adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less likely to have a family history of depression13,15</td>
<td>More likely to have a family history of depression13,15</td>
</tr>
<tr>
<td>More agitation, hypochondriasis, and general as well as gastrointestinal somatic symptoms12</td>
<td>Less agitation, hypochondriasis, and general as well as gastrointestinal somatic symptoms12</td>
</tr>
<tr>
<td>Less guilt and less loss of sexual interest12</td>
<td>More guilt and greater loss of sexual interest12</td>
</tr>
<tr>
<td>Greater rates of psychotic symptoms13</td>
<td>Lesser rates of psychotic symptoms13</td>
</tr>
</tbody>
</table>

MDD, major depressive disorder.

Table 3. Symptoms of Depression-Associated Dementia Compared With Primary Dementia17

- Acute onset of symptoms
- Presence of significant guilt or self-reproach
- Diurnal variations in mood
- Poor effort on cognitive testing
- Significant impairment in both registration and recall
- Absence of deficits in multiple cognitive domains
- Improvement of symptoms with sleep deprivation

Table 4. Biological, Psychological, and Sociological Factors That May Result in Depression Among Older Adults

<table>
<thead>
<tr>
<th>Biological</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Association with common medical disorders</td>
</tr>
<tr>
<td>• Approximately 25% of older adults who are status post-cerebrovascular accident develop MDD.17 They often have colocalization of atrophy and ischemic lesions, especially in the frontotriatal, limbic, and subcortical regions.24 These individuals often present with psychomotor retardation, reduced interest in activities, and poor insight into their illness.2</td>
</tr>
<tr>
<td>• Approximately 40% of older adults with Parkinson disease develop MDD.19</td>
</tr>
<tr>
<td>• Approximately 25% of older adults who are status post-myocardial ischemia develop MDD.20,21</td>
</tr>
<tr>
<td>B. Association with common medications21</td>
</tr>
<tr>
<td>• Antihypertensive medications (eg, methyldopa, reserpine, clonidine, hydralazine)</td>
</tr>
<tr>
<td>• Anti-Parkinson drugs (eg, levodopa)</td>
</tr>
<tr>
<td>• Anticancer drugs (eg, tamoxifen, vinblastine, vincristine)</td>
</tr>
<tr>
<td>• Hormonal agents (eg, estrogen, progesterone)</td>
</tr>
<tr>
<td>• Benzodiazepines</td>
</tr>
<tr>
<td>• Corticosteroids</td>
</tr>
<tr>
<td>• Cimetidine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Neuroticism, pessimistic thinking, and less open attitudes to new experiences have been found to predict the development of depression and suicidal ideation among older adults.12-24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Isolation, bereavement, functional decline, and disability are associated with the development of depression among older adults.25</td>
</tr>
<tr>
<td>• Depression is common among older caregivers when caregiving is long-term, or the person receiving the care has behavioral issues, or the caregiver has limited social supports.25</td>
</tr>
</tbody>
</table>

MDD, major depressive disorder.
Table 5. Medical, Social, and Societal Consequences of Depression in Older Adults

<table>
<thead>
<tr>
<th>Comorbidities</th>
<th>More likely to have a comorbid anxiety disorder and substance use disorder$^{28}$</th>
<th>Depression is a known risk factor for all-cause dementia, including Alzheimer disease and vascular dementia.$^{32}$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More chronic diseases (eg, arthritis and heart diseases) when compared with older adults without depression</td>
<td>The relationship appears to be bidirectional, with depression worsening the outcomes for comorbid medical conditions and comorbid medical illness worsening the outcomes for depression.$^{23}$</td>
</tr>
<tr>
<td></td>
<td>Greater risk for inflammatory activity, bone resorption, cancer, heart disease, and death from heart disease$^{29-31}$</td>
<td></td>
</tr>
<tr>
<td>Suicides</td>
<td>Approximately 15% greater lifetime risk for suicide when compared with age-matched controls$^1$</td>
<td>Among the completers of suicide, about 75% had depression and had visited their primary care physician within the preceding month.$^7$</td>
</tr>
<tr>
<td></td>
<td>Approximately 10% of these individuals die annually from completed suicides.</td>
<td>Suicides due to depression result in an additional $5.4$ billion per year in mortality costs.$^{26}$</td>
</tr>
<tr>
<td></td>
<td>5 times more likely to commit suicide than the general population$^{21}$</td>
<td>Risk factors: comorbid medical disorders, psychiatric disorders, substance use disorders, certain personality traits, and severe social stressors$^{2,19,20}$</td>
</tr>
<tr>
<td>Socioeconomic Factors</td>
<td>Associated with reduced or lost workplace productivity and greater health care utilization$^{20,27}$</td>
<td>About $26.1$ billion yearly is spent on direct medical costs for depression; $51.5$ billion is lost due to workplace costs including absenteeism.$^{26}$</td>
</tr>
</tbody>
</table>

Table 6. Salient Features of Rating Instruments for Depression Among Older Adults$^{20}$

