Contemporary psychiatric genetics has come a long way. While the strong familial and hereditary basis of psychiatric illness has been known for almost a century, buttressed by numerous family, twin, and adoption studies, understanding the molecular underpinnings has proven to be the hard part. The last decade of the 20th century witnessed a surge in genetic linkage and association studies. The former attempted to narrow down chromosomal regions likely to harbor vulnerability genes by studying samples of families with several affected members. The latter were typically focused on comparing the frequency of genetic variants in presumed candidate genes between samples of affected cases and unaffected controls. Alas, these approaches did not bring about the much-desired gain of knowledge, let alone the highly anticipated breakthroughs.

The field was characterized by a lack of replicable findings. Inconsistency of “discoveries” was the rule rather than the exception. Hence, in the waning years of the 20th century, a certain frustration was found among researchers; and this frustration...
The number of patients in the US presenting to the ED with psychiatric complaints has increased by more than 50% since 2006. One in eight ED visits now involves a psychiatric emergency. Meanwhile, the number of psychiatric inpatient beds continues to diminish.

A main driver of boarding is the belief that most patients experiencing psychiatric emergencies require inpatient admission. However, like physical complaints, mental health and substance abuse crises can often be stabilized in the ED. Imagine, for example, that we admitted everyone who presented to the ED with chest pain. If that were the case, we would be lamenting a national shortage of general hospital beds as well. (Fortunately, only 18% of chest pain patients are admitted from the ED to the hospital.) Research strongly suggests that if an appropriate treatment is started promptly, the majority of psychiatric emergencies can be resolved within 24 hours without inpatient hospitalization. To end boarding for this vulnerable population, we must implement effective ways to deliver timely psychiatric care in the ED.

An important clarification: it is completely appropriate for emergency psychiatric patients to come to medical EDs. In fact, the federal Emergency Medical Treatment and Active Labor Act categorizes psychiatric emergencies as equivalent to medical emergencies like trauma and heart attacks. Patients in psychiatric crisis therefore have the same legal requirements for prompt evaluation and stabilizing treatment.

Unfortunately, many systems have sought to divert psychiatric patients from the ED as if they do not belong there. However, psychiatric emergencies like suicidality and psychosis are life-threatening and require the highest level of care available. Thus, instead of looking for ways to avoid it, hospitals need to embrace and prepare for these patients’ urgent care needs, providing systems and procedures in place to provide an effective care environment for them.

Even where community resources are available, like mental health urgent care centers and crisis intervention programs, most of these sites cannot accept patients who are acutely agitated, actively suicidal, have a history of violence, are presently intoxicated or in substance withdrawal, or who have comorbid medical issues. This means sizable numbers of excluded patients will still need to go to hospital EDs for care. But because most EDs typically provide very limited psychiatric treatment, commonly the highest acuity psychiatric patients in any region are ironically the most underserved. (To put things in perspective, only about 16% of emergency physicians report having access to an on-call psychiatrist.)

Many psychiatrists may not realize that the average ED duration of stay for psychiatric patients ranges from seven to 34 hours in the US7—three times longer than patients presenting with physical illnesses and injuries.8 Boarding exacerbates ED crowding, reducing the department’s capacity to care for people experiencing things like heart attack, stroke, or trauma. It also leads to longer wait times, care delays, and ambulance diversions that affect all patients.

The good news is that with the right processes in place, most of these care delays can be effectively eliminated. When appropriately managed, the majority of patients in psychiatric crisis can be stabilized, treated, and discharged within 24 hours. This greatly improves ED capacity while also saving precious inpatient psychiatric beds for those who truly have no alternative.

New approaches to ED psychiatry
A number of health systems around the US have recently pioneered alternative care models to address psychiatric emergencies while ensuring that all psychiatric patients presenting to the ED receive timely assessment and treatment. In many cases, this can mean the difference between boarding and timely discharge with targeted follow-up.

RESEARCH SUGGESTS that the following three approaches can greatly improve care quality:

1. EmPath Units. The noisy, hectic ED can be an upsetting place for psychiatric patients. A long stay without treatment will often worsen symptoms rather than alleviate them. It is therefore beneficial to move medically cleared patients into a calmer environment staffed with trained mental health personnel. One model that follows this philosophy is the EmPath Unit (Emergency Psychiatric Assessment, Treatment and Healing Unit).

An EmPath Unit is a standalone unit or section of the ED dedicated solely to the treatment of high-acuity psychiatric conditions. These units offer a calm, home-like, supportive milieu reminiscent of drop-in crisis programs. But because EmPath Units are hospital-based and ED-affiliated, they are able to treat high-acuity, dangerous, intoxicated/in withdrawal, and/or medically comorbid individuals who normally would be excluded from community-based programs.

EmPath Unit patients receive prompt psychiatric assessment and early initiation of treatment, with ongoing involvement and re-evaluations for up to 24 hours. The calm, supportive environment dramatically reduces levels of agitation and aggression, and use of coercive treatments and restraints is rare, typically in less than one percent of patients. Decisions about hospitalization or disposition are not made until providers have time to observe the patient’s response to treatment. All told, about 75% of EmPath patients who would have been hospitalized in traditional EDs are able to avoid inpatient admission and are discharged to a less-restrictive level of care.

EmPath Units have recently launched or are planned in multiple states. Most are currently located in large cities like Los Angeles and Chicago. However, the Billings Clinic in Montana launched the first regional EmPath Unit serving a largely rural catchment area in April.

(Continued on page 4)
Emergency
Continued from page 3

2 On-demand telepsychiatry.

Not every ED sees a sufficient volume of psychiatric patients to justify a separate unit for psychiatric crisis care. However, smaller-volume EDs still benefit from access to an experienced emergency psychiatrist, especially for complex cases. Many are now meeting this need with on-demand video conferencing.

Telepsychiatry programs provide EDs with around-the-clock access to board-certified emergency psychiatrists for patient assessments and consultations. When an emergency provider requests a consult, a psychiatrist responds quickly and is often evaluating a patient within an hour. The psychiatrist interviews and assesses the patient via a secure two-way video platform and advises the emergency physician on diagnosis, treatment, medications, and disposition planning.

This process provides earlier diagnosis and therapeutic intervention for patients while decreasing ED duration of stay and improving outcomes. Research suggests that telepsychiatry programs save hospitals an estimated $1,000 to $5,000 per patient and can also reduce readmissions by up to 62% in some settings.[10]

Training for ED teams.

Emergency physicians are experts at treating physical illnesses and injuries, but they are often less confident addressing psychiatric emergencies because of minimal psychiatric training. Psychiatrists can therefore play a vital role in helping to train emergency physicians to manage mental health and substance abuse crises. One simple way to get involved is to offer Grand Rounds or an in-service training for local ED providers. ED teams are especially interested in education on suicidality, medication management, de-escalation, and the benefits of avoiding restraints.

Training empowers ED physicians to intervene earlier to relieve psychiatric patients’ suffering, which can decrease the need for coercive treatments, improve outcomes, and reduce both boarding times and the demand for inpatient admissions. Collaborating with ED providers in this way also helps psychiatrists to understand the challenges and realities of crisis care in the ED. This quid-pro-quo benefits everyone involved—most of all, vulnerable and underserved patients who rely on the ED when emergencies arise.

Conclusion

While the challenges cannot be solved overnight, awareness is the first step to leading change. As psychiatrists, it is our duty to understand the care landscape and advocate for psychiatric patients by partnering with the EDs to ensure access to timely, appropriate and compassionate care. Implementing a better care infrastructure in our EDs and utilizing best practice solutions such as EmPATH Units, telepsychiatry and physician training can help EDs to transform the health care experience for all patients who walk through the emergency room doors.

Dr Zeller is Vice President of Acute Psychiatry at Vituity, a multispecialty partnership of physicians, advanced providers, and industry professionals, and is an Assistant Clinical Professor, University of California-Riverside. Dr Zeller reports no conflicts of interest concerning the subject matter of this article.

References

Advanced Psychopharmacology Sessions @ Psych Congress

Advanced Psychopharmacology sessions at Psych Congress are led by expert faculty who “go beyond the basics” to highlight the latest evidence for managing complex cases and psychiatric disorders.

**Thursday, October 25**
- Severity and Treatment of Depression: A Review of Two Controversies
  - MARK ZIMMERMAN, MD
- Solving Clinical Challenges in Geriatric Psychiatry
  - MARC E. AGRONIN, MD
- What’s Hot: An Inflammatory Take on the Immune System in Psychiatry
  - CHARLES E. RAISON, MD
- Neurobiologic Insights Into Major Depressive Disorder: An Update on Emerging Therapies with Novel Mechanisms of Action
  - MICHAEL E. THASE, MD

**Friday, October 26**
- Clinical Relevance of the DSM-5 Mixed Features Specifier: Diagnostic and Therapeutic Implications
  - JOSEPH F. GOLDBERG, MD, CHARLES E. RAISON, MD
- Bipolar Disorder in Women: Considerations Across the Reproductive Lifespan
  - PAUL ZARKOWSKI, MD, MARLENE P. FREEMAN, MD
- Doing More by Prescribing Less: Top 10 Drug Interactions That Limit Efficacy
  - TIMOTHY E. WILENS, MD

**Saturday, October 27**
- Diagnosis and Management of Psychiatric Sequelae of Catastrophes
  - PAMELA G. TUCKER, MD; RICHARD H. WEISLER, MD
- What Will the Treatment of Schizophrenia Look Like in a Decade?
  - JOHN M. KANE, MD
- Ketamine and Other Putative Rapid-Acting Antidepressants: What They Have Taught Us About Neurobiology
  - GERARD SANACORA, MD, PHD

**Sunday, October 28**
- Ketamine in Psychiatric Practice: Taking the Long-Term View
  - SANJAY J. MATHEW, MD
- Solving Clinical Challenges in ADHD and Substance Use Disorders
  - TIMOTHY E. WILENS, MD

**PROGRAM CHAIRS**
- Babita Jha, MD, MPH
- Charles Raizen, MD
- Mary Sue and Mike Shannon Chair for Healthy Minds, Children & Families

**LEARNING OBJECTIVES**
- After completing this activity, participants should be able to:
  - Identify the etiology, pathophysiology, and natural history of various psychiatric diseases and their effects on patients
  - Develop evidence-based models for the use of psychopharmacologic and psychosocial therapeutic interventions to develop treatment plans, predict treatment responses, and prevent relapse
  - Display strategies to identify and encourage patients to treatment improve mental well-being in the context and within treatment development and management of psychiatric disorders
  - Manage psychiatric disorders as well as symptoms of mental health, including co-occurring medical conditions, with the goal of improving diagnosis and treatment

**ADDITIONAL INFORMATION**
- In support of improving patient care, North American Center for Continuing Medical Education (NACCME) is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for healthcare professionals.
- NACCME designates this live activity for a maximum of 27.25 Category 1 Credits. Physicians should only credit the program with the extent of their participation in the activity.
- The continuing nursing education activity awards 27.25 contact hours. Provider approved by the California Board of Registered Nursing Provider #02505 for 27.25 contact hours.
- Contact Information:
- NACCME:[]{@psychcongress} MD, North American Center for Continuing Medical Education, 1000 Thomas St., Suite 200, Alexandria, VA 22314

**GRANT SUPPORT**
- This activity is supported by education grants from Alkermes, Inc., Indivior, Inc., Teva Pharmaceuticals, Inc., Takeda Pharmaceuticals U.S.A., and Teva Pharmaceuticals USA, Inc.

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- North American Center for Continuing Medical Education complies with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. If any participant in this educational activity has a disability that requires accommodation, please contact North American Center for Continuing Medical Education.
The wind of change began to blow strongly after the completion of the Human Genome Project, when both the public and the private initiative published the sequence of the human genome in 2000. A new era was born. Now, researchers had the unique opportunity to make use of this vast resource, educating them about the complex architecture of the genome and allowing them to conduct studies that only a few years earlier would have been considered science fiction.

Genome-wide association studies (GWAS), case-control studies on several ten to hundreds of thousand genetic markers, became the genetic tool of the first decade of the new millennium. And this was true for all of medicine. GWAS started to mushroom, being performed on every human trait of disease phenotype.

This development was further propelled by an unprecedented explosion of technology that in turn led to a dramatic decrease in the time and costs spent on the analysis. Fast forward to 2018: Numerous GWAS with genome-wide significant findings have been reported to date. They have helped develop a more comprehensive picture of the genetic architecture of many diseases.

In psychiatry, the gain in knowledge has been amazing. As of today, more than 250 genetic loci have been found for schizophrenia, more than 40 each for major depression and bipolar disorder. This revolution of genomics has put us in the unprecedented position to have a robust set of findings to work with in further studies, which will include sophisticated systems biology or stem cell approaches. Bioinformatics has begun to combine the findings from genomics and other “omics,” such as proteomics, transcriptomics, metabolomics, epigenomics, and the like, to delineate pathways and networks that lead from genetic variation to a clinical phenotype.

One has to admit that these approaches are still in their infancy, we have not yet delivered clues that can allow for a rapid translation into the clinical world. But we are finally at a point where the rest of complex genetics research is—we have findings to work with which to work. And we can unequivocally declare that psychiatric disorders are not explained by a few genes but, on the contrary, have a polygenic etiology. This gain in knowledge facilitated by GWAS is a major shift in knowledge, it is indeed a paradigm shift. This knowledge is already being used in first studies constructing so-called polygenic or genomic risk scores (PRS or GRS). These scores may in the future be used in algorithms for diagnostics, treatment optimization, or prognostics.

Now, one question that we have not addressed thus far is what made this success possible, which is beyond the technological revolution described. Quite simply, he answer is three things: collaboration, collaboration, collaboration! The GWAS success story would not have been possible without collaborative projects spanning the globe, yielding powerful sample sizes from several thousand up to well over 100,000 individuals. Many of the consortia names have become trademark projects now known all over the world, such as Psychiatric Genomics Consortium (PGC; https://www.med.ucl.ac.uk/pgc), ENIGMA (http://enigma.ini.usc.edu/), or ConLiGen (www.conligen.org).

Aside from the scientific necessity to build large samples that are power-
GENOME-WIDE ASSOCIATION STUDIES

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Many of the consortia names have become trademark projects now known all over the world.

Psychiatric Genomics Consortium
www.med.unc.edu/pgc

ENIGMA
enigma.ini.usc.edu/

ConLiGen
www.conligen.org

The 21st century should not only be the century of revolution in biomedical research, it should also be the century of a friendly collaboration of a global research network. For the future, we would like to continue the collaboration with our partners, to further extend our relationships and to establish a global mental health network in the field of psychiatric genetics including low income countries. In our view, the key for the realization of this goal and for a fruitful, long-term cooperation is to perceive each other as partners and to take into consideration current and local needs.

Dr Schulze is Director of the Institute of Psychiatric Phenomics and Genomics (IPPG), University Hospital, Ludwig Maximilian University, München, Germany. Dr Adorjan is senior Research Associate at the IPPG and the department of Psychiatry and Psychotherapy, University Hospital, Ludwig Maximilian University.
Treatment of Bipolar Depression in Children and Adolescents

Dr. Wagner is Professor and Chair, Department of Psychiatry and Behavioral Sciences, University of Texas Medical Branch, Galveston, TX. She is President of the American Academy of Child and Adolescent Psychiatry.

