Mental Health Crisis in Hong Kong
Its Current Status and Collective Responses From Mental Health Professionals in Hong Kong

Roger M. K. Ng, MBChB, FRCPsych(UK), IDFAPA, DPhil

The 2019 Hong Kong protests, also known as the Anti-Extradition Law Amendment Bill (or Anti-ELAB) movement, are an ongoing series of demonstrations in Hong Kong that were triggered by the introduction of the Fugitives Offenders amendment bill by the Hong Kong Government. If enacted, the bill would allow local authorities to detain and extradite criminal fugitives who are wanted in territories with which Hong Kong does not currently have extradition agreements, including Taiwan and Mainland China.

COMMENTARY
Repairing Our Broken Mental Health Care System: Advice for Policymakers

Allen Frances, MD

Patients with severe mental illness (SMI) routinely have no access to adequate medication, psychological counseling, social support, and/or housing. The horrible result is that 600,000 patients are either prisoners or homeless—or rotate between the two. The past 50 years of neglect and criminalization have made the US one of the worst places in the world to have a mental illness.

Meanwhile, on the mild end of the psychiatric symptom spectrum, we have the opposite problem of massive over-treatment. About 20% of the general population regularly use psychotropic medications, most often prescribed unnecessarily and carelessly after brief visits with rushed primary care doctors eager to get the patient out of the office as quickly as possible. And, perhaps for too many of these patients, psychiatric medications may be no more than expensive placebos, wasteful and carrying the added burden of harmful adverse effects. With that in mind, I offer some advice to policymakers on how to...
Here’s to Resolutions

January is a time of reflection, fresh beginnings, and new opportunities, and a time of new year resolutions. The slate is wiped clean, and we all try to be the best version of ourselves.

We are doing the same thing here at *Psychiatric Times*. We are looking back at where we have been, and we are looking ahead to where we want to be. On our cover, Dr. Allen Frances shares potential new year resolutions for the field that he thinks can be changed for the better.

And, in noting the great potential for this upcoming new decade, Editor in Chief Dr. John Miller shares his wish list of advances. With some perseverance, perhaps we will be looking back 10 years from now feeling satisfied that the field has addressed some, if not all, of those items.

*Psychiatric Times*’ continued resolution is to provide you with clinically useful information to support you. With that in mind, Drs. Pojen Deng and Anusha Yeshokumar shed some light on autoimmune encephalitis, an emerging and unique clinical entity that causes severe neuropsychiatric symptoms. In our Mood Disorders Special Report, you will find strategies for integrating psychopharmacology and psychotherapy and ways to overcome challenges in pediatric bipolar disorder. You also can earn CME credit while exploring how to overcome treatment-resistant depression in older patients. And, you will find many more informative clinical pieces with up-to-date guidance and tips on our website at www.psychiatrictimes.com.

No matter what the challenge, *Psychiatric Times* looks forward to being your go-to resource for clinical updates you can use and important information impacting the field in 2020 and beyond!

Mike Hennessy Sr.
Chairman and Founder, MJH Life Sciences
FROM THE EDITOR
Beginning the Decade With 2020 Vision
John J. Miller, MD | Editor in Chief

It seems like just yesterday that the world was filled with excitement, hope, anxiety, and fear as Y2K was rapidly approaching. A new century was about to begin, a novel experience to most of us alive at the time. Doomsayers were certain all the computers would crash as the clock moved forward into the first second of the 21st century. We did not yet have to carry the burden of 9/11 or of the wars in Afghanistan and Iraq to come. Eyes had not yet become entranced by smart phone technology, a true oxymoron. And climate change had not yet devolved to climate crisis.

But then, like the snap of a finger, two decades passed, and here we are—beginning a new day and a new decade—and, once again, we are filled with excitement, hope, anxiety, and fear. For us in the US, our country has become hyperpolarized beyond recognition, with the matter-of-fact acceptance of convenient relative truths rather than a civilized embrace of absolute truths. Science, although steadfastly moving towards a greater understanding of our objective physical world, has been deemed by many to be partisan and repackaged into a pseudoscience that serves the greed and desires of individuals with power but without wisdom. Sadly, the view through the lens of the past few years is distorted and blurry, unpleasing to the eye and the mind.

Over the past two decades we have experienced how technology and one of its byproducts, social media, have simultaneously guided us down two divergent paths: one filled with division, fake news, conspiracy theories, hostility towards opinions and beliefs that differ from our own, and a festering global pessimism; the other connecting our global community, improving the quality of health care, decoding the human brain, making more of the mysteries of our physical universe that create opportunity and repackaged into a pseudoscience that serves the greed and desires of individuals with power but without wisdom. Sadly, the view through the lens of the past few years is distorted and blurry, unpleasing to the eye and the mind.

Despite the discoveries and progress that has been made in our understanding of the structure and function of the human brain, mental illness continues to be stigmatized. The criminal justice system houses more individuals with serious mental illnesses than psychiatric hospitals. Access to treatment for the mentally ill continues to be quite limited and, in many parts of the country, substandard. Federal and state funding for the treatment of mental illness and ongoing research to understand its etiology and improve diagnosis and treatment continues to be cut. A significant delay exists for many with first onset mental illness from the time of symptom onset to the beginning of aggressive treatment. This delay in treatment is not acceptable, as the duration of untreated symptoms has a direct impact on decreasing ultimate function and degree of recovery.

But, alas, we are beginning a new decade, a perfect metaphorical experience to most of us alive at the time. Doomsayers were certain all the computers would crash as the clock moved forward into the first second of the 21st century. We did not yet have to carry the burden of 9/11 or of the wars in Afghanistan and Iraq to come. Eyes had not yet become entranced by smart phone technology, a true oxymoron. And climate change had not yet devolved to climate crisis.

Beginning the December With 2020 Vision
John J. Miller, MD

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MOOD DISORDERS

Celebrating Progress, but Challenges Remain

Jonathan E. Alpert, MD, PhD

With their early age of onset, high prevalence, chronicity, and pervasive impact on multiple domains of functioning, the burden of mood disorders exceeds that of virtually all medical conditions in the US and globally in terms of disability, cost, and suffering.

My long-term clinical and research interest in mood disorders has two primary sources. First, having a parent with a recurrent mood disorder taught me that vulnerability to depression can freely coexist with notable resilience and strength in many other areas, and that depression can be treated. Second, as a psychiatrist-in-training, I learned that mood disorders may be treatable for some but are barely treatable for far too many others. The field continues to evolve, but the challenges I first learned as a trainee largely remain.

Nevertheless, we have seen major advances over the past decade, including:

- Implementation of routine screening for depression in primary care and some sub-specialty care settings;
- Increasing adoption of measurement-based care;
- Greater emphasis on chronic disease management approaches for those with persistent or recurrent illness;
- A growing range of evidence-based psychotherapies and neuromodulation strategies;
- The quite preliminary yet promising emergence of combinatorial pharmacogenomics and other biomarkers that may augment clinical judgment;
- The FDA approval in 2019 of two rapidly acting antidepressants leveraging novel neural mechanisms; and
- An expanding range of big data approaches that promise to extend the reach of patient-oriented science well beyond traditional clinical trials.

The increased interest in the health and treatment of individuals traditionally under-represented in mood disorders research—including ethnically, culturally, and racially diverse individuals and individuals from sexual and gender minority groups—is also quite encouraging.

As we celebrate progress, we also appreciate the magnitude of the remaining obstacles. The considerable heterogeneity across patients in presentation, course, and treatment responsiveness continues to beg the question of whether the current nosology of mood disorders is meaningful. It remains quite possible that major depressive disorder is a non-specific manifestation of multiple pathophysiological entities. Along with high placebo response rates in depression studies, the potential inclusion of individuals whose symptoms reflect quite distinct etiologies means that the signal of promising treatments is almost certainly often lost amidst the noise of multiple subgroups with diverse responses.

Special patient populations with mood disorders, such as pediatric, geriatric, or peripartum, have been remarkably under-studied. As we welcome the burgeoning number of treatments and treatment modalities, we lack adequate research devoted to their optimal combination and sequencing.

In this Special Report, we have tried to target these important challenges with articles on the integration of psychotherapy and pharmacotherapy in the treatment of major depressive disorder and on diagnostic and treatment challenges in pediatric bipolar disorder.

The profound impact of mood disorders in health care settings and on society is widely acknowledged by clinicians, administrators, and policy makers. Government and health care leaders increasingly understand the value of greater investment in mood disorders. With increasingly sophisticated research approaches and evidence informed treatments, we have reason to look forward to meaningfully improved outcomes for the hundreds of millions of individuals who suffer from mood disorders during their lifetime.

Dr Alpert is Dorothy and Marty Silverman Chair, Department of Psychiatry and Behavioral Sciences, and Professor of Psychiatry, Neuroscience and Pediatrics, Montefiore Medical Center and Albert Einstein College of Medicine, New York. He reports no conflicts of interest concerning the subject matter of this Special Report.
Integrating Psychotherapy and Psychopharmacology in the Treatment of Major Depressive Disorder

Fredric N. Busch, MD

Although multiple interventions exist for major depressive disorder (MDD), only partial response is achieved in many patients and recurrence is common. With monotherapy approximately two-thirds of patients with MDD show a clinical response, but only about one-third achieve remission. Combination therapy has generally been found to be superior compared with single treatment although not all patients require combination therapy (Table).

There are several reasons that combining medication and psychotherapy may enable more effective treatment of MDD. Given variable response to treatments, combining a medication with psychotherapy increases the likelihood of response to at least one of them. In addition, the additive effects of combined treatment may better address ongoing vulnerability to depression, as found with recurrent depressive episodes, and persistent, adverse residual symptoms.

The treatments can work synergistically. Medication can increase the effectiveness of psychotherapy (eg, through easing problems with concentration and motivation), and it is also a means to address adherence problems with medication. Moreover, combined treatment may enable lower medication doses thus having fewer adverse effects; and medication may reduce the need for persistent or more intensive psychotherapy by easing symptoms.

Not all patients require combination therapy to achieve symptom remission or prevent recurrence. Therefore, combination treatments may expose some patients to more treatment than is necessary. Questions of cost effectiveness issues also arise with the greater expense of psychotherapy plus medication, although potential long-term benefits may outweigh the costs.

Another option is to sequence treatments for depression. Begin treatment with pharmacotherapy or psychotherapy, and if the patient does not have an adequate response, add psychotherapy or pharmacotherapy. Studies suggest that a switch to or addition of psychotherapy may decrease the risk of depression recurrence.

Determining when to employ combined treatment strategies

Research findings suggest that chronic depression is more responsive to psychotherapy and medication, although dysthymia without accompanying MDD showed no additional value for combined treatment compared with medication alone. Psychotherapy may be an essential element in the treatment of depressed patients with a history of childhood trauma as well as those with comorbid personality disorder. In addition to comorbid personality disorder, combination therapy should be considered with other psychiatric comorbidities that are unlikely to respond fully to monotherapy, such as obsessive compulsive disorder, eating disorders, and posttraumatic stress disorder. Clinicians should also consider combined treatment if the patient experiences a high level of suffering and functional impairment and is at risk for suicide.

These recommendations are consistent with the American Psychiatric Association Practice guideline for the treatment of patients with MDD.

Combining a depression-focused psychotherapy and pharmacotherapy may be a useful initial treatment choice for patients with moderate to severe major depressive disorder. Other indications for combined treatment include chronic forms of depression, psychosocial issues, intrapsychic conflict, interpersonal problems, or a co-occurring Axis II disorder. In addition, patients who have had a history of only partial response to adequate trials of single treatment modalities may benefit from combined treatment. Poor adherence with pharmacotherapy may also warrant combined treatment with medications and psychotherapy focused on treatment adherence.

Discussing the use of combined treatment with patients

The benefits and risks of the various interventions need to be discussed so that patients can be involved in treatment decisions. In explaining the combination of treatments, a metaphor of a river and depression can be helpful. The river overflowing its banks is seen as equivalent to a depressive disorder. Medication can have an impact on the biochemical contribution, whereas psychotherapy affects the psychological and emotional contributions. The psychiatrist could also explain that the various river tributaries are interconnected; therefore, psychotherapy also has a biochemical impact and medication modulates emotional and psychological factors.