<table>
<thead>
<tr>
<th>Rating instrument</th>
<th>Salient features</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDS</td>
<td>Most commonly used screening tool for evaluating depression among older adults in primary care clinics and day-treatment programs</td>
</tr>
<tr>
<td></td>
<td>Reliable and valid instrument that is available in several languages</td>
</tr>
<tr>
<td></td>
<td>Limited validity when used among older individuals with moderate-to-severe cognitive impairment</td>
</tr>
<tr>
<td>CSDD</td>
<td>Useful for assessing depression among older adults with depression and mild-to-moderate dementia</td>
</tr>
<tr>
<td></td>
<td>Needs a trained rater, needs caregiver input, and takes longer to complete</td>
</tr>
<tr>
<td>HAM-D</td>
<td>Less sensitive instrument in eliciting depressive symptoms among older adults when compared with GDS$^{31,32}$</td>
</tr>
<tr>
<td>MADRS</td>
<td>Does not assess for somatic symptoms</td>
</tr>
<tr>
<td>SDS</td>
<td>Sensitivity among older adults is limited by the use of graded responses, the lack of assessment of somatic symptoms, and the high occurrence of false-positive rates.</td>
</tr>
</tbody>
</table>

male gender, sleep disturbance, bereavement, and the presence of disability.$^{27}$

Consequences
As with younger patients, depression among older adults can result in various poor outcomes. Older adults with depression have 1.5 to 3 times greater morbidity when compared with older adults without depression.$^1$ Table 5 describes the medical, social, and societal consequences of depression in older adults.$^{35,37}$

Assessment
Current evidence indicates that almost 50% of older adults who have MDD go undiagnosed; a major reason for this is that the initial evaluation of these individuals for psychiatric symptoms is often completed by their primary physician rather than a psychiatrist.$^{38,39}$ Additionally, many of these individuals do not report depressive symptoms; instead, they present with somatic complaints, cognitive difficulties, and/or functional changes.$^{37}$ Any older adult who presents with these symptoms should always be screened for possible depression.

The assessment of depression among older adults starts with a thorough history, which should be obtained from the patient and, if possible, a knowledgeable informant.$^{3}$ In addition, these individuals should have a comprehensive medical and psychosocial assessment. There should also be a suicide risk assessment, a cognitive screening, and a functional evaluation.

The use of standardized screening instruments can assist with the diagnosis of depression and the screening for suicide.$^{3}$ In addition, these instruments can help with assessing the severity of depression, identifying psychotropic symptoms, and assessing treatment responses. The common screening tools for depression in older adults are the Geriatric Depression Scale (GDS), the Cornell Scale for Depression in Dementia (CSDD), the Hamilton Rating Scale for Depression (HAM-D), the Montgomery-Asberg Depression Rating Scale (MADRS), and the Zung Self-Rating Depression Scale (SDS). The Brief Psychiatric Rating Scale is the most commonly used scale to detect and rate the severity of psychopathology among older adults with depression and psychotic symptoms. Table 6 discusses the salient features of these rating instruments.$^{40,42}$

A thorough physical examination is an important part of the assessment, as these individuals have greater rates of medical comorbidities when compared with age-matched controls.$^{37}$ Table 7 specifies the medical workup for older adults with depression.$^{43-45}$

Prognosis
Evidence indicates that depression is a chronic and relapsing illness.$^{39}$ Although approximately 25% of older adults with depression will achieve full remission with or without any treatment, another 25% will never achieve any treatment response.$^{2}$ The remaining 50% will have a waxing-and-waning course. Poor prognostic factors include the presence of psychotic features, comorbid medical illness, physical disability, and a lack of social supports.$^{1,16}$ The presence of medical comorbidities is a major risk factor for poor treatment response and poor antidepressant tolerability among these individuals.$^{46}$

Conclusions
Evidence indicates that depression is not an uncommon condition among older adults. Depression is often underdiagnosed in this patient population and is associated with poorer outcomes, including greater rates of morbidity and mortality. A thorough history should include ruling out medical causes and drug effects; a focused physical examination; and appropriate laboratory studies, including neuroimaging and neuropsychological testing when necessary, as these are important in identifying depression among older adults.

Depression remains a chronic and relapsing illness, with approximately half of the individuals...
having a waxing-and-waning course. The presence of psychotic symptoms, medical comorbidities, and physical disability, and the absence of social supports, worsens prognosis for depression among older adults.

Dr Tampi is professor and chairman, Department of Psychiatry, Creighton University School of Medicine and Catholic Health Initiatives (CHI) Health Behavioral Health Services, Omaha, Nebraska. He is also an adjunct professor of psychiatry at Yale School of Medicine. Ms Tampi is cofounder and managing principal, Behavioral Health Advisory Group, Princeton, New Jersey.

REFERENCES

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We're committed to making Better Health easier. Looking for an amazing place to live, work and play? We're actively recruiting physicians specializing in psychiatry to join our dynamic and growing multi-specialty physician group with opportunities throughout New York City! Comprised of over 4,000 physicians and healthcare professionals, our culturally diverse and world-class teams provide services to NYC Health + Hospitals (H+H), the largest public health system in the United States.

Become part of our North Bronx Healthcare Network, affiliated with Albert Einstein College of Medicine, and located in attractive and safe residential Bronx neighborhoods, just 20 minutes from Manhattan. Our facilities offer a full continuum of acute care inpatient and outpatient services within diverse Medical and Surgical specialties, including Psychiatry. Along with employing evidence-based best practices in providing the highest level of quality care to our patients, we utilize a patient-centered approach that is respectful of their individuality, culture, and community.

We're actively recruiting physicians specializing in psychiatry to join our dynamic and growing multi-specialty physician group with opportunities throughout New York City! Comprised of over 4,000 physicians and healthcare professionals, our culturally diverse and world-class teams provide services to NYC Health + Hospitals (H+H), the largest public health system in the United States. Become part of our North Bronx Healthcare Network, affiliated with Albert Einstein College of Medicine, and located in attractive and safe residential Bronx neighborhoods, just 20 minutes from Manhattan. Our facilities offer a full continuum of acute care inpatient and outpatient services within diverse Medical and Surgical specialties, including Psychiatry. Along with employing evidence-based best practices in providing the highest level of quality care to our patients, we utilize a patient-centered approach that is respectful of their individuality, culture, and community.