Bipolar disorder in children and adolescents is a serious illness that adversely affects family, peers, and academic functioning. It increases risk for suicidality and is associated with high rates of occurrence. Bipolar depression presents a significant treatment challenge for clinicians. Although selective serotonin reuptake inhibitors are effective in the treatment of depression, they pose a risk of mania in children with bipolar disorder. There are now two FDA-approved medications: lurasidone and olanzapine/fluoxetine combination for the treatment of bipolar I depression in children and adolescents aged 10 to 17 years.

Lurasidone

The efficacy and safety of lurasidone was investigated in a double-blind, placebo-controlled study of 347 youth aged 10 to 17 years with a diagnosis of bipolar I depression. Patients were randomized to lurasidone (n = 175) or placebo (n = 172) in this 6-week treatment study: 92% of the lurasidone group and 89.7% of the placebo group completed 6 weeks of treatment. The dose range of lurasidone was 20 to 80 mg daily, with a mean dose of 33.6 mg daily. There was a statistically significant difference from baseline to week 6 in the primary efficacy measure, CDRS-R total score, between the OFC and placebo groups, favoring OFC. The effect size was medium, 0.46. Response rates (defined as ≥ 50% reduction from baseline to week 6 in CDRS-R total score and Young Mania Rating Scale item 1 score ≤2 at endpoint) were more significantly higher in the OFC group compared with the placebo group (78.2% vs 59.2%). Adverse events that were statistically significantly more in the OFC than the placebo-treated patients were weight gain, appetite increase, somnolence, sedation, and tremor. Mean weight gain for OFC-treated patients compared with placebo-treated patients was significantly greater (4.4 kg vs 0.5 kg). Patients in the OFC group had significantly greater increase in fasting total cholesterol, triglycerides, prolactin, and hepatic analytes. There were no significant differences in extrapyramidal symptoms and measures of suicidality between the patients receiving OFC and those patients receiving placebo.

Quetiapine

Immediate release and extended release formulations of quetiapine have not demonstrated superiority to placebo in the treatment of adolescents with bipolar I depression. In a study of immediate release quetiapine, 32 adolescents were randomized to quetiapine 300 to 600 mg daily or placebo for an 8-week trial. There was no statistically significant difference in CDRS-R scores from baseline to endpoint between the quetiapine and placebo groups.

Lamotrigine has been evaluated for the treatment of adolescents with bipolar depression. Lamotrigine adjunct or monotherapy. The mean dose of lamotrigine was 131.6 mg daily. Response rate based on criteria of a ≥50% decrease in CDRS-R scores was 63.9%. The most common adverse effects were headache, fatigue, nausea, sweating, and difficulty sleeping. No rashes were attributed to lamotrigine.

Double-blind placebo-controlled trials of lamotrigine are needed to determine the efficacy of lamotrigine adjunct or monotherapy for adolescent bipolar depression.

Lithium

Lithium is a potential agent in the treatment of bipolar depression in youth, however double-blind placebo-controlled studies of lithium are warranted.

Uridine

In an open-label case series of 7 adolescents with bipolar depression treated with uridine 500 mg twice daily for 6 weeks, there was improvement in CDRS-R scores. Meanwhile, recruitment has been completed for a randomized, double-blind placebo-controlled 6-week trial of uridine for treatment as adolescents with bipolar depression.

References

Necessity Is the Mother of Invention: Emergency Psychiatry’s Era of Innovation

Scott A. Simpson, MD, MPH

Emergency department (ED) visits for psychiatric complaints are increasingly common. The 1% to 3% of ED patients who screen positive for suicidal ideation comprise a population at heightened risk of completing suicide. While emergency psychiatric presentations are often associated with serious mental illness, patients of all acuity levels present in this setting. The most common psychiatric presentations in the ED are for anxiety, depression, or stress reactions.

Providing treatment to these patients in the ED introduces complexity of care that emergency psychiatrists are attempting to address with a mix of service delivery models. This article discusses the peculiarities of emergency psychiatric practice and reviews innovations in models of care delivery designed to overcome the challenges of this subspecialty.

A difficult place to provide good care

The growth of psychiatric care in ED settings is driven by several factors. Foremost is a trend towards treating sicker patients in less restrictive care environments. Increasingly, patients with significant psychiatric disease are being treated in outpatient and integrated care environments. At the same time, long-term inpatient and residential treatment has become scarcer. Thus, EDs become the backstop for highly acute patients who present with suicidality, violent thoughts, intoxication, and/or acute psychosis. Other factors driving this trend towards less restrictive treatments include financial incentives and the ready accessibility of emergency care compared with the limited availability of community mental health facilities. Also driving the trend towards less restrictive treatments is the constant sensory stimulation, and ill-suited inpatient environments. At the same time, long-term inpatient facilities to meet patients’ needs. How, then, can we help patients in crisis receive great psychiatric care?

Emergency psychiatry: a subspecialty to the rescue

The subspecialty of emergency psychiatry has attracted growing interest among a range of clinicians who are drawn to its diverse patient population, highly multidisciplinary work environment, and fast pace. There is no Accreditation Council for Graduate Medical Education (ACGME)-accredited subspecialty pathway for emergency psychiatry; rather, psychiatrists often bring their interests in consultation-liaison, addiction, or forensic psychiatry to their ED work. Other clinicians enjoy providing psychotherapy to patients in crisis and appreciate the challenge of quickly building rapport and framing treatment for these patients in the ED.

There are no data on the number of psychiatrists working in EDs. In many locations, the need for psychiatric consultation is filled by advanced practitioners and licensed social workers working alongside emergency medicine providers. Professional organizations that support emergency psychiatry—as such as the Academy of Consultation-Liaison Psychiatry’s Emergency Psychiatry Special Interest Group and the American Association of Emergency Psychiatry—include robust participation by non-psychiatric clinicians.

Interest in the field often begins during psychiatry residency. The ACGME requires residents in psychiatry to experience emergency psychiatry “in an organized, supervised psychiatric emergency service” that “must include crisis evaluation and management, and triage of psychiatric patients.” The ACGME’s emergency medicine requirements do not require specific experience managing behavioral presentations.

The challenges of growing volume and acuity among psychiatric patients in the ED have prompted emergency psychiatrists to work alongside colleagues in medicine and ED leadership to imagine systems to improve the care of behavioral emergencies in their communities. These models typically arise to meet demands of emergency medicine clinicians and hospital systems that are designed to accommodate constraints of staff, facilities, and budget.

New ways forward

Just as communities and hospital systems vary, so too must models for delivering emergency psychiatric care. Table 2 summarizes the challenges of clinical practice in emergency psychiatry.

<table>
<thead>
<tr>
<th>TABLE 1. Challenges of clinical practice in emergency psychiatry</th>
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<tr>
<td>Undifferentiated patient presentations</td>
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<tr>
<td>• Substance-induced, delirium, and primary psychiatric illnesses are all common</td>
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<tr>
<td>High morbidity and mortality</td>
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<tr>
<td>• 21% of patients in the ED with suicidal ideation will self-harm within a year</td>
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<tr>
<td>• Missed diagnosis of delirium is associated with 31% mortality at 6 months</td>
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<tr>
<td>Diversity of patient presentations—medication refills to severe psychosis</td>
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<tr>
<td>Fast pace and high volume</td>
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<tr>
<td>Significant collaboration with community providers and external partners</td>
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<tr>
<td>Significant collaboration with non-psychiatric providers</td>
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<td>Diversity of practice environments</td>
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some of the novel efforts that have been developed to meet the demand for high-quality, affordable psychiatric care that addresses the challenges of managing behavioral emergencies in the ED. These models comprise an overarching philosophy that EDs must provide active treatment of psychiatric emergencies—not merely triage patients to the next step in care.

**Pre-hospital care.** Management of behavioral emergencies begins in the community—well before patients’ arrival to the ED. Emergency psychiatrists have partnered with police departments and other first responders to provide training in the recognition and initial management of psychiatric emergencies. Typical skills include increasing awareness of the prevalence of psychiatric illness in the community and teaching verbal de-escalation to help patients in crisis. Crisis Intervention Training (CIT) is a national model for police departments to use for working with mentally ill patients in the community; some cities now train all officers in CIT. For ambulance crews, researchers have investigated the utility of novel medications for treating agitation quickly and safely prior to arrival in the ED.10

These efforts build on the precedents set by community-based psychiatrists in promulgating patient-centered, easily accessible interventions such as mobile crisis teams and telephone crisis hotlines. Education among pre-hospital providers also encourages use of diversion facilities (eg, crisis centers) over EDs or jails.

**Telepsychiatry.** The need to deliver 24/7 care to rural and low volume EDs may be met in part through telepsychiatry services. ED diagnoses made via telepsychiatry are correlated with those provided by an in-person psychiatrist while enhancing outpatient follow-up, reducing hospital admissions, and decreasing costs.11,12 Large health systems and academic medical centers may utilize telepsychiatry to extend specialty consultation expertise to outlying EDs, urgent care centers, and partnership hospitals. Telepsychiatry is well-suited for patients presenting in crisis who are able to participate and benefit from a therapeutic interview; patients with comorbid presentations may also benefit from evaluation by a telepsychiatry specialist. However, this medium is more limited for providing verbal de-escalation or management of disruptive behaviors and acute agitation.

**Integrated care.** Integrated behavioral health has transformed the delivery of mental health care in primary care settings. Several institutions including the Stanford Medical Center in California and the Denver Health Medical Center in Colorado have piloted integrated care models in ED and urgent care settings. Initial data are highly promising. The Stanford experience has demonstrated a 90% decrease in duration of stay for psychiatric patients in the ED and improved discharge rates by 47%.13 In the ED, integrated care expands the availability of psychiatric services beyond the traditional consultation for suicidal ideation. For example, these models facilitate the treatment of patients with somatic symptom disorders, chronic pain, and high ED utilization. The presence of an integrated care provider also enhances the skill set of medicine providers who benefit from “at the elbow” consultation expertise provided by an integrated mental health provider.

**Sustainable regional collaborations.** Not all health care facilities have the patient volume to justify a dedicated psychiatric emergency service, 24/7 psychiatrist coverage, and dedicated staff on their own; yet when collaborating with other institutions, it becomes feasible to build and sustain such a service. The Unity Center for Behavioral Health in Portland, Oregon offers emergency and inpatient psychiatric services and is supported by 4 different health care systems in that city. By pooling resources to fund a regional psychiatric emergency service, health systems ease patients’ access to psychiatric care while reducing duration of stay and psychiatric boarding in their EDs.14 Bringing together clinicians passionate about emergency psychiatry enable programs to cultivate trauma-informed approaches to emergency psychiatry including the use of multidisciplinary assessment models and peer support services.

**Enhanced training in emergency medicine.** Just as most mental health care is provided in primary care settings, emergency medicine practitioners will continue to see the bulk of patients with psychiatric illness. The American College of Emergency Physicians is collaborating with specialty societies in emergency psychiatry to enhance the training of emergency medicine physicians in behavioral emergencies. This training includes assessing suicide risk, identifying delirium, managing agitation, and coordinating care for boarding psychiatric patients. These teaching efforts extend to the range of advanced practitioners working in the ED.

**New interventions for behavioral emergencies**
These service models enhance access and quality of care in emergency psychiatry across diverse health systems. They also recognize the need to improve services at different points of the patient’s ED visit, from initial contact in the community to facilitating discharge. The Figure illustrates how innovations are improving care at each step of the psychiatric patient’s ED visit. These platforms also provide a means to disseminate innovations in emergency psychiatric treatment.

**Trauma-informed care.** Trauma-informed care (TIC) is a treatment approach that recognizes harmful consequences of trauma on the well-being of individuals.15 In psychiatric care, TIC improves patient satisfaction and encourages collaborative, healing partnerships among patients and providers. Rarely can a busy medical ED provide this environment, but dedicated emergency psychiatry programs routinely integrate TIC into treatment planning. This includes the use of patient-centered de-escalation techniques such as the availability of non-pharmacologic relaxation tools like stress balls and scented lotions; peer counseling; and dedicated training to familiarize staff with TIC principles.

**Peer support.** Peer counselors comprise a growing category of health care workers who use their lived experience with illness to facilitate treatment. Behavioral health peer counselors are increasingly utilized in emergency service settings to engage patients ambivalent about mental health treatment.

**TABLE 2. New ways of delivering emergency psychiatric care**

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**FIGURE. Innovations to improve each step of emergency psychiatry care**

- **First contact in the community**
  - Police and emergency medical personnel training
  - Mobile crisis services
  - Crisis hotlines
  - Crisis walk-in centers

- **Improving ED treatment**
  - Treatment, not triage
  - Accurate diagnosis
  - Provision of specialty care when necessary through integrated care
  - Evidence-based interventions
  - Trauma-informed care
  - Medication-assisted treatment for substance use

- **Connection to follow-up care**
  - Reduce duration of stay through integrated care
  - Reduce hospitalizations through provision of earlier, more intensive treatment
  - Linkage navigation through peer counseling

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uncertain as to positive behavioral change, or in need of linkage to care. In EDs, peer counselors often interact with patients with substance use disorders or chronic mental illness; some programs include follow up with patients after ED discharge. The evidence base supporting peer services remains small but is growing as these services become increasingly available. Nationally, the application of peer counseling will develop heterogeneously alongside similarly varied models for emergency psychiatric care.

Psychological and medication treatments. New discoveries will influence the provision of emergency psychiatric treatment. As in all psychiatric fields, these discoveries will reflect the breadth of psychiatric practice. There is increasing emphasis on the use of verbal de-escalation for the management of agitation, and online training programs make evidence-based techniques freely available for all health care staff. Using standardized rating scales for evaluating agitation helps ED staff feel safer and better prepared in managing agitation. Finally, new medication approaches are fast-changing the face of emergency psychiatric care, from the use of intramuscular ketamine for acute agitation to the pro-active use of medication-assisted treatments of substance use disorders.

Emergency psychiatrists are rising to the challenge
Providing immediately accessible, high quality emergency psychiatric care continues to be a challenge for many communities. Obstacles to providing care include economic constraints, inconsistent training in emergency psychiatry among clinicians, the lack of a scientific evidence base for the field, and the prevalence of treatment-resistant illness. Nonetheless, a growing number of emergency psychiatrists are motivated to enhance the care of psychiatric patients through new models of service delivery and innovations in clinical care. Vital to the continued growth of this subspecialty and the improved treatment of our patients are recognition of this subspecialty among the psychiatric community and continued interest among new generations of psychiatrists.

Acknowledgements—Dr Simpson would like to thank members of the Academy of Consultation-Liaison Psychiatry’s (ACLP) Emergency Psychiatry Special Interest Group for their superb work in emergency psychiatry—and their assistance with this work. He also thanks Dr Christina Wichman DO, FACP and ACLP’s leadership for their continued, robust support for emergency psychiatry. The Academy is the professional home for psychiatrists providing collaborative care bridging physical and mental health. Over 1200 members offer psychiatric treatment in general medical hospitals, primary care, and outpatient medical settings for patients with comorbid medical conditions.