In addition to the river analogy, similarities to treatment with other medical problems can be useful to explain the need for combined treatment. Combining medication and psychotherapy for depression can be compared with combining surgery and physical therapy for orthopedic problems. Similarly, an analogy can be made for combining medication, exercise, and nutritional interventions for diabetes. This perspective emphasizes that, for depression, as with many health conditions, it should not be an either/or between medications and non-medication treatments. This helps to clarify how medication and other forms of intervention can work together to produce a better outcome.

Many factors contribute to patient’s preferences regarding combining medication and psychotherapy, including family, cultural, and personality factors, as well as health belief models. Being able to acknowledge preferences in a nonjudgmental way while providing the rationale for recommending combined treatment, when appropriate, is an important component of dialogue. Thomas M. Gutheil, MD, professor of psychiatry at Harvard, emphasized the concept of “participant prescribing,” in which the clinician collaborates with the patient in considering the potential impact, concerns, and problems with medication in the context of psychotherapy. Such an approach helps to avert potential power struggles involving the physician as the authority pressuring patients to comply with certain treatment, and patients resisting these efforts. An empathic exploration of the patients’ concerns about various treatment interventions will aid with compliance and provide information about psychological factors that may be relevant to symptoms and other life problems.

Considering psychological vulnerabilities to depression

Knowledge of psychological vulnerabilities to depression can aid in addressing problems that can occur in accepting combined treatment. Patients can struggle with low self-esteem, shame, and narcissistic sensitivity that precede or are exacerbated by depression onset. At risk individuals are sensitive to disappointment and rejection, responding with a sense of injury and anger. This anger is often conflated, triggering feelings of guilt and worthlessness, and it can become directed inward in the form of self-critical thoughts and feelings. Another core dynamic in depression is the patient’s attempt to deal with low self-esteem by a compensatory idealization of self or others. However, this idealization increases the likelihood and intensity of eventual disappointments, worsening depression.

Patients can experience shame about their depression, and the illness itself tends to exacerbate self-critical tendencies and feelings of being a bad person. Patients may therefore resist treatments if they experience these interventions as further indications that they are indeed defective, as another narcissistic injury. Thus, they may use medication as a resistance to psychotherapy, if they see the
need for therapy as shameful, or they may resist medication if they view this need as a source of shame.

Furthermore, patients may idealize one or the other treatment as the answer to depression. Such idealization can lead to significant disappointment when the patient realizes that other problems persist or there is a recurrence of depression. Addressing patient resistance can be valuable, particularly when patients are best served by combination treatment.

### Psychotherapy as an aid to medication adherence

Many variables contribute to medication nonadherence, including poor psychoeducation and limited monitoring as well as cultural, psychological, and emotional factors. Shame about depression, medication, or psychotherapy can lead to disruptions in treatment. Adverse effects that are unaddressed can also play a role. Psychotherapy provides an opportunity to explore how patients are affected by various adverse effects and what changes may be necessary in treatment regimens. In addition, common adverse effects may be experienced differently by patients based on their psychological vulnerabilities. For instance, sexual adverse effects could be experienced as an attempt to undermine the patient’s power or as a punishment.

Some patients struggle with recurrent negative reactions to medications—the nocebo effect—that go beyond or are not consistent with possible adverse effects. The nocebo effect can lead to recurrent discontinuation of medications and add to a negative view of the clinician. A history of trauma can contribute to a recurrent nocebo effect, as patients may perceive the medication as an unwelcome intrusion or the doctor prescribing medication as a potential abuser. Psychotherapeutic interventions can be used to address negative reactions to medication and a possible negative transference reaction to the clinician.

### Determining the prescriber and the psychiatrist: issues and warnings

Combined therapy requires either a therapist who is also a prescriber or split treatment in which a therapist provides psychotherapy and a psychiatrist (or other physician) prescribes medication. A psychiatrist who provides both treatments has the advantage of avoiding conflicts between two treating clinicians. Similarly, more frequent visits allow the psychiatrist further opportunities to monitor the effects of medications. However, a psychiatrist who provides psychotherapy may not consistently assess symptoms and medication effects that are central to psychopharmacological visits. This puts the patient at risk of the covert development of a disorder not detected by the treating psychiatrist. It is of value for psychotherapists prescribing medication to arrange some system for regular monitoring of symptoms and medication.

In split treatment, competitive and professional tensions between the two practitioners, as well as different theoretical and clinical models, can generate problems in treatment management. Patients may idealize and devalue one or the other of the clinicians or treatments, or act out in ways that may be difficult to address (such as suddenly stopping medication). Maintaining a triadic therapeutic alliance between the therapist, psychopharmacologist, and patient as well as communication between the treating clinicians can help identify and address problem areas.

### MOOD DISORDERS

#### TABLE. Patients with these clinical factors are likely to benefit from combined treatment

- Chronic depression (excluding dysthymia without accompanying major depression)
- History of childhood trauma
- Comorbid personality disorder
- Other psychiatric comorbidity that is unlikely to respond fully to monotherapy (e.g., obsessive compulsive disorder, eating disorder, or posttraumatic stress disorder)
- High level of suffering and functional impairment
- Interpersonal problems
- Psychosocial issues
- Suicide risk
- Poor adherence to psychopharmacological interventions

### REFERENCES


### CASE VIGNETTE

“Angela,” a 25-year-old real estate agent, whose depression responded to treatment with sertraline and psychodynamic psychotherapy, experienced a recurrence of depression. She admitted that she had not been taking the medication consistently and the recurrence happened not long after. Further questioning revealed that angela viewed medication as a narcissistic injury, a sign that she was defective in some way.

Her negative feelings about taking antidepressants contributed to her sense of isolation and jealousy, which she often experienced when growing up. During that time she had viewed herself as less wealthy and not as cool as others in her community. She felt her father was uninterested in her and withdrawn, which she ascribed to her being unappealing and unattractive.

Her feelings of inadequacy and defectiveness had recently intensified in the context of difficulties with her career including a lack of sales. These problems with her job and associated painful feelings of inadequacy appeared to trigger resurgences of depressive symptoms.

Early life and current stresses, along with negative self-appraisals, seemed to trigger a biochemically based depression, which exacerbated her feelings of inadequacy, low self-esteem and jealousy. Medication played an important role in helping to relieve this cycle.

Her therapist found it essential to explore her difficulties in complying with treatment with antidepressants and explained that noncompliance was exacerbating her problems. When the therapist asked more about her feelings of being defective, angela stated it meant something was wrong with her and people would not want to be with her.

The therapist suggested that it was important to understand how the medication became connected to negative self-views, as discontinuing it exacerbated her depressive symptoms. angela responded that she had previously not connected her discontinuing medication with hurt and anger at her father and would remind herself of this link when she felt an urge to stop taking it. If she became aware of forgetting doses, she would raise it with the therapist for further exploration.
Diagnostic and Treatment Challenges in Bipolar Disorder in Children and Adolescents

Benjamin I. Goldstein, MD, PhD, Boris Birnmaher, MD, and Eric A. Youngstrom, PhD

Mood problems can occur before puberty, with the prevalence more than doubling during and after puberty. Some of the mood problems will follow a bipolar course. The challenge is recognizing which patients have unipolar depression, and which are some form of bipolar disorder (BD).

Four variants of BD recognized in ICD and DSM:
1. BD-I requires at least one manic episode to establish the diagnosis; depressive and hypomanic episodes are optional from a diagnostic point of view, even though clinically they are the more common presentations.
2. BD-II requires a history of at least one major depressive episode and one hypomanic episode; the depressive episode is far more likely to come to clinical attention.
3. Cyclothymic disorder requires a year or more of hypomaniac/manic symptoms and depressive or dysthymic symptoms, not rising to the level of full blown mania (otherwise the diagnosis is bipolar I) or major depression (which indicates bipolar II).
4. Other specified bipolar and related disorders are diagnosed by exclusion of the previous three. The diagnosis can include cases with hypomania in the absence of major depression, insufficient duration of episode, not quite enough symptoms to meet the formal definition, and brief (eg, approximately 6 months) cyclothymic presentations. Clinically, 2- or 3-day hypomanias are common, and do not appear to differ meaningfully from full-duration hypomania. Episodic presentation of symptoms is more suggestive of mood disorder than more chronic histories of the same symptoms.

Conducting the differential diagnosis
People are unlikely to seek help when hypomanic, and much more likely to seek services when depressed than when hypomanic. Thus, one major differential diagnosis is unipolar depression versus bipolar depression. Both depression and hypomania are associated with episodic irritable mood, especially in youths, so another set of differential diagnoses is BD versus disruptive behavior disorders, disruptive mood dysregulation disorder (DMDD) or ADHD. Note that the DMDD phenotype is common among youth with all BD subtypes; as such, identifying a discrete, episodic BD phenotype does not preclude a comorbid DMDD phenotype and vice versa.

Irribility is also pronounced in anxiety disorders and trauma. Cognitive debiasing strategies—including making multiple diagnostic hypotheses, forcing them to compete, and asking about lifetime history of hypomania and mania whenever treating for mood problems—improve the speed and accuracy of detection. More episodic changes that include discrete exacerbations of irritability, energy, and attention problems make the presentation more suggestive of a mood disorder than differential diagnoses with more chronic presentations.

Several checklists and rating scales have been validated in a range of clinical samples. A meta-analysis comparing the published contenders found three that are top-tier, separating cases with BD from clinically realistic comparison groups with good accuracy. Two of these: the Parent General Behavior Inventory-10 item Mania (PGBI-10M) and the Child Mania Rating Scale (CMRS) have one-page short forms available that preserve strong reliability and validity, and also good sensitivity to treatment effects. These also have been translated into several languages including Spanish. Copies of these are available at Wikiversity. These could be sent to patients ahead of the first evaluation or completed in the waiting room, and they are brief enough that they could be repeated to check for treatment response to adjust dosing.

There are also a variety of mood charting apps available for smartphones and online. Adolescent and young adult patients frequently like using these apps, and they can provide helpful information about course and treatment response as well as grist for psychotherapy sessions. (See Youngstrom, Morton, and Murray for a much more extensive review of assessment options.)

Prospective course and prediction
Thus far, the foremost risk factor for BD among children and adolescents is parental BD (Figure 1). In a large prospective study of offspring (6-18 years old at intake) of parents with BD, 23.6% had bipolar spectrum disorders. However, if a parent had early onset BD (eg, before age 21 years) and the offspring has significant symptoms of depression/anxiety, mood lability, and importantly, subsyndromal symptoms of mania, the risk for BD can increase up to 50%. The offspring’s risk for BD also increases if both parents have BD.

These results pertain to the sample as a whole and not for a specific individual. To address this issue, mathematical tools (risk calculators) that integrate information about previous illness course and other factors associated with the outcome studied (eg, new onset of an illness, recurrence risk), yield a risk score that estimates the probability of outcomes for an individual. Risk calculators have been successfully developed and validated, and they are currently utilized as tools to enhance clinical decision-making across several health conditions (eg, cardiovascular disease, cancer).