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New York City Health + Hospitals/North Central Bronx
The Department of Psychiatry has 70 Adult and Geriatric Acute Inpatient Beds, a Partial Hospital Program, Psychiatric Emergency Service, Consultation-Liaison Service, an Adult Ambulatory Practice, and a community-based Assertive Community Treatment Program. Openings available include:

- Director of Psychiatry - Emergency Services
- Attending Psychiatrist - Inpatient Psychiatry Service
- Attending Psychiatrist - Psychiatric Emergency Service
- Attending Psychiatrist - Partial Hospital Program
- Attending Psychiatrist - Inpatient Geriatric Psychiatry Service

- Incentive Bonuses Available for Qualified Candidates/Providers!
- Moonlighting opportunities also available!
- Academic appointments at Albert Einstein College of Medicine offered!
- Proof of Covid-19 vaccination is required prior to hire.

We offer a generous compensation package, along with unparalleled health benefits, opportunities for advancement, retirement plan, malpractice, Sponsorship for H1 & J1 Visas, and much more! For immediate consideration, please contact Joe Mastov – Physician Recruiter, at: Mastov@pagny.org, call 646-895-3875, or apply online at: www.pagny.org

Northwell Health’s Behavioral Health Service Line strives to address the diverse mental health needs of the communities we serve by providing a continuum of accessible, high quality psychiatric and substance abuse services including emergency, crisis, inpatient, and outpatient programs for people of all ages. Northwell’s clinical programs are complemented by a robust education, training, and research enterprise, including the world-renowned Psychiatry Research Department at The Zucker Hillside Hospital, which has led cutting-edge investigations that have meaningfully influenced many lives.

WE ARE RECRUITING BOARD ELIGIBLE/BOARD CERTIFIED PSYCHIATRISTS FOR THE FOLLOWING POSITIONS:

**NORTHERN WESTCHESTER HOSPITAL**
Westchester, NY
- Associate Director

**COHEN CHILDREN’S MEDICAL CENTER**
New Hyde Park, NY
- Child and Adolescent Psychiatrist, School Mental Health
- Psychiatrist for Emergency Department

**PHELPS MEMORIAL HOSPITAL**
Sleepy Hollow, NY
- Outpatient Psychiatrist, Continuing Day Treatment Program

**STATEN ISLAND UNIVERSITY HOSPITAL**
Staten Island, NY
- Addiction Psychiatrist
- Addiction Physician, Part-Time (Brooklyn)
- Vice Chair

**THE ZUCKER HILLSIDE HOSPITAL**
Glen Oaks, NY
- Physician-in-Charge, Perinatal Psychiatry
- Adult Inpatient Psychiatrist
- Psychiatrist ETP Program, Part-Time
- Medical Director, Transgender Medicine, Part-Time
- Outpatient Child and Adolescent Psychiatrist

**LONG ISLAND JEWISH MEDICAL CENTER**
New Hyde Park, NY
- Psychiatrist for Emergency Department, Part-Time

**SOUTH OAKS HOSPITAL**
Amityville, NY
- Outpatient Child and Adolescent Psychiatrist
- Adult Inpatient Psychiatrist
- Evaluations/Admissions Psychiatrist

**SOUTH OAKS HOSPITAL**
Amityville, NY
- Outpatient Child and Adolescent Psychiatrist
- Adult Inpatient Psychiatrist
- Evaluations/Admissions Psychiatrist

Benefits at Northwell Health include:

- Nationally competitive salaries
- Comprehensive benefits package
- Four weeks’ vacation plus paid conference/CME time
- Academic appointment commensurate with experience
- Advanced education opportunities
- College Tuition reimbursement for dependent children

Qualified candidates should forward their CV to Alice Perkins, OPR@Northwell.edu.
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Jules Leo
(609) 495-4367
jleo@mhmgroup.com

As the largest public health care system in northern California, we offer comprehensive healthcare resources to a large and diverse patient population. Psychiatrists are part of a robust team of staff that work in collaboration with other medical specialties and behavioral health clinicians to provide integrated health care to patients.

Psychiatrists are eligible for numerous benefits including 36 days of annual leave, 5 days of educational leave, 12 holidays, $4500 educational funds, health benefits, life insurance and CalPERS retirement plan. No calls required.

In addition, part-time opportunities for BE/BC psychiatrists, PGY IIs and IVs are available.

If you are interested in working in a dynamic and collegial work environment, please submit a CV and letter of interest to MD.Recruitment@hhs.sccgov.org.

The County of Santa Clara is an Equal Opportunity.

PSYCHIATRIST to work full-time in Manteca, CA. Must have CA medical license. Send CV to Mark David Levine, M.D. Professional Corporation 3835 N. Freeway Blvd., Ste 100, Sacramento, CA 95834 or email to: ewen@cpych.com

Our competitive rates can help you promote physician products and services.

Multi-Specialty Teledmedicine Group
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OUTPATIENT Full-time
TELE-PsYCHIATRY POSITION
BE/BC ADULT PSYCHIATRIST licensed or willing to practice in CA. Practice from current State of Residence
Candidate has to be EHR and Computer proficient. You will be doing Psychiatric Evaluations & Med Mgt of SMI patients in County MH Clinics. There is no On-Call. Income potential of $340-$405K, plus CA Lic, DEA and Malpractice is paid, 1099 income. Scan QR code to Apply:

Send CV to Garewalmd@gmail.com, or fax CV to (661) 368-0826

Hawai’i

CHILD & ADOLESCENT MENTAL HEALTH DIVISION

CHILD PSYCHIATRIST – OUTPATIENT
Join the team at the Central O’ahu Family Guidance Center (FGC) of the Child & Adolescent Mental Health Division (CAMHD). We are seeking board certified/eligible psychiatrists.