References
2. Hahner TC, Beall GC, Shah AA, Dark C. Health Policy Consider-
INTRODUCTION:
PTSD Treatment Strategies and New Initiatives

Lori Davis, MD

Dr Davis is Associate Chief of Staff, Research and Development Service, Tuscaloosa VA Medical Center, Tuscaloosa, AL; and Professor of Psychiatry, University of Alabama School of Medicine, Department of Psychiatry, Birmingham, AL.

This Psychiatric Times Special Report on stress and trauma brings together five topics that are neglected in the current literature. Dr Morganstein, who wrote the CME article in this issue, points out that physician work-associated traumatic events are both common and unavoidable. Causes of physician work-associated trauma include medical errors leading to significant patient harm, disasters where health care workers are both provider and victim, and workplace violence such as bullying.

Common responses to traumatic events include distress reactions, health risk behaviors such as increased substance use and decreased social activity, and psychiatric disorders. The goal of intervention is to reduce levels of distress in affected physicians, restore their ability to provide care, and minimize the likelihood of lasting symptoms or impairment.

Interventions for traumatic stress should incorporate the principles of Psychological First Aid: safety, calming, self-efficacy, connectedness, and optimism. Providing a range of patient-centered, evidence-based interventions and formal treatment options can enhance compliance and increase well-being for physicians who have experienced traumatic events.

Interventions for traumatic stress should include an array of options to promote resilience and well-being for physicians who have experienced traumatic stress.

Stigma continues to serve as a barrier to help-seeking for physicians, especially given that physicians may face punishment in the form of pay loss or practice restrictions for coming forward about mental health challenges. Dr Morganstein advocates for employee assistant programs and other early interventions to reduce the likelihood of symptom escalation following work-associated traumatic stress.

Dr Waits reviews the literature that shows the promising results of Accelerated Resolution Therapy (ART) as a treatment for PTSD. A theory for ART’s effectiveness, including a possible mechanism of action, is provided. However, Dr Waits provides a significant disclaimer regarding eligibility for ART: the “unmotivated patient should not be offered ART.” Two case examples illustrate the recovery of patients with PTSD as exemplified by a decrease in patient healthcare utilization following completion of ART.

Dr Youssef explains that it is worth exploring ECT as a potential treatment for PTSD since “a high percentage of patients [with PTSD] still do not achieve remission (or response) from multiple trials of both psychotherapy and psychotherapy.” The preliminary success of electroconvulsive therapy (ECT) in treating PTSD suggests ECT could serve as a complement to existing PTSD treatment and that more rigorous randomized controlled trials could provide evidence for ECT as a standalone treatment for PTSD. Dr Youssef strongly advocates for continued research and implementation of ECT and addresses changes and improvements in ECT over the last few decades. ECT technology has become safer with fewer risks of adverse cognitive effects.

Dr Morganstein and Lang provide a comprehensive summary of complementary and integrative health (CIH) techniques that enhance PTSD treatments. Dr Morganstein advocates for continued research and development of CIH methods as complements rather than replacements for existing treatments. Therefore, most CIH methods are indicated as complements rather than replacements for existing therapies.

Dr Malaktaris and Lang provide a comprehensive summary of complementary and integrative health (CIH) techniques that enhance PTSD treatments. Explanations of techniques, such as meditation or yoga, are followed by descriptions of evidence for each method. Recommendations and cautions to implementation are clearly described for each technique. Consistent among all treatments discussed is a lack of randomized controlled trials supporting their use. Therefore, most CIH methods are indicated as complements rather than replacements for existing therapies.
PTSD in Late Life: Special Issues

**Elissa McCarthy, PhD, and Joan M. Cook, PhD**

Dr McCarthy is a Consultant, Executive Division, VA Department of Veterans Affairs’ National Center for PTSD, White River Junction, VT; Dr Cook is a Researcher, Evaluation Division, VA Department of Veterans Affairs’ National Center for PTSD, West Haven, CT, and an Associate Professor of Psychiatry, Yale School of Medicine, New Haven, CT.

Relative little is known about trauma and PTSD in older adults in comparison to young and middle-aged adults. In fact, up until the past decade, large-scale epidemiological studies examining the prevalence and impact of trauma did not include sufficient numbers of older adults to adequately examine the effects of age. More recent investigations of community-dwelling adults in the US generally indicate that older adults report fewer traumatic events and related psychiatric symptoms than younger individuals. For example, the prevalence of past-year PTSD was significantly higher for younger (4.3%) and middle-aged (5.2%) adults compared with older adults (2.6%) and so were the odds of co-occurring psychiatric disorders.

However, some have surmised that trauma is a hidden variable in the lives of older adults, impacting them in ways they may not recognize or be willing to admit. For instance, older adults may have experienced trauma but do not recognize the potential deleterious health effects or do not disclose these experiences to health care providers. Moreover, health care providers may not recognize trauma and related distress in older adults. This lack of recognition or misattribution of trauma-related symptoms can have negative implications for treatment and recovery, including the design of ineffective treatment plans and administration of incongruent psychotherapy, medication, or other medical intervention.

Prevalence of PTSD in older adults

Although the majority of older adult trauma survivors are not affected with PTSD, those that are or show other related distress are of note. For example, in a large nationally representative prospective cohort study with over 2000 US veterans aged 60 and older, a total of 3.5% met screening criteria for current PTSD—many had significantly increased odds of mood, anxiety, and substance use disorders, suicidal ideation, and suicide attempts. Most of the veterans in this cohort were resilient, having few to no psychiatric symptoms. They exhibited higher emotional stability, social connectedness, protective psychological and social characteristics, and positive perceptions of the military’s effect on one’s life.

Trauma and PTSD in the older adult population has also been linked to physical health problems, disabilities, and poorer cognitive functioning. In a large, longitudinal study of older community-residing male veterans, combat exposure and PTSD were both negatively related to self-reported physical health and to physician-diagnosed medical conditions that included arterial, gastrointestinal, and musculoskeletal disorders. Data from three aggregated nationally representative samples show that older adults with chronic PTSD were three times more likely to have any disability than were those with no PTSD. And, in a sample of over 10,000 veterans aged 65 and older, those with PTSD had almost twice the odds of having a diagnosis of dementia.

There are few longitudinal studies of PTSD across the lifespan but in general it appears that if symptoms occur early in life and are untreated, they often wax and wane across the lifespan. As one ages and transitions into older adulthood, there is typically an increased likelihood for loss and the impact of such events can exacerbate symptoms. Furthermore, as one transitions into older adulthood, there is an increased risk for medical illness, decrements in functional status, bereavement, retirement, changes in social and familial roles, diminishing of control, and more time for reflection—all of which can deepen the impact of PTSD.

Assessment and treatment of PTSD in older adults

Health care providers may not recognize physical or mental health symptoms as the result of traumatic events or may be unsure of how to provide assessment and treatment of trauma and PTSD to an older population. Older adults may express mental health difficulties as somatic concerns or be reluctant to acknowledge such problems because of perceived stigma. It is also important to consider that older adults who experienced a trauma early in life may not have been encouraged by their family or society to discuss it.

Older adults may not be able to readily identify psychological problems given the lack of agreed upon or well-established terminology to describe traumatic experiences and the impact of those experiences during their formative years. Although most older trauma survivors do not develop PTSD, partial or subthreshold PTSD seems to be an issue worthy of assessment and clinical attention.

There is a need to utilize effective evidence-based practices which are safe, acceptable, and appear to be effective in older adults with trauma histories and a considerable range of time since traumas. Three cognitive-behavioral therapies stand out in particular: prolonged exposure, cognitive processing therapy, and eye movement desensitization and reprocessing. All three are trauma-focused models, in which patients address trauma through either detailed enumeration or a challenge of cognitions related to the traumatic event. (For a detailed description of prolonged exposure therapy for older adult trauma survivors, see Cook and Dinnen and Cook et al.)

Although most psychosocial interventions are similar to those used in PTSD treatment with younger adults (eg, education about symptoms, enhancement of social support, coping tools to more effectively manage symptoms), some specific concerns should be considered when working with older traumatized adults. First, it is crucial to consider older adults’ cognitive abilities to help determine the most effective psychotherapeutic approach. For example, older trauma survivors with cognitive impairment (such as non-reversible dementia) may have lowered thresholds for responses to trauma cues or triggers. Older adults with moderate to severe cognitive impairments may not be able to fully benefit from traditional learning-based therapies.

Since older adults may have sensory problems and slower learning rates, repetition is important in the psychotherapy process. Psychoeducation, trauma-processing therapies, or distress management skills can be presented in both verbal and visual modalities (ie, on chalk boards and hand-outs), in order to help them encode and retain information. Psychotherapy with trauma survivors is not a challenge for older adults—many had significantly increased odds of mood, anxiety, and substance use disorders, suicidal ideation, and suicide attempts. Most of the veterans in this cohort were resilient, having few to no psychiatric symptoms. They exhibited higher emotional stability, social connectedness, protective psychological and social characteristics, and positive perceptions of the military’s effect on one’s life.

When working with older adults, it is essential to consider age-related adverse effects of medications, such as sensitivity, metabolic rates of medications, and the impact of polypharmacy.

**SIGNIFICANCE FOR THE PRACTICING PSYCHIATRIST**

It is important for practicing psychiatrists to know that there are evidence-based practices that are safe, acceptable, and effective in older adults with trauma histories and a considerable range of time since their traumatic exposure.

- Although the majority of older adult trauma survivors do not have PTSD, a significant minority do.
- PTSD in older adults is significantly related to a number of psychiatric comorbidities, physical health, and cognitive functioning.
- According to major PTSD guidelines, four medications have received a conditional recommendation for use in the treatment of PTSD: sertraline, paroxetine, fluoxetine, and venlafaxine.

(Continued on page 14)
PTSD in Late Life?

Continued from page 13

Accelerated Resolution Therapy for PTSD

Wendi Waits, MD

Dr Waits is Clinical Associate Professor, Uniformed Services University of the Health Sciences and Director for Behavioral Health, Walter Reed National Military Medical Center, Bethesda, MD.

Accelerated Resolution Therapy (ART) is an emerging, efficient therapy for PTSD and other psychiatric conditions. It is derived from Eye-Movement Desensitization and Reprocessing (EMDR), but it has a tighter protocol, is more directive, more procedural, and easier to learn. (See Kip et al.1 for a general description of the proprietary ART protocol.) ART has been reported to be effective, efficient, easy on patients, and easy on clinicians.2

Research

Unlike psychotherapies developed in university or research environments, the ART protocol was created by an experienced masters-level practitioner in private practice.3 For this reason, ART has not had as much research-based validation as EMDR. Prolonged Exposure, and Cognitive Processing Therapy (CPT). There have been three major clinical trials on ART for PTSD, only one of which involved a control group.4-6

Despite consistently showing impressive results, data from these trials must be interpreted with caution. All three studies were conducted by the same research team out of the University of South Florida, all three relied on patient self-report for outcome measurement, and only one study included a control group. A larger, high-quality randomized controlled trial comparing ART to CPT is currently underway at the Cincinnati Veteran’s Affairs (VA) hospital, although published data from this trial are not expected until 2019 or later.7 Nonetheless, against the backdrop of our current PTSD gold standard treatments, which have demonstrated high dropout rates, low remission rates, and low rates of provider use after training, ART at least seems worthy of a look.

In the ART randomized controlled trial, veterans or active duty service members were randomized to receive up to five sessions of ART or two sessions with a fitness coach or a career counselor. Using an intent-to-treat (ITT) analysis, ART demonstrated a 61% response rate (defined as at least a 10-point drop on the PTSD Checklist (PCL) and a 94% completion rate.7 These are impressive results, given that established PTSD therapies have a response rate of 49% to 70% and a completion rate of 60% to 65%.8,9 Furthermore, the number of ART sessions needed in this trial was 3.7 ± 1.1. This number is significant not only because it is fewer than the 8 to 15 sessions required by traditional evidence-based therapies for PTSD, but because up to 83% of patients who drop out of these treatments do so before their fifth session.

Theory

The key to ART’s efficiency is believed to lie in its exploitation of natural memory consolidation mechanisms. Memories undergo minor modifications every time we recall them, and that memory activation is critical to effective PTSD therapy.10,11 There is evidence to suggest that activating a memory, changing its emotional valence by introducing a novel sensation or stimulus during activation, and reconsolidating it (“putting it away”) within a discrete period of time can modify memory traces at the level of DNA transcription, essentially locking in the changes in a permanent manner.12 This period of time,

<table>
<thead>
<tr>
<th>TABLE 1. Appealing aspects of ART</th>
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<tbody>
<tr>
<td>• Easy to learn</td>
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<td>• Efficient and procedural</td>
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<td>• Encourages significant provider credibility</td>
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<tr>
<td>• Useful for a broad range of symptoms/conditions</td>
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<td>• Only 3–4 sessions typically required for response</td>
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<tr>
<td>• No set interval between sessions</td>
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<td>• No preparation</td>
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<tr>
<td>• No homework</td>
</tr>
<tr>
<td>• No narration</td>
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<tr>
<td>• Patient retains significant control over session</td>
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</table>
or “reconsolidation window,” is believed to be 1 to 6 hours in humans. Like other reconsolidation therapies, the ART protocol not only extinguishes the patient’s fear response, but it also unwires distressing emotions from the factual memories of the events that created them. Said another way, reconsolidation therapies “fulfill the brain’s requirements for allowing new learning to rewrite and erase an old, unwanted learning—and not merely suppress and compete against the old learning.”

Clinical application

In many ways, ART may be easier to integrate into psychiatric practice than traditional PTSD therapies (Table 1). Each ART session is a stand-alone intervention and the time between sessions is not prescribed. ART can also be used in conjunction with other trauma-focused therapies. For example, ART may be a useful adjunct when a patient arrives too distracted by a competing problem to engage in the establishment of an ART clinic. Each referred patient was required to read a brochure, sign a form acknowledging each element of informed consent, and schedule the first 4 appointments. This model worked well because expectations were clear from the beginning and patients were less connected to their therapist (and thus less likely to request continued treatment).

Patients treated with ART by their established providers tend to be more challenging. They can drift into the rhythm of their pre-ART sessions, adding excessive detail, becoming tangential, resisting change, etc. This can sometimes make sessions less efficient and clinical outcomes less dramatic. However, even if a patient does not achieve remission from PTSD, ART may still significantly catalyze non-ART therapies, move patients past clinical outcomes less dramatic. This was a challenging session, but it brought obvious relief. He moved from the area shortly thereafter and was lost to follow-up. We were able to reach him by email 5 months later, and he reported that he had weaned himself off of his meds, was divorcing his wife, and had surrounded himself with positive people. He completed a final PCL and his score was 26.