Recently we developed a risk calculator to predict the individual risk for BD in offspring of parents with the disorder. Similar to other areas of medicine, these group-level findings have been bolstered by a risk calculator that yielded an accuracy of 76%. Nevertheless, the risk calculator requires external validation before it can be adopted in clinical practice. Offspring of BD parents often have additional psychiatric disorders and with exception of substance abuse, most of them manifest before the onset of BD. However, after ad-
SPECIAL REPORT

justing for confounders (eg, parental non-BD psychopathology, socioeconomic status, within family correlations), of all disorders only the presence of major depression and oppositional defiant disorder in the context of family history of BD are associated with increased risk for BD. A large prospective naturalistic showed that once BD develops, after a median of 124 weeks (BD-I:78.3 weeks, BD-II: 76.9 weeks, and BD-NOS: 180 weeks), about 80% of the youths recovered from their index episode. However, about 40% experience a recurrence within 2 to 3 years. The primary differences in the course of BD among youths compared with adults with BD is more mixed presentations and more mood polarity changes (Figure 2). Youths are also at increased risk for suicidality, behavior problems, family conflicts, risk-related sexual behaviors, sexual and physical abuse, substance abuse and other disorders such as ADHD, obesity, and poor functioning. In addition, about 50% of youths with BD-NOS (ie, subsyndromal mania) convert into BD-I/II, especially if they have a family history of BD. Since the course of BD is heterogeneous, efforts have been made to determine whether there are subgroups of youth with BD with different mood trajectories. Indeed, a recent study showed four mood trajectories:

- Mostly euthymic (80% of follow-up time)
- Mostly symptomatic
- Intermediate prospective symptom burden
- Mostly symptomatic initially, but progressively improve and become mostly euthymic approximately 2 years into the illness.

Youths with more comorbid disorders, environmental stressors, poor psycho-social functioning, low socioeconomic status, and family history of psychopathology, including mood disorders, have worse prognosis (Table). Interestingly, in an average 9.4 years of follow-up study, about 24% of the youths (6-18 years old at intake) were euthymic 80% of the follow-up time. The results of this study raise the question, which needs to be investigated, whether all youth with BD should have lifetime pharmacological treatment.

This study appears to converge with prior epidemiologic findings of a putative developmentally limited form of child-adolescent BD, analogous to juvenile inflammatory arthritis. Similar to the individual-level prediction of BD among offspring of parents with BD, a risk calculator was recently developed to predict the 1 to 5 year risk for a mood recurrence with an accuracy of about 80%. While these calculators are publicly available, they require replication before being used in clinical practice.

Sorting through treatment strategies

The literature regarding treatment of children and adolescents with BD has accumulated substantially over the past 20 years, but progress has not been uniform across all aspects of BD. The most recent treatment guideline (2005) and practice parameter (2007) from the American Academy of Child and Adolescent Psychiatry predate much of the literature. The most recent CANNAT (Canadian Network for Mood and Anxiety Treatments) and NICE (National Institute for Health and Care Excellence) guidelines do however, integrate recent literature. Maintenance treatment. Few studies have examined maintenance treatment of BD, to prevent recurrences, and those studies that have are constrained by important limitations including low participant retention, small sample sizes, lack of focus on recurrence, and/or limited duration. There is also evidence of certain benefits of aripiprazole and risperidone compared with placebo, as well as greater likelihood of sustained continuation treatment, in youths with BD. The best continuation/maintenance study thus far found that adjunctive lamotrigine appears to extend time to any recurrence in adolescents—but not children—with BD. Pending long-term (ie, years) maintenance RCTs that mitigate the aforementioned limitations of prior studies, naturalistic data provide helpful insights that can inform treatment selection. Indeed, based on a recent large naturalistic study, lithium may be a leading option—as it is with adults. There have been recommendations of 12 to 24 months maintenance treatment post-mania, and post-discontinuation symptom monitoring for 2 years. However, there have not been studies that evaluated these important questions, and ultimately decisions are individualized.

Comorbid disorders. There are a number of studies that collectively support the conclusion that adjunctive stimulants for comorbid ADHD are efficacious, and thus far not associated with high rates of psychiatric adverse events such as mood destabilization. There are few data regarding pharmacotherapy for comorbid substance use disorders, and effectively no rigorous studies regarding comorbid anxiety. For these conditions, evidence-based skills-oriented therapy (whether individual or family-focused) is arguably the leading treatment approach.

Conclusion and future directions

Just as the progress over recent decades has improved the clinical evaluation and management of BD among children and adolescents, the remaining gaps serve to inform future progress. From an assessment perspective, validated screeners are not yet widely used strategically to streamline and triage more comprehensive assessments. From a diagnostic perspective, DSM and ICD are imperfect but adhering with the diagnostic symptom criteria is superior to a reliance on gestalts, intuition, and/or short cuts. Indeed, there are no reliable shortcuts, and accurate diagnosis of BD requires a comprehensive evaluation of contextual factors, comorbidities, and premorbid characteristics.

The validation of individual-level risk calculators is an imperative and would align pediatric BD with other branches of medicine. With regard to...
Autoimmune Encephalitis
What Psychiatrists Need to Know

Autoimmune encephalitis is an emerging and unique clinical entity that causes severe neuropsychiatric symptoms and results in significant morbidity and mortality. Because it can present with a wide variety of neuropsychiatric manifestations, often indistinguishable from other more common neuropsychiatric syndromes, that cause behavioral disturbance, it can often be a very challenging diagnosis for clinicians to make. This article broadly reviews the pathophysiology of the most common forms of autoimmune encephalitis and provides guidelines tailored toward mental health professionals to best identify and manage these rare but important causes of neuropsychiatric illness. Timely diagnosis of these syndromes helps facilitate appropriate, focused management and reduce morbidity, as delay in evaluation and treatment remains one of the most important hurdles facing patients suffering from autoimmune encephalitis.

Pathophysiology and epidemiology of autoimmune encephalitis

Autoimmune encephalitis is a family of syndromes caused by auto-antibodies to various either intra- or extracellular neuronal antigens. We will first provide an overview before examining common syndromes of each group in detail. Table 1 serves to help organize the categories and delineate the most common specific syndromes for each group.1

The first group comprises auto-antibodies to extracellular antigens, including extracellular receptors and ion channels.2,3 The process itself—of antibodies binding to antigens—is what is thought to be pathogenic. This group includes many well-known autoimmune encephalitis syndromes including anti-NMDA receptor encephalitis and anti-LGI1 antibody encephalitis. Occasionally, some of the syndromes in this second group can also be associated with cancer, although the associations are not as frequently seen.

The second group comprises auto-antibodies to intracellular antigens and is often paraneoplastic with strong associations to various types of cancer. Disease is thought to result from T-cell activation after auto-antibodies bind to their target intracellular antigen. Finally, clinically significant illness is often refractory to treatment, which is in part thought to be related to its paraneoplastic etiology, as well as T-cell-mediated irreversible neuronal injury.

There is a third category of immunologic encephalitis, which is not covered in this article; it comprises brain diseases for which the precise immunological mechanism is uncertain or it is unclear whether auto-antibodies are involved and how they might mediate pathology. This category includes disorders such as CNS lupus, neurosarcoïdosis, and acute disseminated encephalomyelitis.
receptor encephalitis is divided into stages: prodrome, early, middle, and late. Prodromes are typically made up of a nonspecific viral illness of less than two-week periods with headache and fever, as well as retrospective reporting of very subtle non-specific neuropsychiatric symptoms including trouble with attention, concentration, changes in speech, and neurovegetative symptoms. This progresses to prominent psychiatric symptoms, which can initially be indistinguishable from a psychotic break, including: agitation, disinhibited behavior, and most commonly florid psychosis and complex delusional behavior, and most commonly occurring over weeks to months. Typically, subtle memory loss and cognitive deficits that appear out of proportion to duration of psychiatric history or rapid progression to catatonia. If left unchecked, this may progress into the middle and then late stages of the illness over weeks to months, which is characterized by steady decline in cognition and mental status leading to fulminant catatonia and then coma associated with extensor posturing. During this stage, patients often also exhibit dyskinesias including orofacial movements such as lip smacking and writhing hand and arm choreothetosis. Severe autonomic fluctuations, seizures, and cardiac dysrhythmias are also manifestations of this stage. Anti-LG1 receptor antibody encephalitis. This syndrome most commonly affects patients in their 50s through 70s, with a slightly higher predilection for men rather than woman. LG-1 is a specific type of presynaptic glycoprotein involved in the regulation of voltage-gated potassium channels. Clinical symptoms include a classic constellation of hyponatremia, refractory innumerate unilateral facial and upper arm twitching seizures known as fasciobrachial dystonic seizures, and indolent confusion and memory loss occurring over several months. Typically, subtle memory loss and sleep disorder emerge first, giving rise to seizures, hyponatremia, and frank encephalopathy. Anti-AMPA-receptor encephalitis. AMPA is another ionotropic receptor that modulates control of glutamate within the CNS. Anti-AMPA receptor encephalitis has a wide demographic range ranging from 50 to 70 years of age, although the median age is in the 5th or 6th decade. There is a slight female to male predominance, and about half of patients are found to have some type of solid organ tumor. Clinical symptoms share characteristics with anti-NMDA receptor encephalitis, with early onset of confusion, psychosis, visual hallucinations, and personality change followed by frank and focal neurologic deficits such as hemiparesis, aphasia, or ataxia, fulminant confusion, catatonia, coma, posturing, and seizures.4

Intracellular antigen auto-antibody syndromes
Paraneoplastic limbic encephalitis syndromes due to anti-Hu, anti-Ta, and anti-Ma antibodies are well described in the literature. These antibodies are typically generated by solid tumors; roughly 50% are primary lung tumors, namely small cell lung cancer, with smaller but still significant subsets of testicular and breast cancer (20%). Neuropsychiatric symptoms often precede any overt evidence or diagnosis of tumor by several months, and commonly manifest as subacute depression, irritability, hallucinations, or memory loss occurring over weeks to months. These psychiatric symptoms may progress to frank confusion and dementia and can also include symptoms such as sleep disturbance and seizures. Treatment is often focused on identification and management of the underlying tumor, and prognosis of these syndromes is generally guarded.5,6

Clinical assessment of autoimmune encephalitis
Mental health professionals evaluating a case of new onset psychosis should be aware of the expert consensus suggested diagnostic criteria for autoimmune encephalitis.7

DIAGNOSIS CAN BE MADE when all three of the following criteria have been met:

1. Subacute onset (rapid progression of less than 3 months) of working memory deficits (short-term memory loss), altered mental status (lETHargy, personality change, or cognitive deficits), or psychiatric symptoms

2. At least one of the following: new focal CNS findings; seizures not explained by a previously known seizure disorder; cerebrospinal fluid (CSF) pleocytosis (white blood cell count of more than five cells per mm); MRI features suggestive of encephalitis.

3. Reasonable exclusion of alternative causes

Psychiatric practitioners should also take note of any of the following features in psychiatric illness, which would prompt concern for encephalitis:

- Focal neurologic deficits, including hyper-reflexia or signs of meningismus
- Concurrent dysautonomia (ie, tachycardia, hypertension, hypotension, fever)
- Prominent symptoms such as headache or flu-like illness
- New onset catatonia without prior psychiatric history or rapid progression to catatonia
- Refractory psychosis or catatonia to appropriate psychotropic management
- Cognitive deficits that appear out of proportion to duration of psychiatric illness or out of proportion to general psychiatric symptoms
- New onset psychosis developing rapidly without family history, not substance related, and without prodromal symptoms

Clinicians should note that these recommendations are most pertinent for cases of new onset psychosis, and unusual symptoms to be evaluated for most closely overlap with the presenting features of anti-NMDA receptor encephalitis.

Table 1. Delineation and categorization of the most common autoimmune encephalitis syndromes

<table>
<thead>
<tr>
<th>Antibody</th>
<th>Associated syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Hu (Anti ANNA-1)</td>
<td>Encephalomyelitis, associated with SCLC</td>
</tr>
<tr>
<td>Anti-Ri (Anti ANNA-2)</td>
<td>Cerebellar encephalitis, associated with gynecologic and breast tumors</td>
</tr>
<tr>
<td>Anti-Yo (Anti PCA-1)</td>
<td>Cerebellar encephalitis, associated with ovarian and breast tumors</td>
</tr>
<tr>
<td>Anti-Ma</td>
<td>Limbic or brainstem encephalitis, associated with germ cell tumors</td>
</tr>
<tr>
<td>Anti-gliofilipin or anti-glial fibrillary acidic protein</td>
<td>Stiff person syndrome, associated with SCLC</td>
</tr>
<tr>
<td>Anti-CV2 (CRMP5)</td>
<td>Encephalomyelitis associated with SCLC</td>
</tr>
</tbody>
</table>

SCLC, small cell lung cancer.