For more information, visit: health.hawaii.gov/camhd/employment

Submit completed State of Hawai’i Application for Non-Civil Service Appointment, resume, (3) references, and salary requirements to: Kurt Humphrey, M.D. Kurt.Humphrey@doh.hawaii.gov

For more information, visit: health.hawaii.gov/camhd/employment

Full-time psychiatrist for a large public health & hospital system in the Silicon Valley
$275,080 -$357,600 annually 36 days of annual leave Full benefits & retirement
(Above annual salary includes additional pay for Board Certification and Acute Settings)

Santa Clara Valley Health and Hospital System, a public healthcare system in the heart of Silicon Valley, is seeking full-time BE/BC psychiatrists for a variety of clinical settings, including emergency psychiatric services, inpatient consultation liaison services, jail custody health inpatient services, specialty mental health outpatient services and primary care behavioral health services.

www.dosmadres.com or Amazon.com

“Psychiatry, Medicine, and Poetry mix and mingle in Richard Berlin’s poignant reveal of the unspoken and unknown parts of a healer. This is a magical book all healers will take comfort in. Buy and treasure. Also the perfect gift for a friend or colleague.”

- STEVE BIERMAN, MD

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Psychiatry Position Excellent Opportunity in California

Imperial County Behavioral Health Services is currently recruiting for full-time or part-time psychiatrists. Imperial County, a rich farming area with a population of 180,000, is located 90 miles east of San Diego, 90 miles south of Palm Springs, 60 miles west of Yuma, Arizona, and just north of the cosmopolitan city of Mexicali, Mexico. San Diego State University maintains a satellite campus in Calexico, and there are several private and public universities located in Mexicali. Imperial County’s location and diversity make it the perfect place for any professional.

The position pays a highly competitive salary, including health benefits for you and your family, requires no hospital work and minimal after-hours work, freeing you up for more leisurely activities. As a Psychiatrist with Imperial County Behavioral Health, you will be part of a multi-disciplinary treatment team that includes therapists, nurses and rehabilitation technicians that provide comprehensive support and resources to assist clients in achieving recovery.

J-1 and H-1B Applicants welcome. Our agency is experienced in successfully processing J-1 Waiver and H-1B Visa applicants.

Qualified candidates must have a CA medical license or ability to obtain. Send CV to Imperial County Behavioral Health Services, 202 North 8th Street, El Centro, CA 92243.

For additional information, please contact: Marcy Sesma (442) 265-1605 marcysesma@co.imperial.ca.us

OUTPATIENT Full-time PRACTITIONERS, INC

TELE-PSYCHIATRY POSITION

San Joaquin County Behavioral Health Services is seeking to fill Outpatient Adult [General], and Sub-Specialty Psychiatry (Child Psychiatry, Geriatric, Forensic, Addiction and Psychosomatic Medicine) positions in a multidisciplinary, recovery-oriented clinical setting. Services are provided either on-site or using a hybrid model of on-site and tele-psychiatry practice. The positions offer a very competitive salary with a guaranteed base, plus incentive opportunities, board certified Psychiatrists have the potential to easily earn over 300K+ a year; comprehensive health insurance; up to three retirement and pension programs; 35 days of vacation and CME time that increase with tenure. Signing and moving bonuses are also available.

Interested J-1 and H-1B candidates are welcome to apply.

Fax your CV to 209-468-2399 or email to: BHSadministration@sjcbhs.org. EOE

Full-time psychiatrist for a large public health & hospital system in the Silicon Valley
$275,080 -$357,600 annually 36 days of annual leave Full benefits & retirement
(Above annual salary includes additional pay for Board Certification and Acute Settings)

Santa Clara Valley Medical Center Hospital & Clinics

Full-time psychiatrist for a large public health & hospital system in the Silicon Valley
$275,080 -$357,600 annually 36 days of annual leave Full benefits & retirement
(Above annual salary includes additional pay for Board Certification and Acute Settings)

Santa Clara Valley Health and Hospital System, a public healthcare system in the heart of Silicon Valley, is seeking full-time BE/BC psychiatrists for a variety of clinical settings, including emergency psychiatric services, inpatient consultation liaison services, jail custody health inpatient services, specialty mental health outpatient services and primary care behavioral health services.
 MASSACHUSETTS

Cape Cod Healthcare
Cape Cod, Massachusetts
Live and Work Oceanside

New Inpatient/Outpatient Opportunity - Immediate full time opening for BC/BE Adult and/or Geriatric psychiatrist. 40 hour-per-week position in our outpatient clinic in Hyannis, MA every other week and our inpatient 20-bed locked unit the alternating week. Schedule is Monday through Friday. Must also work one weekend on-call (twice a month). No weekend on-call duty is required but available if interested with extra compensation attached. Inpatient responsibilities include: timely evaluation of half of the inpatient unit census. You will be working with another psychiatrist in the unit as well as a psych APRN. Outpatient responsibilities include: evaluations and follow-up appointments for psychiatric patients requiring medication management. Consultation/collaboration with other clinical staff on shared cases as needed.

*Potential to be a full inpatient position if interested.