A 36-year-old male sailor with PTSD from various traumatic experiences as a military affairs officer was in jeopardy of having his overseas orders cancelled because he was on psychotropic medications and required weekly psychotherapy appointments. After 8 months and 18 appointments of traditional behavioral health treatments, his PCL-5 score had only dropped from 54 to 46. His therapist referred him to the ART clinic and he completed three ART sessions in 4 weeks. His PCL-5 score at treatment completion was 10 and a month later it was 2. At that point, he told his therapist that “ART had changed everything.” He reported feeling “happy” and “proud,” had lost his fear of death, was drinking less, and had cut his cigarette use in half. More than a year and a half later, he is deployed overseas, no longer takes medications, and his health care utilization has significantly decreased. Whereas he had 36 documented medical appointments in the 16 months prior to ART, he has only had 3 documented appointments since completing ART.

Table 2. Take-home lessons

- ART is a manualized, trauma-focused therapy with evidence of benefit for PTSD
- A variant of EMDR, but more succinct, procedural, and easier to learn
- Can be used for a variety of symptoms and conditions, not just PTSD
- Only 3-4 sessions typically required for clinically significant improvement
- Each session is a stand-alone intervention
- No homework required by patient
- No preparation required by provider
- Patient is in control throughout session
- Patient may disclose as many or as few details of event(s) as he/she chooses

This is not hypnosis.

Take-home lessons

- ART uses eye movements.
- It involves little talking.
- There is no homework.
- It requires a 10- to 15-minute mental review of painful life experiences.
- The patient may share as much or as little of these experiences as he or she chooses.
- It allows the patient to choose and replace negative images with positive ones.
- Patients will retain the facts of the events they process, potentially even remembering more details than before starting ART.

CASE VIGNETTES

A 44-year-old male soldier with severe combat-related PTSD was referred to the ART clinic by his treating psychiatrist due to lack of response to medications. He received four ART sessions over the course of 5 weeks. His pre-ART PCL score was 72 and dropped to 55 after two sessions, during which he had processed a combat-related event and an intense argument with his wife. His score jumped to 77 just prior to his fourth session, in which he chose to process a childhood sexual assault.

Conclusion

Although its research base is still maturing, ART appears to be a promising and efficient intervention for PTSD and other psychiatric maladies (Table 2). Readers interested in being trained or who want to refer a patient to an ART therapist are directed to the Rosenzweig Center for Rapid Recovery (www.acceleratedresolutiontherapy.com) or ART International (www.arttherapyinternational.org) for more information.

References


Disclaimer: The views expressed in this article are those of the author and do not reflect the official policy of the Department of the Army/Navy/Air Force, Department of Defense, or the US Government.
Treating Recalcitrant PTSD With ECT: Are We There Yet?

Nagy A. Youssef, MD

Dr Youssef is Associate Professor, Department of Psychiatry & Health Behavior, Medical College of Georgia at Augusta University, and Psychiatry Educator for medical students at the office of Academic Affairs, Augusta, GA.

The risk of cognitive adverse effects (eg, long disorientation duration, memory impairments), has been one of the factors that historically limited ECT use. However, modern modifications of ECT parameters have substantially limited these cognitive risks to a smaller portion of patients. For instance, the modern development and use of rectangular instead of sine wave pulse, ultra-brief instead of brief pulse, and right unilateral (RUL) instead of bilateral (BL) electrode placement have improved cognitive effects of ECT.

Further improvement of the cognitive adverse effects has been suggested by using a lower current amplitude than standard ECT, thus more favorable cognitive effects compared with standard ultra-brief RUL ECT, similar efficacy has been shown in 2 preliminary studies on depression and suicidality. Moreover, further modifications in electrode shape and electrode placements might also be helpful for Focal Electrically Administered Seizure Therapy (or FEAST). These proof of concept studies provide additional promise to eliminating or markedly minimizing these adverse effects.

Theoretical justification for use of ECT in PTSD and proposed mechanism of action

Hippocampal neurogenesis has been shown to contribute to the clearances of artificially induced long-term potentiation (a cellular model of learning and memory). This mechanism may have a role in treatment-resistant PTSD and related memories if clearance of hippocampal memory traces in the contextual fear conditioning can be accomplished. Since ECT induces neurogenesis, it might have a role in treatment of PTSD (Figure). ECT has been suggested to induce neurogenesis and neuroplasticity in both brain imaging and in brain pathology studies. Olsen and colleagues measured the number of newly formed neurons in the hippocampal subgranular zone in adult rats exposed to chronic restraint stress and electroconvulsive stimulation alone or in combination. This study found that chronic stress induced depression-like behavior without changing neurogenesis in the hippocampus, while electroconvulsive stimulation prevented stress-induced depression-like behavior and increased neurogenesis.

The role of ECT in inducing neuroplasticity in both animals and humans is best detailed in a comprehensive review by Bouckaert and colleagues. Since hippocampal neurogenesis has also been shown to ameliorate PTSD symptoms, it is plausible to hypothesize that ECT might help PTSD by inducing hippocampal neurogenesis.

Hippocampal neurogenesis may not be the only mechanism. Other mechanisms related directly to memory deconsolidation might also be possible, where ECT could cause more improvement in PTSD symptoms if delivered right after reconsolidation of the traumatic memories. In one study patients with severe treatment-resistant PTSD were administered 6 sessions of ECT after retrieving either traumatic (n = 4) or a neutral memory (n = 4). Study findings indicate that post traumatic retrieval ECT tended to produce better reductions in skin conductance responses and subjective reactivity to the traumatic imagery (P = .026). Thus, supporting the theory that ECT may have its effects augmented if delivered right after reconsolidation of traumatic memories.

Further investigation is warranted, not only from a therapeutic standpoint, but also from mechanistic perspectives. Despite plausibility of these hypotheses, it must be stressed that these hypotheses need to be further tested to be proven or disproven in a well-powered controlled clinical trial, given the preliminary evidence.

Wider availability of ECT in facilities that treat a substantial number of patients with treatment-resistant PTSD and depression, such as VA hospitals, would not only improve care for patients with disorders indicated for ECT (according to the standard of care), but also provide a chance to investigate the potential role of ECT in treatment-resistant PTSD (or PTSD with depression) given that the number of patients needed for such a trial would be unlikely to be obtained by any one center or hospital.

Standard therapeutics fall short of helping many patients with PTSD

Several medications and combinations of medications, including SSRI and other antidepressants have been studied for treatment of PTSD. For instance, 80% of veterans with PTSD seen at the VA receive pharmacologic treatment (with or without psychotherapy), of these, 89% are prescribed antidepressants.

Most of the studies have been positive for the FDA-approved medications, paroxetine and sertraline, although the therapeutic effect size of antidepressants has been small. Moreover, the results of a large multicenter randomized trial of post-FDA-approved sertraline were not positive.

Prazosin has shown evidence of efficacy in some well-designed clinical trials for nightmares (and some other PTSD symptoms). However, a recent, large multicenter clinical trial did not show benefit for night-
mores or other PTSD symptoms in veterans with chronic PTSD.\textsuperscript{13} Neither did another study that examined prazosin for PTSD (but not nightmares).\textsuperscript{16}

Trauma-based therapies such as cognitive processing therapy and prolonged exposure are considered the gold standard treatments for PTSD. However, despite all available standard therapeutics, a high percentage of patients still do not achieve remission (or response) from multi-factorial causes.\textsuperscript{17}

Many patients with treatment resistance suffer the burden of impairment, elevated risk of suicide and violence, and higher incidence of all-cause mortality. This obviously creates significant family and societal burden. Common PTSD psychiatric comorbidities include depression and substance use disorders. In addition, there are high rates of other psychiatric and physical illnesses including hypertension and cardiovascular events.

**Genetic memory and comorbidities**

Traumatic memories generate some of the most persistent memories and are the hardest to erase. This might be explained by the cellular mechanism for encoding durable memories that also involve structural change. At the intranuclear level, a recent review by our group suggests that the effect of these traumatic memories may even be passed to the next generations via epigenetic methylation effects.\textsuperscript{17} These persistently encoded memories might be, at least in part, why so many patients with PTSD are treatment-resistant or partial responders.

Many patients with treatment resistance suffer the burden of impairment, elevated risk of suicide and violence, and higher incidence of all-cause mortality. This obviously creates significant family and societal burden. Common PTSD psychiatric comorbidities include depression and substance use disorders. In addition, there are high rates of other psychiatric and physical illnesses including hypertension and cardiovascular events.

**Preliminary evidence for the role of ECT in treating PTSD**

A serious look at innovative solutions as well as established interventions that are known to be highly effective in other treatment-resistant disorders is needed. Modern ECT has a high level of safety compared with older techniques, not only in terms of anesthesia and muscle relaxation, but also in terms of the improvements in electrical parameter modifications, and electrode placements.

In disorders where ECT is indicated, ECT generally has the advantage of working faster than medications and psychotherapy with an effectiveness rate that is usually at least twice as high as standard therapeutics. It also frequently works in more severe and treatment-resistant cases.

The literature that examined the role of ECT in treating PTSD in humans is scant and totals four preliminary studies (Table). (The reader interested in more details on the topic is referred to a recent synthesis of the existing evidence of the role of ECT in PTSD.\textsuperscript{6,17})

A retrospective chart review investigated the use of ECT in veterans with PTSD.\textsuperscript{18} The statistical analysis included 26 veterans with both MDD and PTSD. PTSD severity was assessed using the PTSD Checklist (PCL) and depression severity by the Montgomery-Asberg Depression Rating Scale (MADRS).\textsuperscript{19,20} Patients had significant reduction in both depressive and PTSD symptoms (\(P < .001\)) after the ECT course. However, only 35% of patients had reduction in symptoms on the PCL. The major limitations of this study are the retrospective nature (which could have cofounded the findings) and the small sample size.

A retrospective case-control study compared patients with comorbid PTSD and MDD who were treated with an ECT course (\(n = 92\)) to those with matched controls that did not receive ECT (\(n = 3393\)).\textsuperscript{21} PTSD and MDD symptoms improved as assessed using the Clinical Global Impression (CGI) scale. The ECT group improved more than those who did not receive ECT but were on antidepressant medications (\(P = .001\)).

The most recent retrospective case-control study compared patients (CONTINUED ON PAGE 18)

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**TABLE. Studies examining the role of ECT in PTSD**

<table>
<thead>
<tr>
<th>Author</th>
<th>Study duration</th>
<th>N</th>
<th>Design</th>
<th>Sample</th>
<th>ECT</th>
<th>Primary outcome measure(s)</th>
<th>Response</th>
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</thead>
<tbody>
<tr>
<td>Watts\textsuperscript{18}</td>
<td>1/98-10/02</td>
<td>26</td>
<td>Retrospective chart review</td>
<td>Veterans with PTSD and comorbid MDD\textsuperscript{a}</td>
<td>All started RUL; 10 switched to bitemporal</td>
<td>PCL and MADRS</td>
<td>MDD improved significantly. PTSD showed some improvement: 71.08; (SD, 4.72) before ECT to 55.62 (SD, 8.84) after ((P = .001)); 35% showed 20% reduction in symptoms</td>
</tr>
<tr>
<td>Ahmadi et al.\textsuperscript{21}</td>
<td>2004-2013</td>
<td>3485\textsuperscript{b}</td>
<td>Retrospective with matched case-control</td>
<td>Patients with PTSD and comorbid MDD</td>
<td>Bifrontal (\geq200% above ST)</td>
<td>CGI-S; long-term endpoints were occurrence of cardiovascular problems, all-cause mortality, and suicide</td>
<td>ECT group had greater symptomatic improvement (on CGI-S), risk reduction of 64% for suicide, 65% for all-cause mortality, and 46% for cardiovascular mortality</td>
</tr>
<tr>
<td>Kaster et al.\textsuperscript{22}</td>
<td>2009-2016</td>
<td>150\textsuperscript{c}</td>
<td>Retrospective matched case-control</td>
<td>Patients treated with ECT who had MDD\textsuperscript{a} and comorbid BPD, PTSD, or both ((n = 75)) with a matched group with MDD and no comorbidities ((n = 75))</td>
<td>Biteamtemporal used 1.0 ms (\times) (1.5 (\times) ST); RUL: 0.3 ms to 0.37 ms or 1.0 ms (6 (\times) ST)</td>
<td>CGI-I determined from medical records</td>
<td>No statistically significant difference in the CGI-I response rates between the 2 groups ((P &gt; .017))</td>
</tr>
<tr>
<td>Margoob and Andrade\textsuperscript{23}</td>
<td>1/05-12/05</td>
<td>20</td>
<td>Open-label, prospective</td>
<td>Adults with PTSD\textsuperscript{a} and eligible outpatients undergoing ECT</td>
<td>Fixed course of 6 bilateral ECT; pulse width 1.5 ms, twice-weekly outpatient ECT</td>
<td>CAPS (primary); MADRS, CGI-S (secondary)</td>
<td>CAPS improvement of 34%, MADRS of 51% (most by 3rd ECT for CAPS and MADRS); response rate was 70% in the ITT and 82% in completers (no remissions); gains maintained at 4 to 6 months (assessed only clinically</td>
</tr>
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\textsuperscript{a}Based on DMS-IV criteria: \(\geq92\) had ECT and 3393 did not: \(\leq75\) in each group.

PCL, PTSD Checklist; MADRS, Montgomery-Asberg Depression Rating Scale; RUL, right unilateral; SD, standard deviation; ST, seizure threshold; CGI-S, Clinical Global Impression-Severity; CGI-I, Clinical Global Impression-Improvement; pw, pulse width; CAPS, Clinician Administered PTSD Scale; MADRS, Montgomery-Asberg Depression Rating Scale; ITT, intent-to-treat analysis.
Dr. Youssef is the principal investigator (PI) of the Low Amplitude Seizure Therapy (LAP-ST) randomized clinical trial and prior PI on a proof of concept LAP-ST clinical trial. He is currently a co-investigator on the FEAST study funded by MECTA, but did not receive any monetary or salary support from MECTA or other device or pharmaceutical companies (past 5 years) for any of the studies. Dr. Youssef received research support from the Veterans Administration, and a grant from ABR Corporation, and the NIH (past 5 years).

Disclaimer: The views expressed are those of Dr. Youssef and do not represent Medical College of Georgia or the Department of Veterans Affairs.

References

Treatment-Resistant PTSD
Continued from page 17

treated with ECT who had MDD and comorbid borderline personality disorder, PTSD, or both (n = 75), and a matched group but with MDD alone without comorbidities (n = 75). The medical records were reviewed to determine treatment response and estimate CGI-improvement (CGI-I). Study findings showed no statistically significant difference in the CGI-I response rates between the 2 groups (P > .017). Limitations of the study were that no specific measures of PTSD were used other than the c-CGI-I, the retrospective design, and that the group of interest was heterogeneous (with comorbid borderline personality disorder, PTSD, or both).

The only clinical trial available in the literature for ECT in PTSD is an open-label non-controlled trial. Participants (N = 20) had severe, chronic, and treatment-resistant PTSD as evidenced by failure to respond to 4 or more adequate antidepressant trials, as well as 12 sessions of cognitive behavior therapy. This is also the only study that measured PTSD with the Clinician-Administered PTSD Scale (CAPS) as the primary measure. CAPS scores for the sample mean decreased by 34% (P < .001). The authors also reported that the correlation between improvement in CAPS and MADRS was low, suggesting that benefits for PTSD were independent from depression improvement.