Clinical symptoms share characteris-
As detailed above, the primary flags are the presence of seizures, dyskinesias, and dysautonomia concurrent with mood symptoms or psychotic features. Other cases that may be considered may have early manifestation of or rapid progression to unusual psychiatric features in a primary psychotic illness, such severe agitation and catatonia, or psychosis and catatonia refractory to appropriate psychotropic management.

Criteria for diagnostic testing in cases of concern about autoimmune encephalitis are provided in Table 2. Psychiatrists concerned about autoimmune encephalitis should involve their neurologic colleagues early in the evaluation. Clinicians should note that nonspecific systemic serologic markers for inflammation such as erythrocyte sedimentation rate and C-reactive protein are often only mildly elevated or within the normal range throughout the disease course and are not recommended to be used in the evaluation of autoimmune encephalitis.

Many diagnostic tests can be normal or show only nonspecific abnormal results early on in the process, although that should not delay testing. Both serum and cerebrospinal fluid (CSF) testing for autoimmune antibody titers exist and should be performed as soon as possible, because these antibody titers often require 14 to 21 days to return results. Serum testing, however, has high rates of false positivity and should only be considered relevant in the setting of a consistent clinical picture or positive CSF result. Clinicians should also be aware that not infrequently, autoimmune encephalitis can be sero-negative, without an identified positive serum or CSF antibody, and such a diagnosis should be made in a multidisciplinary approach with neurologic colleagues.

Finally, important infectious and metabolic causes of encephalitis should also be ruled out with a very detailed history and diagnostic testing for infectious pathologies such as human immunodeficiency virus, herpes simplex virus, mycoplasma, cytomegalovirus, and syphilis. Other viral encephalitides including West Nile virus should be undertaken as well. Serum studies for vitamin testing including B12 and B1 levels are often only mildly elevated or within the normal range throughout the disease course and are not recommended to be used in the evaluation of autoimmune encephalitis.

Management and long-term outcomes

A multi-disciplinary approach is paramount to adequately and appropriately addressing patients, with involvement from psychiatric practitioners, neurologists, and internists. If diagnostic testing confirms a diagnosis of autoimmune encephalitis, or if clinical presentation is highly suggestive of seronegative autoimmune encephalitis, the following treatment strategies are recommended.

Agents such as amantadine, modafinil, stimulants, mood stabilizers, and SSRIs can all be safely considered to target the sequelae of autoimmune encephalitis.

Initial treatment commonly begins with high dose intravenous steroid regimens, generally methylprednisolone 1 mg/kg, followed by or given concurrently with either plasmapheresis or intravenous immunoglobulin (IVIG) administration. Appropriate duration and recurrence of therapy is unclear. Steroid regimens range from 3 to 5 days to subacute/chronic tapers until clinical stabilization, whereas plasma exchange and IVIG regimens generally run roughly 5 to 7 days. Many cases of autoimmune encephalitis are also treated with intravenous administration of rituximab or cyclophosphamide, thought to be beneficial in refractory cases, cases with delay to treatment initiation, and in preventing/decreasing relapses. In addition to these immunosuppressants, we highly advocate for adjunctive psychiatric treatment both acutely as well as chronically for sequelae that may develop. Refractory agitation, often in the form of shouting, screaming, or writhing movements, are very common, and most supportive management strategies include atypical antipsychotics such as quetiapine, risperidone, and olanzapine. Benzodiazepines can also be used, but clinicians should be cautious of delirium effects. Due to the prolonged periods of illness and severity of agitation, lengthy duration and high doses of antipsychotics are often employed, and clinicians should remain cognizant of potential QTc prolongation as well as dysautonomia.

Recovery is often a months-to-years long process, especially for patients with fulminating manifestations such as coma and catatonia. It is not uncommon for several months to 2 years to pass after sufficient immunosuppression and clearance of antibody before patients start to regain appreciable levels of conscious awareness. Many patients experience cognitive deficits, memory loss, extreme fatigue, pseudobulbar affect, mood and anxiety disorders, and dissociative symptoms for months to years, and they may require intensive inpatient and outpatient physical, occupational and speech therapy. Agents such as amantadine, modafinil, stimulants, mood stabilizers, and selective serotonin reuptake inhibitors can all be safely considered to target these sequelae.

Summary

Autoimmune encephalitis is an increasingly recognized but challenging diagnosis with protein manifestations, chiefly many acute neuropsychiatric presentations. However, with adequate clinician awareness and prompt initiation of diagnostic testing and intervention, patients can lead productive lives.

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Crisis in Hong Kong
Continued from Cover

This aroused concern and suspicion that the bill would subject Hong Kong residents and visitors to the Mainland Chinese jurisdiction and legal systems, undermining Hong Kong’s autonomy and its civil liberties. At the time of this writing, there continue to be serious confrontations between the police and protesters, so much so that many major highways linking key areas of Hong Kong are blocked by barricades and the city’s Mass Transit Railway ceases regular service after 10 PM daily.

Negative impact of social unrest on mental health
This unprecedented political crisis affects everyone in Hong Kong. There has been a deterioration in mental health among the people to its worst level in 8 years, 41% of survey respondents said that their mental health is being negatively affected by social unrest.1 Although the exact causes need to be elucidated by additional research studies, there are several possible reasons that explain how and why people are affected adversely by the recent social unrest.

1. Both protesters and the police are directly involved in repeated and major violent conflicts.
2. People working in areas where major confrontations between police and protesters happen are exposed to violent scenes or subjected to physical violence.
3. Families and friends disintegrate because of different political views, which results in shrunken social roles and support network.
4. Because of the socioeconomic downturn associated with traffic chaos and uncertainty among investors, many people who work in the service and tourist industries are facing salary cuts and unemployment.

Financial difficulties understandably lead to detrimental effects on housing, education, and social problems. These socioeconomic adversities are exacerbating factors for a variety of mental health problems. Moreover, there has been a negative impact on mental health caused by exposure to vivid traumatic scenes depicted in television and social media.2 A preference for visual processing may be positively related to intrusion frequency of traumatic images even when only hearing about a traumatic event.3 Therefore, the negative effect of regular and intensive exposure to vivid videos and news of street violence can affect the mental health of people even when not directly exposed to the traumatic event.

Major impact on existing mental health problems
Anecdotal accounts from various mental health facilities indicate an increase of self-reports of acute stress-disorder–like symptoms. Patients with established mental health problems report traumatic flashbacks, hypervigilance, and dissociative experiences as a consequence of regular exposure to newsfeeds and online videos of street violence.

In response to these common complaints among patients, the Hong Kong College of Psychiatrists released a set of mental wellbeing tips for dissemination to schools, social welfare agencies, community centers, health clinics, and hospitals. These tips include advice on restrictions of social media use, better sleep hygiene, balancing different roles and commitments, maintaining normal routines as much as possible, and sustaining existing social networks. With an aim of encouraging news media outlets to provide precise news reports, the College has held workshops with journalists to educate them on the symptoms of stress-related disorders and the negative impact of excessive exposure to news and videos.

A mental health tsunami in Hong Kong
Preliminary territory-wide service statistics data show no obvious surge in the number of people presenting to public mental health services for new onset mental health issues. Although stigma toward mental health and lack of mental health literacy about stress-related disorders may explain this lack of a major surge in service demand, there may be other causes.

The trajectory of stress response is highly complex. An Australian study showed that of those with PTSD onset 12 months after trauma, only 37% had symptoms at 3 months with worsening of symptoms with time.4 This phenomenon is more common among military personnel than civilian trauma survivors.5 The confrontation between protestors and police officers, as well as other responders such as journalists, emergency medical staff, firefighters, and other volunteers and counselors are not unlike military personnel being deployed to a frontline war zone. Thus, the mental health tsunami might only hit the shore weeks or months after social unrest has died down.

Apart from the possible delay in onset of stress-related disorders, there may be a delay in presentation to public mental health systems for political reasons. In past months, there have been rumors among social media and e-news that public health care workers deliberately disclosed personal information of injured protesters seeking help in public hospitals to the police force. Such personal information could be used by the police to facilitate immediate arrest and removal of individuals from hospitals to criminal detention centers.

Conversely, there have been sit-in protests among health professionals in major public hospitals in Hong Kong condemning the use of excessive violence toward the protestors by police officers. As such, many police officers are skeptical about whether they will receive proper care from health professionals. There have been sporadic news reports of confrontations between health care workers and police officers in the emergency departments of public hospitals.

Protestors and police officers also have disclosed to their trusted health care providers that they are concerned that their mental health records will be accessed by legal authorities to their disadvantage. Under the Hong Kong Personal Data Privacy Ordinance, personal data will be released to law courts upon receipt of court orders by the public health au-
Implementing mental health relief actions

Formal and informal mental health care support is available to people affected by current social unrest. Volunteer social workers, counselors, psychologists, and doctors are providing acute psychological support to protesters.

As of the writing of this article, there are no data either on the number of or the expertise and professional background of these underground mental health care workers. Nor is there an official number of persons with mental health problems. One report indicates that more than 35% have symptoms suggestive of PTSD. (Hong Kong Economic Journal, November 1, 2019).

Apart from this informal care network, the Federation of Social Services launched a program in October 2019 whereby people with mental health problems are referred to free psychosocial intervention sessions. The available therapies range from traditional Chinese medicine to clinical psychological services. Workshops and talks have been organized to educate relevant stakeholders in managing conflicts arising from political differences in schools, at workplaces, and within families.

In response to the unmet mental health needs among people from different walks of life, the Hong Kong College of Psychiatrists launched a systematic and multi-level mental health initiative, the Care4ALL Programme. Its goal is to promote mental health resilience; knowledge posts, videos, and pamphlets have been created. The objective is to increase knowledge and skills among relevant community stakeholders in early identification and referral of people with mental health problems.

The College has more than 80 volunteer psychiatric fellows who provide psychiatric care at low cost for a limited number of sessions. Through a collaboration with the Division of Clinical Psychology, the Hong Kong Psychological Society and New Life Psychiatric Association, eligible patients receive a number of protocol-driven psychological interventions in parallel with the care offered by the volunteer psychiatrists.

This program provides a new model of mental health care that addresses the usual cost barrier associated with private psychiatric care and concerns of privacy breaches and perceived discrimination by public mental health workers. The program has received widespread media coverage and has been highly regarded by the Food and Health Bureau and Hospital Authority of Hong Kong.

Every cloud has a silver lining

Although there is ongoing political crisis in Hong Kong, many people are confident that the crisis will resolve eventually and bring about fundamental changes in the political and social landscapes. However, the mental health crisis may last for decades and affect the next two generations.

Although severe trauma can lead to stress-related disorders, the course and outcome of stress symptoms are highly variable and largely depend on posttrauma support and care. The College will continue to take an active role in mobilizing mental health capacities in Hong Kong. It will also endeavor to assume an advocacy role to help the government develop social policies and rebuild a strong social network in schools, within families, and in workplaces. The goal is a tolerant and compassionate society that respects and values diversities in all aspects of life.

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2020 Vision

Continued from page 1

and restore 20/20 vision. As in nature, human societies go through cycles, and we have a rich history of stepping up to the challenges of the times and making the healthy, compassionate, and wise changes that unify us all.

So, as we begin this new decade, I would like to submit my wish list, similar to Dr Frances’ list for policy makers, for accomplishments in psychiatry that we potentially could revel in when this next decade come to an end.