This will be an employed position by Cape Cod Healthcare with a generous base salary, sign-on bonus, and relocation support.

Please take some time to look at the Cape Cod Healthcare website at https://www.capecodhealth.org/medical-services/behavioral-health/

Enjoy coastal living at its best! Miles of sandy beaches for your enjoyment, quaint villages, and beautiful sunsets over Cape Cod Bay make this a great place to practice medicine and enjoy the amenities the Cape has to offer. It is truly a wonderful place to live and work.

If you are interested in speaking further about our position, please email me your CV and the best day/time you are available to talk.

Jolia Georges, Director of Physician Recruitment
Phone: 508-862-5481
jgeorges@capecodhealth.org

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MICHIGAN

Seeking Medical Director
Who Wants the Freedom to Truly Lead, Grow and Develop BH Programs

Seeking a Psychiatrist for an amazing opportunity to be Medical Director over a 116-bed Behavioral Health Service (33 C/A; 60 adults; 16 geriatric patients; and 7 adults for Chemical Dependency). There is no ER here; this is a specialized freestanding facility whose entire focus is recovery, specializing in rehabilitation after surgery, debilitating illness, injury, chemical dependency or mental health issues. Healthsource is not part of a large health system that can tie your hands when it comes to leading, growing and developing behavioral health programs. At Healthsource, the Medical Director will have to freedom to do just that; and there is a top-notch behavioral health team already in place to work with every day. The piece missing is the Psychiatrist to lead the way as the Medical Director.

Contact: Terry Good; 804-684-5241; terry.good@horizonhealth.com. EOE

QUALITY FOR A FREE SUBSCRIPTION ONLINE @ www.psychiatrictimes.com

Neurodevelopmental Child/Adolescent Inpatient Psychiatry

The NEW CHA Center of Excellence for Child/Adolescent Inpatient Mental Health Care at Somerville will provide a continuum of patient- and family-centered care for diverse youth with mental health needs. Including specialized autism spectrum/ neurodevelopmental beds.

Salaries starting at $300,000 and Sign on Bonuses!

- Provide clinical care to patients during periods of inpatient/partial hospitalization
- Develop and maintain comprehensive treatment plans
- Participate in teaching opportunities
- Work in a collaborative practice environment
- Fully integrated electronic medical record (Epic) and robust interpreter service
- Academic appointments available
- Must be BC/BE in Psychiatry
- Candidates with special interest/training in Neurodevelopment encouraged to apply

Submit CV’s to ProviderRecruitment@challiance.org. Visit CHAProviders.org for more information.

In keeping with federal, state and local laws, CHA policy forbids employees and associates to discriminate against anyone based on race, religion, color, gender, age, marital status, national origin, sexual orientation, relationship identity or relationship structure, gender identity or expression, veteran status, disability or any other characteristic protected by law.
NORTH CAROLINA

We Want You to Join Our Behavioral Health Team!
Cape Fear Valley Behavioral Health is one of the largest comprehensive, multi-tiered behavioral health services in North Carolina. Behavioral Health Care’s mission is to meet and respond to the mental health needs of the community. We offer evidence-based, best practice treatments.
Stuffed by psychiatrists, psychologists, clinical social workers, psychiatric nurses, licensed professional counselors, and other mental health professionals, Cape Fear Valley Behavioral Health Care provides a team approach to mental wellness.
Behavioral Health Care is accredited by The Joint Commission and licensed by the State of North Carolina.
The Health System is seeking providers for the following due to regional volumes and commitment to expand services:

Emergency Opportunity
• Two BE/BC providers with experience in ED or trained in ED/Psychiatry. The Emergency Department maintains a Psychiatric Unit of 9 beds for patients in crisis. Support team is specialty trained.
  Schedule consists of 16 hour shifts, approximately 10 shifts per month.

Adult Outpatient Opportunity
• BE/BC provider with training/experience in a variety of mental health treatment conditions as well as Chemical Dependency and Substance Abuse. Candidate with experience in treatment of Bipolar Disorder, Borderline Personality Disorder, and Mood Disorders is preferred.
  Additionally, ECT training and experience is highly desirable. Well established adult team is flexible and transparent for either or both inpatient and outpatient services.
  Clinic hours are Monday - Friday with limited call

Child Outpatient Opportunity
• BE/BC Child & Adolescent providers. The current structure is for 90% outpatient Monday through Friday work schedule.
  We offer best in class compensation plus generous benefits including Paid Malpractice, CME Time and Allowance, Accrued Paid Time Off, 403(b) match and 457(b), Health, Dental, and other desirable benefits.
  Please contact Suzy Cobb, Physician Recruiter for more details at (910) 615-1889 or scobb2@capecarevalley.com

The Health System is flexible and transparent for either or both inpatient care or specific portion of day with the current structure for 90% outpatient.

Behavioral Health Care’s mission is to meet and respond to the mental health needs of the community. We offer evidence-based, best practice treatments.

The current structure is for 90% outpatient Monday through Friday work schedule.