This data seems encouraging; however, the overall evidence is still limited as this study was small and uncontrolled. No randomized controlled clinical trials exist so far. Thus, routine clinical use of ECT for PTSD cannot be recommended, at least not yet. The available studies either have small sample size or design limitations or both. However, most available evidence is positive, although publication bias could not be ruled out. The available evidence warrants further research in this area to provide definitive answers.

Conclusion
The preliminary data on the role of ECT in PTSD seems promising. However, I would caution that (although most studies are positive suggesting a helpful effect of ECT in PTSD), the studies so far are preliminary and publication bias (where negative studies may not have been published) cannot be ruled out.

Thus, definitive, well-powered, randomized controlled clinical trials to confirm or revoke the initial results are warranted, given the severe burden, grave suffering, and lack of revalidation with standard therapeutics in many patients with PTSD. Modification of the clinical trials using the innovative technique of trauma memory arousal to deconsolidate memories shortly before an ECT session may prove to be more fruitful in future clinical trials.

On the clinical side, there is not enough evidence to support the use of ECT for PTSD. However, since PTSD is commonly comorbid with other disorders where ECT is clinically indicated (such as depression and schizophrenia), comorbid PTSD should not dissuade the clinician from treating patients with ECT who are otherwise clinically appropriate to benefit from ECT.

Complementary and Integrative Health Approaches for PTSD

Anne L. Malaktaris, PhD and Ariel J. Lang, PhD, MPH

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In recent years, we have witnessed growing interest in complementary and integrative health (CIH), which involves the incorporation of strategies that currently fall outside of Western medicine into care with the aim of improving wellness as opposed to simply mitigating symptoms. “Complementary” refers to the use of practices and interventions outside of traditional, conventional Western medicine. This is in contrast to “integrative medicine,” which involves combining CIH and conventional Western medicine. The goal of integrative medicine is to use a holistic, patient-centered approach to care that acknowledges the mind-body connection, and the unique needs and preferences of each individual.

Complementary and integrative health approaches include a wide range of interventions, such as meditation, yoga, massage, acupuncture, and herbal remedies. These approaches are often used to support overall health and wellbeing, and can be particularly helpful in managing symptoms of conditions like PTSD. For example, practices like yoga and meditation have been shown to reduce symptoms of anxiety and depression, while acupuncture may help with pain management.

However, the evidence for the effectiveness of CIH in treating PTSD is limited. While some studies have shown promising results, others have found mixed or no effects. More research is needed to determine the role of CIH in the treatment of PTSD, and to identify which interventions are most effective for which patients.

PTSD is a complex disorder that affects many aspects of a person’s life, including their ability to function in daily activities, their relationships, and their ability to engage in activities they enjoy. For many individuals, traditional treatments for PTSD may not be sufficient, and seeking out complementary and integrative approaches may be a valuable addition to their treatment plan.

However, it is important to note that CIH should not replace evidence-based treatments for PTSD like medication and cognitive-behavioral therapy. These treatments have been extensively studied and are supported by a large body of research as effective for managing PTSD symptoms.

It is also important to consider the potential risks and side effects of CIH, as well as the potential for interactions with conventional medications. Patients should discuss any complementary or integrative therapies they are considering with their healthcare provider to ensure that these treatments are safe and appropriate.

In conclusion, while the evidence for the role of CIH in the treatment of PTSD is not yet conclusive, there is potential for these approaches to be helpful for some individuals. Further research is needed to better understand the role of CIH in PTSD, and to identify the most effective interventions for different patients. As such, it is important to approach these approaches with an open mind, but also with a critical eye, and to prioritize evidence-based treatments for PTSD.

Significance for Practicing Psychiatrists

Patients are increasingly using complementary and integrative (CIH) approaches, including meditation, yoga, relaxation, physical exercise, acupuncture, and herbal remedies to ameliorate the symptoms of PTSD. There is emerging evidence to support the recommendation of CIH approaches as complementary treatments for PTSD, and patient interest and preference can guide the selection of technique(s).

Providers can recommend CIH approaches as complementary treatments for PTSD using patient interest and preference as a guide. Providers should support patients in applying one technique at a time, committing to consistent practice, and using an objective method to monitor practice.
Two Misleading Myths Regarding “Medical Aid in Dying”

Assisted Dying,” “Medical Aid in Dying” (MAID), “Physician Assisted Suicide” (PAS)—by whatever label we attach to it controversy continues to swirl around the practice of prescribing a lethal drug for a patient with a putatively terminal illness.1,2 (For now, let’s leave aside the point that physicians are notoriously bad in predicting when a patient will die, getting it wrong about 80% of the time and underestimating life expectancy in about 17% of cases.) (CONTINUED ON PAGE 18B)
To be clear: people of conscience, including many physicians, are sharply divided regarding whether, and under what conditions, MAID/PAS may be ethically justified—even when it is legal. The challenges of providing end-of-life care that preserves the patient’s humanity and minimizes pain and suffering are complex and daunting. We do not believe there are simple, universally applicable clinical or ethical options for addressing these challenges. However, in this essay, we argue that support for “assisted dying” as the preferred option is founded on numerous misconceptions regarding existing MAID/PAS statutes, among both the general public and many physicians. Here, we discuss two fundamental misconceptions: the myth of the patient’s autonomy, and the myth of the incurability of the patient’s illness.

**Authentic autonomy and pseudo-autonomy**
The term “autonomy” literally means, “living by one’s own laws” (autos “self” + nomos “law”). In medical ethics, as Beauchamp and Childress explain,

> **Personal autonomy is, at minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan.**... A person of diminished autonomy, by contrast, is in some respect controlled by others or incapable of deliberating or
that these laws are grounded in the patient’s “autonomy,” and establish “the patient’s right to die” or “the right to death with dignity.” Yet the US Supreme Court has never recognized a constitutionally based “right to die,” a “right to commit suicide,” or a “right to assisted suicide,” although it has upheld a competent patient’s right to refuse life-saving treatment. The Supreme Court’s rulings (eg, Washington v Glucksberg and Vacco v Quill) stand in a long line of legal precedent and common law tradition, reflecting foundational Anglo-American philosophical and religious values. These include the state’s legitimate interest in safeguarding human life and preserving the integrity of the medical profession.

Even a casual perusal of most MAID/PAS legislation—modeled closely on the 1997 Oregon “Death with Dignity” statute—reveals that these statutes provide nothing remotely resembling “autonomy” for the patient, in either the procedural or personal sense. Patients who wish to avail themselves of prescribed, lethal medication must clear a number of procedural and administrative hurdles that depend entirely on the diagnostic, prognostic, and prescriptive authority of the patient’s physician. The controlling decisions regarding the patient’s diagnosis; the need for a con-
sultant to confirm the diagnosis; the putative “terminal” nature of the illness; the completion of required certification forms; and, finally, the writing of the lethal prescription are all exercises of the physician’s autonomy.

In contrast, when competent patients refuse life-sustaining care or choose “voluntarily stopping eating and drinking” (VSED), they are making genuinely autonomous choices. These options may allow patients to regain a sense of control and self-direction. Palliative and hospice care, at their finest, are about empowering such patient-driven choices. Ironically, as Varelius observes, “... in voluntary euthanasia and physician-assisted suicide... one ceases to be an agent and loses control over one’s life.”

The famous libertarian and critic of psychiatry, Thomas Szasz, was one of the first to “call foul” on the notion of patient autonomy in MAID/PAS. As Szasz succinctly puts it in his book, Fatal Freedom,

... the legal definition of PAS as a procedure that only a physician can perform expands the medicalization of everyday life; extends medical control over personal conduct, especially at the end of life; and diminishes patient autonomy...

Indeed, Szasz’s analysis makes clear that the patient who elects PAS is not making a procedurally autonomous decision, but a heteronomous one (ie, subject to a law or standard external to oneself). Ironically, this heteronomy is a form of paternalism that actually undermines the patient’s autonomy by...
surrendering control to “the other,” be it physician or government. Not coincidentally, Szasz regarded physician-assisted suicide as little more than “bureaucratized medical killing.”

Of course, there is much more at stake in this debate than mere procedural autonomy (ie, the ability to “command and control” a particular sequence of events or procedures). At issue is what we would call authentic autonomy, which reflects both the psychology and the core internal values of the person. How, then, is the patient’s authentic autonomy assessed under current PAS statutes? To what degree is the patient’s genuine informed consent ensured? And are there sufficient safeguards under current PAS statutes to ensure that the patient does not have a psychiatric disorder that would impair understanding and undermine informed consent? Can a person in such existential distress truly exercise the voluntarism that is integral to authentic autonomy? We believe that, under current MAID/PAS regulations, these critical issues have not been given serious moral consideration.

Indeed, as our colleague, Dr James L. Knoll IV, has written, “problems not likely to be resolved anytime soon include: the lack of a widely accepted capacity assessment for PAD [physician-assisted dying]; the absence of any legally defined test for capacity to consent to PAD; clearly distinguishing depressive symptoms from a “rational” wish to die; and the fallibility of evaluators…This would seem to lead into a morass of fundamentally subjective determinations.”

(CONTINUED ON PAGE 18F)
Furthermore, it is not true that under current PAD statutes “... mental illness that would affect the rationality of decision-making is screened out,” as erroneously claimed in a position paper from the American Association of Suicidology. One of the most profound and misunderstood limitations of statutes modeled after the Oregon Death with Dignity Act is that they do not require examination by a mental health professional, except when the participating physician is “concerned” and decides to do so. In fact, in Oregon, 204 patients were prescribed lethal drugs in 2016 under the “Death with Dignity” statute, yet only 5 patients were referred for psychiatric or psychological evaluation.

But let’s assume that an ideal assessment process is available; that the physician utilizes it when the request for “aid in dying” is made; and that the physician finds the patient to have the requisite decision-making capacity under the law to receive the lethal prescription. This says little about the patient’s state of mind once he or she leaves the office with the prescription. There remains a huge informational gap, since the physician can in no way guarantee that, once in the home setting, the patient’s decision is free from familial pressure, economic coercion, or “conflicts of interest.”

Under current “Oregon type” statutes, there are no mandatory procedures in place that comprehensively evaluate the dynamics of the patient’s severely stressed family system. For example, does the patient have a family member who stands to gain from the patient’s suicide—by, say, inher-
Grossberg observe in their textbook on long-term care, the preeminence of autonomy as an ethical principle in the United States can sometimes lead health care providers to disregard other moral considerations and common sense when making clinical decisions . . . we strongly feel that the role of the medical profession is to understand but not to support such wishes [for physician-assisted death]. Every person’s life is valuable, irrespective of one’s physical and mental state, even when that person has ceased to be a deep life valuable.  

Re-defining incurability and terminal illness  
Most PAS legislation applies to an adult with a terminal illness or condition predicted to have fewer than six months to live. The common interpretation of this phrase would be, “six months to live even with treatment,” often with the assumption that there is no further or additional therapy capable of halting or reversing the disease process. Good law and sound public policy both depend upon clear and cogent definitions. Yet, incredibly, “terminal illness” is never defined at this level of detail in existing PAS statutes (i.e., with respect to treatment vs no treatment). Nevertheless, in Oregon and Washington State, nearly identical criteria are interpreted to mean fewer than six months to live without treatment. Thus, an otherwise healthy 20-year-old with insulin-dependent diabetes could be deemed “terminal” for the purpose of Oregon’s “Death with Dignity Act,” since, without insulin, the patient would probably die within six months.  

So, too, patients refusing appropriate treatment may be deemed “incurable” or “terminal” under current interpretation of the Oregon law.  
Thus, a patient with anorexia nervosa who refuses treatment could be eligible for PAS under Oregon law, even though she has never tried a course of intensive, evidence-based therapy. By this Orwellian logic, an individual with pneumonia who refuses to take antibiotics could be deemed “incurable” and qualify for physician-assisted suicide! As Swedish investigator Fabian Stahle dryly observes, “This is in fact an alteration of the traditional meaning of the concept of ‘incurable’ . . .”  

In a remarkable, notedarized exchange with the Oregon Health Authority, Mr Stahle posed the following questions:  
In the [Oregon] law, “terminal disease” is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment (in the opinion of the patient’s attending physician and consulting physician), produce death within six months. Is this rule interpreted as “without administration of life-sustaining treatment”?  
Craig New, Research Analyst, Oregon Health Authority, Center for Public Health Practice, Public Health Division, replied as “ . . . your interpretation is correct. The question is: should the disease be allowed to take its course, absent further treatment, is the patient likely to die within six months”? (emphasis added)  
As Mr. Stahle rightly concluded, “So under Oregon’s assisted death law, one can achieve the status of being “incurably” sick even if the disease can be treated! Thus, all diseases which, without treatment, are expected to lead to death within six months are considered to be incurable and therefore qualify for assisted death.”  
Stahle then posé a follow-up question to Mr New:  
If a patient with a chronic disease (for instance, diabetes) by some reason decides to opt out from the life-sustaining medication/treatment and by doing so is likely to die within 6 months, thereby transforming the chronic disease to a terminal disease—does he/she then become eligible to take use of the act?  
New replied that, yes, indeed— the patient would qualify for assisted suicide. In New’s words, the Death With Dignity Act “ . . . does not compel patients to have exhausted all treatment options first, or to continue current treatment . . . [and] if patients decide they don’t want treatment, that is their choice.”  

Conclusion  
There is certainly room for debate regarding the role of the physician in “end-of-life” care. Nonetheless, as psychiatrists and medical ethicists, we believe that so-called “medical aid in dying” (physician-assisted suicide) is a serious boundary violation and an unethical act. This is consistent with the historical positions of the American Medical Association, the American Psychiatric Association (based on the AMA Code of Ethics), the American College of Physicians, the World Medical Association, and the American Nurses Association.22  
Whatever individual physicians decide with respect to MAID/PAS, it must be based on a clear-eyed understanding of current statutes and legislation. This means exposing the myths that surround these statutes.23 Among these are the commonly-received notions that patients choosing PAS act “autonomously” and have a demonstrably incurable condition. In truth, current PAS statutes produce a form of pseudo-autonomy that enshrines the supreme authority of the physician, and re-defines “incurable” to mean almost anyone who is seriously ill.

References  
Two Myths

Continued from page 18G

Laughter Is the Best Medicine

Kavita Khajuria, MD

Dr Khajuria is Staff Psychiatrist, Men’s Forensic Outpatient Unit, Twin Towers Correctional Facility, Los Angeles, CA.

Modern life has become increasingly complicated and it’s believed that stress is the primary obstacle to laughter. Laughter is a physical expression of humor and joy that has numerous protective qualities. It’s one of the best ways to manage perceptions of stress and to develop resilience and improve psychological sturdiness as it strongly correlates with happiness.1 Happy-ness and humor can improve brain function—there is evidence of increased connectivity in various parts of the brain in response to laughter.2

Humor releases brain derived neurotrophic factor, which supports existing neurons and encourages the growth of new neurons and synapses.3 Given the brains neuroplasticity, it’s to our benefit to make our lifetime experiences as positive and hilarious as possible.