My Wish List

1. Increased funding for the necessary basic science, clinical, and social research to raise the standard of care for individuals with mental illnesses.
2. Redistribute the living conditions of the seriously mentally ill from prisons, jails, and living on the street to safe housing, group homes, and supported living settings with, ideally, a meaningful social network (family, friends, and supportive communities).
3. Rapid assessment and diagnosis for individuals with mental status changes with immediate implementation of the best evidence-based treatments.
4. Destigmatization of mental illness, so that a person presenting with acute psychosis is treated as rapidly and carefully as an individual who presents with an acute myocardial infarction.
5. Affordable health care access that is focused on prevention.
6. Continued education about healthy lifestyle adjustments—quality sleep, good nutrition, minimal substance use, safe living conditions, quality food and drinking water, individual-appropriate exercise, social supports, safe work conditions, responsible and realistic gun control reform, antibullying as a societal norm, adequate leisure and family time, teaching our children to learn how to critically think and learn, and self-reflection.
7. A successful decade addressing the substance use disorder crisis in which we currently find ourselves drowning.
8. A healthy partnering of universities, frontline clinicians and clinics, government agencies, the pharmaceutical industry, complementary medical practices, and all individuals collaborating toward the goal of upgrading our health care system so that all of these segments are respected and included in health care planning and implementation.
10. Naming medications by a nomenclature of some variant of the proposed neuroscience-based nomenclature (Nbn). One example would be to replace the word antipsychotic with the more descriptive phrase dopamine-2-receptor antagonist and serotonin receptor modulator.
11. Aggressive innovation into new treatment modalities that have not yet been discovered.
12. Increasing “our kindness and compassion to all, even to those with whom we do not agree, and working toward a common ground of policies that benefit us all.

From myself, and all of us at Psychiatric Times, we wish everyone a happy new year, and a new decade full of accomplishments that continue to move our young field of psychiatry forward toward ever improving mental health.
Family History of Diabetes
Is There an Association With Nonaffective Psychosis?

Brian Miller, MD, PhD, MPH

Longstanding evidence suggests that schizophrenia is associated with type 2 diabetes mellitus (DM2). The research includes maternal and birth studies that identify common risk factors for both conditions, including nulliparity, gestational diabetes, preeclampsia, birth weight, and season of birth. Studies before the advent of antipsychotics showed an increased prevalence of abnormal glucose metabolism in patients with schizophrenia, albeit with methodological limitations. There is also evidence for impaired glucose tolerance and insulin resistance in patients with first-episode psychosis who are either antipsychotic-naïve or have minimal antipsychotic exposure.

These findings suggest that some of the increased risk of DM2 in schizophrenia may be independent of antipsychotic medications and involve host-agent-environment interactions. However, this hypothesis has largely been overshadowed by known metabolic adverse effects of second-generation antipsychotic medications, which increase the risk of DM2.

Methodology
Schizophrenia is associated with an increased risk of the metabolic syndrome, a constellation of metabolic risk factors—including abnormal glucose tolerance—associated with cardiovascular disease morbidity and mortality. In an earlier study, patients with schizophrenia and other nonaffective psychoses (NAP) and a parental history of DM2 were found to have a 3.7-fold increased odds of comorbid DM2 compared with patients without this parental history.

A meta-analysis was undertaken to understand the association between a family history of DM2 and DM2 morbidity in patients with NAP. Studies were identified by systematically searching Medline, PsycInfo, Web of Science, and Science Direct. Nonaffective psychosis was defined to include schizophrenia, schizophreniform disorder, brief psychotic disorder, delusional disorder, schizoaffective disorder, and psychotic disorder not otherwise specified. One hundred thirty-six potential studies were identified; however, most were excluded because of missing family history data about DM2, or because the diagnoses were primarily affective psychosis. Case reports were also excluded. After a detailed review, 10 studies met the inclusion criteria.

Data used included number of subjects with and without a family history of DM2 based on comorbid DM2 status, as well as other clinical and demographic variables. Effect size estimates (odds ratios [ORs] and 95% confidence intervals [95% CIs]) were calculated using the random effects method. Given significant between-study heterogeneity, a sensitivity analysis and a series of meta-regressions to explore possible moderating variables we used to account for heterogeneity (eg, age, sex, geographic region, body mass index, year of publication, study quality).

The total sample consisted of 3780 patients with nonaffective psychoses, including 804 subjects with a family history of DM2 and 2976 without a family history of DM2. A limitation was the heterogeneity in the definition (eg, parents versus any first-degree relative) of what constitutes family history of DM2. For most studies, a family history of DM2 was based on subject self-report. Thus, there is potential for selective recall bias. Data on family psychiatric history were not available for the vast majority of studies, limiting inferences on what proportion of cases of a family history of DM2 might be attributed to psychotropic medication-induced diabetes. However, it is reassuring that the odds of a family history of DM2 in patients with nonaffective psychosis was broadly consistent with findings in the general population. The study did not permit inferences regarding the mechanism(s) of this association, which may be due to shared environmental or genetic risk factors, or gene-environment interactions.

The bottom line
Given the high risk for metabolic syndrome, the association in the study suggests that screening for a family history of DM2 is germane to the clinical care of patients with schizophrenia and other nonaffective psychoses, as it can inform on risk of incident diabetes with antipsychotic treatment. However, it is important to emphasize that patients without a family history of DM2 are also vulnerable to the diabetogenicity of some antipsychotics. Nevertheless, stratifying patients based on DM2 family history status may increase the signal-to-noise ratio of future trials of adjunctive agents for antipsychotic-induced metabolic dysfunction.

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The Opening of the Maudsley Hospital
January 31, 1923

Robert M. Kaplan, MBChB FRANZCP MA, MPhil

In 1907, the eminent psychiatrist Henry Maudsley offered the London County Council £30,000 for the establishment of a new psychiatric hospital to treat acute and voluntary patients with out-patient facilities and teaching/research facilities modelled on German hospitals. Maudsley was an early doyen of British psychiatry whose work was highly regarded. He promoted degeneration theory ad was strongly opposed to women doctors. The intention was for the hospital to treat early cases of psychosis to prevent the condition from becoming intractable and patients having to be sent to country asylums.1

The project was delayed by cost overruns and the onset of World War I, which required the use of the buildings to treat war veterans with shell shock and from August 1919 to October 1920 to treat ex-servicemen suffering from neurasthenia.2 Starting in 1915 as a military hospital, the Maudsley Hospital reopened on January 31, 1923, as a psychiatric hospital with Edward Mapother as medical superintendent.

Mapother, who may have been attracted to psychiatry by the mental illness of his sister, was to be a significant figure in determining the strategic direction, 1923-1939.2 He reports no conflicts of interest concerning the subject matter of this article.3

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Psychiatrists Are Not the Retiring Kind

After reading that 46% of American psychiatrists are over 65 years old.

Richard M. Berlin, MD

The past is prologue riding close behind.
Give up your practice? And do what instead?
Psychiatrists are not the retiring kind!
Fearless explorers of the human mind
With stacks of journals that must be read,
Filled with warnings of what’s close behind.
Assess your options when you’re so inclined.
If life without patients fills you with dread—
Work harder! You’re not the retiring kind!
A career is a tightrope spun from twine,
Thin as the years before you fall dead.
The past is prologue riding close behind.
Go to your office, continue the grind,
Ignore the looming mystery ahead.
Let the wounded become the retiring kind!
You’ve written your notes, a few unsigned,
Each day a search for the decisive thread.
Your past is prologue, arrived right on time,
And alas, dear colleagues, it’s closing time.

Dr Berlin is Instructor in Psychiatry, University of Massachusetts Medical School, Worcester, MA.
solve the cruel paradox that haunts our mental health “nonsystem”—we are massively overtreat-
ing people who do not really need it, while callous-
ly neglecting those who desperately do.

The overall thrust of badly needed policy re-
form must be to correct this wasteful and inhumane misallocation of resources. We should be spending
much less money on long-term medications for the
worried well and for those with mild, transient
problems. Watchful waiting and brief psychother-
apy would be a much better (and cheaper) alterna-
tives for them. And, we should also spend much
less money on misallocated jail, prison, and police
services. In contrast, we must spend much more
money on psychiatric and addiction services to
help patients avoid becoming prisoners or home-
less. The following are my suggestions for policy-
makers in seven key areas.

**Mental illness**

1. The top and urgent priority must be to deinstitutionalize 350,000
mentally ill patients who are now inappropriately warehoused in jails
and prisons and to rehouse 250,000 who are homeless. If we fail to
correct this barbarity, nothing else we succeed in doing really matters.

2. Serious mental illness should be the focus of all publicly funded
psychiatric treatment, social services, and housing—with a full push to
provide universal and easy access to free services for the poor and the
uninsured.

3. A high level and/or high priority mental illness (including addiction)
task force composed of senior representatives from all pertinent
federal agencies should be charged with developing a joint action plan to
provide a nationwide system of community psychiatric, social, and
housing services (along the lines of the Kennedy Community Mental
Health Act of 1963). Legislation should receive urgent priority, speed
through Congress with overwhelming bipartisan support, and be a
feather in the cap of whichever president has the honor of signing it.

4. The funding mechanism should provide strong incentives for states
and local jurisdictions to participate in the planning and
implementation of the new programs and to provide matching funding
over the long haul. Because there are so many stakeholders and moving
parts, it is premature to speculate on precisely how funding would work
and how it would be integrated with, or replace, current funding sources.
It is essential that funding sources be bundled so that psychiatric, social,
and housing services are integrated in seamless, wrap-around fashion.
The chain of care is only as good as its weakest link.

5. Reallocate expenses to address today’s mental health issues. The US
spends about $100 billion on corrections; more than one-third of
which is for people with mental illness, many of whom have
avoided arrest and incarceration had adequate treatment and housing
been available. Ironically and tragically, jails and prisons have become the main
providers of mental health services in the US. Mental illness is also the
most worrying problem facing police officers, whose job has expanded to
be the responsible first responders for untreated and potentially
unpredictable patients.

Moneys saved from reduced expenditures for currently bloated jails,
prisons, police, and emergency services should provide ongoing funding
for community psychiatric, social, and housing services that will replace
them. Deinstitutionalization from psychiatric hospitals failed so miserably
50 years ago, precisely because the large sums of money saved from
closing hospital beds did not follow the patients once they were
discharged into the community. After eliminating prison beds, there must
be an increase in community services and psychiatric beds.

6. Integrated psychiatric, social, and medical services in the community
should include enhanced emergency department (ED) psychiatry;
24-hour crisis teams that replace police first responders; walk-in clinics;
easily accessed long term follow-up treatment; prompt and thorough
medical care; job training; and specialized programs for the most severe
mental disorders. Continuity of care must be emphasized every step of
the way.

7. The number of short-term inpatient psychiatric beds needs to be
increased. Preferably these should be in non-profit, general hospital
settings—and not in free-standing, for-profit private psychiatric hospitals
(which often deliver overpriced and less competent care).

8. Increase the availability of Housing First programs, which are an
essential response to the simple fact that it is impossible to
adequately treat people who have no stable place to live. Homelessness
is rapidly growing in cities throughout the country due to the shortage of
affordable housing and the recent sharp and widespread rise in rents.
The mentally ill constitute more than one third of our homeless
population, now estimated at about 600,000 and are particularly
vulnerable to our national housing crunch.²

Warning note: President Trump recently suggested clearing the streets
of the homeless by forcing them into what would amount to federal
“concentration camps.”² Hopefully, this unconstitutional proposal to
involuntarily incarcerate hundreds of thousands of blameless people was
no more than a transient publicity stunt.

9. Encourage the use of special courts for patients who are mentally ill
and addicted to substances to ensure proper referral of minor
offenders to rehabilitation programs that help remedy the problems that
led to arrest and avoid inappropriate incarceration in jails. Diversion
programs are especially crucial in the interim before easy access to
integrated care protects patients from committing the minor crimes that
currently get them jail time.

10. Integrate psychiatric and medical care with housing programs.
People with severe mental illness usually die prematurely—on
average 20 years before the general population.¹ This is largely a function
of psychiatric, medical, and social neglect and can be improved only by
increasing access to integrated care.

11. Increase the availability and use of vocational and job placement
programs, both of which can be great investments for the individual
as well as the economy. Work is often the best therapy.

12. Tighten quality control and financial audits to ensure good care and
value for money spent. Currently, there is the potential for waste
and mismanagement in psychiatric and addiction programs—particularly
in the private system where the profit motive may drive more decisions
than optimum care.

High standards must be set for allowable billings and accountable
reatment. It is especially important to monitor easy access to care and
continuity of care (eg, by auditing number of days before first outpatient
appointment after an ED visit or hospital discharge).