Hackensack Meridian Health is a leading not-for-profit health care network in New Jersey offering a complete range of medical services, innovative research, and life-enhancing care aiming to serve as a national model for changing and simplifying health care delivery through partnerships with innovative companies and focusing on quality and safety.
Through a partnership between Hackensack Meridian Health and Seton Hall University, the School of Medicine will re-define graduate medical education, research, and clinical practice; reverse the critical physician shortage in both the New York/New Jersey metropolitan area and the nation; and stimulate economic development in northern New Jersey.
The School of Medicine will be the anchor in the development of a comprehensive health sciences campus that will also include research facilities and biotechnology endeavors – all in service of educating tomorrow’s doctors, discovering novel therapies, and facilitating compassionate and effective healthcare that will meet the ever-changing needs of tomorrow’s patients.
The School of Medicine will be the cornerstone of a dynamic venue for the exchange of ideas, the development of healthcare and research thought leaders and practitioners, and the discovery of novel therapies to meet the medical challenges of the future.
“Ocean Medical Center’s psychiatry program will be a community-based program,” said Ramon Snell, M.D., program director for psychiatry as well as founding Chair of Psychiatry & Behavioral Health at the Hackensack Meridian School of Medicine at Seton Hall University. “Our new psychiatry residency program will improve clinical care and ultimately encourage future health care leaders to build practices in the Jersey Shore area,”

As the area’s premier provider of psychiatric services, Hackensack Meridian Behavioral Health Services has provided comprehensive mental health and substance abuse services to the residents of Monmouth, Ocean, Middlesex, and Bergen Counties for over forty years. Due to continued growth and expansion, we are currently accepting applications for Psychiatrists to join our Mental Health and Addiction Interdisciplinary Teams in the following positions:

• Carrier Clinic - - Adult Staff Psychiatrist (Belle Mead, NJ)
• Inpatient - Raritan Bay Medical Center (Perth Amboy, NJ)
• Outpatient - Jersey Shore University Medical Center (Neptune, NJ), Ocean Medical Center (Brick, NJ) and Southern Ocean Medical Center - (Manahawkin, NJ)
• Medical Director for Adult Inpatient Unit: Riverview Medical Center (Red Bank, NJ)
• Outpatient Child & Adolescent Psychiatrist: Hackensack University Medical Center (Hackensack, NJ) and Ocean University Medical Center (Brick, NJ)
• Geriatric Psychiatry: Hackensack University Medical Center (Hackensack, NJ)
• Outpatient Addiction: Jersey Shore University Medical Center (Neptune, NJ)

For immediate consideration, please contact Renee Theobald, at: Renee.Theobald@hackensackmeridian.org or call: 732 751-3597

HackensackMeridianHealth.org

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March 2022
UMass Memorial Health and the University of Massachusetts Chan Medical School currently have openings within the Department of Psychiatry.

The Department of Psychiatry is a national leader in addiction, biological, child and adolescent, and public sector, psychiatry, neuropsychiatry, psychosocial rehabilitation, and women’s mental health. We integrate our clinical, research, teaching and community partnership activities to help individuals and families transform their lives through recovery from mental illness and addiction. We are the largest provider of psychiatric services in central Massachusetts, with over 400 faculty members and 12 hospitals and community mental health centers in varied settings across the state, from urban clinics to beautiful shore-side facilities such as Cape Cod.

Our residency program trains 7 residents per year, including general psychiatry and specialty tracks for combined adult and child psychiatry and combined psychiatry and neurology. We offer fellowships in Addiction, Adult Developmental Disabilities, Child and Adolescent, Forensic Psychiatry, and Neuropsychiatry.

Diversity, equity, and inclusion are integral to the commitment of the Department and University. Accordingly, the Department seeks qualified candidates who can contribute to racial equity, diversity and inclusion through service, mentorship, teaching and scholarship. Further, the Department is keenly interested in diversifying its faculty and staff and encourages applications from diverse candidates. Candidates from historically underrepresented group(s) in higher education and medicine are encouraged to apply. Candidates who possess personal characteristics that might be considered as diversifying elements among the clinical team and the larger psychiatry faculty at UMMS are invited to identify themselves during the application process.

UMass Medical School

Area Medical Director, Department of Mental Health Office of Inpatient Management (Boston, MA): provide administrative and clinical oversight for the DMH operated facility-based service system statewide.

Full-Time Psychiatrist (Brockton Multi-Service Center, Brockton, MA): Outpatient services.

Full-Time Psychiatrist (Worcester Recovery Center and Hospital, Worcester, MA): 2 new inpatient positions for WRCH expansion.

Forensic Psychiatrist (Worcester Recovery Center and Hospital, Worcester, MA): Inpatient Evaluation and Treatment.

Forensic Psychologist (Worcester Recovery Center and Hospital, Worcester, MA): Provides evaluations of competence to stand trial, criminal responsibility, civil commitment, and aid-in sentencing.

Geriatric Researcher, Psychologist/Psychiatrist (UMMS, Worcester, MA)

Part-Time Psychiatrist (Pocasset): for the Partial Hospital Program at Cape Cod and Islands Mental Health Center

For additional information on the above, please contact: Marie Hobart, MD, Vice Chair, Public Sector Psychiatry marie.hobart@umassmed.edu

Interested applicants should apply directly at https://academicjobsonline.org/ajo/UMASSMED/Psych

(J-1 and H-1B candidates are welcome to apply)

UMass Memorial Health Care

Attending Psychiatrist Women’s Health, OPD (Worcester, MA): provide opportunities for integrating mental health care into obstetric settings through education, consultation, and telepsychiatry

(2) Associate Medical Director, CHL (Worcester and North County MA): Provide psychiatric and medical supervision

General Adult Outpatient Psychiatrist, CHL (Worcester, MA): Outpatient evaluation, consultation, and treatment, collaborating with other providers.

Medical Director, PTRC (Worcester, MA): Provide psychiatric and medical supervision services to mental health and substance abuse treatment to a 26-bed locked unit

Inpatient Psychiatrist, PTCR (Worcester, MA): Provide psychiatric services to mental health and substance abuse treatment to a 26-bed locked unit.