The field of medicine has long recognized the importance of humor. In the 1300s, Henri de Mondeville, a professor of surgery, propagated post-operative therapy with humor.4 Norman Cousins, a journalist and a professor, also initiated this trend when he developed his own “treatment,” based on mood elevation through laughter.5 According to Cousins, ten minutes of laughter resulted in two hours of pain free sleep.6

Many studies have demonstrated the beneficial effects of laughter.7 Laughing during a humorous film elevates the pain threshold and can help break the cycle between pain, sleep loss, depression, and immune-suppression.8 Laughter lowers blood pressure, epinephrine, and glucose levels, and increases glucose tolerance. Laughter also assists in the recovery and prevention of cancer by increasing natural killer cell activity, the response of gamma interferon and T cells, and improves the defense against respiratory infections. Humor and laughter produce a discharge of endorphins with both euphoric and calming effects.9

Laughter yoga is a contemporary technique developed in India that encourages participants to mimic the act of laughing with the goal of achieving positive psychological outcomes. The results have shown significant improvements in positive emotions and reductions in the severity of symptoms of stress and anxiety as well as reduced anxiety and improved quality of sleep in patients suffering from Parkinson disease.10,11

Humorous interventions may be especially helpful with aging. Findings indicate that happier people are less likely to develop tau tangles and amyloid plaques.12 Moreover, increased use of humor in the period following the death of a spouse was found to promote greater emotional resilience.13 In particular, those using more humor were better able to keep positive emotions distinct and separate from their negative emotions, resulting in fewer depressive symptoms.14 Humor related benefits have also been reported by elderly residents in assisted living facilities.15

As suggested by Freud, humor may be the highest of the defense processes of the psyche, which we can invoke to guard against anxiety.16-18 Throughout history, humor has been linked to tragedy in literature and theater, but it can also be a form of escape.19,20 Black humor or “Gallows” humor can qualify as support mechanisms in the presence of impossible situations or traumatic circumstances in order to relieve tension and cope with the stress.21,22 The search for a funny aspect in a difficult moment can help us endure it, and when used to help others to copy, can be altruistic.23

Freud postulated that humor works by condensation and displacement and believed that cultivating a sense of humor could lift repression.24 When used appropriately, humor can have a place in therapy for generalized anxiety disorder, depression, and social anxiety. It can be a part of interpersonal therapy and CBT.25 Humor in CBT can help patients reframe their maladaptive thoughts, elevate mood, and overcome perceived obstacles.26

It’s recommended that humor be utilized only after establishment of the therapeutic alliance and knowledge of the cultural customs of the patient.27 In group settings, laughter strengthens interpersonal relationships, promotes group bonding, facilitates teamwork and cooperation, and defuses conflicts.28 If used appropriately, humor can convey a sense of humanity, overcome barriers, build trust and encourage empathy.29

Laughing at oneself also encourages healing. As Poland writes “there is a need to learn to laugh at oneself as an individual and also as a professional.”30 Anne Dean goes so far as to cite humor as a characteristic necessary for a successful career in psychiatry.31 Patch Adams, a physician and a clown, believed that humor and love were at the core of a good bedside manner.32 Humor also facilitates acceptance of traits in others that are unlikely to change.33 Laughing helps tame the inner critic that can demand unattainable standards, and can be used to boost self-esteem and buffer the self.34

It has been suggested that humor differs from other cognitive based emotional regulation strategies in that it doesn’t deny the negative experience, but helps to construe it as less threatening.35 Being able to laugh at traumatic events in our lives doesn’t cause us to ignore them, but prepares us to endure them through playfulness and a changed prism of perception of life’s challenges.

Humor can enhance the willingness to change and improve emotional expectations and can revive habitual narratives that perpetuate shame, hurt, isolation, inferiority, sadness, worry, and perfectionism.36 Of all the commonly endorsed character strengths, humor contributes most strongly to life satisfaction.

A notable body of literature on the role of humor and well-being has developed over recent years and much of it addresses how humor can facilitate coping with stress or enhance personal and social relationships. Research has also provided evidence that humor can serve as an important facet of resilience and can contribute to the enhancement of positive life experiences.

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CIH appears best applied as an adjunct to other treatments for PTSD or for individuals who initially refuse other evidence-based approaches. Generally maintained over time. Furthermore, the development of new pharmacological treatments for PTSD has been described as stagnant. Hence, there is a need for approaches to augment current best practices.

Individuals with PTSD are increasingly seeking CIH (see the Table for summary of CIH approaches); in a 2012 survey, 39% of individuals with PTSD reported using CIH, with meditation and relaxation being the most commonly employed modalities. Despite the increasing popularity of CIH, a 2011 systematic review identified only seven randomized controlled trials (RCTs) of CIH for PTSD; the studies were generally preliminary, under-powered, and methodologically limited. Although many researchers continue to work actively in this area, methodological concerns, such as small sample sizes, lack of active comparators and non-randomized designs, continue to limit the conclusions that can be drawn. As a result, there is no definitive evidence about the use of CIH approaches for the treatment of PTSD or about the selection of one approach over another. Although many studies have demonstrated the potential usefulness of CIH, it would be premature to recommend the use of CIH approaches as front-line treatments for PTSD.

### Meditation

**Open-monitoring meditation.** Open-monitoring meditation involves paying attention to thoughts, feelings, and sensations as they arise, without judgment. Mindfulness, a well-known example of this practice, involves present-focused attention on what is happening in the moment with non-judgmental acceptance of the experience. Mindfulness offers a way to increase awareness and acceptance of difficult experiences. Several preliminary studies and one RCT have demonstrated initial promise of mindfulness-based interventions, such as mindfulness-based stress reduction, in reducing PTSD symptoms.

**Concentrative meditation.** Concentrative meditation, such as transcendent meditation (TM) or mantra meditation, involves focused attention on an object, word, image, or breath. Initial studies have demonstrated the feasibility of mantra meditation and TM for individuals with PTSD. One application, the Mantram Repetition Program (MRP), involves focus on repetition of a spiritually meaningful word or phrase (eg, Om, Ave Maria, Shalom); when attention wanders, it is returned to the word or phrase, without judgment. One RCT demonstrated added benefit of MRP when added to treatment as usual, and additional work is underway to evaluate MRP compared with an active control.

Mantra meditation may be particularly helpful for reducing physiological arousal, which has potential clinical utility in that individuals with prominent hyperarousal symptoms tend to show less overall symptom improvement over time than those without prominent hyperarousal symptoms. A recently completed study that compared TM, prolonged exposure therapy, and psychoeducation will likely contribute to our understanding of the relative benefits of concentrative meditation.

**Contemplative meditation.** Contemplative practices involve focusing on states that have been applied to PTSD include compassion meditation, such as Cognitively Based Compassion Training®, which focuses on the wish that others be free from suffering, and loving-kindness meditation, which involves the repetition of positive intentions for self and others (eg, "may all beings be happy and free"). Compassion meditation has been associated with increases in positive emotion and social connectedness in non-clinical samples. Open trials suggest the feasibility and potential clinical utility of these approaches for veterans with PTSD. Work is ongoing in our laboratory and elsewhere to examine the efficacy of these approaches.

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**TABLE. Overview of CIH approaches for PTSD**

<table>
<thead>
<tr>
<th>CIH approach category</th>
<th>Specific techniques</th>
<th>Possible benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manipulative and body-based practices</td>
<td>Acupuncture, physical exercise</td>
<td>Reduction in inflammatory processes; reduction in HPA stress response; inhibition of sympathetic nervous system response</td>
</tr>
<tr>
<td>Meditation</td>
<td>Mindfulness</td>
<td>Shifting attention to the present; adopting a non-judgmental attitude towards distressing experiences</td>
</tr>
<tr>
<td>Open monitoring</td>
<td>Transcendental meditation, mantra, repetition program</td>
<td>Reduced physiological arousal</td>
</tr>
<tr>
<td>Compassion</td>
<td>Compassion meditation, loving-kindness meditation</td>
<td>Increased positive emotions; increased social connectedness</td>
</tr>
<tr>
<td>Relaxation</td>
<td>Diaphragmatic breathing, progressive muscle relaxation</td>
<td>Reduced physiological arousal</td>
</tr>
<tr>
<td>Yoga</td>
<td>Anusara, Ashtanga, Bikram, Hatha, Iyengar, Kundalini, restorative, Vinyasa, and Yin yoga</td>
<td>Reduced physiological arousal; increased tolerance of/non-reactivity to internal experiences; improvement in focused attention</td>
</tr>
</tbody>
</table>

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**CASE VIGNETTES**

Mr R, aged 55 years, sought treatment for PTSD symptoms, including hypervigilance, insomnia, exaggerated startle response, and irritability. He agreed to engage in a manualized treatment protocol that included exposure, cognitive restructuring, and experiential processing of trauma-related emotions and beliefs. Mr R was offered training and practice in mindful breathing as an adjunct to his trauma-focused psychotherapy.

Mr R did not initially have a positive response to the mindful breathing exercises, stating that he “didn’t get it” and found it “corny.” Nonetheless, he was encouraged to use this practice to help shift his perspective and engage in the present. After about 3 weeks of practice, he stated that “it started to click,” and after 6 weeks of practice, he stated that it helped him feel more relaxed and less irritable. After 12 weeks of practice, Mr R reported improvements in hyperarousal symptoms and was able to respond to trauma reminders in a more functional way due to his ability to shift perspectives.
CIH Approaches for PTSD

Mr L is a veteran with PTSD and chronic pain, who joined our compas-
sion meditation program (Cognitively Based Compassion Training®) as an adjunct to his pharmacologic treatment. He had symptoms of avoidance related to both conditions and reported irrita-
-bility. At the start of training, he report-
ed some struggles with learning medi-
tation, finding it difficult to maintain focus on the breath and becoming frustr-
ated when his attention was drawn away. He persisted with the practice, however, and was particularly comp-
pelled by the contemplative practice in the latter half of the group. Although his PTSD symptom scores reduced mean-
ingfully, his primary provider was most struck by the difference in his appear-
ance after he completed the group. Pre-
viously somewhat disheveled and pre-
paring an angry demeanor, he was dressing and grooming himself more neatly. He had really had it when he was being conveyed a message to others to “stay away,” and wanted now to be seen as open to engaging with others.

RECOMMENDATIONS. Medita-
tion is readily accessible, deliver-
able in a group format, typically well-tolerated by individuals with PTSD, and has low risk of adverse effects. Patient preference may dic-
tate the approach. There is no indi-
cation that meditation would inter-
fer with standard treatment; instead, there is initial evidence that mediation-based approaches may augment usual care. Thus, we rec-
ommend encouraging meditation practice in addition to standard care as consistent with current treatment guidelines.

Yoga

Yoga typically consists of physical movements or postural sequences, inten-
tional regulation of breathing, and focused attention. Yoga may help to reduce physiologic arousal, increase a subjective sense of calm, and increase tolerance of and non-reactivity to internal experienc-
es. Study findings suggest benefits of yoga among individuals with PTSD.17,18

RECOMMENDATIONS. Yoga is acceptable, feasible, and low-risk; yoga can be recommended as a comple-
mentary approach to other evidence-
based treatments. It may be helpful to direct individuals to PTSD to teachers who are familiar with trauma-sensitive yoga. Macy and colleagues19 offer the following guidelines to providers who recom-
mend yoga to their patients:

- Individuals should commit to consistent practice for at least 2 to 3 months.
- Meditation should be a component of yoga practice.
- Formal classes provided by a certified yoga instructor are preferred to independent practice.
- All individuals should consult with a physician prior to beginning the practice of yoga to discuss the unlikely, but possible, physical risks associated with yoga.

Other CIH approaches

Acupuncture. For a summary of the conceptual rationale and pro-
posed mechanisms for the potential efficacy of acupuncture for PTSD, see the review by Hollifield and col-
leagues.20 Several preliminary stud-
ies found promising evidence for the efficacy of acupuncture for treating PTSD; however, firm conclusions regarding the effectiveness of ac-
upuncture cannot be made.21,22

Relaxation. Relaxation techniques, such as diaphragmatic breathing and progressive relaxation, are often taught in cognitive and behavioral therapies for PTSD and may pro-
 mote meaningful engagement in trauma-focused psychotherapy. Some studies have found evidence for the benefits of relaxation train-
 ing for PTSD, however other studies showed minimal clinical benefit from relaxation training.23,24 Relax-
ation training alone is unlikely to be sufficient to address symptoms of PTSD.

Physical exercise. One initial re-
view suggests that physical exercise is inversely related to PTSD symp-
ptoms; another preliminary study found that aerobic exercise before PE augmented treatment gains.25 Despite the paucity of evidence, it is reasonable to believe that physical exercise may confer benefits to indi-
viduals with PTSD, including in-
creased positive affect, improved sleep quality, reduced social isola-
tion/withdrawal, and physiological regulation. Physical exercise can cer-
tainly be recommended to com-
plement standard care.

Herbal remedies. Herbal reme-
dies, such as kava and St. John’s word, may be helpful in treating symptoms that commonly accompa-
nym PTSD, such as depressive and anxiety symptoms. In some cases, life-threatening drug interactions have been reported with the use of St. John’s word.27 Therefore, patients should be cautioned against using herbal treatments combination with alcohol or other medications.

Conclusions

CIH is widely requested and used by patients for a variety of complaints, including managing PTSD symp-
ptoms. Not all CIH approaches appear equally promising in the treat-
ment of PTSD, although research in this area is rapidly evolving. Given the relative lack of rigorous, well-designed RCTs to evaluate the efficacy, safety, and specificity of CIH approaches, CIH appears best applied as an adjunct to other treat-
ments or for individuals who initially refuse other evidence-based ap-
proaches.

In conclusion, CIH approaches can be reason-
bly recommended as complement-
tary treatments for individuals with PTSD; there is no evidence that the techniques are harmful aside from the caveat about herbal remedies. Clinicians are encouraged to take an empirical approach to recommend-
ing these techniques: try one ap-
proach at a time, recommend con-
sistent practice, and use an objective method to monitor response. Given that there is no evidence to suggest that one CIH approach is superior to another, patient interest and prefer-
ence can guide these decisions. Ma-
ny individuals will need guidance and training to implement these ap-
proaches, so clinicians should be knowledgeable and have a concep-
tual understanding of these ap-
proaches to provide support for pa-
tients learning new techniques.

The authors report no conflicts of interest concerning the subject matter of this article.

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Sharing Patient Cases: Balancing Confidentiality and Educational Needs

Theodore Fallon, Jr, MD, MPH, for the Committee on Professionalism and Ethics of the Group for the Advancement of Psychiatry

Prior to 1990, the psychiatric literature often contained detailed clinical case descriptions. These descriptions allowed us to communicate important and nuanced aspects of our psychotherapeutic work. Providing detailed descriptions of interactions that occurred between patient and therapist moved our field forward by both honing our technique and considering more effective ways to help our patients.

Today, the vast majority of professional publications are available to anyone with access to the internet. Perhaps as a result, the number of detailed descriptions in journal articles have decreased, and some have even stopped publishing case reports. In turn, this deprives our field of the opportunities to provide optimal stewardship of our unique and valuable knowledge base. (Of course, presentations to exclusively professional audiences continue; these seminars and conferences remain viable options that can offer this same rich clinical material.)