13. Encourage assisted outpatient treatment, which reduces
incarceration, homelessness, relapse, suicide, and violence. The
coercion of court-mandated psychiatric treatment is ever so much
gentler and more temporary than the cruel and extended coercion of jail
or homelessness.

14. Loosen confidentiality laws in the emergency and long-term
management of serious mental illness. Although appropriate in
other medical settings, strict laws can be detrimental in this setting.
Family support and participation in decision making is needed to help
patients whose judgment may be impaired. Laws must balance the value
of confidentiality against the need for clinical common sense.

15. Temper the enthusiasm for universal screening for psychiatric
disorders. This is a tembile idea in the general population, although
it is extremely popular. The harms done (eg, overdiagnosis, excess
medication, stigma, misallocation of scarce resources away from the
severely ill) far outweigh the benefits. In contrast, screening in high-risk
groups has a very good benefit-to-risk ratio (eg, mothers perinatally,
victims of extreme stress, high risk families).
Addiction

It is past time to stop fighting the long-lost supply side “war against drugs.” Instead, it is time to reduce demand by providing adequate treatment and prevention. All attempts at interdiction and prohibition have failed in the past and will always fail in the future. Where there is a strong will to get drugs, a clever way will be found to provide them.

Adopt harm reduction models—this is the only rational approach for street drugs. Fentanyl is an irrevocable game changer. There has never been a time when illegal street drugs have been so ridiculously cheap, lethally potent, varied, and convenient to smuggle and distribute. By a combination of design and accidental contamination, illegal fentanyl now has become almost ubiquitous in street drugs and counterfeits. In just 6 years, it has grown from minor threat to disaster drug—responsible for almost half of all the exponentially growing overdose deaths.6 Current drug policy is impotent to stop, or even limit, the rush toward fentanyl death and destruction.

Free market competition, not interdiction, is the best way to defeat cartels and reduce drug crime. Legalizing drugs (Table) should be seen both as a safety measure for the users and an economic weapon against the cartels—not a revenue-raiser for states. For legalization to work, legalized drugs must be priced low enough to compete successfully against street drugs. Legalization can help states save big money on corrections; it becomes self-defeating if it also is used as a tax opportunity.

Get rid of the one-size-fits-all notion in treating drug addiction. Puritanical abstinence ideology should not be an exclusive guide to policy. The previous (morality-driven) emphasis on 12-step abstinence has created a great shortage of harm reduction programs using medically assisted treatment. Paradoxically and stupidly, government inaction in regulating the overuse of prescription drugs facilitated the opioid epidemic, while excessive government restrictions prevented the widespread use of the very medications (eg, suboxone) needed to reduce impairment and deaths. Abstinence is possible for some, an aspirational goal for many, but not a foundation for sensible drug policy.

Take control of the vaping crisis. The e-cigarette epidemic among young teenagers (started via candy-flavored nicotine products) has already become a gateway to the vaping of much more dangerous pot synthetics. The next logical step in this dangerous progression may be the lethal vaping of hard street drugs. We must hope that this cat is not already out of the bag.

Unscrupulous vaping companies must be sued and fined; schools need to regain control of their bathrooms; and well-funded public education campaigns should make vaping as uncool as smoking. Drug prevention has never been very successful in the past, but it has never been tried on the same massive scale that worked in making smoking tobacco a dirty habit rather than a rite of passage to adulthood.

It is crucial that opioid money awarded to state and local jurisdictions be used exclusively to fund addiction programs. There will be massive fines and settlements (my guess about $100 billion) imposed on the drug companies, distributors, and retailers that knowingly promoted the opioid epidemic. The tobacco settlement money (more than twice as much) never found its way to the victims, as states instead used it to reduce taxes or fund other programs (notably prisons).

We must not allow political and commercial foaxes to guard the public health henhouse. Regulatory capture by industry contributed greatly to the damage done by the tobacco, opioid, and vaping epemics. The FDA is 45% financed by the drug industry.7 Its staff and leadership may have a much-too-intimate, revolving door relationship with it.

The FDA’s independence and monitoring authority has also been steadily eroded by political pressure and Congressional statute. The Drug Enforcement Agency was a toothless tiger in controlling the prescription opioid epidemic because its leadership was subservient to industry.8

### Table. Benefits of legalizing and regulating street drugs

<table>
<thead>
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<th>Benefits</th>
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<tr>
<td>Increased purity, predictability, and safety of the drugs</td>
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<tr>
<td>Decreased dangers of overdose death</td>
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<tr>
<td>Decreased medical complications and cost</td>
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<tr>
<td>Decreased power of cartels and related crime</td>
</tr>
<tr>
<td>Decreased costs and harms of imprisonment</td>
</tr>
<tr>
<td>Increased funds for treatment come from money saved from correctional institutions</td>
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Gun control

Don’t forget the basic fact: guns kill people. The US has a remarkably high rate of gun death compared with peer countries. Each year guns are responsible for about 24,000 deaths by suicide, 15,000 deaths by homicide, 1000 deaths by accident, and an additional 70,000 non-lethal gun injuries. We do not have higher rates of mental illness than peer countries, but we do have remarkably lax gun regulation and 400 million guns in circulation.6

Red flag laws that restrict gun access for people with severe and persistent mental illness or addictions make great clinical and policy sense, particularly in reducing deaths by suicide. However, such laws will not come close to solving America’s gun violence problem because only a tiny percentage of murders are committed by people with mentally ill illness (who are much more likely to be victims of gun violence than perpetrators).

Be wary of the National Rifle Association’s political support for better mental health care, which is a great good being done for a great evil. The NRA is attempting to distract attention from desperately needed gun control laws with the absurd and stigmatizing claim that most people who misuse guns are mentally ill.

Mental health advocates are understandably delighted to exploit powerful NRA political support for more mental health services. But we must not be deterred from simultaneously continuing the fight for desperately needed gun control. America would still have terrible gun violence statistics even if we could suddenly cure everyone with a mental illness. We need both much improved mental health services and better gun control laws.
Reducing over-treatment

29 Direct to consumer marketing of pharmaceuticals needs more oversight. The US is the only country in the world (aside from New Zealand) that allows direct-to-consumer advertising. This privilege has been abused and should be eliminated. Rules governing marketing to doctors should be tightened. The public needs to learn that a pill for every problem does not exist.

30 Ensure a separation of church and state—industry and the FDA. There is a revolving door that creates an inherent pro-pharma bias—FDA leadership and staff are often recruited from industry and return to it. The result—ineffective, unsafe, and expensive new drugs are almost never rejected and, once approved, drugs are inadequately monitored for harm or not monitored at all. The only way to protect patients and taxpayers is to restore complete FDA independence from industry and political influence.

31 Ensure proper training of other specialties. Primary care doctors now prescribe 80% of all psychiatric medications—often after very brief visits for patients who do not need them. They would prescribe fewer unnecessary medications if they had more time to talk to their patients. Most of the emotional problems mistreated with medications may be better handled with advice, support, and watchful waiting.

32 Remove the diagnostic requirement for insurance coverage. Insurance companies require doctors to jump to premature diagnosis and treatment as the precondition for reimbursement. Instead, allowing for an extended period of evaluation would result in much more careful diagnostic and prescribing habits and less long-term use of unnecessary medications.

33 Deprescribing should be extensively taught during medical school and residency training as well as continuing medical education. Physician training includes extensive teaching on how to prescribe drugs and almost no teaching on how to deprescribe them. This is backwards—prescribing is fairly easy to learn and requires relatively little skill. Deprescribing is complicated and requires the finest clinical judgement.

34 There is an urgent need for unified medical care, which is essential and generally lacking. The more doctors a patient has, the more medications will be prescribed—particularly when each doctor neither knows nor cares what the others are doing. Medication adverse effects are the most common cause of new symptoms in someone taking multiple drugs, particularly common among the elderly, who clear and metabolize drugs much more slowly.

35 Make brief psychotherapy easily accessible. Psychotherapy is preferable to medications for most mild to moderate psychiatric problems. It is just as effective, much safer, and with an enduring positive impact. The misleading mantra that psychiatric problems all result from a chemical imbalance and therefore everyone requires a chemical cure is misleading.

Research

36 Research budgets should be rebalanced to provide adequate funding for projects that contribute practical findings to improve people’s lives—even if they do not further scientific understanding of brain or gene functioning. The massive budgets of the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism are focused on brain mechanisms—not on clinical and services research.

Not surprisingly, we have learned a great deal about brain function and genetics, which has very little value in helping patients. The past 30 years of intense research and fascinating discovery has made it abundantly clear that the brain and genetics are far too complex to yield any simple answers or breakthrough cures. We must reduce patient suffering now, not wait for promised breakthroughs that never happen.

37 Top priority should be given to research studies and demonstration projects that reduce the incarceration and homelessness of people with serious mental illness and addiction. Public health significance, not just scientific interest, should be an important factor in selecting which projects are funded.

38 Keep in mind that there is an enterprise-wide bias hype positive results, ignore negative studies, and neglect to replicate study results. This distortion leads to tried-and-true treatments for mentally ill patients to be overlooked while the untried and untrue are prematurely promoted.

Advocacy

39 Advocacy has failed in the past and, unless radically changed, is likely to continue to fail in the future. We are the richest country in the world, but we shamelessly and barbarically neglect our most vulnerable citizens in a way that would not be tolerated in any of our peer countries. Politicians respond only to money, votes, and public shame—patients with serious mental illness and addiction are often poor, don’t or can’t vote, and have no public voice.

40 Our current crisis makes this a potential moment of rare opportunity—don’t waste it. The armies of homeless living desperate lives in plain sight in most major cities are impossible to ignore. The “not in my neighborhood” reflex against treatment programs and housing becomes much less powerful when the homeless are already in your neighborhood.

The opioid crisis, that afflicts millions, and kills tens of thousands every year, is also impossible to ignore. The push for correctional reform occasioned by frequent police shootings and the prison crisis have made police officers and sheriffs the most effective advocates for better services and housing for those suffering from serious mental illness and addiction.

41 Remember that mental illness and addiction strike families indiscriminately across the political divide. This is one issue that can and should achieve universal bipartisan political support.

Concluding thoughts

I would love to end on an uplifting “Yes we can” inspirational note. But the past 60 years of neglect would make it ring hollow. Our best (only) hope is that the most concerted efforts, occurring in what is now the most inescapably desperate context, will end the complicity and achieve what has heretofore been impossible: at long last, to force our country to do the simple and right thing, which also happens to be the smart thing.

Dr Frances is Professor Emeritus and former Chair, Department of Psychiatry, Duke University; Chair, DSM-V Task Force. He is the author of Saving Normal and Essentials of Psychiatric Diagnosis. Twitter: @AllenFrancesMD. The views expressed in this article are those of the author and do not necessarily reflect the opinions of Psychiatric Times.

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CLIMATE CHANGE

Disaster Response, Mental Health, and Community Resilience

Josef I. Ruzek, PhD

The increase in repeated disasters and associated social stressors linked to global warming is likely to affect the mental wellbeing of billions of persons in the 21st century, increasing risk for depression, anxiety, PTSD, anger and violence, social disruption and displacement, and social conflict. This means that our current conceptual frame of disaster response will be too narrow to address the many problems created and exacerbated by climate change—disaster mental health no longer should remain the sole model guiding our preparation and response. We need an expanded view that encompasses diverse responses to match a greatly expanded set of threats.

The importance of strengthening disaster mental health response system

Disaster mental health response in the US commonly includes a stepped care system that includes community outreach and delivery of psychological first aid (PFA), crisis counseling, and, for those most greatly affected, formal treatment. The brief education and support included in PFA is offered to as much of the affected population as possible, with more intensive services made available for those at greatest risk for problems. Brief crisis counseling programs offer support and, increasingly, teach skillsets to improve coping (eg, problem-solving, relaxation, positive activity scheduling).