FT Clinical Rotating Adult Attending Psychiatrist (Worcester, MA): flexibility in clinical care, ranging from inpatient to emergency mental health services.

Interested applicants should submit a letter of interest and curriculum vitae addressed to Kimberly A. Yonkers, MD: c/o: Jessica Saintelus, Physician Recruiter Jessica.Saintelus@umassmemorial.org

http://jobs.jobvite.com/umassmemorialmedicalgroupphysicians/search?q=&d=Psychiatry

As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

Please consult Full Prescribing Information before use.

WARNING: CONCOMITANT USE WITH OPIOIDS; ABUSE, MISUSE, ADDICTION; and DEPENDENCE AND WITHDRAWAL

Concomitant use with opioids may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant use for patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation.

LOREEV XR exposes users to risks of abuse, misuse, and addiction, which can lead to overdose or death. Abuse and misuse commonly involve concomitant use of other medications, alcohol, and/or illicit substances, all of which are associated with an increased frequency of serious adverse outcomes. Before prescribing LOREEV XR and throughout treatment, assess each patient’s risk for abuse, misuse, and addiction.

Continued use of LOREEV XR may lead to clinically significant physical dependence. The risks of dependence and withdrawal increase with longer treatment duration and higher daily dose. Abrupt discontinuation or rapid dosage reduction of LOREEV XR after continued use may precipitate acute withdrawal reactions, which can be life-threatening. To reduce the risk of withdrawal reactions, use a gradual taper to discontinue LOREEV XR, or reduce the dosage.

INDICATIONS AND USAGE

LOREEV XR is indicated for the treatment of anxiety disorders in adults who are receiving stable, evenly divided, three times daily dosing with lorazepam tablets.

DOSE AND ADMINISTRATION

Recommended Dosage

Initiate LOREEV XR in those being treated with lorazepam tablets, administered three times daily in evenly divided doses. Discontinue lorazepam tablets and administer the first dose of LOREEV XR in the morning on the day after the final dose of lorazepam tablets.

Administration Information

Administer LOREEV XR orally once daily in the morning. Do not crush or chew. Swallow LOREEV XR capsules whole, or open the capsule and sprinkle over a tablespoon of applesauce, followed by drinking water. Consume sprinkled LOREEV XR in its entirety within 2 hours; do not store for future use.

Dosage Increase for Inadequate Clinical Response

If the clinical response to LOREEV XR is inadequate and a dosage increase is needed, discontinue LOREEV XR and switch to lorazepam tablets. If an adequate clinical response is achieved with a stable, evenly divided three times daily dosage of lorazepam tablets, resume LOREEV XR once-daily dosing with the total daily dose of lorazepam tablets.

Discontinuation or Dosage Reduction

To reduce the risk of withdrawal reactions, use a gradual taper to discontinue LOREEV XR, or reduce the dosage. If a patient develops withdrawal reactions, consider pausing the taper or increasing the dosage to the previous tapered dosage level. Subsequently decrease the dosage more slowly.

Concomitant Use with UDP-glucuronosyltransferase (UGT) Inhibitors

If a UGT inhibitor is initiated during treatment with LOREEV XR, discontinue LOREEV XR and switch to lorazepam tablets to reduce the dosage.

CONTRAINDICATIONS

LOREEV XR is contraindicated in patients with:

- hypersensitivity to benzodiazepines or to any of the ingredients in LOREEV XR
- acute narrow-angle glaucoma

WARNINGS AND PRECAUTIONS

Dependence and Withdrawal Reactions

Acute Withdrawal Reactions

LOREEV XR may lead to clinically significant physical dependence. Abrupt discontinuation or rapid dosage reduction after continued use or administration of flumazenil may precipitate acute withdrawal reactions, which can be life-threatening.

Protracted Withdrawal Syndrome

In some cases, benzodiazepine users have withdrawal symptoms lasting weeks to more than 12 months.

Central Nervous System (CNS) Depression

LOREEV XR may produce CNS depression. Caution patients against engaging in hazardous occupations/activities requiring complete mental alertness, such as operating machinery or driving a motor vehicle. Alcohol should be avoided and other CNS depressant drugs used with caution.

Patients With Depression or Psychosis

LOREEV XR is not recommended for patients with a primary depressive disorder or psychosis. Preexisting depression may emerge or worsen during use. In patients with depression, a possibility for suicide should be borne in mind. LOREEV XR should not be used in such patients without adequate antidepressant therapy.

Risk of Paradoxical Reactions

Paradoxical reactions (agitation, irritability, impulsivity, violent behavior, confusion, restlessness, excitement, and talkativeness) have been reported during benzodiazepine use. Such reactions may be more likely to occur in the elderly. Discontinue LOREEV XR if the patient has these reactions.

Allergic Reactions to FD&C Yellow No. 5

LOREEV XR 1 mg capsules contain FD&C Yellow No. 5 (tartrazine), which may cause allergic-type reactions (including bronchial asthma) in certain susceptible persons. Although the overall incidence of sensitivity is low, it is frequently seen in patients who also have aspirin hypersensitivity.

Neonatal Sedation and Withdrawal Syndrome

Use of LOREEV XR during the later stages of pregnancy can result in sedation (respiratory depression, lethargy, hypotonia) and/or withdrawal symptoms (hyperreflexia, irritability, restlessness, tremors, inconsolable crying, and feeding difficulties) in the neonate. Monitor neonates during pregnancy and labor for signs of sedation and neonates exposed to LOREEV XR during pregnancy for signs of withdrawal; manage these infants accordingly.