To maximize our continued progress, we need to retain our practice of presenting detailed clinical reports. Only detailed narratives provide the actual, in-the-moment, give and take of clinical work. Unfortunately, using composite or disguised cases, now a common practice, creates fiction that may fall short of our unique and valuable knowledge base. (Of course, presentations to exclusively professional audiences continue; these seminars and conferences remain viable options that can offer this same rich clinical material.)

There is an inherent dilemma when we publish detailed clinical material. Prior to the internet, journal articles were much less accessible to the public. Now, published material can be retrieved rapidly by anyone with internet access and the thought that patients will not find their therapist’s published work is simply naive.

Since clinicians who participate in educational activities are sworn to maintain the same confidentiality as the treating clinicians, teaching and professional presentations are not considered violations of patient confidentiality. Even in these situations, though, we customarily provide only de-identified material to reduce the chances of accidental disclosure.

When it comes to publishing detailed clinical case material, however, de-identification may not offer enough protection, but too much disguise may threaten to make the case a fiction that loses the specificity necessary to advance knowledge. Changing small details, as previously illustrated, can drastically alter the dynamics of a case.

The third option, to inform the patient, may be the safest and most effective approach at this time. In fact, most journals now require written consent from the patient. However, there are concerns with this approach, too. We begin our clinical work with each patient by promising them confidentiality. As we discover our patients’ secrets, how can we turn around and say, in essence, “Now I would like to tell the entire world about your thoughts and feelings.”

Similarly, can (and should) we ask the patient for consent, given the potential power differential between patient and therapist? Might the patient react negatively to the publication, even if we ask for and obtain consent in advance? Might what we publish have an adverse effect on the patient’s future life? If we are to assure continuing advancement of our psychotherapies, we must find solutions to these dilemmas. With the intent of supporting continued stewardship of a progressive knowledge base, the Committee offers the following suggestions in hopes they will open a dialogue that leads to practical, effective solutions to these dilemmas.

To begin, let us consider psychotherapy as a field in medicine that is built on a tripartite model of practice, teaching, and research. The knowledge base for this three-pronged endeavor must rest on a foundation of real, not fabricated, clinical observations.

We must also understand that we are not in full control of the clinical process. Neither are we omniscient. Instead, in psychotherapy, we listen with an open mind, stretching ourselves to be aware of the vast uncertainties that always lie before us when we work with our patients. With these perspectives in mind, we might begin our treatments with a consent that acknowledges these perspectives. An example is the following:

“From time to time in our work, if and only if it is fully acceptable to you, it may be useful to share what we do here with my colleagues. I might do this to teach or to better understand what we are doing here. Of course, these other medical professionals will keep this material private, just as I do. It may also be useful to share this material with a wider audience, such as by publishing in a professional journal. I would speak with you about this possibility before pursuing it. Again, if you agree, I would work with you to make such a publication acceptable to you, and you will always have absolute veto power to say no to anything before it is submitted for publication.”

This sort of consent lays the groundwork for helping the patient become aware of, and participate in, a collaborative process.

**WE OFFER 10 GUIDELINES TO CONSIDER**

**When working toward a publication of detailed clinical material and case reports.**

These guidelines lay out the details of this collaboration, and they further specify principles to considered in this process.

1. The work to be published should be a finished product, meaning the treatment has been completed or, at a minimum, that the therapeutic work has moved on to other areas and the area of interest has been settled.

2. The therapist should review the work with the patient. Together, they should consider if there is an agreement on the initial problem, the process by which the problem was addressed and settled, and the gains made. This can be a naturally flowing process of constructing a narrative over time. Optimally, the process should culminate in a summary created collaboratively by the therapist and the patient.

3. The therapist and the patient should discuss the importance of sharing this new understanding/narrative with the field, eg, its potential to benefit others. It is important to identify with the patient the patient’s own motivations for consenting.

4. There should be review and oversight of the detailed clinical material that is being considered for dissemination, similar to what an Institutional Review Board (IRB) does for research. Such oversight considers not only the patient’s perspective, but also the importance to the field.

The step should involve both the review (CONTINUED ON PAGE 22)
The Hills of Paraguay

Richard M. Berlin, MD

All summer southwest wind stirs the weeping willows the way my breath disturbs a settled life when I whisper the cancer diagnosis. But this afternoon our clinic feels far from my garden, more distant than traffic pounding the Pulaski Skyway built long ago without shoulders where police might hide to ambush speeders who roam undetected like occult cancers. At random moments, my mind returns to work, to tumors growing fast and invasive as tipuana trees on the hills of Paraguay, where farmers slash limbs with sharpened machetes to spill blood red resin. And deep in southern summer los viejos proclaim, “The heart is a leaf, and the wind makes it throb,” though I would say the heart of a doctor’s life is the wind in willows that makes him weep.

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Emergency Psychiatry

Continued from page 11

Sharing Patient Cases

Continued from page 21

the clinical material as well as the venue of dissemination. At stake is the potential harm to the patient (both present and future) weighed against the benefit to the field.

This process has traditionally been completed by consulting a respected colleague. Ideally this oversight/review should be completed by persons sufficiently knowledgeable and impartial so they may offer objective reflections. The reviewer(s) should not be too close to the author or have any competing interests with respect to the author; these conditions will make it more difficult to render a contrasting view, as bias may be conscious or unconscious.

Input from the patient should be elicited during this process. The writing should be offered to the patient, who may want to read and even edit it. This is not to burden the patient, who may not want to participate in the process. Instead, the patient may wish to simply consent to disseminating the agreed upon and previously discussed material.

The therapist must make sure that the patient understands the revocable nature of the initial consent—the patient’s veto power—but also understand that once published, the material cannot be unpublished.

The therapist must help the patient consider the implications for the patient’s future, including the uncertainty of these speculations.

This process of acquiring and maintaining the patient’s consent needs to be accomplished over time. The therapist must consider how to differentiation between collaboration and compliance. This notion should be discussed with the patient.

De-identifying the material is important to consider. One way to accomplish this is author anonymity; either use a pseudonym or do not use a byline. Another way is to strip away persons, places and time identifiers, as long as this process does not impact the essence of the clinical presentation.

In cases of children and adolescents, parents and other guardians need to be involved in the process. The parents can give consent; the child can assent. Consider approaches that are appropriate for the age and capacities of the child. Techniques are well developed for child/parent assent/consent for research. Thus, therapists might contact nationally respected sources such as the National Institutes of Health regarding their pediatric informed assent protocols.

We offer these ideas as an invitation to a dialogue that seeks a way to resume sharing our detailed clinical work. We hope this will help move our field forward. We welcome your comments. (Please send your comments and thoughts to editor@psychiatrtimes.com.)

Reference


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The Role of ECT in the Suicide Epidemic

Charles H. Kellner, MD and Shaili B. Patel

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The recent increase in suicides, including those of Kate Spade and Anthony Bourdain, highlights the urgent need for better treatment of severe depression. Recent data from the CDC document an alarming trend: suicide is up by nearly 30% since 1999.1 It is now the 10th leading cause of death, with 45,000 suicides in 2016. While the antecedents of suicide are multifactorial, at least half of the people who attempt or complete suicide have a psychiatric illness, mostly a mood or psychotic disorder.

In a piece in the New York Times, Richard A. Friedman, a psychiatrist, noted, “last year, the National Institutes of Health spent more money researching dietary supplements than it did suicide and suicide prevention. Any other disease that comes close to killing as many Americans as suicide does, like HIV and heart disease, gets marqueee recognition as a public health menace and major federal research funding... the simple reason suicide has been neglected for so long is stigma.”2 Benedict Carey, in a New York Times article about the same CDC suicide data, wrote, “one of the few proven interventions [to reduce suicides] is unpalatable to wide swaths of the American public: reduced access to guns.”3 We believe that another intervention proven to reduce suicidality, ECT, is underused because it is similarly stigmatized and considered “unpalatable.”

A recent series of articles and editorials documents the current state of ECT use (actually underuse) in the US. Herein, we review the new data and make suggestions about “right sizing” ECT in contemporary American psychiatric practice.

Efficacy and cost savings

In the August 2017 issue of JAMA Psychiatry, Harold Sackeim, PhD, wrote an editorial, which accompanied an important study that demonstrated that inpatients with mood disorders who received ECT had half the rate of hospital re-admission in 30 days than those who were treated with medications.4 More recent findings indicate that only 0.25% of patients with mood disorders in a large health care database received ECT.5 Similarly, in a cohort of over 11,000 veterans with psychiatric illness, only 50 received ECT (0.45%).6 Because of its speed and effectiveness, ECT may actually be a cost-saving intervention; this benefit is in addition to its ability to relieve suffering and save lives. The cost-effectiveness of ECT was investigated in a major health economics study.7 Six alternative strategies for incorporating ECT into depression treatment were modeled based on data drawn from multiple meta-analyses, randomized trials, and observational studies of patients with depression. The researchers concluded that an optimal cost-effective strategy is to offer ECT after two failed pharmacotherapy trials, not relinking it to a “last resort” position after innumerable trials. Furthermore, they found, “over 4 years, ECT was projected to reduce time with uncontrolled depression from 50% of life-years to 33% to 37% of life-years, with greater improvements when ECT is offered earlier.”

Utilization of ECT

How much is the right amount of ECT for optimum mental health outcomes? If ECT were used more often, would some suicides be prevented?8 Let’s start by addressing what we know about how much ECT is now done in the US. Unfortunately, in contrast with many European countries where national health databases provide accurate epidemiological data about the utilization of most medical procedures, including ECT, the US lacks such data.

ECT utilization rates have been shown to vary widely, both between regions in the US and between countries around the world.9 In a review, Leiknes and colleagues10 collected data about ECT utilization worldwide. They reported that, despite wide variability, the average ECT treated person rate (TPR) approximates 2.2 per 10,000 resident population per year. In select countries, where ECT may be less stigmatized, the rate is higher. For example, the TPR in Belgium is ~4.5 per 10,000 residents.11 In the US, a TPR of 3 would equate to approximately 90,000 ECT patients per year. This accords well with an estimate derived from one of the best sources of population data in the US, the Medicare database.12 A similar extrapolation from this database is that approximately 450,000 to 500,000 ECT procedures are done annually in the US.

There are 49,000 psychiatrists in the US, but only 1216 were found in the 2016 Medicare database as having performed ECT.13 The International Society for ECT and Neurostimulation (ISEN), has about 360 members.14 There is a gender gap among ECT practitioners, with only 19% being female, despite the fact that psychiatry residency classes for the past decade have been more than 50% female. Only 14% of ECT procedures performed in the US are done by women psychiatrists.15

The ambivalence with which ECT is regarded derives from multiple sources, but the media, with its sensationalized and anachronistportrayals, has been the major influencer. Unfortunately, ambivalence also comes from within the psychiatric profession, where residency experience in ECT is woefully lacking, leading to practitioners who are uncomfortable prescribing it.16

ECT today

Modern ECT has been refined to the point that its morbidity and mortality are remarkably low. A recent systematic review and meta-analysis found a mortality rate of 2.1/100,000 procedures, making it among the safest treatments performed under general anesthesia.17 The technical advancement of ultrabrief pulse right unilateral ECT allows many seriously ill patients to recover with very few cognitive effects.18 ECT practice and research are advancing in the US and abroad. PubMed contains over 15,000 citations for ECT. And, ECT research continues around the world as we mark the 80th anniversary of the invention of ECT.19 Despite the enthusiasm with which newer brain stimulation techniques have been embraced, ECT remains alone; no other modality can come close to ECT for antidepressant/anti-psychotic efficacy, speed of response, and clinical track record of utility. We do a disservice to our seriously ill patients when we confine ECT with other “neurostimulation” techniques.

Conclusion

Taken together, the above data suggest that ECT is, in fact, vastly improved, but still underutilized. We believe that greater, and earlier, prescription of ECT in appropriately selected patients would lead to better mental health outcomes, including fewer suicides. While an exact right-sized figure is hard to come by, we speculate that closer to 250,000 ECT patients per year (resulting in about 1.5 million ECT procedures) in the US is a more appropriate number for optimal mental health outcomes and reduced suicides. Currently, it is easier to get a gun than a prescription for ECT in the US. Fortunately, that is now changing. ECT—marginalized for decades—is regaining its rightful place in the treatment armamentarium of contemporary psychiatric medicine.

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References

Physicians are exposed to a range of traumatic events throughout training and professional practice, including workplace violence, disasters, and hazardous exposures (Table 1). Physicians experience psychological and behavioral effects of trauma with the same range of response (eg, distress reactions, health risk behaviors, psychiatric disorders) as does the general population. An understanding of evidence-based interventions can assist with the management of physician work-associated trauma within the unique setting of health care environments.

To understand work-associated trauma, it is first necessary to properly define terms. Trauma is a physical or mental injury. The criteria for PTSD describe traumatic events as exposure to actual or threatened death, serious injury or sexual violence through direct experience, witnessing, or repeated or extreme exposure to aversive details. Traumatic stress refers to the range of distress reactions, health risk behaviors, and psychiatric disorders that can occur in response to traumatic events. Stressors are defined as external stimuli that disrupt the equilibrium of an individual.

Causes and consequences
Psychological and behavioral responses to trauma
The literature on the effects of traumatic events comes largely from studies of individual and community responses to emergency and disaster events. Most individuals exposed to traumatic events will emerge with limited or no adverse effects, promptly and effectively resuming their social and occupational roles (resilience). Some may experience an increased sense of competence, self-efficacy, and belief in their ability to manage future stressors (often termed “posttraumatic growth”). However, a sizable minority will experience a range of adverse psychological and behavioral effects, including distress reactions, health risk behaviors, and psychiatric disorders (Figure).

Distress reactions include insomnia, irritability, and distractibility. Anger, diminished sense of safety, loss of faith, and demoralization may occur. Somatic symptoms may occur, such as headaches, dizziness, and fatigue. Most who seek care present to primary care and emergency settings. Health risk behaviors include increased use of alcohol, caffeine, and tobacco to self-medicate distress symptoms. Decreased social activities and isolation occur as well, which reduce access to helpful social support networks. Intimate partner and community violence may increase as distress escalates.

ACTIVITY GOAL
To goal of this activity is to understand the etiology of work-associated trauma in physicians, adverse psychological and behavioral responses, and evidence-based interventions.

LEARNING OBJECTIVES
At the end of this CE activity, participants should be able to:

- Describe the causes of work-associated trauma in physicians
- Understand the consequences of traumatic exposure on physicians
- Identify the interventions available for treating physicians who have been exposed to trauma

TARGET AUDIENCE
This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

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Joshua C. Morganstein, MD, has no conflicts to report.

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Approximately 10% to 20% of individuals exposed to a traumatic event present with PTSD, although many experience milder symptoms that can persist and become problematic. The course of PTSD varies, with symptoms escalating over time. Individuals directly exposed to the traumatic event are at greatest risk for psychiatric disorders. Additional risk factors include having an attachment to primary victims, sustaining physical injuries, a personal history of developmental trauma and abuse, or other interpersonal violence.