Most communities only develop the ability to implement these disaster response elements after they find themselves affected by a disaster. Prior to such emergent need, these services seem relatively optional and have not, to date, been able to compete with other political priorities. As a result, they do not attract significant organizational focus and allocation of resources. Moreover, after external funding goes away, the various organizational structures used to respond often disappear. If we are to improve our ability to respond to repeated events, an effort to transform acute response systems into enduring, sustainable programs is needed. Given the heightened awareness of disaster in the face of climate change, greater levels of preparation are needed for responding to mental health requirements as well as a way to sustain the capacities developed in response to specific disasters for ongoing use in future events.

The problems created by global warming (including recurrent disasters) are multifaceted. The all-hazard community-based resources and capabilities will enable more effective action in the face of climate-induced problems and will also spill over into the many challenges already troubling our communities (eg, family problems, work stress, drug addiction, suicide). In this sense, actions to increase climate change resilience tie in with other existing programs and services for social problems and life improvement.

Towards resilient communities: some components of a more adequate response

Improving disaster mental health programs will not be adequate to meet upcoming challenges. Rather, these programs will need to be supplemented by novel initiatives and combined into an integrated program of community support and resilience. They will require creativity and significant contributions from many quarters.

Coping skills training and support. Individuals who have effective coping and management skills will more successfully manage their experiences of disaster and climate-related stressors.

Individuals who have effective coping and management skills will more successfully manage their experiences of disaster and climate-related stressors.

Findings from research suggest that internet-facilitated interventions can be effective in addressing a range of mental health problems especially when supplemented by human support. Mental health apps such as Calm and PTSD Coach are widely used and can reach large numbers of individuals; similar approaches are being harnessed for disaster response. For example, the Sonoma County Wildfire Collaborative deployed MySonomaStrong, an internet-based self-management tool (MySonomaStrong.com) and a mental heath app (SonomaRises).

Another strategy for strengthening effective coping and spreading key skills is to expand training for health care professionals as well as lay community members on effective coping and crisis counseling. Primary and acute care medical clinicians can provide disaster response and critical incident stress management.

In addition, trained laypersons can be deployed to support community caregivers in disaster response. However, the capacity to train laypersons and paraprofessionals in delivery of effective interventions to address such adversity must be developed. This involves identifying effective interventions and training mental health professionals who will then train a large cadre of lay community members in these interventions.

Capacity to supervise trainees and...
administer training programs also would need to be established. While there are many evidence-based treat-
ments for mental health problems, there continues to be a large gap be-
tween routine care and best practices, because of limited availability of
trained providers. Expansion of ac-
tess to training would help spread
coping skills among disaster- and
climate-affected populations while
also increasing access to effective
treatments in many mental health and
social service settings.

Beyond psychological coping: actions for climate solutions. While a focus on
coping and emotional wellbeing is
necessary, it is also critical that direct
actions to address the realities of cli-
mate change and mitigate its effects
are undertaken as part of community
response. In fact, involvement in ac-
tivities intended to reduce global
warming and address proximal cli-
mate problems is likely to bring di-
rect psychological benefits, in addi-
tion to creating a safer and sustainable
local environment.

“The expanded threats call for
new kinds of interdisciplinary
collaboration.”

Cumulative exposure to media
coverage of the impacts of climate
change compound stress responses
via increases in perceived threat to
our environment and our wellbeing.
Already observable are increases in
“eco-anxiety” as we worry about the
future for ourselves, our children,
and future generations. Adoption of
behavioral changes (eg, use of public
transportation, development of green
spaces, adoption of clean energy
technologies), efforts to take on
problems that exacerbate the effects
of climate change (eg, poverty, inequal-
ity), and participation in political ac-
tions to address climate change can
help reduce stress and anxiety associ-
ated with a climate change. Making
such changes can build confidence in
one’s ability to cope (self-efficacy)
and help reduce distressing thoughts
and beliefs.

Self-efficacy can be expected to
increase when individuals take prac-
tical actions to address aspects of a
problem (eg, develop family emer-
gency plans, participate in activities
of the climate change movement,
practice energy-conserving personal
behaviors). Some climate-related ac-
tions, such as increasing commuting
via bicycle and walking, are likely to
reduce stress by increasing cardio-
vascular health and reducing physi-
tical tension. Increasing recreation
and work in green spaces might reduce
personal stress levels while at the
same time increasing positive social
interactions. Increased use of public
transportation might increase percep-
tions of community cohesion. If in-
dividuals increase their engagement
in such activities, it will help transform
the negative thinking associated with
worry about environmental problems
into effective action, building hope
and resilience in place of anxiety
and depression, fatigue and despair.

Community-based readiness and
sense of community. Over time, glob-
al warming is likely to increase social
relationship stress, substance abuse,
interpersonal aggression, violent
crime, and social instability, the com-
bined effects of which are likely to
decrease community cohesion and,
potentially, divide the global commu-
nity. While social cohesion and so-
cial capital are thought to protect
communities against mental and
physical health impacts of disasters,
it is not clear how to rapidly or reli-
ably build these. However, even in
the face of limited knowledge, it
seems prudent to invest in and ex-
pand community mental health infra-
structures; take steps to reduce dis-
parities in resources and increase
supports for vulnerable subgroups;
strengthend capabilities for public
mental health communication related
to disasters and emergency incidents
along with capacities to harness so-
cial media in the service of wellbe-
ing; develop and strengthen pre-
paredness planning; and establish
and develop online communities for
mutual support.

In addition to these specialized
community-wide mental health ac-
tivities, some more general initia-
tives will improve the wellbeing of
community members. One key step is
to increase the availability and use
of public transportation, which in turn
can be expected to increase commu-
nity cohesion, recreational activities,
neighborhood walkability, and physi-
cal exercise, all of which are likely to
reduce symptoms of depression and
stress. A second step is to increase
the availability of contact with na-
ture. More time spent interacting
with nature can improve health and
lower stress via several mechanisms
including exposure to better airqual-
ity, increased exercise, the calming
effects of natural environments, and
increased social cohesion. Increased
familiarity with nature might also help
to create commitment to environmen-
tally positive behaviors and actions
to reduce global warming.

Collaboration and commu-
nity: toward resilient commu-
nities. Critical to a comprehensive response
to climate change is bringing togeth-
er climate activists, health care orga-
nizations, local government, self-
help groups, educational institutions,
business groups, and technology pro-
vokers, to create a sustainable focus
on these issues. Such a “big tent” ap-
proach is needed to ensure commu-
ity buy-in and enable the kind of
multidisciplinary expertise required
for the various tasks.

Existing institutional structures
may create barriers to needed col-
laboration. The various scopes of
practice of disaster response person-
nel may make it difficult to jump the
corridors of professional identity.

The institutions in which mental
health professionals work might have
difficulty in expanding their missions
to encompass the broader sets of ac-

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A Case of the Chicken or the Egg: Social Media, GAD, & Substance Use

Dr Howard: In our study, we found that individuals with GAD were more likely to make upward social comparisons. This is not surprising, since research has shown that when individuals perceive themselves as worse off than others through these upward social comparisons, their response often increases negative affect. Individuals with GAD commonly exhibit symptoms of excessive worry, and they often ruminate. What is unfortunate about social comparisons on social media is that these images are often enhanced and unrealistic.

Dr Ceballos: We were not too surprised to see an association between GAD and posting on social media while drinking alcohol. Anxiety disorders and alcohol misuse are often comorbid, and findings from previous research suggest that merely being on social media actually causing harm.

To examine its impact, Texas State University researchers conducted a study of 1314 adults who reported actively using social media. Their goal was to identify specific social media behaviors related to generalized anxiety disorder (GAD). Psychiatric Times invited two of the authors, Krista Howard, PhD, and Natalie Ceballos, PhD, to reflect on their work.

Psychiatric Times (PT): Your study found that two social media behaviors were associated with GAD. Would you tell our readers about those?

Dr Howard: Different mental health disorders can predispose individuals to be more susceptible to making upward social comparisons, which can exacerbate their symptoms. But there is no evidence that making upward social comparisons causes depression or anxiety disorders. Various social media platforms are known for impression management, that is, presenting yourself in the best possible way via filters and photoshop applications. And while users know these pictures may not be credible, they still have the tendency to compare themselves with these unrealistic images.

Dr Ceballos: In terms of the association between alcohol use and anxiety, it is a bit of a vicious cycle. Much like some anxiolytic medications, alcohol acts as a sedative on the nervous system. So at least acutely, it can make people feel more relaxed, and this can be a desirable effect, especially for someone with an anxiety disorder. Unfortunately, some studies suggest that chronic alcohol misuse may change the nervous system, making it more difficult for someone to cope with anxiety in the future.

PT: Is this a chicken versus egg situation? Are patients with GAD more likely to have issues with those behaviors, or do you think those behaviors cause or exacerbate anxiety?

Dr Howard: There are a few possible reasons for these different results. First, alcohol and marijuana act through different pharmacological mechanisms, and compared to marijuana, alcohol’s mechanism of action tends to more closely resemble that of anxiolytic medications. So, it is possible that alcohol (to a greater extent than marijuana) may have differentially decreased anxiety among GAD participants, leading to a decrease in inhibition that made using social media more enjoyable for them.

Also, while some people may use marijuana for relaxation purposes, it is important to note that, depending on the strain that is used, the tetrahydrocannabinol (THC) content (or ratio of THC to cannabidiol), and other individual vulnerability factors, marijuana could have the opposite effect—increasing anxiety or paranoia in some users.

Finally, compared with marijuana, alcohol was much more likely to have been legally available for many of our participants, and this might have contributed to its more significant associations in our study.

PT: Can you comment on these behaviors outside of social media? In other words, do patients with GAD generally have issues with the “comparison” factor and alcohol use?

Dr Howard: Individuals with GAD experience a variety of symptoms, including restlessness, worry, and sleep disturbance, and many tend to ruminate. Social comparisons, both online and offline, are very likely to influence these symptoms in individuals with GAD. Social Comparison Theory was developed in the 1950s and has been studied extensively, particularly in relation to self-esteem. It really depends on the individual and what he or she is worrying about. For some, social comparisons may greatly influence their symptoms, and for others it may not.

Dr Ceballos: In our study of 1314 adults who reported anxiety in the future.

PT: What are the clinical implications of this research?

Dr Howard: We are conducting an experiment to assess for physiological reactivity (cardiovascular and salivary cortisol) responses to anxiety-provoking social media stimuli. Essentially, we are seeking to see if certain types of social media posts can cause a physiological stress response. We know that long-term exposures to stress can reduce immune functioning and increase cardiovascular problems. Can social media make us sick?

Dr Ceballos: Is Associate Professor of Psychology and Dr Ceballos is Professor of Psychology, Texas State University-San Marcos. They report no conflicts of interest concerning the subject matter of this article.

REFERENCE
Management of Treatment Resistant Depression in the Elderly: Clinical Assessment and Treatment Strategies

Fred Liu, MD, and Awais Aftab, MD

ACTIVITY GOAL
The goal of this activity is to provide an understanding of treatment-resistant depression (TRD) in elderly patients.

LEARNING OBJECTIVES
After engaging with the content of this CME activity, you should be better prepared to:

• Differentiate the presentation of TRD in older patients
• Describe medical comorbidities in older patients with TRD
• Explain treatment strategies for elderly patients with TRD: switching versus augmentation
• Describe FDA-approved pharmacological agents for treating depression and TRD

TARGET AUDIENCE
This continuing medical education (CME) 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.

ACCREDITATION/CREDIT DESIGNATION/FINANCIAL SUPPORT
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership Physicians’ Education Resource®, LLC and Psychiatric Times. Physicians’ Education Resource®, LLC is accredited by the ACCME to provide continuing medical education for physicians. Physicians’ Education Resource®, LLC designates this enduring material for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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mong adults aged more than 55 years, the prevalence of major depressive disorder is about 2% globally overall with up to 10% to 20% of all older adults suffering from a clinically significant depressive syndrome; the prevalence is higher among patients in hospitals and nursing homes who are older than 85.1 Unprevalence is higher among patients in hospitals clinically significant depressive syndrome; the increased morbidity and mortality, increased use of A treatment refractory depression can lead to a variety of negative outcomes such as functional impairment, increased risk of a neurocognitive disorder, increased morbidity and mortality, increased use of illicit substances and alcohol, more hospitalizations, and higher rates of suicide. Moreover, many depressed elderly patients will not respond to first-line pharmacological therapy and will need a switch to another agent or will need to have treatment augmentation (Figure 1).