Risk in Patients With Impaired Respiratory Function

In patients with impaired respiratory function, respiratory depression and apnea have been reported with benzodiazepines. Closely monitor patients with impaired respiratory function. If signs and symptoms of respiratory depression or apnea occur, consider discontinuing LOREEV XR.

Laboratory Tests

Leukopenia and elevations of lactate dehydrogenase (LDH) have developed in patients receiving lorazepam tablets. Periodic blood counts and liver function tests are recommended for patients on long-term therapy.

ADVERSE REACTIONS

In a sample of approximately 3,500 patients treated for anxiety, the most frequent adverse reactions to lorazepam tablets were sedation (15.9%), dizziness (6.3%), weakness (4.2%), and unsteadiness (3.4%). The incidence of sedation and unsteadiness increased with age. The following reported adverse reactions are categorized by System Organ Class (SOC):

- Blood and Lymphatic System Disorders: agranulocytosis, leukopenia, pancytopenia, thrombocytopenia;
- Endocrine Disorders: SIADH;
- Eye Disorder: eye function/visual disturbance (including diplopia and blurred vision);
- Gastrointestinal Disorder: constipation and gastrointestinal symptoms, including nausea;
- General Disorders and Administration Site Conditions: asthenia, fatigue, hypothermia;
- Hepatobiliary Disorders: jaundice;

(Cont’d)
WARNING: RISKS FROM CONCOMITANT USE WITH OPIOIDS; ABUSE, MISUSE, AND ADDICTION; and DEPENDENCE AND WITHDRAWAL REACTIONS

- Concomitant use with opioids may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant use for patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation.
- Use of LOREEV XR exposes users to risks of abuse, misuse, and addiction, which can lead to overdose or death. Before prescribing and throughout treatment, assess each patient's risk for abuse, misuse, and addiction.
- Abrupt discontinuation or rapid dosage reduction of LOREEV XR after continued use may precipitate acute withdrawal reactions, which can be life-threatening. To reduce this risk, use a gradual taper to discontinue or reduce the dosage.

**CONTRAINDICATIONS**
LOREEV XR is contraindicated in patients with:
- hypersensitivity to benzodiazepines or any ingredients in LOREEV XR
- acute narrow-angle glaucoma

**WARNINGS AND PRECAUTIONS**
Central Nervous System (CNS) Depression
- LOREEV XR may produce CNS depression. Caution against engaging in hazardous occupations or activities requiring complete mental alertness.
- Use alone and with other CNS depressants may lead to potentially fatal respiratory depression. Alcohol should be avoided, and other CNS depressants used with caution.

Patients with Depression or Psychosis
- LOREEV XR is not recommended in patients with a primary depressive disorder or psychosis. Preexisting depression may emerge or worsen.
- A possibility for suicide should be kept in mind in patients with depression. Benzodiazepines should not be used without adequate antidepressant therapy.

Risk of Paradoxical Reactions
- Paradoxical reactions have occasionally been reported during benzodiazepine use and are more likely to occur in the elderly. If this occurs, discontinue LOREEV XR.

Allergic Reactions to FD&C Yellow No. 5 (Tartrazine)
- LOREEV XR 1 mg capsules contain FD&C Yellow No. 5 (tartrazine), which may cause allergic-type reactions in certain individuals and is seen frequently in patients who also have aspirin hypersensitivity.

Neonatal Sedation and Withdrawal Syndrome
- LOREEV XR use during later stages of pregnancy can result in sedation and/or withdrawal symptoms in the neonate. Monitor neonates during pregnancy and labor for signs of sedation and withdrawal.

Risk in Patients With Impaired Respiratory Function
- Closely monitor patients taking LOREEV XR for impaired respiratory function, and consider discontinuing it if signs and symptoms of respiratory depression or apnea occur.

Laboratory Tests
- Leukopenia and elevations of lactase dehydrogenase (LDH) have developed in patients receiving lorazepam tablets. Periodic blood counts and liver function tests are recommended during long-term therapy.

**ADVERSE REACTIONS**
Most frequent adverse reactions in clinical trials were sedation (15.9%), dizziness (6.9%), weakness (4.2%), and unsteadiness (3.4%).

**DRUG INTERACTIONS**
Avoid initiation of UDP-glucuronosyltransferase (UGT) inhibitors. Dose reduction requires switching to lorazepam tablets for dose adjustment.

**USE IN SPECIFIC POPULATIONS**
Because of the potential for serious adverse reactions, breastfeeding is not recommended during treatment with LOREEV XR.

For additional safety information about LOREEV XR, visit loreevxrHCP.com for the LOREEV XR Full Prescribing Information.

Please see the accompanying Brief Summary.

You are encouraged to report negative side effects of prescription drugs to Almatica at 1-877-447-7979 or the FDA at www.fda.gov/medwatch, or call 1-800-FDA-1088.

NEW

LOREEV XR™ (LORAZEPAM) IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS
LOREEV XR is contraindicated in patients with:
• Hypersensitivity to benzodiazepines or any ingredients in LOREEV XR
• Acute narrow-angle glaucoma

Please see Important Safety Information continued on the back, and accompanying Full Prescribing Information, including BOXED WARNING, and Medication Guide.
IMPORTANT SAFETY INFORMATION (con’t)

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* Study design (N-48): Randomized, open-label, 2-way cross-over, 2-period, 2-sequence, 2-treatment, relative bioavailability study at steady state, with a 10-day washout period. Pharmacokinetic profile draws on day 8. Steady state was achieved by day 5.2