The element of “repeated or extreme exposure to aversive details” in the DSM-5 definition of trauma typically refers to professions such as child victim units within law enforcement or other professions where exposure to the most extreme events is a routine aspect of professional work. However, the terms “secondary traumatic stress” and “vicarious traumatization” have been used to define a spectrum of psychological and behavioral responses that may result from exposure to traumatic material or the account of patients’ traumatic exposures during clinical care.

Psychiatrists, emergency physicians, and primary care physicians, among others, may experience a range of distress reactions, health risk behaviors, and other traumatic stress symptoms in response to these exposures. It is important to understand that these psychological and behavioral responses may occur for physicians in many different circumstances.

**Traumatic exposures for physicians**

Physicians experience reactions to injury and death throughout their careers and no specialty is immune. In a survey of 113 surgeons, one in five reported medical errors or complications could have been me”). Increases risk for adverse psychological symptoms. Identification with those who have been severely harmed (“that could have been me”) increases risk for adverse psychological symptoms.

**Table 1. Examples of traumatic events experienced by physicians**

<table>
<thead>
<tr>
<th>Trauma</th>
<th>Mechanisms</th>
<th>Factors affecting outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death and injury</td>
<td>Unexpected or sudden patient death; death of a</td>
<td>Self-blame and second-guessing; uncertainty about training and protocols; punitive or</td>
</tr>
<tr>
<td></td>
<td>child; medical errors and complications</td>
<td>disciplinary action; adverse response by patient’s family</td>
</tr>
<tr>
<td>Exposure and contamination</td>
<td>Bloodborne pathogens; aerosolized infectious</td>
<td>Uncertain effectiveness of PPE; clarity of treatment protocols; availability of</td>
</tr>
<tr>
<td></td>
<td>agents; toxic chemicals</td>
<td>treatment and antidote; isolation and quarantine; family safety</td>
</tr>
<tr>
<td>Natural disasters</td>
<td>Hurricane; earthquake; tornado; tsunami</td>
<td>Large number of sick and injured; loss of infrastructure and care resources; reverse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>triage and rationing care; provider’s family injured or in danger</td>
</tr>
<tr>
<td>Mass violence</td>
<td>Active shooter; bombing; civil unrest; war</td>
<td>Treating serious injured patients; large numbers of wounded; proximity of attack and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>community safety</td>
</tr>
<tr>
<td>Workplace violence</td>
<td>Physical or verbal assault; harassment;</td>
<td>Proximity of perpetrator; unclear reporting procedures; culture of silence; fear of</td>
</tr>
<tr>
<td></td>
<td>bullying and intimidation</td>
<td>recurrence; social isolation; stigma</td>
</tr>
</tbody>
</table>

PPE, personal protective equipment.

### Table 2. Types of workplace violence

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Perpetrator has no association with the workplace or</td>
<td>Person with criminal intent commits a robbery</td>
</tr>
<tr>
<td></td>
<td>employees</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Perpetrator is a customer or patient of the workplace</td>
<td>Intoxicated patient punches a nurse’s aide</td>
</tr>
<tr>
<td></td>
<td>or employees</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Perpetrator is a current or former employee of the</td>
<td>Recently fired employee assaults former supervisor</td>
</tr>
<tr>
<td></td>
<td>workplace</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Perpetrator has a personal relationship with employees,</td>
<td>Ex-husband assaults ex-wife at her place of work</td>
</tr>
<tr>
<td></td>
<td>none with the workplace</td>
<td></td>
</tr>
</tbody>
</table>

Following a disaster, health care workers may be both provider and victim. Physician disaster responders may be exposed to mass death and injury, grotesque and disturbing sensory input, and extreme distress in patients. After the Christchurch earthquake in New Zealand in 2011, approximately 10% of medical students experienced moderate to severe distress 7 months later.3 Environmental hazards include chemical, radiological, and infectious exposures both during routine medical care and disaster response. Exposure to these materials lead to a predominance of somatic symptoms, often termed multiple unexplained physical symptoms (MUPS) or multiple idiopathic physical symptoms (MIPS).4 These somatic symptoms will often be the presenting complaint when care is sought by physicians concerned about exposure or contamination. Infectious diseases may be the biggest threat. The Ebola outbreak of 2014-2015 and highly virulent strains of more common pathogens, such as influenza, have caused considerable distress in physicians and other health care providers and been associated with poor work atten-
dance. Mass violence is a highly traumatic event for the public and health care workers involved. Mass shootings in health care settings have captured public attention and generated significant anxiety and fear. Kelen and colleagues\(^5\) reviewed media reports of hospital shooting events between 2000 and 2011 and identified 154 hospital-related shootings, of which 91 occurred inside the hospital. Motives for shooting varied, including grudge (27%), suicide (21%), and euthanizing an ill relative (14%). In 45% of hospital shootings, the victim was the perpetrator, either self-inflicted or shot by security response. Health care providers are at a relatively higher risk of workplace injury and violence compared with other occupations. US hospitals and nursing care facilities have higher than average rates of non-fatal workplace injuries (Table 2). Verbal violence is the most common. Physical violence occurs most frequently in emergency settings where delays in care, intoxication, and psychiatric disorders account for most cases.

Bullying of health care providers is another form of violence and occurs both in person and online. Bullying is experienced by physicians in various levels of training and across disciplines. Although not generally considered a traumatic event, workplace bullying is a significant stressor associated with the development of a similar range of responses resulting from other well-characterized traumatic events. Consequently, bullying should be considered in the discussion of physicians and work-associated trauma. Physicians who are bullied may experience depression and posttraumatic stress symptoms for years following the event. In a study examining cyberbullying of medical students, fellow trainees outpaced the frequency of bullying by other personnel in the training environment by nearly three-fold.\(^6\)

### Interventions

Physician well-being and performance can be enhanced by organizational efforts to reduce adverse effects and promote recovery; provide thorough assessment of affected individuals; and institute prompt, evidence-based intervention following traumatic events. Important considerations include education about and normalizing of response, prevention measures, effective leadership, and barriers to care. Assessment should examine a broad range of behavioral and psychological reactions to traumatic events as well as level of impairment. Evidence-based treatments focus on reducing distress, enhancing well-being, and optimizing social and occupational function.

#### Promoting recovery

Education on stress, normalizing responses, when to get help, and what resources exist are at the core of effective prevention of psychological impairment following traumatic events. Ensuring “adequate equipment” and “protection” increase feelings of safety and reduce perception of risk, allowing health care providers to focus on doing their jobs. It is also important to recognize traumatic events with high-risk characteristics, identify at-risk physicians and system vulnerabilities, and take mitigation steps that promote individual and organizational resilience (Table 3).

Leaders, including those who manage or supervise medical students, residents, or staff physicians, play an important role in preventing and mitigating the impact of trauma exposure. Active listening, empathy, and support reduce feelings of fear and isolation. In this way, leaders can provide the initial support to health care providers affected by traumatic events, a critical element in reducing distress and promoting recovery. Leaders need to address grief and loss that arise following traumatic events. Grief leadership is the process of recognizing and giving voice to what has been lost following traumatic events, providing a sense of hopefulness about recovery, and a positive outlook on the future.

In spite of increased awareness and understanding of mental health, stigma continues to serve as a barrier to help-seeking for physicians.\(^7\) Health care institutions can also foster a professional culture that stigmatizes the use of help-seeking resources. The requirements to monitor and restrict the practice of physicians who are found to be impaired may serve as a significant barrier to help-seeking behaviors. Health care systems can encourage provider self-identification by minimizing or eliminating measures that will be experienced as punitive, including being publicly identified, confidentiality violations, and loss of pay.

#### Assessment

Physicians experiencing significant or impairing distress need timely assessment by personnel trained to understand the unique effects and comorbidity associated with traumatic stress. Employee Assistant Program personnel serve this role in many institutions. Some organizations utilize in-house or contracted medical providers who are able to conduct formal evaluations when traumatic stress is the presenting concern. Assessment should consider not simply the presenting concern or specific traumatic event, but the physician’s entire “network of stressors” (Table 4).

#### Treatment

Treatment for physician work trauma includes early interventions to reduce adverse effects, preserve functioning, and decrease progression to psychiatric disease. When psychiatric disorders occur, evidence-based psychotherapy and pharmacotherapy may help reduce symptoms and functional impairment. Complementary and alternative interventions have an increasing body of evidence supporting their use in the treatment of traumatic stress. A range of behavioral self-help interventions that are patient-centered and provider supported may be used throughout. Many physicians will prefer peer support over formal intervention. A comprehensive treatment plan involves the use of interventions that address the unique circumstances of the trauma in the context of the physician’s preferences (Table 5).

The Psychological First Aid (PFA) principles serve as an evidence-based framework for interventions designed to support the well-being of individuals and communities in the aftermath of traumatic events and includes promoting the following: safety, calming, individual and community efficacy, connectedness, and hope or optimism.\(^8\) Although rigorous studies in physician populations have not been done, the utility of PFA principles can reasonably be extrapolated to the physician population and serve as an important evidence-based guide to developing appropriate interventions. Online and mobile resources as well as web-based training in PFA can help health care personnel enhance their skills to trauma response.\(^9\)
Well-established self-help behavioral interventions for managing distress reactions include diaphragmatic breathing, progressive muscle relaxation, and guided visual imagery. These can be taught by a health care provider or learned through online or other resources by the physician who requires treatment for trauma. These interventions facilitate the essential element of calming and reducing physiological arousal. Their benefits include being easily accessible, having little or no adverse effects, and increasing patient self-efficacy.

Trauma-focused psychotherapies, such as cognitive processing therapy and prolonged exposure therapy, have the best evidence for treating trauma-related disorders. Stress inoculation training and eye movement desensitization and reprocessing have also been found to be helpful in reducing symptoms of trauma. Trauma-focused psychotherapies incorporate imaginal exposure to the traumatic event in conjunction with an examination of cognitions the physician may have about aspects of the event and their meaning.

Pharmacotherapy following a traumatic event should generally be time-limited and symptom focused. Insomnia is a nearly universal symptom following a traumatic event. Because regulating sleep is critical to reducing arousal symptoms (and promoting the “calming” element of PFA), short-term sedative-hypnotic medication may be used to relieve insomnia. Although conflicting evidence exists, some studies suggest that prazosin is effective in treating insomnia and nightmares associated with posttraumatic symptoms.

Complementary and alternative approaches to the treatment of trauma stress have an increasing body of research supporting their efficacy, and preliminary studies as well as anecdotal evidence of benefit are promising. Mindfulness practices have the most robust research base to support their efficacy. Mindfulness is the practice of purposefully focusing on what is going on in the present moment without passing judgment. Animal-assisted therapy, yoga, meditation, and acupuncture are additional alternatives that are increasingly popular and should be considered with patient preference being an important factor in considering their use.

**Conclusion**

Physician work-associated traumatic events are both common and unavoidable. Common responses to traumatic events include distress reactions, health risk behaviors, and psychiatric disorders. The goal of intervention is to reduce levels of distress in affected physicians, restore their ability to provide care, and minimize the likelihood of lasting symptoms or impairment. Interventions for traumatic stress should incorporate the principles of PFA: safety, calming, self-efficacy, connectedness, and optimism. Providing a range of patient-centered, evidence-based interventions and formal treatment options can enhance compliance and increase well-being for health care providers who have experienced traumatic events.

**Disclaimer:** The views expressed are those of the author and do not necessarily reflect the views of the Department of Defense, the Uniformed Services University, the Department of Health and Human Services, or the United States Public Health Service.
UMass Memorial Health Care and the University of Massachusetts Medical School currently has openings within the Department of Psychiatry. To view these openings directly, please click on either of the two links below.

- UMass Memorial Health Care: [https://www.umassmemorialhealthcare.org/careers/physician-opportunities](https://www.umassmemorialhealthcare.org/careers/physician-opportunities)
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Please contact Terry Good, Horizon Health, at 804-684-5661; terry.good@horizonhealth.com; Fax: 1-804-684-5663.

T  E  X  A  S

TEXAS UNIVERSITY HEALTH SCIENCES CENTER.

Department Chair of Psychiatry-Transmountain

Texas Tech University Health Sciences Center El Paso
Texas Tech University Health Sciences Center El Paso’s Paul L. Foster School of Medicine (PLFSOM) is accepting applications for the position of Department Chair, Psychiatry-Transmountain. This is a unique opportunity for a dynamic, entrepreneurial clinician to build a department at our new Transmountain location in a collaboration between TTUHSC El Paso and The Hospitals of Providence (THOP).

The Department Chair will report to the Dean of Paul L. Foster School of Medicine. The Department Chair will participate in the recruitment of faculty and development of clinical services at the Transmountain site. A new full service 106-bed general acute care hospital and an adjacent 110,000 sq. ft. new medical office building will serve as a training site for medical students, residents, nursing students and researchers. A new psychiatry residency program is anticipated to open in 2023. The Department Chair of Psychiatry-Transmountain will work closely with community physicians in the role as Chief of Psychiatry at THOP-Transmountain.

Candidates should be a currently practicing MD/DO, eligible for a Texas medical license, with program development skills and an understanding of budgeting, productivity and revenue management. The successful candidate will have experience in an academic medical center, possess leadership qualities, with the ability to secure the confidence and cooperation of others, and demonstrate an understanding of the synergy between patient care, education, and scholarly activity as well as the interdependent relationships in a health science center/private hospital partnership. Experience in a private/academic collaboration is highly valued.

El Paso is ranked second in the “Safest Metro Cities in America 2017” SafeWise Report. The city is also among the top 15 best places to live in the U.S. for quality of life in 2018 (U.S. News and World Report). Nestled at the base of the Franklin Mountains with over 300 days of sunshine annually, El Paso residents enjoy a friendly community with numerous outdoor and cultural pursuits, and no state income tax.

Interested candidates may view a full position description and apply online at http://careers.texas的技术.

Search for requisition #58778R.

For confidential inquiries, please contact:
Dan Schuller, M.D.,
Department Chair of Internal Medicine-Transmountain and Search Committee Chair.
dan.schuller@ttuhsc.edu or (915) 215-4126

As an EEO/AA employer, the Texas Tech University System and its components will not discriminate in our employment practices based on an applicant’s race, ethnicity, color, religion, sex, national origin, age, disability, genetic information or status as a protected veteran.

V  I  R  G  I  N  I  A

Psychiatrist Opportunity
Southwestern Virginia Mental Health Institute is located in Marion, Virginia, sitting in the heart of the Blue Ridge Mountains. Our 179-bed behavioral health facility offers an exciting career in a wide range of interesting pathology in psychiatric treatment while providing a highly desirable work-life balance.

We have opportunities in our inpatient setting for Psychiatrists for our Adult Admissions and Geriatric Units. These positions are employed positions offering a competitive salary with generous state benefits and paid malpractice insurance, loan repayment, CME stipend/leave, sign-on bonus, and relocation allowance. No on-call required, with compensated on-call available.

If you are licensed or eligible for licensure in Virginia, and have completed a psychiatric residency, please send your current CV to kim.sayers@dbhds.virginia.gov or you may contact a member of our Human Resources staff at 276-783-1204 to discuss this opportunity.

We invite you to join a team of dedicated physicians and loyal staff who are committed to promoting a life of possibilities for all Virginians.

For more information, please visit:
www.svmhi.dbhds.virginia.gov;
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