Defining depression
Despite the high incidence of treatment-resistant depression (TRD), there is no universally agreed upon definition for it; a common definition is “an inadequate response to at least two antidepressant trials of adequate dose and duration.” Another construct is treatment refractory depression (TremD), which is sometimes used synonymously with TRD and sometimes refers only to highly resistant forms of depression that have not responded to numerous interventions.

A categorical definition of treatment resistance may be devoid of validity. This has resulted in a focus on staging and levels of resistance, as well as an alternative notion of “difficult to treat” depression, which may fit better with the recurrent and chronic nature of the illness.

Furthermore, aside from specific cases such as vascular depression where MRI can detect subcortical white matter hyperintensities (Figure 2), there remains no validated biological marker for depression in clinical use for the diagnosis and treatment of TRD. Rating scales such as the Geriatric Depression Scale (GDS), the Patient Health Questionnaire (PHQ-9), and the Hamilton Depression Rating Scale (HRSD) can be clinically helpful in identifying and monitoring treatment progress.

Special concerns in the elderly
An important consideration in assessment of late-
life depression is to distinguish late-onset depression, in which depressive disorder is experienced for the first time in later life, from early-onset depression, in which depression symptoms are the continuation of a depressive illness that started earlier in life. This distinction is clinically important because late-onset depression frequently develops in the context of medical morbidity, such as heart disease/stroke (vascular etiology), dementia (neurodegenerative illness), or multimorbidity and chronic inflammation.

Vascular depression is a subtype of late-life depression, especially late-onset, characterized by a distinct clinical presentation and an association with cerebrovascular damage, with MRI findings of extensive white matter hyperintensities, subcortical microvascular lesions, lacunes, and microinfarcts. Depression in elderly patients may not present with a straightforward textbook presentation (Figure 3). There can be a myriad of atypical symptoms such as memory problems, physical symptoms (eg, fatigue, weight loss, pain), and behavioral symptoms (eg, social withdrawal, difficulty with self-care, refusal to eat or drink).

Major neurocognitive disorder (MND) in its early stages can present predominantly with depressive symptoms. There is a 10% to 30% prevalence of depressive symptoms in elderly patients with Alzheimer disease. Even with appropriate treatment, patients with MND may be mistakenly labeled as having TRD because of ongoing psychomotor retardation, sleep problems, and cognitive impairments. Thus, a low threshold for suspecting an underlying MND is recommended in depressed elderly patients.

General medical illness also can contribute to affective disorders in elderly patients. Treating the medical illness is an integral part in treating depression in these patients (Figure 4).

Examples of medical comorbidities recognized as being associated with a higher risk of depression include endocrinologic disorders such as hypothyroidism and Cushing syndrome as well as neurological disorders (eg, stroke, heart disease, arthritis, pancreatic carcinoma and other cancers, connective tissue disorders, vitamin deficiencies, and viral infections).

Vitamin B12 and folate deficiency may increase the risk of depression; moreover, this deficiency has been linked to poor antidepressant responses. Nevertheless, vitamin deficiencies are often underestimated, and there are no clear clinical guidelines regarding screening for vitamin deficiencies in MDD. Medications such as steroids, sedatives, and immunosuppressants may play a role in depression and must also be considered in the elderly patient.

Elderly patients with depression are more likely to have psychotic symptoms that may be severe enough to require hospitalization. In these cases, treatment involves the use of antipsychotics in addition to antidepressants. However, in milder cases, symptom remission may occur with antidepressants alone. Flint and colleagues examined maintenance treatment for psychotic depression (mean age=55). Their findings indicate long-term treatment with olanzapine and sertraline was more effective for relapse prevention than sertraline or placebo.

The prevalence of substance and alcohol misuse in the elderly is surprisingly high and should not be overlooked. Depressive symptoms are unlikely to respond to treatment in the presence of an active substance or alcohol use disorder.

**Treatment considerations**

The inability to tolerate an antidepressant due to adverse effects that leads to nonadherence may be mistaken clinically as treatment-resistance. Nonadherence and difficulty tolerating medications can lead to worse treatment outcomes in the depressed elderly patient.

The choice of initial antidepressant therapy has a bearing on treatment tolerance and adherence. Tricyclic antidepressants (TCAs) are strong anticholinergic agents. Paroxetine should be carefully utilized because of its anticholinergic effects and medication interactions via inhibition of the cytochrome P450 system. Caution is also warranted with fluoxetine because of its long half-life, active metabolites and its inhibition of the cytochrome P450 system.

The typical duration for an adequate trial of antidepressant is typically 6 to 8 weeks in adults. However, elderly patients may require a longer duration of treatment to achieve adequate response, upwards of 8, 10, or 12 weeks. Treatment response may be slower in some elderly, thus they will need longer antidepressant trials.

After appropriate diagnosis and assessment of special considerations in the elderly patient, treat-
ment decisions need to be made. Interventions can be pharmacological, nonpharmacological, or a combination of both.

**Psychopharmacology**

There is some evidence that in geriatric TRD, switching from a selective serotonin reuptake inhibitors to venlafaxine or duloxetine (serotonin–norepinephrine reuptake inhibitor) may lead to response or remission.54 Clinical experience also supports the use of bupropion, mirtazapine, and other atypical antidepressants such as vortioxetine and vilazodone, although evidence specific to late-life TRD is lacking.

Seleglide has also shown efficacy in a study of older adults with TRD, and it was well tolerated at high doses (eg, 60 mg/d). In another study that included older patients, monoamine oxidase inhibitors (MAOIs) were shown to be more effective than tricyclic antidepressants (TCAs) in early stage TRD.7 There are several FDA-approved antipsychotics that can be used as augmentation therapy for patients with TRD or inadequate response to first-line antidepressants. FDA-approved antipsychotics include olanzapine (in conjunction with fluoxetine, quetiapine, aripiprazole, and brexpiprazole. Other atypical antipsychotics such as risperidone and ziprasidone also have some evidence of efficacy but are not FDA approved. Among the atypical antipsychotics, aripiprazole augmentation has perhaps the best evidence for use in the elderly population and has the most data that supports its efficacy and safety. Lenze and colleagues5 under-took a study of aripiprazole augmentation in adults aged 60 years or older who had not achieved remission from depression with a first-line antidepressant: 44% experienced remission with aripiprazole augmentation compared to 29% with placebo.

Lithium augmentation is an effective but underutilized strategy for TRD in elderly patients. An open, randomized controlled trial compared lithium augmentation to phenelzine in 29 elderly inpatients with TRD.55 Symptom remission, measured by a MADRS score of less than or equal to 10, was seen in 33.3% of the patients who received lithium; no symptoms remission seen in the patients who received phenelzine.

Findings from a recent study showed a response rate of 68% in elderly patients (improvement in depressive symptoms by at least 50%) treated with lithium augmentation.56 It is interesting to note that elderly patients were twice as likely to achieving a response compared with younger patients.

The use of triiodothyronine (T3) is an evidence-based augmentation strategy for depression, which has been shown to be beneficial in multiple randomized clinical trials. In the STAR*D study, which included elderly patients with TRD, T3 augmentation up to 50 mcg daily led to remission rates of 24.7% compared with 15.9% with lithium augmentation. Moreover, T3 was better tolerated than lithium.57 Although not beneficial on its own, augmentation with methylphenidate has some evidence to support its use in the treatment of depression in elderly patients. In a 16-week randomized double-blind placebo-controlled trial on geriatric depression in 143 outpatients, methylphenidate (5-40 mg) augmentation to citalopram (20-60 mg) had greater efficacy in treating depression than either citalopram or methylphenidate alone.58

In research studies, intravenous ketamine shows a rapid reduction in depressive symptoms with effects peaking at 24 hours, and usually lasting up to a week.59 The FDA recently approved the use of intranasal esketamine (S+ enantiomer of ketamine) for adults with TRD when used in conjunction with an oral antidepressant.

A 4-week, randomized, double-blind study conducted specifically in elderly patients with TRD compared flexibly-dosed intranasal esketamine plus a newly initiated oral antidepressant with placebo and an antidepressant.60 The results showed no statistically significant difference between the two groups on the primary efficacy endpoint at week 4. However, in a subgroup analysis restricted to US patients, significant improvement in MADRS total scores was seen with intranasal esketamine. More research is needed to determine the relative efficacy and safety of various formulations of ketamine in the elderly population.

There are indications that memantine has no effect on depression.61,62 On the other hand, omega-3 fatty acids may have some benefit for elderly patients with mild to moderate depression.63 Other possible treatments for TRD include the use of antimuscarnic agents (such as scopolamine), anti-inflammatory agents, and psychedelics such as psilocybin, but more research is needed for their use in general as well as in the elderly patient. L-methylfolate has also emerged as a promising treatment for SSRI-resistant major depression in adults, but remains to be studied specifically in late-life TRD.

In a 3-year study of late-life patients with TRD, 81 patients were treated sequentially with a variety of different interventions, such as venlafaxine/nortriptyline, lithium, monoamine oxidase inhibitor, TCA, and ECT. At the end of this sequential study, 78 of the 81 patients (96.3%) had achieved response and 68 patients (84%) achieved remission within the 3 years of observation. In the 68 patients who had symptom remission, the mean time to remission was 27.3 weeks. This study demonstrates the clinical utility of sequential, stepped treatments—with time and continued treatment favorable results can be expected for most patients (Figure 5).65

**Nonpharmacological interventions**

Overall, the research on the efficacy of psychotherapy for elderly patients with TRD is limited; however, it is reasonable and highly recommended to utilize this as part of the treatment plan for TRD (Figure 6). Various psychotherapy modalities such as problem-solving therapy, cognitive behavioral therapy (CBT), and interpersonal psychotherapy have been shown to be effective for late-life depression, especially CBT which is the best studied.66 Psychotherapeutic interventions have a large antidepressant effect size among older patients compared with control groups (Hedges g 0.64, 95% CI, 0.47-0.80; NNT of 3), which sug-
suggests many treatment-resistant depressed elderly patients may benefit from these interventions. Repetitive transcranial magnetic stimulation (rTMS) has been approved for the treatment of TRD in adults, although there are only a few studies specific to elderly patients. Some findings suggest response rates of up to 58.5% while others have shown either no benefit or diminishing treat-ment response with increasing age. A recent study showed a response rate of 40% in elderly patients with TRD with bilateral TMS compared with unilateral and sham treatments with good tolerability and few drop-outs.

ECT is considered the most effective treatment for MDD and TRD with remission rates of 75% and 50%, respectively. In fact, the response rate in elderly patients may be even better than that in younger patients, although it may take longer for the elderly patient to respond to treatment. Findings suggest that 78% of elderly patients with TRD treated with ECT have at least a 50% reduction in symptoms; more than 60% of participants meet criteria for remission. Patients who benefit from ECT include elderly patients with psychotic symptoms and TRD. It was noted that a higher number of psychotic symptoms was associated with better response.

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**Conclusion**

TRD is often clinically defined as failure to re-ss many treatment-resistant depressed elderly patients may benefit from these interventions. Repetitive transcranial magnetic stimulation (rTMS) has been approved for the treatment of TRD in adults, although there are only a few studies specific to elderly patients. Some findings suggest response rates of up to 58.5% while others have shown either no benefit or diminishing treat-ment response with increasing age. A recent study showed a response rate of 40% in elderly patients with TRD with bilateral TMS compared with unilateral and sham treatments with good tolerability and few drop-outs.

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**Conclusion**

TRD is often clinically defined as failure to re-
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Evan.Feibusch@doh.nj.gov  |  609.438.4158
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- Backup for our Emergency Services
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